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The Mental Health of Male Victims and Their Children Affected by Legal and Administrative Partner Aggression

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The authors recently developed a psychometrically valid measure of legal and administrative (LA) intimate partner violence (IPV) victimization (Hines, Douglas, & Berger, 2014). The current article explores the impact of actual and threatened LA aggression on the mental health of male physical IPV victims and their children. In the current study, a sample of 611 men who sought help after experiencing physical IPV from their female partners completed a survey assessing the types and extent of IPV that occurred in their relationship, including LA aggression, their own mental health outcomes, and the mental health of their oldest child. A series of OLS regressions indicated that after controlling for covariates, actual LA aggression was associated with more symptoms of PTSD and depression in male victims, and that both threatened and actual LA aggression were associated with higher levels of affective and oppositional defiant symptoms in the men's school age children. The current findings suggest that it is important to screen couples for the presence of LA aggression and male partners and their children should be referred for mental health treatment if LA aggression is occurring in the relationship. Aggr. Behav. 9999:1–16, 2015. **© 2015 Wiley Periodicals, Inc.**

Keywords: partner violence; male victims; legal abuse; domestic violence; children's mental health; children's exposure to partner violence

INTRODUCTION

Intimate partner violence (IPV) is a multidimensional construct that requires researchers to measure a variety of different behaviors to further understand how it functions and capture its full range, extent, and severity (Follingstad & Rogers, 2013; Sotskova & Woodin, 2013). The U.S. Centers for Disease Control and Prevention (CDC) identifies four types of IPV: physical violence, sexual violence, threats of physical or sexual violence, and psychological/emotional violence (Saltzman, Fanslow, McMahon, & Shelle, 2002), all of which are associated with emotional harm, distress, mental health concerns, and physical health problems among its victims (Black et al., 2011). One notable absence is the measurement of legal and administrative (LA) aggression, which Tilbrook, Allan, and Dear (2010) define as the manipulation of legal and administrative resources in an attempt to control or inflict emotional and financial harm on one's partner. In a previous paper, we documented the psychometric properties of a LA aggression scale among two samples: male victims of physical IPV who sought help and a population-based sample of men (Hines et al., 2014). The purpose of this paper is to investigate the potential mental health consequences of LA aggression on men who sought help for physical IPV and their children.

Definition of Legal and Administrative Aggression

The notion of LA aggression was first conceptualized by Tilbrook et al. (2010) in their qualitative study of fifteen heterosexual male IPV victims, eight service providers for male victims, and five significant people in the lives of male IPV victims. LA aggression occurs when one partner uses the legal and administrative system (e.g., courts, law enforcement, child protection

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Relative Influence of Various Forms of Partner Violence on the Health of Male Victims: Study of a Help Seeking Sample

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Researchers argue that partner violence (PV) is a multidimensional and heterogeneous phenomenon that needs to be measured in multiple ways to capture its range, extent, severity, and potential consequences. Several large scale, population-based studies show that about 40% to 50% of PV victims in a 1-year time period are men; this finding is consistent whether the study focuses on physical PV or a combination of several forms of PV. However, no one has investigated how the different forms of PV contribute to male victims' poor mental health, although research suggests that physical, psychological, and sexual PV contribute unique variance to female victims' poor health. The current study investigated how 6 forms of PV—physical, sexual, severe psychological, controlling, legal/administrative (LA), and injury—contributed to the poor health of 611 male victims of PV who sought help. We found that the combination of PV contributed significant unique variance to men's depression, posttraumatic stress disorder, physical health, and poor health symptoms, after controlling for demographic and other traumatic experiences. The common variance among the forms of PV victimization was the strongest contributor to victims' poor health; the types of PV that contributed the most unique variance were controlling behaviors, LA aggression, sexual aggression, and injury. Discussion focuses on the research and practice implications of these findings.

Keywords: male victims, partner violence, men's health, posttraumatic stress disorder, depression

Information regarding partner violence (PV) by women toward men has come from several sources, such as the National Violence Against Women Survey (NVAWS) (Tjaden & Thoennes, 2000), the National Family Violence Surveys (NFVS; Straus, 1995), and the National Intimate Partner and Sexual Violence Survey (NISVS; Black et al., 2011). These surveys show that within any given year, 40% to 50% of all victims of physical PV are men. The majority of this PV is minor, but there is consistent evidence that men are the victims of severe physical PV (e.g., punching, beating up) at the hands of their female partners (e.g., Hines & Douglas, 2010a; 2010b), at rates that are similar to male-to-female severe PV (e.g., Ehrensaft, Moffitt, & Caspi, 2004; Laroche, 2005). For example, in one study of 302 men who sustained physical PV from their female partner and sought help, 90.4% sustained severe physical IPV (e.g., beating up, punching) and 54.0% sustained life-threatening physical PV (Hines & Douglas, 2010a, 2010b, 2013). In fact, the frequency with which these men sustained violence in the previous year (46.7 acts) was comparable with the frequency of violence sustained in samples of battered women (between 15 and 68 acts per year; Giles-Sims, 1983; Johnson, 2006; Okun, 1986; Straus, 1990b). Moreover, almost 80.0% of participants reported that they were injured by their female partners within the previous year, with 77.5% stating they sustained a minor injury and 35.1% sustaining a severe injury, and the male victims reported that they were injured 11.7 times in the previous year (Hines & Douglas, 2010a, 2010b).

Many experts argue that the study of PV should not be confined to physical PV because PV is a multidimensional and heterogeneous phenomenon that needs to be measured in multiple ways to capture its range, extent, severity, and potential consequences (e.g., Follingstad & Rogers, 2013; Woodin, Sotskova, & O'Leary, 2013). For example, the U.S. Centers for Disease Control outlines four different types of PV: physical violence, sexual violence, threats of physical/sexual violence, and emotional/psychological violence (Centers for Disease Control, 2009). The purpose of the current article is to investigate how different forms of PV victimization contribute to male victims' health.

Theoretical and Empirical Associations Between PV and Health Indicators

PV victimization may be related to health through several mechanisms. Certain health conditions may directly result from PV; other health conditions may result from maladaptive coping in response to PV victimization, and still others may be associated

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with a biological response to the stresses of experiencing PV (Black, 2011). Although both genders are PV victims, most studies on PV victims' health concerns focus on female victims of physical PV in comparison to female nonvictims. These studies show that female PV victims are at increased risk for depression (e.g., Golding, 1999; Hathaway et al., 2000; Leserman, Li, Drossman, & Hu, 1998), posttraumatic stress disorder (PTSD; e.g., Golding, 1999), and poor overall health (e.g., Coker, Smith, Bethea, King, & McKeown, 2000; Weinbaum et al., 2001).

Depression and PTSD are among the most common mental health problems of PV victims reported in the literature (Golding, 1999). PV victims tend to live in constant fear of violence (Walker & Browne, 1985), which is a sufficient stressor that can affect a victim's mental health in many ways. Both the fear of violence and the violence itself are stressors, and stress is well-known predictor of mental health disorders (Coyne & Downey, 1991). This cumulative adversity in the form of exposure to multiple, ongoing stressors is associated with a downward spiral of depressive symptoms among female PV victims (Anderson, Saunders, Yoshihama, Bybee, & Sullivan, 2003).

PTSD is a psychiatric condition that can follow the experience of a traumatic incident involving intense fear (American Psychiatric Association, 1994). Although severe and persistent symptoms are needed to be diagnosed with PTSD (Wakefield & Spitzer, 2002), many people who experience a traumatic event respond with at least some of the symptoms of PTSD. The experience of PV is generally considered to be a traumatic event (Walker, 2000), and indeed, PTSD has consistently been found among women who sustain PV (Astin, Lawrence, & Foy, 1993; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Gleason, 1993; Kemp, Rawlings, & Green, 1991; Saunders, 1994), with increasing symptoms positively correlated with greater severity of PV exposure (Astin et al., 1993; Houskamp & Foy, 1991; Kemp et al., 1991; Woods & Isenberg, 2001). Emerging research suggests that the same patterns exist for male victims of PV (e.g., Hines, 2007; Hines & Douglas, 2011a).

PV victimization can influence a person's physical health through the direct impact of repeated physical assaults and resulting injuries, which may lead to chronic pain, broken bones, sensory disabilities, headaches, and/or arthritis (Coker et al., 2000). Similar to mental health, physical health problems may also become long-term and/or chronic because of the cumulative and ongoing stress associated with PV victimization. Such outcomes include gastrointestinal problems (e.g., ulcers, frequent indigestion), cardiovascular problems (e.g., angina, hypertension), recurrent infections (e.g., colds and flu), and central nervous system problems (e.g., seizures, fainting; Campbell et al., 2002; Coker et al., 2000). Indeed, the extant research among male PV victims suggests that victimization is associated with many of these health problems (Coker et al., 2002; Hines & Douglas, 2014a; Pimlott-Kubiak & Cortina, 2003).

Need for a Multidimensional Assessment of PV

Although research shows that men experience severe physical PV from their female partners, research on male PV victims' experiences remains controversial. Some researchers argue that although men may experience physical PV, they are not subjected to the types of PV that also involve systematic control, severe psychological aggression, and sexual aggression, and therefore, their experiences are relatively minor in comparison to female PV victims (e.g., Johnson, 2008; Stark, 2010). Empirical research refutes this argument, however. For example, in the above-mentioned study of 302 male PV victims who sought help (Hines & Douglas, 2010a, 2010b), not only did the large majority of men sustain severe physical PV and injuries, but 96.0% and 93.4% of the men reportedly sustained severe psychological PV and controlling behaviors, respectively, and sustained an average 28.9 acts of severe psychological IPV and 42.6 acts of controlling behaviors in the previous year. In addition, previous analyses of the sample used in the current article showed that almost half of the men sustained sexual PV, with 28% sustaining forced or threatened sexual intercourse (Hines & Douglas, 2014b).

Population-based studies also show that men sustain a combination of various types of PV, at rates comparable with women. For example, the General Social Survey in Canada showed that about 40% of the victims of intimate terrorism (i.e., a combination of physical PV and controlling behaviors) were men (Laroche, 2005), and the U.S. 2010 NISVS (Black et al., 2011) showed when PV was defined as a combination of physical violence, sexual violence, psychological aggression, and stalking, 51% of PV victims in a 1-year time period were men (calculated from Black et al., 2011). Thus, contrary to assertions by Johnson (2008) and Stark (2010), men do experience a combination of forms of PV.

In addition, evidence shows that men who experience this combination of forms of PV have poor health. For example, in the study of 302 male victims of PV (Hines & Douglas, 2011a), their rates of PTSD were similar to samples of battered women (Golding, 1999), with 57.9% of the men reaching a clinical cut-off for PTSD (Hines & Douglas, 2011a). The current article focuses on another sample of men who sought help for PV victimization and experienced a combination of forms of PV; prior analyses using this sample also provide evidence of poor health. Specifically, in comparison with a population-based sample of men, male PV victims who sought help were significantly more likely to reach clinical cut-offs for depression and PTSD, and be diagnosed with a range of cardiovascular problems, asthma, and a sexually transmitted disease, even after controlling for potential confounds (Hines & Douglas, 2014a).

Assessing multiple dimensions of PV victimization is important because research shows that each of these dimensions may contribute differently and uniquely to health indicators in female victims, although to our knowledge, no one has investigated this same association among male PV victims. For example, most female PV victims who seek help state that psychological PV is much worse than physical PV (e.g., Baldry, 2003; Follingstad, Rutledge, Berg, Hause, & Polek, 1990). In multivariable analyses of battered women's experiences that controlled for physical PV, psychological PV was a significant unique predictor of women's low self-esteem (Aguilar & Nightingale, 1994), psychological maladjustment and distress (Khan, Welch, & Zillmer, 1993; Marshall, 1999), alcoholism (Khan et al., 1993), depression (Marshall, 1999), physical health (Marshall, 1999), and PTSD (Arias & Pape, 1999; Khan et al., 1993). Both Dutton and colleagues (1999) and Taft and colleagues (2005) found more consistent relationships between psychological PV and mental health indicators (e.g., depression, PTSD) than they did between physical PV and mental health indicators. Mechanic and colleagues (2008) argued that

psychological PV may contribute uniquely to mental health indicators because it erodes the woman's self-esteem and sense of self-worth.

Studies have also examined the relative influences of physical and sexual PV on women's mental health. Bennice and colleagues (2003) showed that sexual PV severity predicted unique variance in PTSD symptoms beyond that explained by physical PV severity, whereas Wingood and colleagues (2000) found that sexual PV independently predicted suicide attempts in female victims, but not depression, anxiety, or PTSD symptoms.

Finally, some studies have assessed the relative influence of physical, sexual, and psychological PV victimization on female victims' mental health, although measurement and statistical techniques make it difficult to come to firm conclusions. For example, in a sample of female victims from community battered women's programs, Mechanic et al. (2008) found that psychological PV victimization predicted PTSD and depression symptoms, above and beyond physical and sexual PV victimization, and that physical and sexual PV did not predict symptoms after psychological PV was added into the model. However, they did not parse out the independent influences of physical and sexual PV, and they measured sexual PV with only two items. Moreover, they found that sustaining minor injuries was a unique predictor of PTSD symptoms. Pico-Alfonso and colleagues (2006) found that sexual PV victimization contributed uniquely to depression and suicidal behavior (but not PTSD or anxiety), above and beyond physical and psychological PV victimization among female PV victims who sought help.

These studies lend support to the notion that we need to measure multiple dimensions of PV and investigate their relative influences on victims' health indicators. In addition, Dutton (2009) discusses the importance of considering other potential influences on health, such as childhood trauma, family history of violence, other traumatic victimizations, indicators of socioeconomic status, and relationship status. Most of the above-mentioned studies did not control for these potential confounds in their analyses, but it is important to tease apart the unique influences of PV from other previous or co-occurring adversity and trauma.

Pico-Alfonso et al. (2006) took a first step toward Dutton's recommendation by controlling for both childhood and adult victimization experiences other than PV. After controlling for prior victimization, physical and psychological PV victimization were the strongest predictors of depression and anxiety, and psychological PV was the sole unique predictor of PTSD. Moreover, they found that prior victimization was not a significant unique contributor to any of the mental health indicators.

Current Study

These findings on the relative influences of different forms of PV on female victims can be used to develop and refine treatment programs for female victims because they provide an understanding of how different forms of PV may differentially and uniquely contribute to their health. However, to our knowledge, no one has included male PV victims in such analyses, and thus, we do not have an understanding of how different forms of PV may influence men's health. The purpose of the current study is to address this shortcoming in the literature and evaluate the relative influence of different forms of PV on men's health, after controlling for other potential confounds.

Based on the research on female victims of PV, we hypothesize that (a) each of the following forms of PV victimization—controlling behaviors, severe psychological aggression, legal/administrative aggression, physical aggression, sexual aggression, and injury—would significantly, uniquely, and positively predict depressive symptoms, PTSD symptoms, physical health symptoms, and poor health. Moreover, because theoretically and empirically, there tends to be much overlap among the different forms of PV, we also hypothesize that (b) the combination of these six forms of PV would significantly and positively predict these same four outcome variables.

Method

Participants and Procedure

We recruited a help seeking sample of male physical PV victims ($n = 611$). The men had to speak English, live in the U.S., and be between the ages of 18 and 59 to be eligible. They also had to have been involved in an intimate relationship with a woman lasting at least 1 month in their lifetime, in which they sustained a physical assault from their female partner at some point in that relationship. Finally, they had to have sought assistance for their partner's violence from at least one of the following sources: medical doctor or dentist, domestic violence agency, domestic violence hotline, the Internet, a lawyer, the police, a clergy member, a family member, a friend, or a mental health practitioner.

We recruited our sample from a variety of online sources. We posted advertisements on our research Web page and Facebook page, and we posted ads on Web pages and Facebook pages of agencies that specialize in male victims of PV, the physical and mental health of men and minority men, fathers' issues, and divorced men's issues. We also sent announcements to a database of researchers, practitioners, and other interested parties who signed up to be on our e-mailing list through our research Web page, which has been in existence since 2008. The advertisement stated that we were conducting "a study on men who experienced aggression from their girlfriends, wives, or female partners." The ad then provided a link to the anonymous online questionnaire. After providing consent, the men completed the next two pages of the survey, which contained questions to assess for the above screening criteria. Men who were eligible were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an "exit page" of the survey.

Demographics of the sample are in Table 1. On average, the men were 43.9 years of age ($SD = 9.2$), and the majority (75.5%) were White. Their average income and education indicated that they were middle class. Only 26.3% reported that they were still in the abusive relationship, and on average, these relationships lasted 9.4 years and ended 3.8 years ago. Just over two-thirds (67.7%) reported that they parented minor children with their abusive female partner.

The methods for this study were approved by the boards of ethics at our institutions of higher education. All participants were apprised of their rights as study participants and participated anonymously. Steps were taken to ensure participants' safety: At the completion of

Table 1
Descriptive Information of the Sample, n = 611

	% or *M* (*SD*)	Potential range of scores
Demographics		
Age	43.89 (9.18)	
White	75.5%	
Black	4.1%	
Hispanic/Latino	4.9%	
Asian	4.3%	
Native American	2.9%	
Income (in thousands)	47.7 (27.7)	
Educational status[a]	4.71 (1.63)	
Body Mass Index	28.26 (5.53)	
Abusive relationship characteristics		
Currently in the abusive relationship	26.3%	
Length of abusive relationship (months)	112.33 (87.62)	
Time since abusive relationship ended (in months)	45.17 (54.33)	
Minors involved in the abusive relationship	67.7%	
% victimization ever in abusive relationship from partner violence		
Any physical aggression	100%	
Severe psychological aggression	95.8%	
Controlling behaviors	94.3%	
Legal/administrative aggression	78.9%	
Any injuries	72.3%	
Any sexual aggression	48.1%	
Victimization from partner violence—Variety types ever in abusive relationship		
Any physical aggression	6.19 (2.87)	0–12
Severe psychological aggression	2.80 (1.18)	0–4
Controlling behaviors	4.17 (2.41)	0–9
Legal/administrative aggression	2.56 (1.93)	0–6
Any injuries	1.98 (1.62)	0–6
Any sexual aggression	1.13 (1.57)	0–6
Other trauma experiences		
Childhood neglect score	12.39 (2.08)	5–20
Childhood sexual abuse score	2.96 (1.49)	2–8
Childhood violence exposure in home score	3.89 (1.65)	2–8
TEQ score	2.55 (1.86)	0–7
Scores on health indicators[b]		
CES-D	26.43 (14.81)	0–60
PCL	42.24 (16.89)	16–80
SF-4	6.69 (4.02)	0–17
CHIPS	48.85 (30.63)	0–150

[a] Educational Status: 1 = less than high school, 2 = high school graduate or GED, 3 = some college/trade school, 4 = two-year college graduate, 5 = 4-year college graduate, 6 = at least some graduate school. [b] TEQ = Traumatic Events Questionnaire; CES-D = Center for Epidemiological Studies Depression Scale; PCL = PTSD Checklist; SF-4 = indicator of poor health; CHIPS = Cohen-Hoberman Inventory of Physical Symptoms.

the survey the participants were given information about obtaining help for PV victimization and psychological distress, and on how to delete the history on their Internet Web browser.

Measures

Participants were given questionnaires assessing demographics, aggressive behaviors that they and their abusive female partners may have used, their mental and physical health, and risk factors for PV. Men who had children were asked to report information about their eldest child in terms of their child's mental health and other risk factors. Only the questionnaires used in the current analyses are described here.

Demographic information. Men were asked basic demographic information, including age, race/ethnicity, personal income, and education. Men were also asked about the current status of their abusive relationship, the length of their relationship with their abusive partners, how long ago the abusive relationship ended (if applicable), and whether they parented any minor children with their abusive female partner. Men also reported on their height and weight; we used that information to calculate their Body Mass Index (BMI).

Revised Conflict Tactics Scales (CTS2). We used the CTS2 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) to measure the extent to which the men perpetrated and sustained severe psychological, physical, and sexual aggression, and injuries in

their relationships. Only the victimization items were used in the current analyses. The items used for this study included four items assessing severe psychological aggression (e.g., threatening to hit or throw something at partner, calling partner fat or ugly), 12 items assessing physical aggression (e.g., slapping, beating up), 6 items assessing injuries (e.g., having a small cut or bruise, broken bone, passing out), and 6 items assessing sexual aggression (e.g., insisting on, threatening, or using force to have sex when the partner did not want to).

Consistent with our previous research on male victims (e.g., Hines & Douglas, 2010a; 2010b, 2011a, 2011b, 2012, 2013), we supplemented the CTS2 with nine items from the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1995) that focused on controlling behaviors and could be applied to men as victims. A factor analysis (Hines & Douglas, 2010b) showed that these items represented a unique factor that was distinct from the severe psychological aggression items of the CTS2.

Participants responded to items depicting each of the conflict tactics by indicating the number of times these tactics were used by the participant and his partner in the previous year; participants also indicated whether the tactic was *ever* used in the relationship. Participants indicated on a scale from 0 to 7 how many times they experienced each of the acts, 0 = *never*, 1 = *1 time in previous year*, 2 = *2 times in previous year*, 3 = *3–5 times in previous year*, 4 = *6–10 times in previous year*, 5 = *11–20 times in previous year*, 6 = *more than 20 times in previous year*, 7 = *did not happen in the previous year, but has happened in the past*.

Because the majority of the participants reported on previous relationships that had ended on average over 3.5 years before their study participation, we did not use the continuous variable that assessed how many times each aggressive act happened in the past year. Instead, we dichotomized each item so that if they indicated the tactic ever happened during the relationship (i.e., they indicated 1–7 on the scale), they were coded as having used or experienced that tactic (= 1), and if they indicated the tactic never happened (i.e., they indicated a zero), they were coded as never having used/experienced that tactic (= 0).

For the current analyses, each subscale of the CTS2 (i.e., perpetration and victimization of each type of PV) was scored in two ways: (a) Whether any of the types of aggression *ever* happened (dichotomous yes/no variable; i.e., if they indicated a 1–7 on any of the items that comprised that subscale), and (b) The number of different acts of each type of aggression that *ever* happened. Thus, the number of times they indicated a 1–7 on any of the items that comprised that subscale were added together (e.g., there were a total of 12 items of physical aggression, so participants could be victimized by up to 12 types of physical aggression; see Table 1 for the range of potential variety scores on each scale). This method of scoring is called a variety score and is recommended by Moffitt et al. (1997), who showed that variety scores provide reliable and valid assessment of the severity and frequency of the various forms of IPV, without violating statistical assumptions, and they have stronger reliability and predictive validity than frequency or seriousness measures (Ehrensaft et al., 2004).

The CTS2 has been shown to have good construct and discriminant validity and good reliability (Straus et al., 1996). For example, in prior studies, victimization from physical PV, sexual PV, controlling behaviors, severe psychological aggression, and injury were related to symptoms of PTSD (e.g., Hines & Douglas, 2011a, 2013, 2014b). It is the most widely used measure of PV, and has been used in hundreds of studies (Straus, 1990a, 2004). Alpha reliability statistics for the current sample were .88 for controlling behavior victimization, .84 for severe psychological aggression, .82 for injury, .93 for physical aggression, and .85 for sexual aggression. The percentage of men who were ever victimized by each of the forms of aggression is presented in Table 1, along with the average variety score for each form of victimization.

Legal/administrative aggression. To measure acts of legal/administrative (LA) aggression perpetrated by both partners, we used the Actual LA Aggression scale (as opposed to the Threatened LA aggression scale, which measures LA aggression that was threatened by not actually carried out by the partner) developed and validated on the current sample and a population-based sample by Hines, Douglas, and Berger (2014). The victimization scale showed excellent psychometric properties, including good construct, concurrent, and discriminant validity, and good α reliability. Construct validity of was supported through significant correlations with other forms of PV victimization and higher rates of LA aggression in the victims sample versus the population-based sample (Hines et al., 2014). This scale contained six dichotomous yes/no questions that assessed whether the participant and/or his partner ever engaged in any of the following behaviors: making false accusations to authorities that the partner physically or sexually abused the other, making false accusations to authorities that the partner physically or sexually abused the children, leaving and taking the children away, leaving and taking all the money and possessions, ruining the partner's reputation at work, and ruining the partner's reputation in the community. The scale was scored by counting the number of acts of LA aggression the participant and his partner engaged in, and indicating whether the participant and/or his partner engaged in any of the six acts listed (1 = *yes*, 0 = *no*). Alpha reliability for the current sample was .75.

PTSD symptoms. The PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 16-item, self-administered instrument for assessing the severity of PTSD symptomatology. Items cover three symptom clusters: re-experiencing, numbing/avoidance, and hyperarousal. Participants indicate on a 5-point scale (1 = *not at all*, 5 = *extremely*) the extent to which they were bothered by each symptom in the previous month. Items are then summed. The PCL has been used to evaluate PTSD symptomatology in a variety of populations, including female sexual assault victims (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996) and male victims of PV (Hines & Douglas, 2011a). The PCL has demonstrated excellent reliability, with α coefficients above .90 (Blanchard et al., 1996; Lang, Laffaye, Satz, Dresselhaus, & Stein, 2003; Weathers et al., 1993) and test–retest reliability of .96 (Weathers et al., 1993). The measure has also shown strong convergent and divergent validity (Blanchard et al., 1996; Ruggiero, Del Ben, Scotti, & Rabalais, 2003). Construct validity has been demonstrated through correlations with traumatic events (e.g., Hines & Douglas, 2011a). Cronbach's α for the current sample was .97.

Depression symptoms. The Center for Epidemiologic Studies Depression (CES-D; Radloff, 1977) scale was used to measure depressive symptomology. The CES-D contains 20 questions about feelings and behaviors from the past week. Response options range from 0 (*rarely or none of the time*) to 3 (*most or all of the time*). Items are summed. The CES-D has high internal consistency

and adequate test–retest reliability. Construct validity has been demonstrated through significant correlations with measures of fatigue, anxiety, and global mental health functioning (Hann, Winter, & Jacobsen, 1999). Cronbach's α for the current sample was .95.

Physical health symptoms. Physical health symptoms were assessed with the Cohen-Hoberman Inventory of Physical Symptoms (CHIPS; Cohen & Hoberman, 1983). Participants indicated on a 6-point scale, ranging from 0 (*never*) to 5 (>4 *times/week*) the frequency with which they experienced each of the 30 symptoms listed, including sleep problems, fatigue, and various aches and pains, in the previous 6 months (e.g., "felt low in energy," "felt nauseous or vomited"). Items are summed. The CHIPS has been used successfully in clinical samples of women who have sustained PV (Sutherland, Sullivan, & Bybee, 2001), with internal consistencies above .90. Cohen and Hoberman (1983) established construct validity in two separate samples of college students, in which scores on the CHIPS significantly correlated with use of Student Health Facilities in the 5 week period after completion of the scale. For the current sample, Cronbach's α was .96.

Poor health. Poor health was measured with the SF-4, a 4-item measure of the limitations that physical or emotional problems may have placed on work, physical, and social activities, and general levels of energy and pain. Participants were asked to rate aspects of their health on a 6-point scale (0 = *very poor*; 5 = *excellent*), or indicate on a 5-point scale how much their health limitations interfered with various aspects of their life (0 = *not at all*, 4 = *could not do*). An example item is, "During the past 4 weeks, how much did physical or mental health problems limit your usual physical activities (such as walking or climbing stairs)?" The SF-4 is a shortened version of both the SF-36 (McHorney, Ware, Lu, & Sherbourne, 1994) and the SF-8, widely used measures of general health that have shown excellent reliability and validity. Construct validity of the SF-8 has been demonstrated through a strong principal components analysis (Roberts, Browne, Ocaka, Oyok, & Sondorp, 2008). We shortened it to four items. Items were summed. Cronbach's α for this 4-item scale was .88.

Child maltreatment experiences. Childhood maltreatment experiences of the male participants were assessed using four questions that condensed the 16 items from Sexual Abuse History (SAH) and Violence Socialization (VS) scales of the Personal and Relationships Profile (PRP; Straus, Hamby, Boney-McCoy, & Sugarman, 1999). We used these same four questions in previous studies of male IPV victims, and they showed excellent construct validity through their associations with later sexual and physical violence experiences (e.g., Brownridge, 2006; Hines & Douglas, 2011a). Participants were asked the extent to which they agree (1 = *strongly disagree*, 4 = *strongly agree*) with each statement regarding witnessing and sustaining abuse. Items were then summed. Both scales have adequate validity and overall αs of .73 (VS scale) and .76 (SAH scale; Straus & Mouradian, 1999). We measured childhood neglect using 5 items from the Multidimensional Neglectful Behavior Scale (Kantor et al., 2004). Participants were asked the extent to which they agreed (1 = *strongly disagree*, 4 = *strongly agree*) with statements concerning the extent to which their parents physically and emotionally provided for them. Items were summed. Construct validity of this scale has been demonstrated through its correlations with having unmarried parents, being raised by at least one nonbiological parent, perpetration of PV, and lower social integration (Straus, Kinard, & Williams, 2004).

Other trauma exposure. We used the Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994) to assess exposure to seven specific traumatic events: combat; large fires/explosions; serious industrial/farm accidents; sexual assault/rape (forced unwanted sexual activity); natural disasters; violent crime; witnessing someone being mutilated, seriously injured, or violently killed; other life threatening situations; and violent or unexpected death of a loved one. We eliminated the item assessing adult abusive relationships, and for all other items that could relate to their abusive relationship, we specified that the perpetrator of that event had to be someone other than their abusive female partner. Men indicated whether they were exposed to each event or not, and the number of events to which they were exposed was added. The TEQ has demonstrated excellent test–retest reliability and validity (Lauterbach & Vrana, 1996; Vrana & Lauterbach, 1994). Construct validity has been established through the scale's associations with depression, anxiety, and PTSD symptomatology, which is stronger among participants who report multiple traumatic events (Vrana & Lauterbach, 1994).

Results

Bivariate Associations With Health Indicators

Our first series of analyses consisted of bivariate correlations between the four health indicators of depression symptoms (CES-D), PTSD symptoms (PCL), poor health indicators (SF-4), and physical health symptoms (CHIPS) and (a) demographic variables, (b) prior trauma and adversity, and (c) the variety scores for all six forms of PV we measured (see Table 2).

The correlations between demographics and the health indicators provided guidance as to which demographic variables needed to be controlled for in the later multivariable analyses. As shown and with few exceptions, younger age, and lower education and income, were associated with worse health. Men who were currently in their abusive relationships also had worse health, and the longer it had been since the relationship had ended (men who were still in the relationship were given a value of "0" for this variable), the better health they had. Furthermore, being Asian and not parenting a child with the abusive female partner were associated with greater PTSD symptoms, and higher BMI was associated with increased poor health.

In addition, bivariate correlations between prior trauma (i.e., childhood neglect, childhood sexual abuse, childhood violence exposure in the home, and their score on the TEQ) and the four health indicators showed that greater experiences of all forms of trauma were associated with greater symptomatology on all four health indicators. Thus, we controlled for all four forms of prior trauma in multivariable analyses.

The last series of correlations show that all forms of PV were associated with poorer health. Specifically, increasing variety scores for controlling behaviors, severe psychological PV, LA aggression, injury, physical PV, and sexual PV, were associated with increasing depression symptoms, PTSD symptoms, poor health indicators, and physical health symptoms.

Table 2
Correlations Among Demographics, Prior Trauma, and Partner Violence (PV) Types With Health Indicators, n = 611

	Depression symptoms (CES-D)	PTSD symptoms (PCL)	Poor physical health (SF4)	Physical health symptoms (CHIPS)
Demographics of male participants				
Age	−.17***	−.13***	−.03	−.11**
Education	−.15***	−.05	−.15***	−.17***
Income	−.18***	−.08*	−.17***	−.20***
BMI	−.02	−.02	.12**	.07
Asian	.05	.11**	−.03	.00
Black	.00	.01	.05	.00
Latino	.00	.04	.01	.06
Native American	.04	.03	.03	.06
White	−.04	−.05	.00	.02
Demographics of abusive relationship				
Parenting children with abusive female partner	−.04	−.09*	−.03	−.04
Currently in their abusive relationship	.12**	.05	.11**	.06
How long ago abusive relationship ended (in months)	−.26***	−.18***	−.20***	−.16***
Length of abusive relationship (in months)	−.04	−.07	.04	−.02
Other trauma experiences				
Childhood neglect	.17***	.18***	.19***	.18***
Childhood sexual abuse	.10**	.10*	.11**	.16***
Childhood violence exposure in home	.13***	.12**	.13***	.16***
TEQ total	.11**	.13**	.20***	.27***
PV—Variety scores				
Controlling behaviors	.28***	.38***	.24***	.37***
Severe psychological aggression	.25***	.29***	.19***	.25***
Legal/administrative aggression	.13**	.18***	.13**	.15***
Any injury	.25***	.32***	.22***	.31***
Any physical aggression	.21***	.26***	.15***	.29***
Any sexual aggression	.25***	.32***	.20***	.29***

Note. TEQ = Traumatic Events Questionnaire; CES-D = Center for Epidemiological Studies Depression Scale; PCL = PTSD Checklist; SF-4 = indicator of poor health; CHIPS = Cohen-Hoberman Inventory of Physical Symptoms.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Correlations Among the Forms of Partner Violence

Table 3 presents the zero-order correlations among the variety scores of the six forms of PV. With one exception (between LA aggression and sexual aggression), all forms of PV were significantly correlated with all other forms of PV. However, none of the correlations reached a level where multicollinearity would be a concern in the multivariable analyses (Meyers, Gamst, & Guarino, 2013). Indeed, collinearity diagnostics of the multivariable analyses reported in the next section did not reveal any problems.

Multivariable Analyses

To investigate whether the various forms of PV predicted health, above and beyond the covariates, we conducted a series of ordinary least squares (OLS) regression models. Our analytic methods were chosen for two reasons: (a) to be consistent with the literature thus far on female victims; and (b) because little research has established strong findings or theory on the associations between PV victimization and health among male victims, constructing more complex models—such as structural equation models, which rely on strong theoretical guidance—was premature.

Variables were entered in steps. At Step 1, we entered the demographic variables that were significantly related to each health outcome from Table 2; at Step 2, we entered the four scores for prior traumatic experiences; and at Step 3, we entered the variety scores for the six forms of PV. To reduce multicollinearity of the covariates at Steps 1 and 2 and to build a more parsimonious model, covariates at those two steps were removed one at a time

Table 3
Zero-Order Correlations Among the Variety Scores of the Six Measures of Partner Violence (PV)

PV variety scores	1	2	3	4	5	6
1. Controlling behaviors	—					
2. Severe psychological aggression	.51***	—				
3. Legal/administrative aggression	.25***	.19***	—			
4. Any injury	.41***	.32***	.20***	—		
5. Any physical aggression	.47***	.48***	.22***	.64***	—	
6. Any sexual aggression	.39***	.25***	.05	.31***	.33***	—

*** $p < .001$.

with a removal criterion of $p > .10$. At Step 3, all forms of PV remained to ascertain (a) the amount of unique variance explained by the six forms of PV as a whole and (b) the relative unique influence of each form of PV on the health indicators.

The final models are displayed in Table 4. To evaluate the overall model, we examined the adjusted R^2 for the model and its p value. Because four regression models were conducted, one for each health indicator, we adjusted our α level using a Bonferonni correction; thus, our α level for each model was .0125. For each step, we looked at the change in R^2 and its p value, as indicators of how much additional variance each step explained. Finally, for each predictor, we looked at its p value and its squared semipartial correlation (sr^2), which is an indicator of how much unique variance each predictor explained in the dependent variable.

The first health indicator we examined was depression. The model as a whole explained 20.2% of the variance in depression symptoms, with the PV variables explaining 10.1% above and beyond the significant demographic and prior trauma variables. Of the demographic variables, only income and time since relationship ended emerged as significant predictors, explaining 1.2% and

Table 4
Stepwise Ordinary Least Squares (OLS) Regressions Predicting Health Indicators, n = 611

Step	Predictor	B	*SE*	β	*t*	*p*	sr^2	ΔR^2
Depression symptoms (CES-D): $F(9, 572) = 17.30$, $p < .001$, $R^2 = .214$, Adj. $R^2 = .202$								
1	Income	−.60	.20	−.11	−2.96	.003	.012	.094***
	Time since abusive relationship ended (in months)	−.07	.01	−.24	−6.17	<.001	.052	
2	Childhood neglect	.72	.27	.10	2.66	.008	.010	.018***
3	Controlling behaviors	.56	.29	.09	1.90	.058	.005	.101***
	Severe psychological aggression	1.15	.57	.09	2.01	.045	.006	
	Legal/administrative aggression	.81	.30	.11	2.68	.008	.010	
	Injury	1.12	.46	.12	2.45	.015	.008	
	Physical aggression	−.18	.28	−.03	−.63	.528	.001	
	Sexual aggression	1.08	.39	.12	2.77	.006	.011	
PTSD symptoms (PCL): $F(10, 564) = 21.19$, $p < .001$, $R^2 = .273$, Adj. $R^2 = .260$								
1	Time since abusive relationship ended (in months)	−.05	.01	−.16	−4.24	<.001	.023	.053***
	Asian	6.49	3.02	.08	2.15	.032	.006	
	Parenting minor children with abusive partner	−5.44	1.44	−.15	−3.79	<.001	.018	
2	Childhood neglect	1.03	.30	.13	3.45	.001	.015	.030***
3	Controlling behaviors	1.33	.32	.19	4.12	<.001	.022	.190***
	Severe psychological aggression	1.09	.64	.08	1.70	.089	.004	
	Legal/administrative aggression	1.50	.37	.17	4.10	<.001	.022	
	Injury	1.42	.51	.14	2.81	.005	.010	
	Physical aggression	−.30	.31	−.05	−0.96	.337	.001	
	Sexual aggression	1.58	.43	.15	3.65	<.001	.017	
Poor physical health (SF4): $F(13, 508) = 10.36$, $p < .001$, $R^2 = .210$, Adj. $R^2 = .189$								
1	Time since abusive relationship ended (in months)	−.01	.003	−.15	−3.12	.002	.015	.095***
	Education	−.22	.12	−.08	−1.75	.081	.005	
	Income	−.15	.06	−.10	−2.41	.016	.009	
	BMI	.08	.03	.12	2.86	.004	.013	
	Currently in relationship with abusive partner	.93	.45	.10	2.08	.038	.007	
2	Childhood neglect	.22	.08	.12	2.84	.005	.013	.051***
	TEQ total	.27	.09	.13	2.99	.003	.014	
3	Controlling behaviors	.20	.09	.12	2.38	.018	.009	.064***
	Severe psychological aggression	.07	.17	.02	0.39	.698	.0002	
	Legal/administrative aggression	.30	.09	.14	3.15	.002	.015	
	Injury	.28	.13	.11	2.15	.032	.007	
	Physical aggression	−.12	.08	−.08	−1.45	.148	.003	
	Sexual aggression	.17	.11	.07	1.50	.136	.003	
Physical health symptoms (CHIPS): $F(11, 552) = 19.48$, $p < .001$, $R^2 = .280$, Adj. $R^2 = .265$								
1	Education	−1.85	.87	−.08	−2.12	.034	.006	.076***
	Income	−1.04	.43	−.09	−2.44	.015	.008	
	Time since abusive relationship ended (in months)	−.07	.02	−.13	−3.41	.001	.015	
2	Childhood neglect	1.12	.55	.08	2.04	.042	.005	.079***
	TEQ total	3.06	.63	.18	4.85	<.001	.031	
3	Controlling behaviors	2.64	.59	.21	4.45	<.001	.026	.124***
	Severe psychological aggression	.85	1.17	.03	0.73	.467	.001	
	Legal/administrative aggression	1.15	.61	.07	1.87	.063	.004	
	Injury	1.81	.93	.09	1.95	.052	.005	
	Physical aggression	.24	.56	.02	0.43	.665	.0003	
	Sexual aggression	1.86	.80	.10	2.34	.020	.007	

Note. At Step 3, the variety types for each form of PV were entered into the model; BMI = body mass index; TEQ = Traumatic Events Questionnaire; CES-D = Center for Epidemiological Studies Depression Scale; PCL = PTSD Checklist; SF-4 = indicator of poor health; CHIPS = Cohen-Hoberman Inventory of Physical Symptoms; sr^2 = squared semi-partial correlation.
* $p < .05$. ** $p < .01$. *** $p < .001$.

5.2% of the unique variance in depression symptoms, respectively. Of the prior trauma variables (Step 2), only childhood neglect (1.0% of the unique variance) emerged as a significant unique predictor. At Step 3, physical PV was not a unique predictor of depression symptoms, and controlling behaviors only approached significance. Unique PV predictors included sexual PV, explaining 1.1% of the unique variance; LA aggression (1.0% of the unique variance); injury (0.8% of the unique variance); and severe psychological aggression (0.6% of the unique variance). When we summed the squared semipartial correlations, we found that they add to .041, which means that 6% of the variance in depression (10.1% − 4.1%) is explained by what is shared among the six types of PV.

For PTSD symptoms, the final model explained 26.0% of the variance, with 19.0% of the variance explained by the six forms of PV. At Step 1, the unique demographic predictors included time since the relationship ended (2.3% of the unique variance), parenting minor children with the abusive partner (1.8% of the unique variance), and Asian ethnicity (0.6%). Again, the only significant prior trauma was childhood neglect, explaining 1.5% of the unique variance in PTSD symptoms. At Step 3, neither severe psychological aggression nor physical PV emerged as significant unique predictors. Controlling behaviors and LA aggression both explained 2.2% of the variance each; sexual PV explained 1.7% of the variance, and injury explained 1.0%. When we added the squared semipartial correlations, only 7.6% of the unique variance was explained, which means that 11.4% of the variance (19.0% − 7.6%) in PTSD symptoms was explained by what is shared among the six types of PV.

The final model for poor physical health (SF-4) shows that we explained 18.9% of its variance, with the six forms of PV explaining 6.4%. For the demographic predictors (Step 1), time since abusive relationship ended (1.5% of the unique variance), education (0.5%), income (0.9%), BMI (1.3%), and currently in a relationship (0.7%) with the abusive partner were the significant unique predictors of poor physical health. Of the prior traumas (Step 2), both childhood neglect (1.3%) and TEQ score (1.4%) emerged as significant unique predictors. Only three forms of PV emerged as significant unique predictors: LA aggression explained 1.5% of the unique variance, controlling behaviors explained 0.9%, and injury explained 0.7%. After accounting for unique variance explained (3.4%), we found that 2.7% of the variance in poor physical health was explained by what was shared among the six forms of PV.

Finally, the final model for physical health symptoms (CHIPS) explained 26.5% of the variance, with 12.4% of the variance explained by the six forms of PV. As with the SF-4, at Step 1, time since abusive relationship ended (1.5%), education (0.6%), and income (0.8%), were all significant unique predictors of physical health. Also as with the SF-4, for prior trauma (Step 2), both childhood neglect (0.5%) and TEQ score (3.1%) emerged as significant unique predictors. Of the PV variables, neither severe psychological nor physical PV provided a unique contribution to the men's CHIPS score, and LA aggression and injury only approached significance. Controlling behaviors explained 2.6% of the unique variance, and sexual aggression explained 0.7% of the unique variance. However, 8.1% of the variance in the men's physical health symptoms was explained by what was shared among the six forms of PV.

Discussion

The purpose of the current study was to ascertain the relative influences of various forms of PV on mental and physical health indicators in male victims of PV who sought help. We controlled for other traumatic experiences and the men's demographics, and found that PV as a whole significantly and uniquely contributed to various measures of men's poor physical and mental health.

One major finding was that the combined variance among the six types of PV measured was the strongest contributor to all four poor health indicators, which means that what is common among the various forms of PV that men experience is what contributes most strongly to their poor health. Although various forms of PV contributed significant unique variance (as discussed below) to each health indicator, our overarching finding is that the six types of PV measured for the current study form a multidimensional, overlapping construct that contributes the largest proportion of variance to the health indicators, specifically PTSD, depression, and physical health symptoms. This finding provides further evidence that PV is multidimensional and heterogeneous construct that needs to be measured in multiple ways to capture its range, extent, severity, and potential consequences (e.g., Follingstad & Rogers, 2013; Woodin et al., 2013). This finding also provides further evidence that as with female victims who seek help, male PV victims who seek help experience the full range of PV types, all of which contribute to the male victims' poor health.

Individual types of PV also contributed significant unique variance to each of the four health outcomes, although regardless of the health indicator, the proportion of unique variance they explained was relatively small. The most consistent unique PV predictors across the various health indicators were controlling behaviors, injuries, sexual PV, and LA aggression. The associations with controlling behaviors are somewhat consistent with the literature on female PV victims, which finds that psychological forms of PV are uniquely associated with poor health indicators (e.g., Arias & Pape, 1999; Dutton et al., 1999; Khan et al., 1993; Marshall, 1999; Mechanic et al., 2008; Taft et al., 2005), even after controlling for other forms of traumatic victimization (Pico-Alfonso et al., 2006). However, we separated severe forms of psychological PV (e.g., intentionally destroying something belonging to you; threatening to hit or throw something at you) from controlling behaviors (e.g., restricting your use of the phone and/or car; not allowing you to leave the house) because factor analyses showed that these were separate constructs (Hines & Douglas, 2010b). Because the studies with female PV victims did not separate these types of nonphysical PV, it is unknown whether our results are completely consistent with their findings. Nonetheless, the associations with various indicators of poor health may be because of the fact that these controlling behaviors are eroding the victims' sense of self-worth and self-esteem (Mechanic et al., 2008).

The unique associations between injury and each of the health outcomes are consistent with Mechanic et al.'s (2008) findings, and are likely because of the fact that injuries represent a more severe level of physical PV that can negatively impact a victim's mental and physical health. As Mechanic et al. also suggested, injuries may cause physical limitations, which can lead to symptoms of depression.

The unique associations between each of the four poor health indicators and sexual PV are important findings as well because sexual PV is often overlooked as a form of PV that women can perpetrate against men, even within romantic relationships (e.g., Martin, Taft, & Resick, 2007). Our findings are consistent with the literature on female PV victims (e.g., Mechanic et al., 2008; Pico-Alfonso et al., 2006), and point toward the necessity of assessing sexual PV among male victims of physical PV. Because it uniquely contributes to three of the four poor health indicators assessed in our study, our findings suggest that to understand the full range of male PV victims' experiences and health indicators, we need to assess their experiences of sexual PV.

Finally, LA aggression uniquely contributed to men's poor health for three of the four health indicators assessed. LA aggression occurs when one partner makes inappropriate use of the legal and administrative system (e.g., courts, law enforcement, child protection services) either during or after the termination of a relationship in an abusive way, and often involves false allegations against the victims (Hines et al., 2014). Previous research has shown that LA aggression can have dire consequences for male victims, such as losing custody of their children, jeopardizing their financial stability, and ruining their reputation at work or in their community (Cook, 2009). It is these outcomes that may account for LA aggression's unique associations with several of the poor health indicators in male PV victims.

For all health indicators, men's physical PV victimization was not a significant unique contributor. Initially this finding may seem surprising, but this lack of significance is likely because of its statistical overlap with injury, which was a significant unique predictor for both depression symptoms and poor physical health. In addition, physical PV shared variance with all other forms of PV measured, which may have masked any influence.

We recommend that future research investigate potential mechanisms that account for the associations between PV and health indicators among both male and female PV victims. Although our research on the health indicators of male PV victims are consistent with those documented in the literature on female PV victims, the mechanisms through which PV influences health could differ. For example, several social learning theories of masculinity—including gender role conflict (O'Neil, Good, & Holmes, 1995), gender role strain (Pleck, 1995), and gender role stress (Eisler, 1995)—provide guidance on how restrictive ideologies and norms related to masculinity can impact men's physical and mental health (Addis & Cohane, 2005). Such ideologies and norms include physical toughness, emotional stoicism, antifemininity, and rigid self-reliance (Mahalik et al., 2003; O'Neil et al., 1995), all of which are antithetical to PV victimization, particularly that perpetrated by women. Thus, the extent to which male PV victims are impacted by and adhere to these masculinity norms should be considered in future research on the mechanisms through which PV victimization impacts their health. Furthermore, because both helping professionals and society in general likely also adhere to these norms, future research should investigate how societal and professional adherence to these norms and subsequent responses to men's disclosure of PV victimization can impact men's health. Indeed, research suggests that when male PV victims do seek help, in the majority of cases, they are turned away, ridiculed, or told they must have done something to deserve it (Douglas & Hines, 2011).

Another potential mediating mechanism is precarious manhood, which has three basic tenets: (a) manhood is a social status that is earned, (b) manhood is a social status that is unstable and can easily be lost, and (c) manhood requires public displays of proof (Vandello & Bosson, 2013). Evidence shows that men perceive threats to their manhood when asked to perform stereotypical feminine tasks or when they receive feedback that suggests that their psychological profile is similar to a woman's; men will also avoid situations that may risk their manhood status, particularly those that are considered feminine (Vandello & Bosson, 2013). Because PV is typically considered a woman's issue, it is possible that PV victimization is a threat to men's manhood, which could in turn, lead to poor mental health, as research suggests that precarious manhood is associated with anxiety and long-term health problems (Vandello & Bosson, 2013). Furthermore, because help seeking is typically considered a feminine behavior (Vandello & Bosson, 2013), seeking help for PV victimization may also be seen as a threat to a male victim's manhood. Men may also be socially punished for publicly admitting to and engaging in these stereotypical feminine behaviors, which could also lead to worse health outcomes. Indeed, evidence suggests that men are punished more harshly than women for engaging in gender-atypical behavior (Levy, Taylor, & Gelman, 1995).

Limitations and Future Research

The current study has several limitations that should be considered in future research. First, this study was solely based on the self-reports of the male PV victims, which can lead to two potential problems: (a) shared method variance, which may cause inflated correlations because the same person reported on both his PV experiences and health; and (b) inaccurate reporting of PV victimization and perpetration. For the former issue, it is possible that male PV victims who report negative behaviors by their partners are likely to also report negative health in themselves. For the latter issue, research shows that the typical pattern is underreporting of one's own use of undesirable behavior, but not of one's partner's undesirable behavior (Woodin et al., 2013). However, even for the partner's behavior, underreporting is common, as victims tend to feel embarrassed or humiliated by being abused (Follingstad & Rogers, 2013). Nonetheless, future studies should strive to obtain information about men's experiences with PV and their health indicators from multiple informants.

A second limitation is that because this is a cross-sectional study, we cannot conclusively say that PV caused the health problems among the men. Without longitudinal designs, we cannot know whether PV causes health problems in male victims, whether having health problems makes men more vulnerable to PV, or whether a third variable mediates the relationship between PV and health problems. These are important areas to address in future research.

A third limitation concerns the generalizability of our findings. We specifically recruited our sample of male PV victims so that it would be comparable to the majority of studies on battered women, which typically recruit battered women who sought help for PV victimization. Thus, we also required that the male PV victims sought help. This limits generalizability because it is likely that the majority of male PV victims do not seek help. It is unknown the extent to which nonhelp seekers experience the

various forms of PV assessed in the current study and the extent to which each is associated with men's health. It is possible that men who seek help for PV victimization experience more serious attacks than male PV victims who do not seek help. However, the reverse it also possible, as research suggests that men who experience the most gender role conflict are the most vulnerable to mental health problems; moreover, they are the men who are the most resistant to seeking help (Vandello & Bosson, 2013). It is important to note that the research on male help seeking for a variety of mental and physical health concerns shows that men have to overcome several societal and internal barriers to seek help (Addis & Mahalik, 2003). These barriers are compounded when the problem is viewed to be nonnormative by society and something that men should be able to handle themselves (Addis & Mahalik, 2003), as would be the case for male PV victims. Related to this issue of generalizability and sampling method, the help seekers had to have seen our advertisement on the Internet or been alerted to our study by a service provider who saw our advertisement online. In addition, they had to complete the study online. Therefore, help seekers without access to the Internet were excluded. Future studies should aim to recruit men who may have sought help from other sources of support or who may not have sought help at all to investigate any possible differences in their experiences.

Finally, the current study only contained four health indicators. Future studies should investigate a broader array of health indicators that research shows to be problematic for female PV victims, including anxiety and suicidal behaviors (Pico-Alfonso et al., 2006; Wingood et al., 2000). In addition, future studies should investigate additional potential mediators (e.g., poor coping mechanisms) and moderators (e.g., strong vs. weak social support) of the associations between PV and health indicators among victims.

Implications

The current study has several implications for PV researchers and practitioners. First, it is important to do a multidimensional assessment of PV for all PV victims, regardless of gender. The current study suggests that the common variance among the forms of PV victimization is the strongest contributor to victims' poor health. It is especially important to acknowledge that nonphysical forms of PV contribute to the poor health and adjustment of victims. Research suggests that nonphysical forms of PV are considered minor and receive less attention from clinicians, lawyers, policymakers, and researchers (e.g., Dutton et al., 1999; O'Leary, 1999; Pico-Alfonso et al., 2006), yet our study contributes to a growing body of literature showing how detrimental such forms of PV can be. Furthermore, our findings suggest the importance for researchers and practitioners to consider female-perpetrated sexual PV against men because it is a largely overlooked form of PV (e.g., Martin et al., 2007) that contributes to male victims' poor health.

Second, it is important for all PV victims to be assessed for a range of physical and mental health indicators because PV victimization contributes to victims' poor health. It is also important for doctors and mental health practitioners to assess for PV among their male patients. In the current study, PV as a whole contributed more variance than demographics or other traumatic experiences to men's depression, PTSD, and physical health symptoms. Thus, it is a potential risk for men's poor health, and assessment for PV should be a routine part of men's health screening. Currently, the Affordable Care Act only mandates health insurance coverage for PV screening and counseling for women (Health Resources and Services Administration, 2014). These results suggest that patients should be screened regardless of gender.

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A special issue of *Psychological Services* on "Military Sexual Trauma" releases in November, 2015. MST is a term used by the United States Department of Veterans Affairs (DVA) to refer to rape, sexual assault and sexual harassment that occurs during military service. The issue, guest edited by Michi Fu and Tracy Sbrocco, features 13 articles that include sexual trauma in male and female service members, sexual intimate partner violence, utilization of healthcare, and a training program to treat MST. The issue examines MST among non-traditional populations as well as treatment recommendations. An anonymous piece offers a first-hand experience of MST. The table of contents is available at http://psycnet.apa.org/journals/ser/12/4.

Sexual Aggression Experiences Among Male Victims of Physical Partner Violence: Prevalence, Severity, and Health Correlates for Male Victims and Their Children

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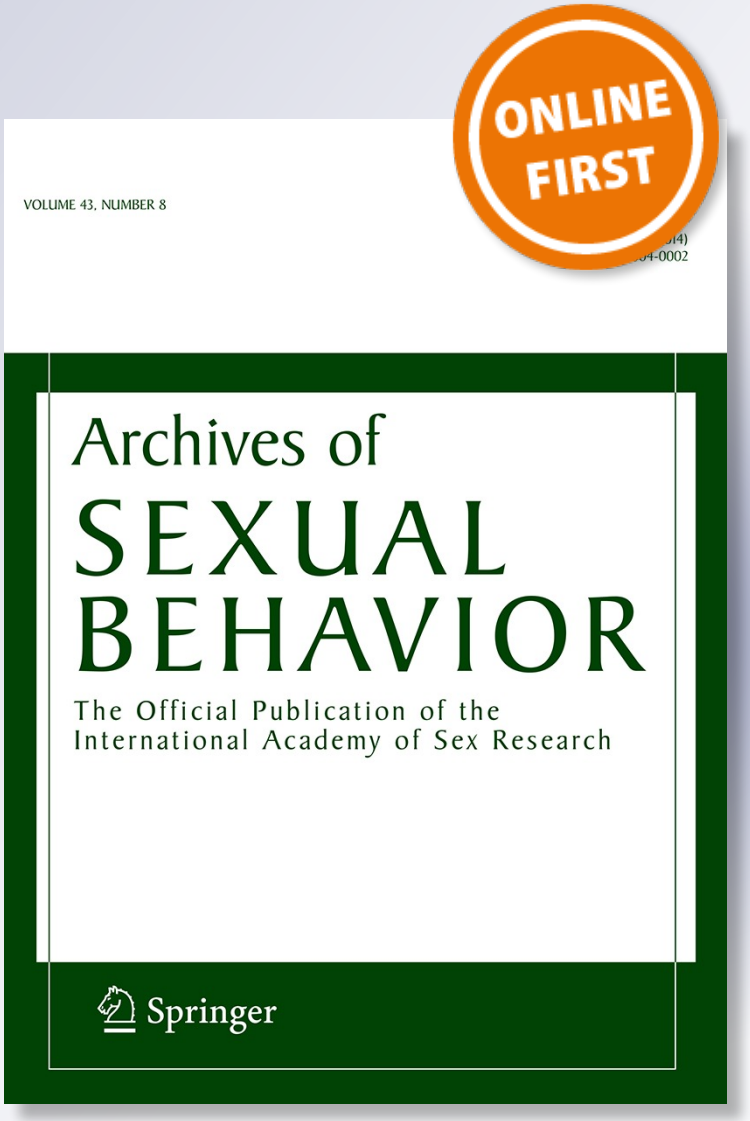

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ORIGINAL PAPER

Sexual Aggression Experiences Among Male Victims of Physical Partner Violence: Prevalence, Severity, and Health Correlates for Male Victims and Their Children

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Abstract Although research has documented the prevalence and health correlates of sexual aggression among women who have experienced severe partner violence (PV), no research has documented the parallel issues among male victims of severe PV. Research also suggests that children of female victims of both physical and sexual PV have worse mental health than children of female victims of physical PV only, but no research has assessed the mental health of children whose fathers experienced both physical and sexual PV. We surveyed 611 men who experienced physical PV from their female partners and sought help. We assessed the types and extent of various forms of PV, the men's mental and physical health, and the mental health of their oldest child. Results showed that almost half of the men experienced sexual aggression in their relationship, and 28 % severe sexual aggression. Increasing levels of severity of sexual aggression victimization was associated with greater prevalence and types of other forms of PV. In addition, greater levels of severity of sexual aggression victimization among the men was significantly associated with depression symptoms, post-traumatic stress disorder symptoms, physical health symptoms, and poor health, and attention deficit and affective symptoms among their children. These associations held after controlling for demographics and other violence and trauma exposure. Discussion focused on the importance of broadening our conceptualization of PV against men by women to include sexual aggression as well.

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Keywords Sexual aggression · Male victims · Partner violence · Domestic violence · Child witnesses

Introduction

Studies show that approximately 40–50 % of women who seek help for severe physical partner violence (PV) victimization (i.e., battered women) also experience sexual aggression by their abuser (e.g., Bennice & Resick, 2003; Campbell, 1989; Campbell & Soeken, 1999; McFarlane & Malecha, 2005). In this article, sexual aggression encompasses a range of behaviors from coercion to engage in sexual intercourse that one does not want to engage in (i.e., unwanted, although not necessarily non-consensual, sexual intercourse) to being physically forced to have sexual intercourse. Battered women also report being raped within their abusive relationships, where rape is defined as vaginal, oral, or anal intercourse without the consent of the victim (e.g., through force, threats, or incapacitation).

Women who experience sexual aggression within the context of a physically abusive relationship experience more frequent, severe, and dangerous abuse at the hands of their perpetrators in comparison to women who are physically assaulted only (Bennice & Resick, 2003; Bennice, Resick, Mechanic, & Astin, 2003; Meyer, Vivian, & O'Leary, 1998; Monson, Langhinrichsen-Rohling, & Taft, 2009). In addition, physically assaulted women who also experience sexual aggression are more likely to suffer from a range of physical and mental health problems (Bennice & Resick, 2003; Bennice et al., 2003; Dutton, 2009; McFarlane & Malecha, 2005; McFarlane et al., 2005). Initial studies also suggest their children experience more mental health problems in comparison to children of women who are physically assaulted only (McFarlane et al., 2007; Spiller, Jouriles, McDonald, & Skopp, 2012). Despite this consistent evidence among battered women, no study has investigated the parallel issues among male physical

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PV victims who have sought help. The current study represents an initial investigation into the rates, severity, and health correlates of female sexual aggression against male victims of physical PV who sought help.

Male Victims of Severe Partner Violence

Information regarding PV by women toward men has come from several sources, such as the National Crime Victimization Survey (Truman & Morgan, 2014), the National Violence Against Women Survey (NVAWS; Tjaden & Thoennes, 2000), the National Family Violence Survey (NFVS; Straus, 1995), and the National Intimate Partner and Sexual Violence Survey (NISVS; Black et al., 2011). These surveys show that within any given year, 25–50 % of all victims of physical PV are men.

The majority of this PV is minor, but there is also evidence that men are the victims of severe physical PV (e.g., punching, beating up) and other forms of severe PV (e.g., controlling behaviors, severe psychological aggression) at the hands of their female partners (Hines & Douglas, 2010a, b), at rates that are similar to male-to-female severe PV (Ehrensaft, Moffitt, & Caspi, 2004; Laroche, 2005). For example, in one study of 302 men who sustained physical PV from their female partner and sought help, 96.0 and 93.4 % of the men reportedly sustained severe psychological PV and controlling behaviors, respectively, and sustained on average 28.9 acts of severe psychological PV and 42.6 acts of controlling behaviors in the previous year. For physical PV, 100 % of men reportedly sustained physical PV overall (because it was a sampling criterion), with 90.4 % sustaining severe physical IPV (e.g., beating up, punching) and 54.0 % sustaining life-threatening physical PV. Almost 80.0 % of participants reported that they were injured by their female partners within the previous year, with 77.5 % stating they sustained a minor injury and 35.1 % sustaining a severe injury; the male helpseekers reported that they were injured 11.7 times in the previous year (Hines & Douglas, 2010a, b). In fact, the frequency with which men sustained violence in the previous year (46.7 acts) was comparable to the frequency of violence sustained in samples of battered women (between 15 and 68 acts per year; Giles-Sims, 1983; Johnson, 2006; Okun, 1986; Straus, 1990). In addition, their rates of PTSD (Hines & Douglas, 2011) were also similar to samples of battered women (Golding, 1999).

Research documenting that men can be victims of severe PV at the hands of their female partners has been controversial, but this growing body of research makes it difficult to ignore or deny this type of PV. It also lays a foundation for moving the field toward exploring and better understanding female-to-male sexual aggression within the context of intimate relationships. To our knowledge, no one has yet investigated the extent to which male physical PV victims who sought help sustain sexual PV from their female partners, nor looked at its independent contribution to the health of the male PV victims and their children.

Evidence of Female-Perpetrated Sexual Assault Against Men

One reason that no study has been conducted on the sexual aggression experiences of male victims of physical PV who seek help is because few people in the field acknowledge that women can sexually aggress against men. In fact, in a comprehensive review of the intimate partner sexual aggression literature, Martin, Taft, and Resick (2007) did not consider the possibility of female perpetration against male partners. They used the terms "perpetrator" and "male partner" synonymously, and "victim" and "female partner" synonymously. All of the theories they discussed also assumed a male perpetrator and female victim. Moreover, the researchers did not call for research on the issue of female-perpetrated sexual aggression against their male partners.

Nevertheless, research conclusively shows that women can and do sexually aggress against—even rape—men. Sarrel and Masters' (1982) seminal article showed that the male sexual response can happen in a variety of emotional states, including anger and terror. As these researchers showed, arousal and stimulation are not the same; sexual arousal is the arousal of sexual desire, whereas sexual stimulation is a physiological response to physical touching of sexual body parts; thus, a man can obtain an erection through physical stimulation, even if he is not sexually aroused, and it is possible for women to sexually aggress against and force their male partners to have sexual intercourse against their will.

The majority of studies on female-perpetrated sexual aggression against men use college student samples, and some of the earliest studies were conducted in the 1980s. For example, Struckman-Johnson (1988) found that 16 % of college men reported they had been forced to engage in sexual intercourse at least once in their lifetimes. Of these men, 52 % said it was due to psychological pressure (e.g., guilt trip, relationship would end, blackmailed), 28 % said it was a combination of psychological pressure and physical restraint/force, 10 % said it involved only physical force, and 10 % said there was no consent due to intoxication.

More recently, evidence shows that a minority of college men report various forms of sexual aggression victimization (Hines, Armstrong, Reed, & Cameron, 2012; Krebs, Lindquist, Warner, Fisher, & Martin, 2007), and some college sample studies focus on sexual aggression within heterosexual romantic relationships. For example, in a large multi-national study of college students, 2.8 % of men reported forced sex in their relationships within the previous year and 22.0 % reported verbal coercion to engage in sex (Hines, 2007). In a review of the college dating violence literature, Monson et al. (2009) concluded that between 1 and 5 % of women perpetrate sexual acts against their boyfriends that would meet the definition of rape (i.e., vaginal, oral, or anal intercourse without his consent, through force, threats, or incapacitation).

Larger, more representative studies also show evidence of women sexually aggressing against men. For example, in the

Los Angeles Epidemiologic Catchment Area Project (Struckman-Johnson, 1991), 7.2 % of the men reported that since the age of 16 they had been pressured or forced to have sexual contact. During the most recent episode, nearly 80 % of the perpetrators were acquaintances or lovers, and intercourse (oral, vaginal, or anal) occurred in 39 % of the incidents. Of the victims, 62 % said that verbal pressure was used, 9 % were physically harmed or threatened, and 29 % endured a combination of harm, threats, and verbal pressure. In the recent NISVS survey (Black et al., 2011), 1.4 % of men reported lifetime experiences of rape, which was defined as forced anal penetration; 4.8 % reported being made to penetrate someone (i.e., being made to have sexual intercourse without consent); 6.0 % reported sexual coercion; 11.7 % reported unwanted sexual contact; and 12.8 % reported non-contact unwanted sexual experiences. In almost half of the incidents in which the man was forced to penetrate someone, the perpetrator was an intimate partner and 79.2 % of the perpetrators were women. Overall, the NISVS showed that in a lifetime, approximately 8 % of men (i.e., 9 million)—and in the preceding year, 2.5 % of men (i.e., 2.8 million)—have experienced some form of sexual aggression from an intimate partner.

Rates, Frequency, and Relationship Characteristics of Female Victims of Sexual PV

Estimate of the rates of sexual aggression against battered women vary, but most suggest that somewhere between 40 and 50 % of battered women have been victims of sexual aggression by their abusers (Bennice & Resick, 2003; Campbell, 1989; Campbell & Soeken, 1999; McFarlane & Malecha, 2005), which is 4–5 times higher than community and national samples of women (e.g., Tjaden & Thoennes, 2000). Bennice and Resick (2003) and Monson et al. (2009) estimated that 33–59 % of all battered women have been raped, a rate that is 19 times greater than that for non-battered women.

Battered women who sustain sexual aggression experience other abusive and dangerous behaviors as well. More severe and frequent sexual aggression is related to more severe physical assault (Bennice & Resick, 2003; Bennice et al., 2003; Meyer et al., 1998; Monson et al., 2009). Sexually victimized battered women are at greater risk than battered women who are not sexually victimized for strangulation and threats from the abuser to kill the woman and hurt the children (McFarlane & Malecha, 2005). In addition, they are at twice the risk for homicide (Campbell et al., 2003). Thus, we know that a substantial portion of battered women also experience sexual aggression and/or rape, and that their relationships are more dangerous. We do not know whether any of these findings also apply to male PV victims who seek help.

Health Correlates of Sexual Aggression Among Battered Women and Their Children

Not only are the relationships of battered women who experience sexual aggression more dangerous, but these women also are at greater risk for poor mental and physical health, even after controlling for the severity of the violence (Bennice & Resick, 2003; Bennice et al., 2003; Meyer et al., 1998; Monson et al., 2009). Examples of potential outcomes include PTSD symptoms (Bennice & Resick, 2003; Bennice et al., 2003; Dutton, 2009; McFarlane & Malecha, 2005; McFarlane et al., 2005), depression (Bennice & Resick, 2003; Bennice et al., 2003; Pico-Alfonso et al., 2006), anxiety (Bennice & Resick, 2003), suicidal threats and attempts (McFarlane & Malecha, 2005; McFarlane et al., 2005; Pico-Alfonso et al., 2006), substance use (McFarlane & Malecha, 2005; McFarlane et al., 2005), lower self-esteem, poorer body image, sexual dysfunction (Bennice & Resick, 2003), and vaginal/rectal bleeding, STDs, and pelvic inflammatory disease (McFarlane, 2007; McFarlane & Malecha, 2005). Researchers argue that sexual PV may be an important unique predictor of battered women's physical and mental health because of the perceived severity and sense of violation.

Similarly, the children of battered women who also experience sexual aggression may experience worse mental health outcomes than children of women who are battered only. For example, in one study school-age children whose mothers experienced both physical and sexual aggression had significantly more internalizing problems than children whose mothers experienced physical aggression only (McFarlane et al., 2007). Moreover, among a sample of 4–8 year olds, those children whose mothers experienced sexual PV victimization had more disruptive behavior problems than children whose mothers were not sexually victimized (Spiller et al., 2012). Although the researchers did not know whether the children actually witnessed the sexual PV, they argued that sexual PV may predict children's poor mental health because the children are living in homes where the parents may not be psychologically available to the child, may express more hostility and irritability when they do interact with their child, and/or may be less consistent with discipline. Moreover, sexual PV may be a marker for other dysfunctional family processes that may negatively influence a child's mental health, such as alcohol, mental health, and self-control problems in the perpetrator.

Given the associations between sexual PV and the health of battered women and their children, it is important to assess whether similar associations occur among male physical PV victims who seek help. Currently, the PV field of scholars and practitioners has no knowledge as to whether male PV victims who seek help and their children are at greater risk for a range of poor health outcomes if the men also experience sexual PV.

Research Questions

The goal of the current study was to address the following four research questions:

1. How much sexual aggression do men who sustain physical PV and seek help experience?
2. Is male helpseekers' victimization from sexual PV associated with more severe levels of PV overall?
3. Is male helpseekers' victimization from sexual PV associated with worse mental and physical health, above and beyond their victimization from other forms of PV?
4. Is male helpseekers' victimization from sexual PV associated with worse mental health in their children, above and beyond children's exposure to other forms of PV and violence in the community?

Method

Participants and Procedure

We recruited a helpseeking sample of male physical PV victims ($n = 611$). The men had to speak English, live in the US, and be between the ages of 18 and 59 to be eligible. They also had to have been involved in an intimate relationship with a woman lasting at least 1 month in their lifetime, in which they sustained a physical assault from their female partner at some point in that relationship. Finally, they had to have sought assistance for their partner's violence from at least one of the following sources: medical doctor or dentist, domestic violence agency, domestic violence hotline, the Internet, a lawyer, the police, a clergy member, a family member, a friend, or a mental health therapist.

We recruited our sample from a variety of online sources. We posted advertisements on our research webpage and Facebook page, and we posted ads on webpages and Facebook pages of agencies that specialize in male victims of IPV, the physical and mental health of men and minority men, fathers' issues, and divorced men's issues. We also sent announcements to a database of researchers, practitioners, and other interested parties who signed up to be on our e-mailing list through our research webpage, which has been in existence since 2008. The advertisement stated that we were conducting "a study on men who experienced aggression from their girlfriends, wives, or female partners." The ad then provided a link to the anonymous online questionnaire. After providing consent, the next two pages of the survey contained questions to assess for the above screening criteria. Men who were eligible were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an "exit page" of the survey.

Demographics of the sample are displayed in Table 1. On average, the men were 43.9 years of age (SD = 9.2), while their female partners were about 3 years younger ($M = 40.8$, SD = 9.5). The majority (75.5 %) were White, as were their female partners (67.4 %). Their average income and education indicated that they were middle class. Only 26.3 % reported that they were still in the abusive relationship, and on average, these relationships lasted 9.4 years and ended 3.8 years ago. Just over two-thirds (67.7 %) reported that they parented minor children with their abusive female partner, on average just over one child. The oldest child was on average 9.9 years of age (SD = 4.9) and equally likely to be a boy or a girl. In 92.9 % of the cases, the oldest child was the participant's biological child.

The methods for this study were approved by the boards of ethics at our institutions of higher education. All participants were apprised of their rights as study participants and participated anonymously. Steps were taken to ensure participants' safety: At the completion of the survey the participants were given information about obtaining help for PV victimization or psychological distress, and on how to delete the history on their Internet web browser.

Measures

Demographic Information

Men were asked basic demographic information about both themselves and their partners, including age, race/ethnicity, personal income, and education. Men were also asked about the current status of their relationship, the length of their relationship with their partners, how long ago the relationship ended (if applicable), whether they parented any minor children with their abusive female partner, and how many minor children they parented together. Finally, men provided basic demographic information about their children, including gender, age, and whether the children were the biological or adoptive children of themselves and/or their female partner.

Revised Conflict Tactics Scales (CTS2)

We used the *CTS2* (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) to measure the extent to which the men perpetrated and sustained severe psychological, physical, and sexual aggression, and injuries in their relationships. The items used for this study included 4 items assessing severe psychological aggression (e.g., threatening to hit or throw something at partner, calling partner fat or ugly), 12 items assessing physical aggression (e.g., slapping, beating up), 6 items assessing injuries (e.g., having a small cut or bruise, broken bone, passing out), and 6 items assessing sexual aggression (e.g., insisting on, threatening, or using force to have sex when the partner did not want to). For the physical aggression, injury, and sexual aggression items, we further divided the behaviors into subcategories, according to Straus et al. (1996) and Johnson (1995).

Table 1 Demographics and partner violence victimization of the male helpseekers ($n = 611$)

	Helpseeking sample % or *M* (SD)	Female partners % or *M* (SD)	χ^2 or *t*
Demographics			
Age	43.9 (9.2)	40.8 (9.5)	14.09***
White[a]	75.5 %	67.4 %	21.94***
Black[a]	4.1 %	4.1 %	0.05
Hispanic/Latino[a]	4.9 %	9.7 %	13.29***
Asian[a]	4.3 %	5.7 %	1.83
Native American[a]	2.9 %	1.0 %	5.04*
Income (in thousands)	47.7 (27.7)	38.9 (29.6)	7.85***
Educational status[b]	4.7 (1.6)	4.2 (1.8)	5.95***
Relationship characteristics			
Currently in the Relationship	26.3 %	–	–
Relationship length (months)	112.3 (87.6)	–	–
Time since relationship ended (in months)	45.2 (54.3)	–	–
Minors involved in the relationship	67.7 %	–	–
No. of minors involved in relationship	1.1 (1.0)	–	–
Demographics of oldest child ($n = 408$)			
Age	9.9 (4.9)	–	–
% Female	50.0 %	–	–
Helpseeker's biological child	92.9 %	–	–
Female partner's biological child	44.6 %	–	–
% Victimization from partner aggression[a]			
Severe psychological aggression	94.9 %	31.9 %	371.13***
Controlling behaviors	93.3 %	35.7 %	327.99***
Legal/administrative aggression	90.5 %	11.0 %	478.00***
Any physical aggression	100 %	43.2 %	323.00***
Severe physical aggression	85.1 %	15.1 %	409.51***
Very severe physical aggression	50.4 %	7.0 %	241.56***
Sexual aggression	48.6 %	14.2 %	166.08***
Minor sexual aggression	43.4 %	12.6 %	142.85***
Severe sexual aggression	28.0 %	3.1 %	140.51***
Any injuries	72.8 %	22.6 %	288.71***
Severe injuries	40.9 %	8.0 %	174.24***
No. of variety types of partner aggression experienced			
Severe psychological aggression	2.8 (1.2)	0.5 (0.9)	42.72***
Controlling behaviors	4.2 (2.4)	0.6 (1.0)	34.60***
Legal/administrative aggression	3.6 (1.9)	0.2 (0.5)	43.81***
Any physical aggression	6.2 (2.9)	1.1 (1.7)	41.50***
Severe physical aggression	2.5 (1.9)	0.3 (0.7)	29.59***
Very severe physical aggression	0.9 (1.1)	0.1 (0.4)	17.93***
Sexual aggression	1.1 (1.6)	0.2 (0.5)	14.81***
Minor sexual aggression	0.6 (0.8)	0.2 (0.4)	13.86***
Severe sexual aggression	0.5 (1.0)	0.0 (0.2)	12.17***
Any injuries	2.0 (1.6)	0.4 (0.8)	24.15***
Severe injuries	0.7 (1.0)	0.1 (0.4)	15.08***

* $p < .05$; ** $p < .01$; *** $p < .001$

[a] Differences in race/ethnicity and victimization within the relationship between male helpseekers and their abusive female partners were tested using a McNemar's test

[b] Educational status: 1 = less than high school, 2 = high school graduate or GED, 3 = some college/trade school, 4 = 2-year college graduate, 5 = 4-year college graduate, 6 = at least some graduate school

Severe physical aggression was aggression that had a higher likelihood of causing an injury (e.g., punching, kicking). Very severe physical aggression was considered even more life-threatening (e.g., beating up, using a knife or gun). Severe injury was an injury that needed medical attention (e.g., broken bone, passing out from being hit on the head). Minor sexual aggression was insisting on vaginal, oral, or anal sex when one's partner did not want to, whereas severe sexual aggression was threatening or forcing one's partner to engage in vaginal, oral, or anal sex.

Consistent with our previous research on male victims (e.g., Hines & Douglas, 2010a, b, 2011, 2012, 2013), we supplemented the *CTS2* with nine items from the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1995) that focused on controlling behaviors and could be applied to men as victims. A factor analysis (Hines & Douglas, 2010a) showed that these items represented a unique factor that was distinct from the severe psychological aggression items of the CTS2. We also added six items to measure men's perpetration and victimization from legal/administrative aggression, which included making false accusations to authorities that the partner physically or sexually abused the other, making false accusations to authorities that the partner physically or sexually abused the children, leaving and taking the children away, leaving and taking all the money and possessions, ruining the partner's reputation at work, and ruining the partner's reputation in the community. Previous analyses of this subscale with the current sample showed that it has excellent psychometric properties, including good construct validity and good alpha reliability (Hines, Douglas, & Berger, 2014).

Participants responded to items depicting each of the conflict tactics by indicating the number of times these tactics were used by the participant and his partner. Participants indicated on a scale from 0 to 7 how many times they experienced each of the acts, 0 = never; 1 = 1 time in previous year; 2 = 2 times in

previous year; 3 = 3–5 times in previous year; 4 = 6–10 times in previous year; 5 = 11–20 times in previous year; 6 = more than 20 times in previous year; 7 = did not happen in the previous year, but has happened in the past.

For the current analyses, each subscale of the CTS2 (i.e., perpetration and victimization of each type of PV) was scored in two ways: (1) whether any of the types of aggression ever happened (dichotomous yes/no variable), and (2) the number of different acts of each type of aggression that ever happened (e.g., there were a total of 12 items of physical aggression, so participants could be victimized by up to 12 types of physical aggression). This method of scoring is called variety scores and is recommended by Moffitt et al. (1997), who showed that it provides a reliable and valid assessment of the severity and frequency of the various forms of IPV, without violating statistical assumptions.

The *CTS2* has been shown to have good construct validity and good reliability (Straus et al., 1996). Alpha reliability statistics for the current samples ranged from .69 (perpetration of severe psychological aggression) to .94 (victimization from physical aggression). The percentage of men who were ever victimized or ever perpetrated each of the forms of aggression is presented in Table 1, along with the average number of types of each form of aggression perpetrated and experienced.

Post-traumatic Stress Disorder Symptoms

The *PTSD Checklist* (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 16-item, self-administered instrument for assessing the severity of PTSD symptomatology. Items cover three symptom clusters: re-experiencing, numbing/avoidance, and hyperarousal. Participants indicate on a 5-point scale (1 = not at all, 5 = extremely) the extent to which they were bothered by each symptom in the previous month. The PCL has been used to evaluate PTSD symptomatology in a variety of populations, including female sexual assault victims (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996) and male victims of IPV (Hines & Douglas, 2011). The PCL has demonstrated excellent reliability, with alpha coefficients above .90 (Blanchard et al., 1996; Lang, Laffaye, Satz, Dresselhaus, & Stein, 2003; Weathers et al., 1993) and test–retest reliability of .96 (Weathers et al., 1993). The measure has also shown strong convergent and divergent validity (Blanchard et al., 1996; Ruggiero, DelBen, Scotti, & Rabalais, 2003). Cronbach's alpha for the current sample was .97.

Depression Symptoms

The Center for Epidemiologic Studies Depression (CES-D; Radloff, 1977) scale was used to measure depressive symptomatology. The CES-D contains 20 questions about feelings and behaviors from the past week. Response options range from 0 (rarely or none of the time) to 3 (most or all of the time). The CES-D has high internal consistency and adequate test–retest reliability. Cronbach's alpha for the current sample was .95.

Physical Health Symptoms

Physical health symptoms were assessed with the Cohen-Hoberman Inventory of Physical Symptoms (CHIPS; Cohen & Hoberman, 1983). Participants indicated on a 6-point scale, ranging from 0 (never) to 5 (>4 times/week) the frequency with which they experienced each of the 30 symptoms listed, including sleep problems, fatigue, and various aches and pains. The CHIPS has been used successfully in clinical samples of women who have sustained PV (Sutherland, Sullivan, & Bybee, 2001), with internal consistencies above .90. For the current sample, Cronbach's alpha was .96.

Poor Health

Poor health was measured with the SF-4, a 4-item measure of the limitations that physical or emotional problems may have placed on work, physical, and social activities, and general levels of energy and pain. This is a shortened version of both the SF-36 (McHorney, Ware, Lu, & Sherbourne, 1994) and the SF-8, widely used measures of general health that have shown excellent reliability and validity. The SF-8 is recommended for use in general population-based research surveys to reduce participant burden. We shortened it to four items. Cronbach's alpha for this 4-item scale was .88.

Child Maltreatment Experiences

Childhood maltreatment experiences of the male participants were assessed using four questions that condensed the 16 items from Sexual Abuse History (SAH) and Violence Socialization (VS) scales of the Personal and Relationships Profile (PRP; Straus, Hamby, Boney-McCoy, & Sugarman, 1999). We used these same four questions in previous studies of male IPV victims, and they showed excellent validity (Hines & Douglas, 2011, 2012). Participants were asked the extent to which they agree (1 = strongly disagree, 4 = strongly agree) with each statement regarding witnessing and sustaining abuse. Both scales have adequate validity and overall alphas of .73 (VS scale) and .76 (SAH scale; Straus & Mouradian, 1999). We measured childhood neglect using six items from the Multidimensional Neglectful Behavior Scale (Kantor et al., 2004). Participants were asked the degree to which they agreed (1 = strongly disagree, 4 = strongly agree) with statements concerning the extent to which their parents physically and emotionally provided for them.

Other Trauma Exposure

We used the Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994) to assess exposure to seven specific traumatic events: combat; large fires/explosions; serious industrial/farm accidents; sexual assault/rape (forced unwanted sexual activity); natural disasters; violent crime; adult abusive relationships; physical/sexual child abuse; witnessing someone being mutilated, seriously injured, or violently killed; other life-threatening situations; and violent or unexpected death of a loved one. We eliminated the item assessing adult abusive relationships, and for all other items that could relate to their abusive relationship; we specified that the perpetrator of that event had to be someone other than their abusive female partner. Men indicated whether they were exposed to each event or not, and the number of events to which they were exposed were added. The TEQ has demonstrated excellent test–retest reliability and validity (Lauterbach & Vrana, 1996; Vrana & Lauterbach, 1994).

Child Behavior Checklist (CBCL)

The CBCL (Achenbach, 1991; Achenbach & Rescorla, 2001) has demonstrated excellent reliability and validity (Achenbach & Rescorla, n.d.-a, n.d.-b). The 2001 revision includes DSM IV-oriented scales which have demonstrated strong reliability and convergent and discriminative validity (Nakamura, Ebesutani, Bernstein, & Chorpita, 2009). Two versions of the parent report were employed: (1) the CBCL/1½–5 is a 99-item measure for parents of children 1½–5 years of age; there are five DSM IV-oriented scales: Affective Problems, Anxiety Problems, Pervasive Developmental Problems, Attention Deficit/Hyperactivity (ADH) Problems, and Oppositional Defiant Problems; and (2) the CBCL/6–18 is a 118-item measure for parents of children aged 6–18 and includes six DSM IV-oriented scales: Affective Problems; Anxiety Problems; Somatic Problems; ADH Problems; Oppositional Defiant Problems; and Conduct Problems. For each item, the male helpseekers rated on a 3-point scale how true each statement was for his oldest child: 0 = not true (as far as you know); 1 = somewhat/sometimes true; 2 = very or often true. Research on the ability of these scales to accurately identify DSM diagnoses shows moderate predictive ability for anxiety disorders and strong predictive ability for depressive disorders (Ferdinand, 2008). In the current study, alphas ranged from .80 (Anxiety Problems) to .92 (Conduct Problems) for the school-age children, and from .72 (ADH Problems) to .84 (Pervasive Developmental Problems) for the preschool children.

Things I Have Seen and Heard (TIHSH)

To measure the oldest child's exposure to other types of violence in their communities, we used the parent version of TIHSH (Richters & Martinez, 1993). This 20-item tool measures events to which children might have been exposed, such as hearing gun shots or witnessing an arrest, on a scale of 0–4 (0 = never, 4 = many times). The items are then totaled. TIHSH has demonstrated very good internal consistency across cultures (Richters & Martinez, 1992), and the parent version has been successfully used in research on child witnesses of IPV (Spilsbury et al., 2008). For all items, we specified that the event had to have occurred outside of witnessing any violence between the helpseeker and his abusive female partner. Cronbach's alpha for the current sample was .77.

Analyses

To assess the extent to which male PV victims sustained sexual PV in their relationships, we calculated descriptive statistics (i.e., frequency, means, SDs). Using McNemar's test, we compared the prevalence of the men's reports of sustaining versus perpetrating sexual PV; we used paired-samples *t* tests to compare the average number of types of sexual PV the men reported sustaining with the average number of types they reported perpetrating. For ease of testing our research questions, we then separated the men into three groups: no sexual aggression victimization ($n = 309$; 50.6 %), minor sexual aggression victimization only ($n = 131$; 21.4 %), and severe sexual aggression victimization ($n = 171$; 28.0 %).

To test the associations between severity of sexual aggression and other forms of PV, we conducted Pearson correlation analyses. To initially test the associations between sexual PV victimization and the health of the male victims and their children, we performed bivariate correlations between sexual PV group type and the various health indicators we assessed. For any significant bivariate correlations, we then ran a series of regressions to investigate whether those associations remained after controlling for other significant predictors of the health of the men and their children. The dependent variables in these analyses were the various health indicators, and we entered the predictors in blocks. At Step 1, we included significant demographic variables because we wanted to control for those variables first before considering the potential influence of other trauma and abuse variables. The remaining steps were determined based upon (1) how distal/proximal that trauma/abuse was to the relationship, with more distal variables entered first, and (2) whether the PV was perpetrated or sustained by the male helpseeker, with perpetration entered first because we wanted to understand the influence of victimization after controlling for perpetration. At the final step, sexual PV victimization was entered because that was our main predictor of interest. More specific information about the exact variables entered at each step for the regressions predicting men's health versus those predicting the children's health is presented in their respective sub-sections in the "Results" section.

Results

Descriptive Information on Sexual Aggression Against Male Helpseekers

Table 1 presents the descriptive information about the rates and frequency of sexual aggression against the male helpseekers. Almost 50 % of the men reported being victimized by at least one form of sexual aggression in their relationship; 43.4 % reported minor sexual aggression (i.e., verbal coercion to engage in vaginal, oral, and/or anal sex), while 28.0 % reported severe sexual aggression (i.e., threats or force to engage in vaginal, oral, and/or anal sex). The male helpseekers' rates of all forms of sexual aggression victimization were significantly greater than the rates at which they perpetrated sexual aggression.

The bottom portion of Table 1 presents the average number of types of sexual aggression experienced among all helpseekers, regardless of whether they reported sexual aggression victimization. Male helpseekers reported significantly more types of sexual aggression victimization than they reported perpetrating. If only victims of sexual aggression are selected, then the average number of sexual aggression types they experienced was 2.3 (SD = 1.5; maximum possible = 6); for minor sexual aggression, the average number of types was 1.4 (SD = 0.5; maximum possible = 2), and for severe sexual aggression, 1.9 (SD = 1.1; maximum possible = 4).

Associations of Sexual Aggression with Other Forms of PV Victimization

Table 2 presents results from analyses investigating whether sexual aggression victimization severity was associated with other forms of PV; the top half of Table 2 shows the correlations between severity level of sexual PV and the prevalence of all other forms of PV. With the exception of legal/administrative aggression and severe psychological aggression, all forms of PV were significantly positively associated with sexual aggression severity level, although the associations with severe physical PV and controlling behaviors were small.

The bottom half of Table 2 presents the correlations between sexual aggression severity level and the variety scores of each form of PV. With the exception of legal/administrative aggression, all forms of PV were significantly positively correlated with sexual aggression severity level, and the correlations with sexual aggression ranged from $r = .22$ for severe psychological aggression to $r = .35$ for controlling behaviors. The correlation between sexual aggression severity level and number of types of sexual PV experienced was $r = .84$.

Sexual Aggression Victimization and Male Helpseekers' Mental and Physical Health

Table 3 presents bivariate correlations between the severity level of men's sexual aggression victimization and the four measures of men's health: depression symptoms, PTSD symptoms, physical health symptoms, and poor health. As shown, men's severity of sexual aggression victimization was significantly correlated with all four measures.

We then performed a multiple regression with each of the four measures of mental and physical health as our outcome variable. At Step 1, we included men's demographic variables that significantly correlated with that outcome on a bivariate level (analyses not shown). We chose to only use the demographics that significantly correlated with the outcome variable for simplicity of presentation; however, this method could potentially decrease the generalizability of the findings. At Step 2, we added men's experiences of other traumatic experiences, which included their scores on our measures of childhood neglect, childhood sexual abuse, and childhood violence exposure in the home, as well as their score on the TEQ. At Step 3, we added the men's own perpetration of sexual aggression in the relationship. At Step 4, we added the men's victimization from other forms of PV in their relationship. Finally, at Step 5, we added the men's victimization from sexual aggression to see if their victimization from sexual aggression significantly predicted each of the health outcomes above and beyond all of the other variables in the model.

As shown in Table 4, after controlling for all other predictors, sexual aggression victimization was a significant predictor of all four health outcomes. For PTSD symptoms, it explained an additional 2.2 % of the variance; for depressive and physical health symptoms, an additional 1.1 %; and for poor health, an additional 0.6 %. In addition, even though sexual aggression severity was entered last in the equation, it consistently had one of the stronger standardized coefficients in the regression equations. Among the other variables, for all health outcomes, neither physical aggression nor severe psychological aggression contributed significant unique variance. Childhood neglect was a consistent significant predictor across all health outcomes. Men's sexual aggression perpetration did not predict their health in any analyses.

Helpseekers' Sexual Aggression Victimization and Their Children's Mental Health

Our next analyses focused on whether the male helpseekers' sexual aggression victimization level was associated with the mental health of their children, according to the scores on the DSM scales of the CBCL for both the preschool and school-age

Table 2 Correlations between sexual aggression victimization severity groups and other types of IPV

IPV victimization type	No sexual aggression victimization ($n = 309$)	Minor sexual aggression victimization only ($n = 131$)	Severe sexual aggression victimization ($n = 171$)	Correlation with male helpseekers' sexual aggression severity
% Victimized				
Controlling behaviors	92.8 %	94.6 %	97.0 %	.08*
Severe psychological	94.4 %	93.9 %	98.2 %	.07†
Legal/administrative	92.5 %	88.5 %	91.7 %	.06
Severe injury	33.8 %	40.0 %	55.9 %	.19***
Any injury	67.2 %	71.5 %	86.5 %	.19***
Severe physical	82.9 %	87.7 %	90.1 %	.09*
Very severe physical	43.4 %	49.2 %	65.5 %	.19***
	M (SD)	*M* (SD)	*M* (SD)	
No. of types of victimization ever (variety score)				
Controlling behaviors	3.5 (2.14)	4.0 (2.4)	5.5 (2.4)	.35***
Severe psychological	2.6 (1.20)	2.7 (1.2)	3.3 (1.0)	.22***
Legal/administrative	3.6 (1.87)	3.4 (2.1)	3.8 (1.9)	.05
Any injury	1.7 (1.51)	2.0 (1.6)	2.6 (1.7)	.24***
Severe injury	0.5 (0.87)	0.7 (1.0)	1.1 (1.2)	.23***
Any physical	5.5 (2.72)	6.1 (2.6)	7.4 (2.9)	.28***
Severe physical	2.1 (1.66)	2.3 (1.6)	3.3 (2.1)	.28***
Very severe physical	0.7 (0.91)	0.8 (0.9)	1.3 (1.3)	.27***
Total sexual	–	1.2 (0.4)	3.1 (1.6)	.84***

† $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$

children. Table 3 presents the correlational analyses between these variables. For preschoolers, the male helpseekers' sexual aggression victimization level was significantly correlated with affective problems, oppositional defiant problems, and pervasive developmental problems, with the strongest correlation for affective problems. For school-age children, the male helpseekers' sexual aggression victimization level was significantly correlated with all of the scale scores, and the strongest correlation was with ADH problems.

We then conducted a series of regression models. We conducted these for the school-age children only because of the small sample size for the preschool children. At Step 1, for each regression equation was a basic demographic information on the child—whether they were the male helpseekers' biological child, his abusive female partner's biological child, the child's age, and the child's gender. At Step 2, we added the amount of community violence to which the child had been exposed (TIHSH score). Step 3 contained the variety scores of different forms of PV that the children had been exposed to in the home; these variables combined both the male helpseekers' and his female partners' use of PV. At Step 4, we added the male helpseekers' use of sexual aggression (none, minor only, severe), and at Step 5, we added his victimization from sexual aggression (none, minor only, severe). This final step allows for an investigation of whether the male helpseekers' sexual aggression victimization severity influenced the children's mental health above and beyond all other forms of trauma and abuse measured in this study and above and beyond the male helpseekers' own use of sexual aggression.

Table 5 presents the results. The male helpseekers' sexual aggression victimization severity level was a significant predictor of both the ADH problems and the affective problems of the children. It contributed an additional 2.9 % of the variance to the ADH problems and an additional 1.3 % to the affective problems, even after considering all of the other trauma and abuse to which the child had been exposed. The male helpseekers' perpetration of sexual aggression did not significantly contribute to the variance of either ADH or affective problems. Neither the victimization nor perpetration of sexual aggression by the male helpseekers contributed any significant variance for anxiety, conduct, or oppositional defiant problems, above and beyond the other variables in the analysis. For somatic problems, only the male helpseekers' perpetration of sexual aggression contributed significantly to the variance, with an additional 1.4 % of the variance explained. For all of the children's mental health outcomes, the children's exposure to community violence was a consistently strong and significant predictor. For other types of PV in the home, a consistent predictor was the number of types of legal/administrative aggression.

Table 3 Bivariate correlations between men's and children's health outcomes and sexual aggression severity

Health outcome	No sexual aggression victimization *M* (SD) $n = 301$	Minor sexual aggression victimization only *M* (SD) $n = 131$	Severe sexual aggression victimization *M* (SD) $n = 171$	Correlation with male helpseekers' sexual aggression severity
Male participants' health ($n = 603$)[a]				
PTSD symptoms (PCL)	38.2 (15.2)	41.7 (17.0)	49.9 (17.4)	.29***
Depressive symptoms (CES-D)	23.5 (14.0)	26.4 (15.0)	31.6 (14.9)	.23***
Physical health symptoms (CHIPS)	40.8 (26.8)	50.9 (31.4)	61.0 (32.5)	.28***
Poor health and well-being (SF4)	5.9 (3.9)	7.0 (4.2)	7.8 (3.9)	.20***
	$n = 37$	$n = 16$	$n = 26$	
Preschool children's health ($n = 79$)[a]				
Affective problems	1.9 (1.9)	0.9 (2.1)	4.5 (3.8)	.35***
Anxiety problems	2.9 (3.1)	1.4 (4.1)	4.7 (4.3)	.19
Attention deficit/hyperactivity problems	2.6 (2.2)	1.6 (1.9)	3.9 (2.5)	.20
Oppositional defiant problems	2.3 (2.1)	1.2 (2.6)	3.8 (3.1)	.23*
Pervasive developmental problems	3.2 (2.5)	1.9 (4.3)	5.8 (5.5)	.26*
	$n = 160$	$n = 60$	$n = 74$	
School-age children's health ($n = 294$)[a]				
Affective problems	3.6 (3.8)	3.8 (4.3)	5.5 (4.4)	.17**
Anxiety problems	2.4 (2.5)	2.8 (2.7)	3.5 (2.9)	.16**
Attention deficit/hyperactivity problems	3.1 (3.1)	4.2 (3.8)	4.9 (3.3)	.23***
Conduct problems	3.5 (4.9)	4.3 (5.9)	5.7 (6.7)	.15*
Oppositional defiant problems	2.5 (2.3)	3.3 (3.0)	3.5 (2.9)	.15**
Somatic problems	1.3 (2.2)	1.7 (2.7)	2.1 (2.7)	.12*

* $p < .05$; ** $p < .01$; *** $p < .001$

[a] Due to too much missing data for some participants, sample sizes for these analyses are smaller than the total sample size

Discussion

The purpose of this study was to explore the experiences of sexual aggression victimization among male victims of physical PV who sought help. We investigated the rates, relationship experiences, and potential health outcomes of the men and their children, and found that for the most part, men's experiences were similar to their female counterparts' experiences documented in the literature.

Rates and Other Types of Violence in the Relationship

Almost half of the men reported experiencing some form of sexual aggression within their abusive relationship, with close to one-third reporting sustaining threatened or forced vaginal, oral, or anal sex. The rates of any sexual aggression are within range of what has been estimated among battered women who have sought help (Bennice & Resick, 2003; Campbell, 1989; Campbell & Soeken, 1999; McFarlane & Malecha, 2005), whereas rates of threatened or forced sex are slightly below what has been found with battered women (Bennice & Resick, 2003; Monson et al., 2009). Moreover, among men who experienced sexual aggression, they reportedly experienced on average more than two types of sexual aggression. Thus, sexual aggression is a major concern among male victims of physical PV who seek help.

Also, similar to what we see among battered women (Bennice & Resick, 2003; Bennice et al., 2003; Meyer et al., 1998; Monson et al., 2009) is the finding that severity level of sexual aggression victimization was significantly associated with other forms of violence and abuse in their relationships. For example, among male victims of severe sexual PV, close to 90 % reportedly sustained an injury in their relationships; over half reported sustaining a severe injury (i.e., severe enough to warrant medical attention); over 90 % sustained severe physical aggression (i.e., more likely to cause an injury), and almost two-thirds reportedly sustained very severe physical aggression (i.e., life-threatening). According to the men's reports, they were also significantly more likely to sustain more types of all forms of aggression, with the exception of legal/administrative aggression. Thus, it might be the case that as with battered women (Campbell et al., 2003), severity of male PV victims' sexual aggression victimization may predict more dangerous relationships where homicide is more likely. Homicide risk among male PV victims and its

Table 4 Final step-wise regression models predicting men's health outcomes, $n = 603$

Step	Predictor	*B*	SE	β	*t*	*p*	ΔR^2
PTSD symptoms[c]							
1	Age	−0.10	0.08	−.05	−1.30	.194	.048***
	Parented children with abusive female partner	−5.79	1.59	−.16	−3.64	<.001	
	Personal income	0.13	0.24	.02	0.55	.580	
	Length of time since relationship ended (in months)	−0.04	0.01	−.14	−3.39	.001	
2	Childhood neglect	1.13	0.33	.14	3.47	.001	.045***
	Childhood sexual abuse	−0.46	0.47	−.04	−0.99	.325	
	Childhood violence exposure in home	0.79	0.42	.08	1.88	.061	
	Other traumatic experiences (TEQ)	0.36	0.38	.04	0.96	.335	
3	No. of types of sexual aggression perpetrated	−2.84	1.25	−.09	−2.27	.024	.002
4	No. of types of controlling behaviors victimization	1.52	0.34	.21	4.49	<.001	.138***
	No. of types of legal/admin aggression victimization	1.42	0.44	.16	3.12	.001	
	No. of types of severe psychological aggression victimization	0.60	0.69	.04	0.87	.385	
	No. of types of physical aggression victimization	0.12	0.28	.02	0.42	.676	
5	Sexual victimization severity[a]	3.31	0.83	.17	3.97	<.001	.022***
Depressive symptoms[d]							
1	Age	−0.10	0.07	−.06	−1.37	.171	.112***
	Personal income	−0.45	0.23	−.09	−1.97	.049	
	Length of time since relationship ended (in months)	−0.05	0.01	−.20	−4.25	<.001	
	Currently in the relationship[b]	1.56	1.58	.05	0.99	.322	
	Education	−0.37	0.46	−.03	−0.80	.424	
2	Childhood neglect	0.85	0.30	.12	2.84	.005	.029**
	Childhood sexual abuse	−0.37	0.44	−.04	−0.84	.403	
	Childhood violence exposure in home	0.70	0.38	.8	1.83	.067	
	Other traumatic experiences	0.20	0.35	.03	0.57	.572	
3	No. of types of sexual aggression perpetrated	−2.46	1.17	−.09	−0.21	.035	.003
4	No. of types of controlling behaviors victimization	0.73	0.31	.12	2.35	.019	.063***
	No. of types of legal/admin aggression victimization	0.63	0.37	.08	1.72	.087	
	No. of types of severe psychological aggression victimization	0.77	0.64	.06	1.20	.230	
	No. of types of physical aggression victimization	0.18	0.25	.03	0.70	.485	
5	Sexual victimization severity[a]	2.10	0.78	.12	2.71	.007	.011**
Physical health symptoms (CHIPS)[e]							
1	Age	−0.04	0.14	−.01	−0.27	.788	.072***
	Personal income	−1.00	0.44	−.09	−2.26	.024	
	Length of time since relationship ended (in months)	−0.07	0.02	−.12	−2.95	.003	
	Education	−1.57	0.89	−.07	−1.78	.076	
2	Childhood neglect	1.15	0.59	.08	1.96	.051	.083***
	Childhood sexual abuse	−0.19	0.84	−.01	−0.23	.818	
	Childhood violence exposure in home	0.96	0.75	.05	1.27	.203	
	Other traumatic experiences	3.12	0.67	.19	4.65	<.001	
3	No. of types of sexual aggression perpetrated	−2.12	2.24	−.04	−0.95	.343	.000
4	No. of types of controlling behaviors victimization	2.91	0.60	.23	4.82	<.001	.105***
	No. of types of legal/admin aggression victimization	0.64	0.69	.04	0.93	.352	
	No. of types of severe psychological aggression victimization	0.42	1.23	.02	0.34	.731	
	No. of types of physical aggression victimization	0.91	0.49	.08	1.85	.065	
5	Sexual victimization severity[a]	4.20	1.49	.12	2.82	.005	.011**
Poor health (SF4)[f]							
1	Personal income	−0.13	0.06	−.09	−2.13	.034	.070***

Table 4 continued

Step	Predictor	*B*	SE	*β*	*t*	*p*	ΔR^2
	Length of time since relationship ended (in months)	−0.01	.003	−.16	−3.96	<.001	
	Education	−0.20	0.12	−.07	−1.60	.110	
2	Childhood neglect	0.22	0.08	.12	2.72	.007	.060***
	Childhood sexual abuse	−0.11	0.12	−.04	−0.92	.357	
	Childhood violence exposure in home	0.09	0.10	.04	0.81	.416	
	Other traumatic experiences	0.36	0.09	.16	3.90	<.001	
3	No. of types of sexual aggression perpetrated	−0.01	0.31	.00	−0.04	.966	.000
4	No. of types of controlling behaviors victimization	0.21	0.08	.13	2.54	.011	.041***
	No. of types of legal/admin aggression victimization	0.10	0.10	.05	1.03	.303	
	No. of types of severe psychological aggression victimization	0.22	0.17	.06	1.28	.203	
	No. of types of physical aggression victimization	−0.03	0.07	−.02	−0.37	.713	
5	Sexual victimization severity[a]	0.41	0.21	.09	1.98	.048	.006*

* $p < .05$; ** $p < .01$; *** $p < .001$

[a] Sexual victimization severity: 0 = no sexual aggression victimization, 1 = minor sexual aggression victimization only, 2 = severe sexual aggression victimization

[b] Currently in the relationship: 1 = yes, 0 = no

[c] PTSD symptoms final model: adjusted $R^2 = .236$, $F(14, 540) = 13.23$, $p < .001$

[d] Depressive symptoms final model: adjusted $R^2 = .196$, $F(15, 517) = 9.38$, $p < .001$

[e] CHIPS final model: adjusted $R^2 = .252$, $F(14, 545) = 14.47$, $p < .001$

[f] SF4 final model: adjusted $R^2 = .157$, $F(13, 546) = 9.01$, $p < .001$

association with severity of sexual PV victimization is an important area of future research.

Health of Male Victims and Their Children

We found that men's physical and mental health was significantly and uniquely associated with their reports of victimization from increasing levels of sexual aggression severity. This parallels research findings on battered women (Bennice & Resick, 2003; Bennice et al., 2003; Dutton, 2009; McFarlane et al., 2005; McFarlane & Malecha, 2005) and was true for the male helpseekers' PTSD symptoms, depressive symptoms, physical health symptoms, and poor health. Moreover, the significant association with these health indicators remained after we statistically controlled for all other trauma assessed in our study, including childhood experiences of abuse and traumatic experiences outside the home. It also held above and beyond all other forms of PV the men experienced. Thus, male PV victims' reports of sexual aggression victimization in their relationships are significantly and uniquely associated with their mental and physical health.

Future research should investigate the mechanisms underlying this association. Is it due to a direct causal relationship between experiencing sexual PV and the male victim's health? Perhaps, the association is due to the men's cognitive appraisal of the sexual PV victimization, which may be perceived as a more severe form of violation. Are men with health problems more at risk for sexual PV victimization? Is the experience of sexual PV perhaps contributing to an exacerbation of these problems? Is the association due to a third variable, such as other dysfunctional family processes that may occur in households where male partner's victimization from sexual PV occurs? Whatever the underlying mechanisms, these findings show that for both male and female PV victims, we need to conceptualize PV more broadly to incorporate other forms of PV, not just physical PV. Thus, sexual aggression should no longer be overlooked as a type of PV that men can and do experience.

Not only was the level of sexual aggression severity associated with the men's health, it was associated with that of their children as well. Again, this is similar to what we see among children of battered women (McFarlane et al., 2007; Spiller et al., 2012). In our study, for preschool children, men's reported level of sexual aggression victimization significantly correlated with affective, oppositional defiant, and pervasive development problems. Due to the small sample size of men with preschool children, however, we could not perform multivariate tests to investigate whether these associations remained after controlling for other traumatic exposure for children. That is an important area of future research.

Among the school-age children of the men in our sample, we found that on the bivariate level, their father's reported severity of sexual PV victimization was associated with all of the mental health problems we assessed in the children. On a multivariate level, their father's reported level of sexual PV victimization severity was significantly and uniquely associated with two mental

Table 5 Step-wise multiple regressions predicting school-age children's CBCL DSM Scale Scores ($n = 281$)

Step	Predictor	*B*	SE	*β*	*t*	*p*	ΔR^2
Attention deficit/hyperactivity problems[d]							
1	Partner's biological child[b]	0.64	0.38	.10	1.70	.090	.083***
	Helpseeker's biological child[b]	−2.13	0.76	−.16	−2.79	.006	
	Child's age	−0.03	0.05	−.03	−0.60	.551	
	Child's gender[c]	1.35	0.36	.20	3.73	<.001	
2	Amount of community violence exposure	0.17	0.03	.28	4.89	<.001	.097***
3	No. of types of controlling behaviors between parents	−0.02	0.08	−.02	−0.24	.813	.022
	No. of types of legal/administrative aggression between parents	0.09	0.11	.05	0.74	.460	
	No. of types of severe psychological aggression between parents	0.23	0.14	.11	1.58	.115	
	No. of types of physical aggression between parents	−0.02	0.06	−.02	−0.28	.784	
4	Severity level of sexual aggression perpetrated by helpseeker[a]	−0.25	0.42	−.03	−0.59	.558	.001
5	Severity level of sexual aggression victimization by helpseeker[a]	0.74	0.23	.18	3.21	.001	.029***
Affective problems[e]							
1	Partner's biological child[b]	0.70	0.46	.09	1.53	.128	.058**
	Helpseeker's biological child[b]	−0.39	0.94	−.02	−0.42	.674	
	Child's age	0.18	0.07	.16	2.80	.005	
	Child's gender[c]	−0.30	0.44	−.04	−0.67	.503	
2	Amount of community violence exposure	0.15	0.04	.21	3.58	<.001	.072***
3	No. of types of controlling behaviors between parents	0.01	0.10	.004	0.05	.959	.051**
	No. of types of legal/administrative aggression between parents	0.43	0.14	.20	3.04	.003	
	No. of types of severe psychological aggression between parents	0.17	0.18	.07	0.93	.352	
	No. of types of physical aggression between parents	−0.05	0.08	−.04	−0.65	.517	
4	Severity level of sexual aggression perpetrated by helpseeker[a]	0.61	0.52	.07	1.18	.238	.004
5	Severity level of sexual aggression victimization by helpseeker[a]	0.59	0.28	.12	2.08	.038	.013*
Anxiety problems[f]							
1	Partner's biological child[b]	0.30	0.33	.06	0.91	.362	.010
	Helpseeker's biological child[b]	−0.67	0.67	−.06	−1.00	.317	
	Child's age	−0.004	0.05	−.01	−0.09	.926	
	Child's gender[c]	0.06	0.32	.01	0.20	.843	
2	Amount of community violence exposure	0.06	0.03	.14	2.14	.034	.033**
3	No. of types of controlling behaviors between parents	0.08	0.07	.08	1.07	.287	.032
	No. of types of legal/administrative aggression between parents	0.14	0.10	.10	1.40	.162	
	No. of types of severe psychological aggression between parents	0.08	0.13	.05	0.67	.503	
	No. of types of physical aggression between parents	−0.04	0.06	−.06	−0.78	.435	
4	Severity level of sexual aggression perpetrated by helpseeker[a]	0.14	0.37	.02	0.39	.699	.001
5	Severity level of sexual aggression victimization by helpseeker[a]	0.38	0.20	.12	1.88	.061	.012
Conduct problems[g]							
1	Partner's biological child[b]	1.49	0.60	.14	2.49	.013	.069***
	Helpseeker's biological child[b]	−1.27	1.22	−.06	−1.04	.299	
	Child's age	0.20	0.08	.13	2.32	.021	
	Child's gender[c]	0.47	0.58	.04	0.81	.421	
2	Amount of community violence exposure	0.34	0.05	.36	6.29	<.001	.151***
3	No. of types of controlling behaviors between parents	−0.05	0.13	−.02	−0.35	.729	.031*
	No. of types of legal/administrative aggression between parents	0.40	0.18	.13	2.17	.031	
	No. of types of severe psychological aggression between parents	0.36	0.23	.10	1.57	.117	
	No. of types of physical aggression between parents	−0.01	0.10	−.07	−1.12	.265	
4	Severity level of sexual aggression perpetrated by helpseeker[a]	1.23	0.67	.09	1.68	.093	.008
5	Severity level of sexual aggression victimization by helpseeker[a]	0.53	0.37	.08	1.45	.150	.006

Table 5 continued

Step	Predictor	*B*	SE	*β*	*t*	*p*	ΔR^2
Oppositional defiant problems[h]							
1	Partner's biological child[b]	0.69	0.30	.13	2.27	.024	.031
	Helpseeker's biological child[b]	−0.04	0.62	−.004	−0.07	.948	
	Child's age	0.02	0.04	.03	0.51	.610	
	Child's gender[c]	0.17	0.29	.03	0.59	.555	
2	Amount of community violence exposure	0.08	0.03	.18	3.02	.003	.060***
3	No. of types of controlling behaviors between parents	−0.05	0.07	−.06	−0.80	.427	.047**
	No. of types of legal/administrative aggression between parents	0.24	0.09	.17	2.65	.009	
	No. of types of severe psychological aggression between parents	0.08	0.12	.05	0.66	.510	
	No. of types of physical aggression between parents	0.07	0.05	.09	1.26	.208	
4	Severity level of sexual aggression perpetrated by helpseeker[a]	0.61	0.34	.10	1.80	.072	.011
5	Severity level of sexual aggression victimization by helpseeker[a]	0.29	0.19	.09	1.56	.120	.008
Somatic problems[i]							
1	Partner's biological child[b]	0.36	0.29	.07	1.26	.211	.038*
	Helpseeker's biological child[b]	−0.45	0.59	−.05	−0.76	.451	
	Child's age	0.07	0.04	.10	1.69	.092	
	Child's gender[c]	−0.47	0.28	−.10	−1.67	.096	
2	Amount of community violence exposure	0.08	0.03	.18	2.86	.005	.047***
3	No. of types of controlling behaviors between parents	0.03	0.07	.03	0.39	.697	.032*
	No. of types of legal/administrative aggression between parents	0.21	0.09	.16	2.33	.020	
	No. of types of severe psychological aggression between parents	0.05	0.11	.03	0.47	.642	
	No. of types of physical aggression between parents	−0.05	0.05	−.07	−1.09	.278	
4	Severity level of sexual aggression perpetrated by helpseeker[a]	0.67	0.33	.12	2.05	.042	.014*
5	Severity level of sexual aggression victimization by helpseeker[a]	0.24	0.18	.08	1.34	.182	.006

Due to missing data on some of the children, sample size for these analyses were lower than the total sample

* $p < .05$; ** $p < .01$; *** $p < .001$

[a] Sexual assault severity: 0 = no sexual aggression, 1 = minor sexual aggression only, 2 = severe sexual aggression

[b] Biological child: 1 = yes, 0 = no

[c] Child's gender: 0 = female, 1 = male

[d] ADH problems: adjusted $R^2 = .201$, $F(11, 269) = 7.39$, $p < .001$

[e] Affective problems: adjusted $R^2 = .165$, $F(11, 269) = 6.03$, $p < .001$

[f] Anxiety problems: adjusted $R^2 = .050$, $F(11, 269) = 2.34$, $p = .009$

[g] Conduct problems: adjusted $R^2 = .235$, $F(11, 269) = 8.84$, $p < .001$

[h] Oppositional defiant problems: adjusted $R^2 = .122$, $F(11, 269) = 4.53$, $p < .001$

[i] Somatic problems: adjusted $R^2 = .101$, $F(11, 269) = 3.85$, $p < .001$

health issues—ADH and affective problems—after controlling for child demographics, children's exposure to violence in the community, their exposure to all other forms of PV between their parents, and their fathers' reported perpetration of sexual PV.

Notably, we do not know whether the children actually witnessed the sexual aggression against their fathers, which shows that regardless of whether children witness sexual PV, being in a home where sexual PV against their fathers occurs is associated with children's mental health. It may be associated with these aspects of the children's mental health because the parents are not psychologically available to the child, may express more hostility and irritability when they do interact with their child, and may be less consistent with discipline. Sexual PV may also be a marker for other dysfunctional family processes that may negatively influence a child's mental health, such as alcohol abuse, mental health issues, and self-control problems in the perpetrator (Spiller et al., 2012), and perhaps certain psychological instability in the male victims. Relatedly, it is important to note that although the oldest child was the biological child of the participant in 92.9 % of the cases, the child was the biological child of the female perpetrator in only 44.6 % of the cases. Therefore, there may be issues of family instability and multiple mother-figures for these children that may also influence their mental health.

Although we controlled for whether the child was the biological child of both the participant and the female perpetrator, we did not control for other forms of family instability that might contribute to children's poor mental health. This issue of instability as a mediator for these associations should be investigated in future research.

One other notable finding was that the male victims' reported perpetration of sexual PV was significantly and uniquely associated with school-age children's somatic problems, after controlling for other forms of violence exposure; further, men's reported victimization of sexual PV was not associated with their children's somatic problems above and beyond their reported perpetration. There is no previous research that can inform how or why PV victims' use of sexual aggression may be associated with their children's mental health, or why somatic problems may be particularly relevant. Thus, this finding points toward the need for future research on how and why PV victims' use of sexual aggression may be associated with their children mental health, among both male and female PV victims.

Limitations and Future Research

The current study had several limitations that should be considered in future research. First, our scale contained only a limited number of sexual aggression items, but sexual aggression can encompass a broad array of behaviors, such as withholding sex to manipulate one's partner (Felson, 2002), physical attacks on sexual organs (Cook & Hodo, 2013), partner trying to get pregnant or stopping the other from using birth control without their consent (Black et al., 2011), sexual humiliation and degradation, penetration while sleeping (Logan, Cole, & Shannon, 2007), and substance-facilitated sexual assaults (Anderson & Savage, 2005; Logan et al., 2007). When these forms of sexual aggression are taken into consideration, rates may increase, and some of the associations found here may change. A related concern is that our measure of minor sexual aggression encompassed behaviors that may have been consensual, although were unwanted (i.e., insisting on sex when partner did not want to). Future research should address how non-consensual experiences differ from unwanted (but consensual) experiences in their prediction of other forms of PV in the relationship and health outcomes in the male victims and their children. A similar problem is that interpretation of the CTS2 sexual aggression items can be subjective. For example, when one is threatened to engage in sexual intercourse against one's will, we do not know whether the threat is a physical threat (e.g., by knife-point) or a psychological one (e.g., threatening to leave the relationship or ruin one's reputation), and whether participants made their own decisions about which threats would qualify as threats. Thus, future research should specifically ask about various types of threats, force, or verbal coercion that one's partner may use in a sexually aggressive incident.

A second limitation was that this study was solely based on the self-reports by the male PV victims, which can lead to two potential problems: (1) shared method variance, which may cause inflated correlations because the same person reported on PV, men's health, and children's mental health; and (2) inaccurate reporting of PV victimization and perpetration. For the former issue, it is possible that male PV victims who report negative behaviors by their partners are likely to also report/notice negative health in themselves and their children in comparison to men who do not experience PV. For the latter issue, research shows that the typical pattern is under-reporting of one's own use of undesirable behavior, but not of one's partner's undesirable behavior (Woodin, Sotskova, & O'Leary, 2013). However, even for the partner's behavior, under-reporting is common, as victims tend to feel embarrassed or humiliated by being abused (Follingstad & Rogers, 2013). Nonetheless, future studies should strive to obtain information about men's experiences with IPV from multiple informants.

A third limitation results from our sampling method. We recruited our sample online and our participants remained anonymous, which could result in at least two problems (1) the same man may have taken the survey more than once, and (2) men who completed the survey were not actually helpseekers. These are valid concerns, but were likely minimized by safeguards we instituted in the survey. For the former issue, we programmed the survey so that it could only be taken once from a given IP address. Although a participant could have taken the survey again from a different computer, the fact that the survey took 20–30 min to complete without compensation likely deterred participants from doing so. For the latter issue, our recruitment advertisement did not indicate that we were looking for men who sought help. The second page of the survey contained screener questions asking about helpseeking from the sources we listed in our Method section. Our analyses showed that 22.4 % of the people who provided consent for the study did not qualify based on the first page of screener questions which asked about their demographics (e.g., they were female or lived outside the US), and an additional 4.8 % did not qualify because they reported that they did not seek help from any of the sources listed. Nonetheless, participants could have falsified their helpseeking information, and we have no way to verify whether they did indeed seek help.

A fourth limitation was that because this was a cross-sectional study we can neither establish the sequence of events of PV in this study, nor can we conclusively say that the sexual PV caused the health problems among the men and their children. For example, McFarlane and Malecha (2005) found that a majority of battered women in their study reported a change in the relationship before the sexual aggression began, with an increase in violence, possessiveness, and control. This type of sequencing needs to be investigated among male PV victims because it could indicate a turning point in the relationship

where the PV becomes more dangerous. Similarly, without longitudinal designs, we cannot know whether sexual PV causes health problems in male victims and their children, whether having health problems makes men more vulnerable to sexual PV, or whether a third variable mediates the relationship between sexual PV and health problems in male victims and their children. These are important areas to address in future research.

A fifth limitation is that our study did not provide any information beyond the demographic characteristics of the female perpetrator of sexual PV in these relationships. Preliminary work among college students shows that female perpetrators of sexual aggression tend to have much dating experience, sex with their partners very early in relationships, and relationships characterized by violence, game playing (Craig Shea, 1998), and psychological aggression (Hines & Saudino, 2003). Further, they seem to be more aggressive and power-oriented than women who are not sexually aggressive, and they are less traditional in their views about women and relationships. Specifically, they feel that women have the right to express their sexual desires, and see relationships as a means of gaining power, not as a means of expressing tenderness and love (Craig Shea, 1998). Similar work needs to be done among female perpetrators of sexual PV in the types of relationships discussed in the current study.

A sixth limitation is the sample size. Logistic regression analyses require large samples, typically 30 cases per variable in the analysis (Meyers, Gamst, & Guarino, 2013). Thus, we may not have had the power to detect whether some of the covariates and/or sexual PV victimization of the men were associated with the health outcomes for the children, particularly, if the effect sizes were small. Thus, future research should aim for larger sample sizes of men with children.

A final limitation concerns the generalizability of our findings. We specifically recruited our sample of male PV victims so that it would be comparable to the majority of studies on battered women, which typically recruit battered women who sought help for PV victimization. Thus, we also required that the male PV victims sought help. This limits generalizability because it is likely that the majority of male PV victims do not seek help. The extent to which non-helpseekers experience sexual PV and the extent to which it is associated with their health and the mental health of their children are unknown. It is possible that men who seek help for PV victimization experience more serious attacks, including sexual attacks, than male PV victims who do not seek help. It is important to note that the research on male helpseeking for a variety of mental and physical health concerns shows that men have to overcome several societal and internal barriers to seek help (Addis & Mahalik, 2003). These barriers are compounded when the problem is viewed to be non-normative by society and something that men should be able to handle themselves (Addis & Mahalik, 2003), as would be the case for male PV victims. Related to this issue of generalizability and sampling method, the helpseekers had to have seen our advertisement on the Internet or been alerted to our study by a service provider who saw our advertisement online. In addition, they had to complete the study online. Therefore, helpseekers without access to the Internet were excluded. Future studies should aim to recruit men who may have sought help from other sources of support or who may not have sought help at all to investigate any possible differences in their experiences.

Implications

The current study showed that we can no longer overlook that women can and do sexually aggress against their male intimate partners, and that such aggression is associated with severe health indicators for both the male victims and their children. This topic has suffered from a serious lack of attention, perhaps because many in society hold the stereotype of men as the sexual pursuer, women as the pursued, men as the perpetrator, and women as the victim (George, 2003). Hopefully, by documenting that women's sexual perpetration against their male partners has potential health consequences for the men—something that many may find difficult to believe or sympathize with (Felson, 2002)—and also for their children, we can help increase awareness that the sexual victimization of male partners is a serious problem.

Bennice and Resick (2003) outlined several barriers for female sexual PV victims. These include that the victims do not typically receive the medical, mental health, and social service help they need to address their trauma issues; that their experiences are often invalidated by treatment providers who do not recognize sexual PV within relationships as a problem; that treatment providers may minimize the contributions of sexual PV to the mental health problems the women are experiencing; that sexual PV is not a trauma or serious at all; that female victims may fear being blamed by their friends, relatives, and service providers, which may dissuade them from seeking help; and that they may question that what they experienced was even a sexual assault. We would argue that all of these issues are likely exacerbated in male victims of sexual PV.

Our study showed that almost half of male physical PV victims who seek help reported experiencing sexual aggression from their female partner, and that almost one-third reported experiencing severe sexual aggression. Thus, service providers who encounter male victims should assess for sexual victimization as well. However, assessment for sexual aggression should be based on behaviorally specific questions because male victims may not be able or willing to label their experiences as sexual aggression, nor may they be willing to disclose what happened to them. Pino and Meier (1999), for example, found that male victims of rape only report it when it is physically or emotionally unavoidable, such as when it caused them bodily harm or they needed medical attention.

In addition, this study suggests that child welfare and mental health professionals should conduct a thorough assessment of PV by both partners that includes assessments of sexual aggression between partners. This study on male victims and other research on female victims (McFarlane et al., 2007; Spiller et al., 2012) show that children who live in homes where sexual aggression occurs between parents have poorer mental health, even if they do not actually witness the sexual aggression. Thus, providers working with children in a supportive role should assess for this form of PV to ascertain whether there is a heightened risk for poorer mental health functioning among the children.

Assessing for and validating sexual aggression experiences among male physical PV victims are extremely important because these experiences are associated with more violent and abusive relationships, and with poorer mental and physical health in the men and their children. We recommend that this trauma be recognized as such, and that domestic violence service providers, police, child welfare workers, court officials, mental health providers, and medical providers be educated about its existence and wide-ranging potential consequences.

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Symptoms of Posttraumatic Stress Disorder in Men Who Sustain Intimate Partner Violence: A Study of Helpseeking and Community Samples

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Extensive work has documented an association between sustaining intimate partner violence (IPV) and posttraumatic stress disorder (PTSD) among women, yet little research has documented the same association in men, even though men comprise 25–50% of all IPV victims in a given year. Previous studies also show that women who sustain intimate terrorism (IT), a form of IPV that is characterized by much violence and controlling behavior, are at even greater risk for PTSD than women who sustain common couple violence (CCV), a lower level of more minor, reciprocal IPV. However, no research has documented this trend in men who sustain IT versus CCV. The present study investigates the associations among sustaining IPV and PTSD among both a clinical and community sample of men. The clinical sample is comprised of 302 men who sustained IT from their female partners and sought help. The community sample is comprised of 520 men, 16% of whom sustained CCV. Analyses showed that in both samples, the associations between sustaining several types of IPV and PTSD were significant, and that men who sustained IT were at exponentially increased risk of exceeding the clinical cut-off on the PTSD measure than men who sustained CCV or no violence. The path models predicting PTSD symptoms differed for both samples, indicating that perhaps treatment implications differ by group as well.

Keywords: domestic violence, male victims, trauma, intimate terrorism

Intimate partner violence (IPV), which includes physical, sexual, and psychological maltreatment of one partner against another, is a national social and health problem affecting hundreds of thousands of individuals and families a year (Centers for Disease Control, 2006; Tjaden & Thoennes, 2000). Studies of female victims of IPV have consistently shown that physical IPV can lead to symptoms of posttraumatic stress disorder (PTSD; Astin, Lawrence, & Foy, 1993; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Gleason, 1993; Housekamp & Foy, 1991; Kemp, Rawlings, & Green, 1991; Saunders, 1994; Woods & Isenberg, 2001). However, although between 25% and 50% of victims of physical IPV in a given year are men (Catalano, 2007; Straus, 1995; Tjaden & Thoennes, 2000), little research has documented this same association in men who sustain physical IPV. The few studies that do examine this association have used convenience or population-based samples (Coker, Weston, Creson, Justice, & Blakeney, 2005; Dansky, Byrne, & Brady, 1999; Hines, 2007), with no investigation of clinical samples of male victims of physical IPV, who, like samples of battered women (Astin et al., 1993; Cascardi et al., 1995; Gleason, 1993; Saunders, 1994), may be at an even greater risk for PTSD symptoms. The current study is an investigation of PTSD and sustaining IPV among both convenience and clinical samples of men.

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PTSD and Sustaining IPV

PTSD is a psychiatric condition that can follow the experience of a traumatic incident, and according to the fourth edition of the Diagnostic and Statistical Manual (American Psychiatric Association, 1994), its symptoms tend to cluster on three dimensions: persistent reexperiencing of the trauma, persistent avoidance of stimuli associated with the trauma, and persistent increased arousal. Although severe and persistent symptoms are needed to be diagnosed with PTSD (Wakefield & Spitzer, 2002), many people who experience a traumatic event respond with at least some of the symptoms of PTSD. The experience of IPV is generally considered to be a traumatic event (Walker, 2000).

PTSD has consistently been found among women who sustain IPV. For example, among battered women, approximately 30–85% evidence PTSD (Astin et al., 1993; Cascardi et al., 1995; Gleason, 1993; Kemp et al., 1991; Saunders, 1994). Moreover, increased symptoms are positively correlated with greater severity of IPV exposure, although even psychological or mild physical IPV can elicit posttraumatic stress (PTS) symptoms (Astin et al., 1993; Housekamp & Foy, 1991; Kemp et al., 1991; Woods & Isenberg, 2001).

Thus, PTSD as a possible outcome of IPV among women has been extensively studied; however, little work has been conducted on whether men could have similar outcomes when sustaining IPV. There is evidence that men who sustain IPV can experience it as a traumatic event (Cook, 2009), and preliminary work is suggestive that sustaining physical IPV among men is associated with increased PTSD symptoms. In one of the few studies on this issue, Dansky, Byrne, and Brady (1999) found that among 58 cocaine-dependent men, men who sustained physical IPV were more likely to report PTSD than men who were assaulted by a non-intimate. In an analysis of data from the National Violence Against Women Survey (NVAWS), Coker and her colleagues (2005) showed that 20% of the 185 men who reported sustaining physical IPV had moderate-to-severe PTSD symptoms. Hines (2007), in a 60-site multinational college student sample of 3,461 men, found that PTSD symptoms was associated with sustaining physical IPV at all sites.

Limitations of Current Research: Convenience Versus Clinical Samples

Although PTSD symptoms and sustaining physical IPV have been shown to be associated in men, the existing research is limited in a number of ways. The study on cocaine-dependent men (Dansky et al., 1999) is a very select sample with limited generalizability, and although larger in its scope, the Hines (2007) study contained only college men, and therefore, its generalizability may be limited as well. The NVAWS is more generalizable because it is a population-based survey; however, Coker et al.'s (2005) analyses did not assess how the severity of the physical IPV sustained might contribute to PTS symptoms. Because research shows that it is not just the exposure to trauma that elicits such symptoms, but rather the severity level of the trauma (e.g., Marsella, Friedman, & Spain, 1996), it is possible that men who report a greater severity of sustained IPV will report more symptoms of PTS.

Moreover, some researchers argue that the IPV that is studied in such convenience and population-based samples may be different from the IPV that is studied in clinical samples, such as samples of battered women (Johnson, 1995), and therefore, the associations among key predictor and outcome variables with sustaining IPV may be different. Johnson (1995, 2006; Johnson & Ferraro, 2000) argues that there are really two distinct types of IPV: (1) common couple violence (CCV), which is typically found in convenience, community, and population-based samples, and is characterized by low-level (e.g., slapping, pushing), low-frequency violence in a couple where both members are about equally violent; this IPV is not part of an overall pattern of control of one partner over the other, but is the result of a conflict "getting out of hand;" and (2) intimate terrorism (IT), which is typically found in shelter, police, or other clinical samples, in which the violence is one tactic in a general pattern of control of one member of the couple over the other. The physical IPV is more frequent than what is found in cases of CCV, is less likely to be mutual, and is more likely to involve serious injury; moreover, IT involves emotional abuse as well. Studies of women have shown that these distinctions may be necessary because each type may have different predictors and

outcomes—indeed, female victims of IT experience significantly greater levels of PTSD than female victims of CCV (Johnson & Leone, 2005; Leone, Johnson, Cohan, & Lloyd, 2004).

In a previous analysis of the two samples used in the current study (Hines & Douglas, 2010), we found that the men in our "helpseeking" sample (i.e., men who sustained physical IPV from a female partner and sought help for this problem) conformed to Johnson's (1995, 2006; Johnson & Ferraro, 2000) definition of IT—the frequency of physical IPV they sustained was comparable to the frequency with which shelter samples of battered women sustained physical IPV (Giles-Sims, 1983; Johnson, 2006; Okun, 1986; Straus, 1990); this physical IPV was accompanied by high levels of controlling behaviors, severe psychological aggression, and physical injuries. Moreover, their responses to the IPV and controlling behaviors, including violent responses, were comparable to the responses that have been observed in samples of battered women (Giles-Sims, 1983; McDonald, Jouriles, Tart, & Minze, 2009; Saunders, 1988), and the overwhelming majority of the physical arguments were initiated by the female partner. On the other hand, the 16% of the men in our community sample who sustained physical IPV conformed to Johnson's conceptualization of CCV—they and their female partners used low-level, low-frequency physical IPV at approximately the same rates, with an equal likelihood that either the man or his female partner hit first.

Given these clear differences between the samples in the experiences of men who sustain physical IPV, it is likely that their reactions to such IPV may be different. Associations between PTSD symptoms and sustaining physical IPV have been found in samples similar to our community sample (Coker et al., 2005; Dansky et al., 1999; Hines, 2007); we hypothesize that this association is the same among men in the helpseeking sample. In addition, we hypothesize that in comparison to men who sustain CCV, the symptoms of PTSD are more severe among men who sustain IT, given that their experiences of IPV are much more severe and thus, likely more traumatic. Finally, we hypothesize that the association between IPV, PTSD symptoms, and other key influential variables will be different between the two samples. Although there is a clear functional relationship among traumatic events and PTSD, studies of the development of PTSD symptoms after a traumatic exposure show that peri-exposure and postexposure environments are important in the development of this disorder. The two that have received the most empirical support are: (1) the level of violence experienced during the childhood of those who experienced the traumatic event; and (2) the level of social support the person receives after the traumatic event (Fontana & Rosenheck, 1994). We hypothesize that these peri- and postexposure environments will function differently in the development of PTSD symptoms in community versus helpseeking samples of men who sustain IPV.

Method

Participants and Procedure

Two separate samples of male participants were recruited for this study: a helpseeking sample and a community sample. For both samples, the men had to speak English, live in the U.S., and be between the ages of 18 and 59 years to be eligible; they also had to have been involved in an intimate relationship with a woman lasting at least 1 month in the previous year. In addition, to be eligible for the helpseeking sample, the men had to have sustained a physical assault from their female partner within the previous year, and they had to have sought help/assistance for their partner's violence. Help/assistance was broadly defined and included seeking help from formal sources such as hotlines, domestic violence agencies, the police, mental health and medical health professionals, lawyers, and ministers, to more informal helpseeking efforts, such as talking with friends and family members and searching the Internet for information or support groups for male victims.

The helpseeking sample of men ($n = 302$) was recruited from a variety of sources, including the Domestic Abuse Helpline for Men and Women (DAHMW; the only U.S. national hotline specializing in male victims of domestic violence), and online websites, newsletters, blogs, and listservs that specialized in treatment of IPV, male victims of IPV, fathers' rights issues, divorced men's issues, men's health issues, and men's rights issues. Men who called the DAHMW seeking assistance and who met

the eligibility criteria were invited to participate in this study either by calling a survey research center to complete the interview over the phone or by visiting the study website to complete an anonymous, secure version of the study questionnaire online. Men who saw an advertisement for the study online were directed to the study website to complete the online version of the study. Screener questions regarding the study criteria were on the first page of the survey, and men who were eligible were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an "exit page" of the survey. Sixteen men completed the interview over the phone; the remaining 286 completed it online. Demographics of the helpseeking sample can be found in Table 1.

Participants also included 520 men from the community. Approximately half of the commu-

Table 1
Demographics, Intimate Partner Violence Sustained, Social Support, and Childhood Aggression Experiences

	Helpseeking sample (n = 302)	Community sample (n = 520)	
	% or *M* (*SD*)	% or *M* (*SD*)	χ^2 or t
Demographics			
Age, years	40.49 (8.97)	43.68 (10.88)	4.52***
Education[a]	4.40 (1.56)	4.04 (1.72)	3.13**
	(n = 300)	(n = 514)	
Income, in thousands	$50.44K (25.69)	$48.98K (26.13)	0.77
	(n = 296)	(n = 508)	
% White	86.8	84.8	0.59
% Currently in a relationship	56.3	95.8	193.70***
% With minor children	73.2	45.3	64.60***
Length of relationship (in months)	97.90 (82.06)	164.90 (131.01)	8.93***
% Sustaining IPV			
% Controlling behaviors	93.4	20.0	412.20***
% Severe psychological aggression	96.0	13.7	526.31***
% Physical aggression	100.0	16.3	536.60***
% Injured in previous year	78.5	4.0	491.56***
Mean number of acts of IPV sustained in those sustaining IPV			
Number of controlling acts in previous year	42.62 (36.25)	11.36 (16.31)	11.64***
	(n = 282)	(n = 104)	
Number of severe psychological aggression acts in previous year	28.90 (26.20)	9.13 (13.26)	8.98***
	(n = 290)	(n = 71)	
Number of physically aggressive acts in previous year	46.72 (53.48)	12.22 (33.29)	7.27***
	(n = 302)	(n = 85)	
Number of injuries sustained in previous year	11.68 (15.61)	5.52 (11.42)	2.29*
	(n = 237)	(n = 21)	
Social support and childhood aggression experienced			
Social support	5.95 (5.91)	23.73 (5.24)	18.95***
% Sustaining child physical aggression	46.8	35.3	10.65***
% Witnessing IPV between parents	21.5	14.3	7.03**
% Sustaining familial child sexual abuse	12.9	6.4	10.20***
% Sustaining non-familial child sexual abuse	17.2	8.5	14.13***

[a] Educational status: 1 = Less than high school, 2 = High school graduate or GED, 3 = Some college/trade school, 4 = Two-year college graduate, 5 = Four-year college graduate, 6 = Some graduate school, 7 = Graduate degree.
* $p < .05$. ** $p < .01$. *** $p < .001$.

nity sample ($n = 255$) was recruited to participate in a phone version of the survey by a survey research center, using a random digit dialing technique and CATI administration. The interviewers attempted to reach each phone number on 15 different days, at different times of the day, and made call-back appointments whenever possible. They also made refusal conversion efforts when appropriate. Because of low response rates (8%) during the first 2 months, advanced letters were sent to potential participants informing them that they were randomly selected to participate in a study sponsored by the National Institutes of Health that was focusing on how men and women get along and that they would be contacted within a week by a survey research center interviewer. The response rate for the participants who received an advanced letter was 15.5%. The overall response rate was 9.8%. The other half of the community sample ($n = 265$) was recruited through a panel of survey participants maintained by Survey Sampling, Inc. (SSI), to complete an online version of the same survey. Email invitations were sent to 16,000 male SSI panel members inviting them to participate in a study on how men and women get along. They were directed to an anonymous, secure, online version of the survey. The first page of the survey included screener questions testing for eligibility. Eligible men were able to continue to the rest of the survey, whereas ineligible men were thanked for their time. The survey was closed after we met our target sample size of 265 men. Because data collection was ceased when the target goal for the number of completed surveys was reached and we did not wait for all men who received invitations to complete the survey, response rates for the Internet sample cannot be reliably calculated. Demographic information on the full community sample ($n = 520$) can be found in Table 1.[1]

The methods for this study were approved by the boards of ethics at the participating institutions. All of the men participated anonymously and were apprised of their rights as study participants. Steps were taken to ensure their safety: At the completion of the survey the participants were given information about obtaining help for IPV victimization and how to delete the history on their Internet web browser. Previous analyses of these datasets did not focus on the associations between PTSD symptoms and the IPV these men experienced.

Measures

Both the helpseeking and community samples were given the same core questionnaires regarding demographics, aggressive behaviors that they and their female partners may have used in the previous year, more detailed information regarding their last physical argument (if applicable), their mental health, and various risk factors. The helpseeking sample was given additional questions pertaining to their specific helpseeking experiences in an aggressive relationship and what prevents them from leaving the relationship. Only the questionnaires used in the current analyses will be described below.

Demographic information. Men were asked basic demographic information about both themselves and their partners, including age, race/ethnicity, personal income, education, and occupation. Men were also asked about the current status of their relationship, the length of their relationship with their partners, how long ago the relationship ended (if applicable), and how many minor children were involved in that relationship, if any.

Revised Conflict Tactics Scales (CTS2). The *CTS2* (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used to measure the extent to which the men in the study sustained psychological, physical, and sexual aggression, and injuries in their relationships. The items used for the current study included 5 items assessing minor physical aggression (e.g., grabbing, shoving, slapping) and 7 items assessing severe physical aggression (e.g., beating up, using knife/gun) that were combined into a total physical aggression scale; and 6 items assessing injuries (e.g., having a small cut or bruise, broken bone, passing out). The eight *CTS2* items regarding psychological aggression were supplemented with seven items from the Psychological Maltreatment of Women Inventory (Tol-

[1] Although beyond the scope of the current article, readers may be interested in learning about differences between the men in community sample who took the survey via phone versus online. Further information on these differences can be found in Hines, Douglas, and Mahmood (2010). None of the differences found impacted the findings of the current study.

man, 1995). To investigate the factor structure of this combined psychological aggression scale, a factor analysis that combined the two samples was conducted using the victimization items (see Hines & Douglas, 2010, for further details on this analysis). The factor analysis revealed that there were three subscales: Minor Psychological Aggression (e.g., insulting/swearing, shouting/yelling, doing something to spite partner), Controlling Behaviors (e.g., not allowing to leave the house, monitoring time and whereabouts), and Severe Psychological Aggression (e.g., threatening to harm partner, intentionally destroying something belonging to partner). For the current study, only the controlling behaviors and severe psychological aggression scales were used, because they are the types of IPV that differentiate IT from CCV.

Participants responded to items depicting each of the conflict tactics by indicating the number of times these tactics were used by the participant and his partner in the previous year. Participants indicated on a scale from 0 to 6 how many times they experienced each of the acts in the previous year, 0 = 0 times; 1 = 1 time; 2 = 2 times; 3 = 3–5 times; 4 = 6–10 times; 5 = 11–20 times; 6 = more than 20 times. Congruent with Straus et al. (1996), these data were then transformed in order to obtain an approximate count of the number of times each act occurred in the previous year, using the following scale: 0 = 0 acts in previous year; 1 = 1 act in the previous year; 2 = 2 acts in the previous year; 3 = 4 acts in the previous year; 4 = 8 acts in the previous year; 5 = 16 acts in the previous year; 6 = 25 acts in the previous year.

The *CTS2* has been shown to have good construct and discriminant validity and good reliability, with internal consistency coefficients ranging from .79 to .95 (Straus et al., 1996). Reliability statistics for the current samples were .82 for both the Controlling Behaviors and Severe Psychological Aggression scales, .92 for the Physical Aggression scale, and .68 for the Injury scale.

Aggressive childhood experiences. Aggressive childhood experiences were assessed using items from Sexual Abuse History (SAH) and Violence Socialization (VS) scales of the *Personal and Relationships Profile* (Straus, Hamby, Boney-McCoy, & Sugarman, 1999). To reduce participant burden, we condensed the 16 items from these two scales into four items. Participants indicated the extent to which they agreed or disagreed (1 = strongly disagree, 4 = strongly agree) with each statement: "When I was less than 12 years old, I was spanked or hit a lot by my mother or father" (sustaining child physical aggression), "When I was a kid, I saw my mother or father kick, punch, or beat up their partner" (witnessed interparental IPV), "Before I was 18, a family member did things to me that I now think might have been sexual abuse" (sustained familial child sexual abuse), and "Before I was 18, someone who was not part of my family did things to me that I now think might have been sexual abuse" (sustained nonfamilial child sexual abuse). Reports of the psychometric properties of both scales indicate that they have adequate validity and overall alphas of .73 (VS scale) and .76 (SAH scale) (Straus & Mouradian, 1999). For the current study, we also dichotomized each item: Participants who indicated they agreed/strongly agreed with an item were coded as having sustained that type of childhood abuse; if they disagreed/strongly disagreed, they were coded as not having sustained that type of childhood abuse.

The ENRICHD Social Support Instrument (Mitchell et al., 2003) was used it measure the perceived social support of the participants. It contains 6 items that measure emotional and instrumental support. Participants indicated on a 5-point scale the extent to which each statement was true of their situation (1 = none of the time, 5 = all of the time). Example items include, "How often is someone available to you whom you can count on to listen to when you need to talk?" and "How often is someone available to help you with daily chores?" This instrument has demonstrated excellent convergent and predictive validity, and excellent internal consistency reliability, with an overall alpha of .86 (Mitchell et al., 2003). For the present study, the overall alpha was .94.

PTS symptoms. The *PTSD Checklist* (*PCL*) (Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item self-report measure of the severity of PTSD symptomology. Items reflect three symptom clusters: reexperiencing, numbing/avoidance, and hyperarousal. Consistent with the concept of PTSD and per the instructions of the *PCL*, the questions were anchored to one specific traumatic event. For this study, respondents were asked to think about

their worst argument with their female partner, and then indicate the extent to which they were bothered by each symptom in the preceding month using a 5-point scale (1 = not at all, 5 = extremely). The items were then summed to create a continuous measure of PTSD symptoms. Scores were also dichotomized to indicate the likely presence or absence of PTSD. Although there is currently debate regarding the exact cut-off score that is possibly indicative of PTSD (e.g., suggestions range from 44 to 50), we chose a cut-off score of 45 that was used in a study of breast cancer patients (Andrykowski, Cordova, Studts, & Miller, 1998). It is important to also note that Ruggiero, DelBen, Scotti, and Rabalais (2003) found little differences in the diagnostic efficiency of these various cut-points using a civilian sample. One item, "Feeling as if your future will somehow be cut short," was not included in the survey because participants reported that they did not understand the item during pilot testing of the instrument. The PCL has been validated for use in both combat and civilian populations, and the civilian version was used for this study. The *PCL* has been shown to have excellent reliability (Weathers et al., 1993) and strong convergent and divergent validity (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Ruggiero et al., 2003). Furthermore, the *PCL* has been shown to have high diagnostic utility (.79–.90) when validated against "gold standard" measures such as the Structured Clinical Interview for *DSM*–IV Axis I Disorders (First, Gibbon, Spitzer, & Williams, 1996). For the current samples, the alpha for all items combined was .97, and ranged from .91 for the avoidance/numbness subscale to .93 for the reexperiencing subscale.

Results

Differences Between Samples in Demographics, IPV, and Possible Mediators

Table 1 presents the differences between the helpseeking and community samples in demographic characteristics, the prevalence and frequency of sustaining four types of IPV, social support, and the prevalence of experiencing childhood aggression. The men in the community sample were significantly older, more likely to be currently in a relationship, and in significantly longer relationships than the men in the helpseeking sample. The men in the helpseeking sample attained significantly higher levels of education and were more likely to have minor children. These demographic differences were used as potential covariates in subsequent ANCOVAs.

For sustaining IPV, chi-square analyses showed that the helpseeking sample was significantly more likely to sustain all four types of IPV: Controlling Behaviors, Severe Psychological Aggression, Physical Aggression, and Injuries. In addition, after removing men from both samples who did not sustain a given act of IPV, *t* tests showed that men in the helpseeking sample sustained significantly more acts of IPV in the previous year than men in the community sample.

Finally, *t* tests showed that men in the helpseeking sample reported significantly lower social support than community men, and chi-square analyses revealed that men in the helpseeking sample were significantly more likely to have sustained all types of childhood aggression.

Differences Among Groups in PTSD Scores

We first investigated whether men who sustained IT had a greater likelihood of reaching a clinical cut-off for PTSD than men who sustained CCV or men who sustained no IPV. Thus, congruent with our previous analysis of and findings from this dataset (Hines & Douglas, 2010), we divided the community sample into those who sustained physical IPV (CCV group) and those who sustained no physical IPV (No IPV group). As discussed in the Introduction and shown in Hines and Douglas (2010), the helpseeking sample was a sample of IT victims, and therefore, that sample was used as an indicator of men who sustained IT.[2] We then performed a chi-square analysis to investigate

[2] A full description of how we determined that the helpseeking sample was a sample of IT victims can be found in Hines and Douglas (2010). Briefly, we did a series of comparisons between the helpseeking and community samples in the rates and frequencies of physical IPV, controlling behaviors, severe psychological IPV, and injuries reported by the male participants to test Johnson's conceptualization that IT is physical IPV in the context of controlling behaviors and severe psychological IPV, whereas CCV is characterized by low-level mutual physical IPV without the same level of controlling behaviors as in IT. In comparison to the male helpseekers, the female partners of men in the helpseeking sample had significantly higher rates of all types of IPV, and just among those men and women who engaged in physical and

whether there were significant differences among the three groups in the percentage of men scoring above the clinical cut-off. As shown in Figure 1, only 2.1% of the no IPV men scored above the clinical cut-off; this jumped to 8.2% for the CCV group, and then increased exponentially to 57.9% for the IT group. Chi-square analyses and post hoc tests showed that all three groups were significantly different from each other, $\chi^2(2, N = 822) = 323.99$, $p < .0000001$.

We then investigated whether there were differences between the no IPV, CCV, and IT groups on their total score on the PCL and the subscale scores. A series of ANCOVAs were performed, controlling for significant covariates, and Tamhane post-hoc tests (which correct for heterogeneity of variance among groups) were used to identify the locus of any significant differences. As shown in Table 2, all three groups were significantly different from each other on the total PCL score and all three subscales. Moreover, as indicated by the effect size, group membership explained 49.8–57.3% of the differences in PCL scores.

psychological IPV, the female partners used 5–6 times the frequency of physical IPV, severe psychological IPV, and controlling behaviors. The helpseeking men also had significantly higher rates of injuries than their female partners; among those men and women who sustained injuries, the men were injured at approximately twice the frequency. Finally, the frequency with which men sustained violence in the previous year (46.72 acts) is comparable to the frequency of violence sustained in samples of battered women (between 15 and 68 acts per year). Patterns of IT were also found when we compared the helpseeking with the community sample. In comparison to the female partners of community men, the female partners of helpseeking men engaged in significantly higher rates and frequencies of all types of IPV: they were 54 (controlling behaviors) to 407 (minor physical IPV) times more likely to use IPV. Among just those women who used IPV, the female partners in the helpseeking sample had significantly higher frequencies of IPV, ranging from about 1.5 times (severe physical IPV) to over 3.75 times (controlling behaviors, total physical IPV) the frequency of IPV than female partners in the community sample. Moreover, the men in the helpseeking sample were injured at higher rates and frequencies—they were close to 90 times more likely to have sustained an injury in the past year, and when comparing just those men who were injured, men in the helpseeking sample had about twice the frequency of injuries. Finally, the female partners in the helpseeking sample were significantly more likely to have used physical IPV first, in both the last physical argument (97% vs. 56.9%) and ever (91.7% vs. 53.0%).

Bivariate Correlations Between IPV and PTSD for Both Samples

We then performed a series of analyses to investigate the associations among sustaining IPV, PTSD symptoms, and possible mediators. We performed these analyses on the community and helpseeking samples separately because of Johnson's (1995) assertion that each of these samples would be measuring different phenomena. Our first step in investigating the associations between PTSD and sustaining IPV consisted of a series of correlational analyses (see Table 3). We correlated, for each sample separately, the frequency with which the participants sustained all four forms of IPV with their total score on the PCL, their three subscale scores, and the dichotomous variable of whether the participant exceeded the clinical cut-off for PTSD. As shown, for both samples, the frequency of all four forms of sustaining IPV was significantly correlated with the total score on the PCL, the scores on all of the subscales, and with the clinical cut-off variable. The only exception was that among helpseekers, the frequency of sustaining injuries was not significantly correlated with the clinical cut-off score. Moreover, the correlations in the community sample appear to be higher than the correlations in the helpseeking sample. However, *z*-score analyses of the differences between correlation coefficients showed that after Bonferonni corrections for multiple tests of hypothesis, no correlations were significantly different from each other. Thus, sustaining IPV is similarly correlated with PTSD symptoms for both community and helpseeking men.

Path Models

We then investigated the direction of effects among sustaining IPV, PTSD symptoms, social support, and experiences of childhood aggression. In the interest of parsimony, we combined the scores on the two childhood physical aggression measures (sustaining child physical aggression and witnessing interparental IPV) into a variable called "Violent Socialization" and the scores on the two childhood sexual abuse measures (sustaining familial and nonfamilal child sexual abuse). For sustaining IPV, we only used the frequency with which they sustained physical aggression and controlling behaviors be-

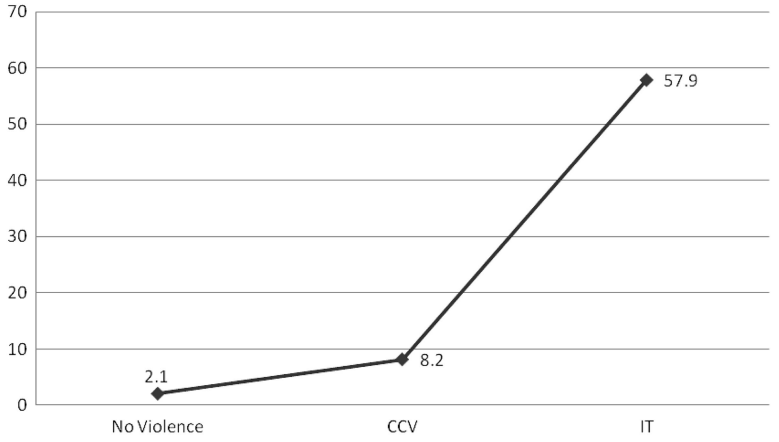

Figure 1. Percent of each group scoring above the clinical cut-off on the PCL.

cause these are the two types of IPV that are the central features of IT. Finally, we used the total score on the PCL as our indicator of PTSD. Although PTSD is typically considered to be a dichotomous diagnostic category, we chose to use the continuous measure as our outcome to increase variability because of increasing evidence that it may be more of a dimensional disorder (Broman-Fulks et al., 2006) and of little agreement as to the exact cut-off that should be used to indicate the presence of PTSD (Ruggiero et al., 2003).

The full model that we tested is shown in Figure 2. As indicated by this figure, we hypothesized that involvement in childhood aggression would predict sustaining IPV in adulthood and would also predict PTSD symptoms. We also predicted that sustaining IPV would have both direct and indirect, through social support, influences on PTSD. This full model was tested on each sample separately. Initially, the full model for each sample was evaluated for its adherence to the assumption of multivariate normality. For the community sample, Mardia's (1970, 1974) normalized estimate of multivariate kurtosis equaled 280.33, which is well above the standard cut-off of 5 and indicates a non-normal distribution (Bentler, 2005). For the helpseeking sample, multivariate kurtosis was lower, 9.12, but still indicated a non-normal distribution.

Therefore, we employed the bootstrapping procedure for estimating standard errors and reducing bias in our estimates of parameters and their significance. Although not without its limitations, bootstrapping is a procedure that is routinely used when estimating path models with non-normal data (Byrne, 2010). Each bootstrapped model was evaluated using four fit measures—chi-square, root mean square error

Table 2
AN(C)OVA Results on the Differences Among IPV Groups in PTSD

PCL scale	No violence *M* (*SD*)	CCV *M* (*SD*)	IT *M* (*SD*)	*F* (*df*)	η^2
Total PCL score	19.50 (7.08)[a]	25.20 (11.72)[a]	46.56 (14.25)[a]	547.76*** (2, 815)	.573
Re-experiencing	6.28 (2.45)[b]	8.06 (4.50)[b]	14.98 (5.15)[b]	458.94*** (2, 819)	.528
Avoidance/numbness	7.45 (2.99)[a]	9.81 (4.62)[a]	17.26 (6.42)[a]	404.50*** (2, 815)	.498
Hyperarousal	5.78 (2.23)[b]	7.33 (3.70)[b]	14.32 (5.04)[b]	497.93*** (2, 819)	.549

Note. CCV = common couple violence; IT = intimate terrorism.
[a] Means in the same row sharing superscripts are significantly different from each other after controlling for age. [b] Means in the same row sharing superscripts are significantly different from each other according to a Tamhane's post-hoc test.
*** $p < .001$.

Table 3
Bivariate Correlations Among Sustained IPV and PTSD for Both Samples

	Helpseeking sample (n = 302)				Community sample (n = 520)			
PCL scale	Controlling behaviors	Severe psychological aggression	Physical aggression	Injuries	Controlling behaviors	Severe psychological Aggression	Physical aggression	Injuries
Total score	.29***	.21***	.25***	.19***	.44***	.31***	.22***	.24***
Re-Experiencing	.25***	.12*	.20***	.17**	.44***	.32***	.25***	.32***
Avoidance/numbness	.24***	.21***	.24***	.17**	.41***	.27***	.18***	.18***
Hyperarousal	.27***	.23***	.21***	.15**	.38***	.27***	.19***	.18***
Scored > 45[a]	.26***	.18**	.16**	.11	.38***	.29***	.21***	.31***

Note. After Bonferonni corrections, analyses show no significant differences between the corresponding correlations of the two samples.
[a] 45 is the clinical cut-off for PTSD on the PCL.
* $p < .05$. ** $p < .01$. *** $p < .001$.

of approximation (RMSEA), normed fit index (NFI), and comparative fit index (CFI)—as recommended by Tabachnik and Fidell (2006). This method ensures that a model fit is tested from several different perspectives (Meyers, Gamst, & Guarino, 2006). Model statistics were then examined to investigate whether better fitting models could be achieved. Modification indices were first examined to investigate whether there were theoretical and statistical reasons to add any paths to the model. Next, nonsignificant paths were pruned one-by-one until an excellent-fitting model was achieved. This end model was compared with the original model on their Aikake's Information Criterion (AIC) and Expected Cross-Validation Index (ECVI); smaller AIC values represent better-fitting models, and smaller ECVI values represent the greatest potential for replication (Byrne, 2010).

For the community sample, five cases were removed because of incomplete data on the childhood aggression measures. The full hypothesized model achieved an excellent fit to the data: $\chi^2(2) = 2.38$, $p = .30$; NFI = .99; CFI = .99; RMSEA = .02, AIC = 40.38, ECVI = .08. In the interest of parsimony, nonsignificant paths were pruned one at time until only significant paths remained. The final, parsimonious model had similar fit statistics, but with smaller AIC and ECVI: $\chi^2(4) = 7.94$, $p = .10$; NFI = .98; CFI = .99; RMSEA = .04,

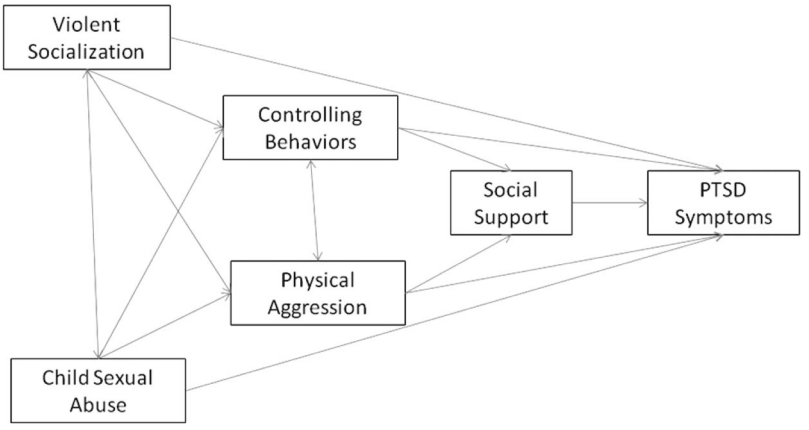

Figure 2. Conceptual model predicting PTSD symptoms from sustained aggression tested on both samples.

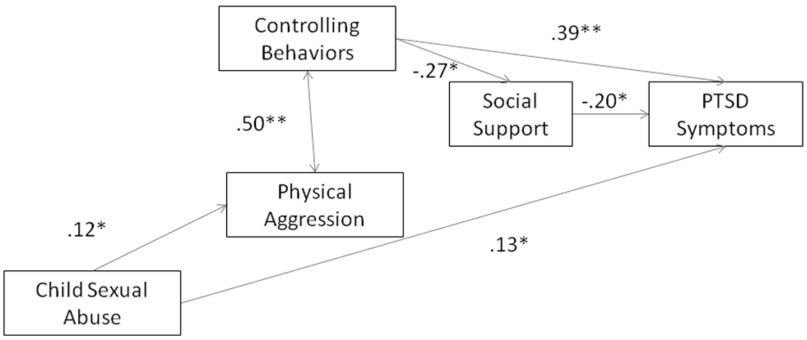

Figure 3. Final model for the community sample predicting PTSD symptoms from sustained aggression. * $p < .05$. ** $p < .01$.

AIC = 29.94, ECVI = .06; the parameter estimates for this model are shown in Figure 3. The only childhood aggression variable to achieve significance was child sexual abuse, which predicted sustaining physical IPV and PTSD symptoms. Sustaining physical IPV did not have any direct or indirect influence on PTSD symptoms, but was correlated with sustaining controlling behaviors. Sustaining controlling behaviors, on the other hand, had both direct and indirect influences on PTSD symptoms, and in fact, had the strongest direct influence on PTSD symptoms of all of the aggression items. For the indirect effect, sustaining controlling behaviors was associated with lower social support, and lower social support was subsequently associated with higher levels of PTSD symptoms.

For the helpseeking sample, one case was removed because of incomplete data on a childhood aggression variable. When the data were tested against the full hypothesized model, the model achieved a moderate-to-poor fit: $\chi^2(2) = 13.34$, $p < .001$; NFI = .93; CFI = .93; RMSEA = .14, AIC = 51.338, ECVI = .171. Nonsignificant paths were pruned one-by-one until an excellent fitting model was achieved: $\chi^2(2) = 2.17$, $p = .34$; NFI = .98; CFI = .99; RMSEA = .02, AIC = 18.172, ECVI = .061; this final model is shown in Figure 4. Violent socialization had the strongest influence on PTSD, although controlling behavior and physical IPV victimization made significant unique contributions as well. Violent socialization did not predict controlling behavior or physical IPV victimization, which were significantly associated with each other. Social support did not mediate the association between IPV victimization and PTSD, and childhood sexual abuse did not predict IPV victimization or PTSD.

Discussion

Our study, the first to investigate the associations among PTSD and IPV victimization among a clinical sample of men, provides strong initial evidence that PTSD is a major concern among men who sustain IPV and seek help. In addition, by comparing levels of PTSD

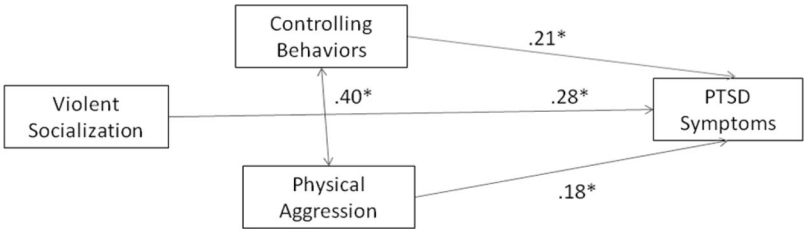

Figure 4. Final model for the helpseeking sample predicting PTSD symptoms from sustained aggression. * $p < .05$.

and its associations with other key variables, we were able to provide some support to the theory that such associations would be different when researchers study clinical versus convenience samples of men.

In support of previous research (Coker et al., 2005; Dansky et al., 1999; Hines, 2007), we found that for both samples of men, sustaining IPV was significantly correlated with PTSD and its three clusters of symptoms. However, we also found that in comparison to men who sustain no physical IPV and men who sustain CCV, men who sustain IT (a type of IPV that is characterized by severe violence and controlling behaviors) are at exponentially increased risk for exceeding a clinical cut-off for PTSD. In fact, almost 60% of the male helpseekers exceeded this cut-off, a percentage that is similar to what samples of battered women typically show (Astin et al., 1993; Cascardi et al., 1995; Gleason, 1993; Saunders, 1994). Moreover, when comparing samples on the scores that the men had on the PTSD measure, we found that group membership explained over 50% of the variance in PTSD scores—this is a very large effect size (according to Cohen [1988], an effect size of .15 is considered large for an *F* statistic), and shows just how at risk men who sustain IT are for both experiencing PTSD symptoms and exceeding a clinical cut-off for this disorder.

In addition, these findings provide further evidence that the IPV that the helpseeking sample of men are sustaining is IT. Researchers have found that among women, IT victims report significantly more symptoms of PTSD than victims of CCV do (Cohen, 1988; Johnson & Leone, 2005; Leone et al., 2004) and have therefore concluded that another feature of IT is the severe psychological consequences of the IPV. Moreover, they point toward this difference as further evidence that the predictors, theories, and intervention methods would necessarily differ between studies using community/population-based samples and those using clinical samples (Johnson & Leone, 2005).

Our study supports these notions as well. In addition to PTSD being exponentially higher in the helpseeking sample, the associations between PTSD and sustaining different types of IPV were somewhat different. The model for the community sample was congruent with what others have found regarding the influence of prior history of abuse, sustaining trauma, and social support on PTSD (Fontana & Rosenheck, 1994). Consistent with this previous research, among the community sample of men, sustaining childhood abuse put the men at risk for both sustaining IPV and PTSD, and the influence of sustaining controlling behaviors on PTSD was at least partially mediated by social support. What is unique about this model is that it appears that it is the controlling behaviors, not the physical IPV, that are experienced as traumatic for the community men, which is congruent with research among battered women that shows that it is often the controlling and psychologically abusive aspects of a relationship that are viewed as more traumatic than the physical violence (e.g., Follingstad, Rutledge, Berg, Hause, & Polek, 1990).

On the other hand, our proposed model was a poor fitting model for the helpseeking sample, and the best-fitting model was a simpler model that posited direct, additive influences of sustaining both childhood physical aggression and adult physical IPV and controlling behaviors on symptoms of PTSD. Why the more complex model did not fit for the helpseeking sample and why this simple model provides such an excellent fit are unknown. In addition, the fact that a childhood history of aggression provided such a strong influence on current symptoms of PTSD also contradicts previous literature that shows only small influences of childhood abuse on adult symptoms of PTSD after exposure to subsequent trauma (Brewin, Andrews, & Valentine, 2000). Therefore, the results presented here should be replicated in other samples of men sustaining IT, and future research should explore other potential mediators, such as shame, anger, and self-blame, that have been shown to be important mediators of PTSD development in victims of violent crime (Andrews, Brewin, Rose, & Kirk, 2000; Weaver & Clum, 1995).

Nonetheless, our findings that there is an additive influence of childhood and adult experiences of intrafamilial aggression on PTSD symptoms in this helpseeking sample are informative and provide tentative treatment implications. First, it is important for any treatment provider who encounters a man who discloses physical IPV and controlling behaviors against him by his partner to acknowledge that this man likely has been traumatized. This is an impor-

tant first step, because previous research on this sample showed that not only did men experience more negative than positive experiences with treatment providers, but every time a man in our helpseeking sample experienced a negative response from a treatment provider, his odds of exceeding the clinical cut-off for PTSD increased significantly (Douglas & Hines, provisionally accepted). Next, the traumas of experiencing aggression as a child, and controlling behaviors and physical IPV as an adult, should be central to any treatment program, and should be linked to other traumatic experiences, such as combat exposure and natural disasters; by establishing this link, it could remove any self-blame the men may be feeling (Kemp et al., 1991). According to Kemp et al., the most effective therapy for women who sustain IT would involve a combination of supportive and trauma processing sessions, with a crucial emphasis on the support that can be provided through involvement in battered women support groups. Given that there is no research exploring treatment options for men who sustain IT, we would urge therapists to use and evaluate a similar model for men who sustain IT and seek help, and to then tailor a more appropriate model for men. A crucial aspect of this development would be the institution of support groups for men who sustain IT, which are currently lacking (Hines & Douglas, 2011).

In addition, the fact that the community sample had a substantially different explanatory model for PTSD provides preliminary implications for treatment as well. Service providers who encounter men who sustain IPV will need to make the distinction between whether the IPV they are experiencing is IT or CCV because the relationship dynamics and the effect that the IPV has on the man will differ between the two (Johnson & Leone, 2005). Men who are experiencing CCV might benefit from couples' therapy, an intervention that has been shown to be very effective in certain types of couples experiencing lower levels of IPV because it teaches important skills in problem solving, anger management, and conflict resolution (O'Leary, Heyman, & Neidig, 1999; Stith, Rosen, & McCollum, 2003). However, this type of intervention may not be appropriate for men experiencing IT, because their female partners are engaging in more severe types of IPV and controlling behaviors as well; the men may risk retaliation if they disclose certain behaviors of their partners in the context of couples' therapy (Johnson & Leone, 2005).

The limitations of this study need to be addressed so that future research can replicate and expand on the findings reported here. First, this is a correlational study, and therefore, inferences about causality cannot be firmly established. However, our measure of PTSD did orient the men around their worst argument with their female partner; in addition, the childhood experiences of aggression naturally came earlier in time that both IPV experiences and PTSD symptoms they experienced in the previous month, so some cause-effect can be implied.

A second limitation is that the study relies solely on the men's reports of their partners' aggressive behaviors and their own psychosocial characteristics. This limitation is important to consider for three primary reasons. First, correlations between aggressive behaviors and psychosocial characteristics may be inflated because certain traits of the participant may influence how he answers both sets of questions (Cooper, 2002). Second, it is possible that the men overestimated their female partners' use of IPV. Although studies of couples reporting on IPV show no difference between male and female partners in their estimates of women's use of physical IPV (Archer, 1999), it could be the case that when men are seeking help because of their partner's IPV, they may overestimate their female partner's use of various types of IPV. Third, by using only the men's reports, we have no external validation of the authenticity of their reports. We were concerned, particularly for our helpseeking sample, about the confidentiality and safety of the participants if we asked their partners to participate in this study as well. Therefore, we opted not to obtain these data directly from the female partner, but note that such methodology has been used in other social science research [e.g., studies of battered women (Walker, 2000) and divorced families (Furstenberg, Morgan, & Allison, 1987; Lee, 1997; Seltzer, 1991; Seltzer & Bianchi, 1988)]. Thus, future studies should strive to obtain information from multiple informants.

Overall, our study is the first to provide information on the mental health of men who sustain IT and seek help. A majority of these men are suffering from PTSD, which seems to be a direct result of the physical IPV and con-

trolling behaviors they are sustaining in their relationships and a history of aggression they sustained in childhood. Their experiences are markedly different from men who sustain CCV, which is also correlated with PTSD, but is not experienced at such high frequencies by men involved in such relationships. Therefore, we recommend that when working with men who sustain IPV that treatment providers distinguish between whether clients have experienced CCV or IT, and that they provide the appropriate treatment depending upon the type of IPV the men have experienced. The results of this study and other work on IPV indicate that this may be the most fruitful way to provide treatment for men who have experienced IPV and present with PTSD symptoms.

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Alcohol and Drug Abuse in Men Who Sustain Intimate Partner Violence

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Extensive work has documented an association between sustaining intimate partner violence (IPV) and alcohol/drug abuse among women, yet little research has documented the same association in men, even though men comprise 25–50% of all IPV victims in a given year. This study investigates the associations among sustaining IPV and alcohol/drug abuse among both a clinical and community sample of men. The clinical sample is comprised of 302 men who sustained intimate terrorism—a form of IPV that is characterized by much violence and controlling behavior—from their female partners and sought help. The community sample is composed of 520 men, 16% of whom sustained common couple violence, a lower level of more minor reciprocal IPV. Analyses showed that among both groups of men who sustained IPV, the prevalence and frequency of alcohol/drug abuse was significantly higher than in men who did not sustain IPV. However, a dose–response relationship between sustaining IPV and alcohol/drug abuse was found only among men in the community sample. Path modeling showed that, for the community sample, the best fitting models were ones that showed that the alcohol/drug abuse predicted IPV victimization, an association that was fully mediated by their use of IPV. Aggr. Behav. 37:1–16, 2011. © 2011 Wiley Periodicals, Inc.

Keywords: domestic violence; male victims; intimate terrorism; alcohol abuse; drug abuse

INTRODUCTION

A significant association between alcohol/drug abuse and women sustaining intimate partner violence (IPV) has been well-documented [Amaro et al., 1990; Kantor and Asdigian, 1997; Salomon et al., 2002; Stark and Flitcraft, 1988; Stith et al., 2004], yet little research has documented whether there is an association between alcohol/drug abuse and men sustaining IPV. To our knowledge, only a handful studies have investigated this association, with no focus on men who report sustaining more severe types of IPV. For example, Halford and Osgarby [1993] investigated, among other issues, the association between female partners' violence and men's alcohol abuse among 56 men seeking marital therapy in Australia. Although they found no association, their sample size was small, had limited generalizability, and did not investigate the abuse of other substances. Among male college students, Simons et al. [2008] found that IPV victimization was associated with higher rates of both alcohol and drug use, but this study also has limited generalizability and does not test possible mediators of this association. More research among men who sustain IPV is warranted, especially given that between 25 and 50% of people who sustain IPV in a given year are men [Archer, 2000; Catalano, 2007; Straus, 1995; Tjaden and Thoennes, 2000], and men are more likely than women to abuse alcohol or other substances in response to a stressful event [Cooper et al., 1992]. We propose to address these limitations in this article.

Theoretical Models Explaining Associations Among IPV and Alcohol/Drug Abuse

In this study, we investigated whether there was an association between alcohol/substance abuse and sustaining IPV among two samples of men: a

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community sample and those who sustained IPV from their female partner and sought help. We then investigated possible reasons for any association. Specifically, if alcohol/substance abuse is related to sustaining IPV in men, previous research on female IPV victims suggests at least two possibilities for explaining that relationship [Kilpatrick et al., 1997].

The first possibility is that alcohol/drug abuse is a risk factor for sustaining IPV [Kilpatrick et al., 1997]. This possibility is thought to be related to one's lifestyle, such that alcohol/drug abuse leads one into certain situations or relationships in which sustaining IPV is more likely. Another explanation is that alcohol/drug abuse can lead to certain behaviors that increase the likelihood of sustaining IPV, and one such behavior could be IPV perpetration. It has been well-documented that both alcohol and drug abuse are risk factors for men using IPV against their female partners [Fals-Stewart, 2003; Fals-Stewart et al., 2005; Leonard, 1993; Murphy et al., 2001; O'Farrell et al., 2003], and the strongest risk for sustaining IPV is perpetrating IPV [Kessler et al., 2001; Stets and Straus, 1990]. Thus, IPV perpetration can be a mediator for the relationship between alcohol/drug abuse and sustaining IPV.

A second possibility is that sustaining IPV is a risk factor for alcohol/drug abuse [Kilpatrick et al., 1997]. This association is typically thought to be related to the overwhelmingly negative emotions or posttraumatic stress symptoms that someone who experiences a traumatic event, such as IPV, would experience. In an effort to cope with and reduce these emotions, the person might use alcohol or other drugs [Jacobsen et al., 2001; Simons et al., 2005; Stewart, 1996]. In fact, post-traumatic stress disorder (PTSD) and alcohol/drug abuse are highly comorbid disorders that are functionally related [Chilcoat and Breslau, 1998; Jacobsen et al., 2001; Stewart, 1996; Stewart et al., 1998], and the model with the most support to explain this association is the self-medication model [Chilcoat and Breslau, 1998; Jacobsen et al., 2001; Stewart, 1996; Stewart et al., 1998]. In this model, alcohol and other drugs seem to provide acute symptom relief of PTSD; in particular, they seem to lessen the hyperarousal components and facilitate forgetting traumatic memories through their effects on the central nervous system [Chilcoat and Breslau, 1998; Jacobsen et al., 2001; Stewart, 1996; Stewart et al., 1998, 1999,]. In other words, alcohol and other drugs seem to be used in an effort to self-medicate for the distressing symptoms of PTSD [Chilcoat and Breslau, 1998]. Thus, PTSD symptoms may serve as a mediator for any association between sustaining IPV and alcohol/drug abuse.

In addition, it is well-documented that sustaining physical abuse or witnessing interparental violence during childhood can put one at risk for abusing alcohol or other drugs [e.g., Liebschutz et al., 2002] and for sustaining IPV [e.g., Stith et al., 2000]. Thus, any model investigating the associations among IPV and alcohol/drug abuse should consider any potential trauma of previous childhood abuse.

Previous longitudinal research among female victims of IPV and assault in general provide some support for the hypothesized models [Kilpatrick et al., 1997; Martino et al., 2005; Salomon et al., 2002; Testa et al., 2003], yet there are some caveats. For example, in a longitudinal population-based sample of women, drug abuse, but not alcohol abuse, may put one at risk for sustaining any kind of assault; and sustaining an assault puts one at risk for alcohol and drug abuse, a relationship that is particularly strong for alcohol abuse [Kilpatrick et al., 1997]. In a multiyear panel study of women living with a male partner, drug use did not predict subsequent IPV nor did IPV predict subsequent drug use, but IPV did predict later heavy drinking [Martino et al., 2005]. In a longitudinal random-digit dial phone survey of Buffalo-area women, drug abuse predicted subsequent IPV victimization; and although alcohol abuse did not predict subsequent victimization, IPV victimization did predict alcohol abuse [Testa et al., 2003]. Among poor women in a longitudinal study, sustaining IPV put one at risk for abusing drugs, but not alcohol; sustaining child abuse also contributed to drug abuse, PTSD was only a weak mediator of the association between sustaining IPV and drug abuse; and there was no support for a model positing that alcohol/drug abuse put one at risk for sustaining IPV [Salomon et al., 2002].

Overall, there is support for IPV victimization predicting subsequent alcohol abuse, some support for IPV victimization predicting drug abuse, some support for drug abuse predicting subsequent IPV victimization, and no support for alcohol abuse predicting IPV victimization. In addition, there is support for child abuse as a contributor to drug abuse and PTSD as a possible mediator. Given these caveats, it is important to test models separately for alcohol and drug abuse.

Although there is little research on the association between alcohol/drug abuse and IPV victimization among men, studies mentioned previously suggest that such association exists [Simons et al., 2008]. Moreover, there are studies investigating whether alcohol/drug abuse is linked with violent victimization in general among males. For example,

in adolescent males, problem alcohol use is a risk factor for subsequent violent victimization as assessed with longitudinal data [Thompson et al., 2008], and cross-sectional studies show that experiencing a physical or sexual assault either within the home or in general is associated with subsequent drug abuse and that PTSD increases the risk of drug abuse [Kilpatrick et al., 2000]. In addition, among male college students, sustaining a sexual assault is associated with a subsequent increased risk of using alcohol or drugs [Amos et al., 2008]. Given these findings, it is important to further investigate these associations among men who sustain IPV.

Intimate Terrorism vs. Common Couple Violence

In addition to studying these associations among men who sustain IPV, it is also important to investigate whether these associations may differ among men who represent two different types of IPV: intimate terrorism (IT) and common couple violence (CCV). According to Johnson [Johnson, 1995, 2006; Johnson and Ferraro, 2000], IT is a type of IPV that is characterized by frequent and severe physical IPV and controlling behaviors, and has traditionally been used to describe and is consistent with samples of battered women seeking shelter. He labeled the IPV found in community and population-based samples CCV, which is characterized by low-level (e.g., slapping, pushing), low-frequency violence in a couple where both members are about equally violent; this IPV is not part of an overall pattern of control of one partner over the other, but is the result of a conflict "getting out of hand."

This study utilizes both "help-seeking" and "community" samples of men with regard to IPV. The help-seeking sample is comprised of men who sustained IPV from their female partners and sought help of some sort; the community sample is comprised of a convenience sample of men recruited from the community to participate in a study on how men and women get along. In a previous analysis that focused on describing the IPV in these two samples [Hines and Douglas, 2010], we found that the help-seeking sample conformed to Johnson's [1995, 2006; Johnson and Ferraro, 2000] definition of IT; the frequency of physical IPV the men sustained was comparable to the frequency with which shelter samples of battered women sustained physical IPV [Giles-Sims, 1983; Johnson, 2006; McDonald et al., 2009; Okun, 1986; Straus, 1990]; the physical assaults were accompanied by high levels of controlling behaviors, severe psychological aggression, and physical injuries. Moreover, the overwhelming majority of the physical arguments were reportedly initiated by the female partner [Hines and Douglas, 2010].

On the other hand, the 16% of the men in our community sample who sustained physical IPV conformed to Johnson's [1995, 2006; Johnson and Ferraro, 2000] conceptualization of CCV. These men reported that they and their female partners used low-level, low-frequency IPV at approximately the same rates, with an equal likelihood that either the man or his female partner hit first, and the aggression did not involve frequent and severe physical IPV or controlling behaviors [Hines and Douglas, 2010].

Johnson [1995] argues that such help-seeking and community samples are functionally different and should, therefore, have different patterns of predictors and consequences of IPV. For example, he would argue that the conceptual models outlined above would be different between the community and help-seeking samples of men. Therefore, although we will test the above models on both samples, we hypothesize that they will operate differently between them. Moreover, Johnson would argue that any potential consequences of IPV, such as alcohol/drug abuse, would be more severe among men in help-seeking samples vs. men in community samples, because their experiences of IPV are much more severe, and thus more traumatic. Therefore, in this study, we hypothesized that in comparison to men in the community sample who sustained either CCV or no violence, alcohol/drug abuse would be more severe among the men who sustained IT (i.e., the help-seeking sample). Previous analyses of these datasets did not focus on the associations between alcohol/drug abuse and the IPV these men experienced.

METHOD

Participants and Procedure

Two separate samples of male participants were recruited for this study: a help-seeking sample and a community sample. For both samples, the men had to speak English, live in the United States, and be between the ages of 18 and 59 to be eligible; they also had to have been involved in an intimate relationship with a woman lasting at least 1 month in the previous year. In addition, to be eligible for the help-seeking sample, the men had to have sustained a physical assault from their female partner within the previous year, and they had to

have sought help/assistance for their partner's violence. Help/assistance was broadly defined and included seeking help from formal sources, such as hotlines, domestic violence agencies, the police, mental health and medical health professionals, lawyers, and ministers, to more informal help-seeking efforts, such as talking with friends and family members and searching the Internet for information on IPV or support groups for IPV victims in general or male IPV victims specifically.

The help-seeking sample of men ($n = 302$) was recruited from a variety of sources, including the Domestic Abuse Helpline for Men and Women (DAHMW; a U.S. national hotline specializing in male victims of domestic violence), and online websites, newsletters, blogs, and listservs that specialized in treatment of IPV, male victims of IPV, fathers' rights issues, divorced men's issues, men's health issues, and men's rights issues. Men who called the DAHMW seeking assistance and who met the eligibility criteria were invited to participate in this study either by calling a survey research center to complete the interview over the phone or by visiting the study website to complete an anonymous secure version of the study questionnaire online. Men who saw an advertisement for the study online were directed to the study website to complete the online version of the study. Screener questions regarding the study criteria were on the first page of the survey, and men who were eligible, given the stated criteria for the help-seeking sample, were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an "exit page" of the survey. Sixteen men completed the interview over the phone; the remaining 286 completed it online. Demographics of the help-seeking sample can be found in Table I.

Participants also included 520 men from the community. Approximately half the community sample ($n = 255$) was recruited to participate in a phone version of the survey by a survey research center, using a random digit dialing technique and CATI administration. The interviewers attempted to reach each phone number on 15 different days, at different times of the day, and made call-back appointments whenever possible. They also made refusal conversion efforts when appropriate. Because of low response rates (8%) during the first 2 months, advanced letters were sent to potential participants informing them that they were randomly selected to participate in a study sponsored by the National Institutes of Health that was focusing on how men and women get along and that they would be contacted within a week by a survey research center interviewer. The response rate for the participants who received an advanced letter was 15.5%. The overall response rate was 9.8%. The other half of the community sample ($n = 265$) was recruited through a panel of survey participants maintained by Survey Sampling, Inc. (SSI), to complete an online version of the same survey. Email invitations were sent to 16,000 male SSI panel members inviting them to participate in a study on how men and women get along. They were directed to an anonymous, secure, online version of the survey. The first page of the survey included screener questions testing for eligibility (i.e., between 18 and 59 years of age; in an intimate relationship with a woman lasting at least 1 month in the previous year). Eligible men were able to continue to the survey, whereas noneligible men were thanked for their time. The survey was closed after we met our target sample size of 265 men. Because data collection ceased when the target goal for the number of completed surveys was reached and we did not wait for all men who received invitations to complete the survey, response rates for the Internet sample cannot be reliably calculated. Demographic information on the full community sample ($n = 520$) can be found in Table I. Multivariate analyses indicated that the only differences between the phone and online community samples were that men in the phone sample had more social support, were less likely to score above a clinical cut-off for PTSD symptoms, and were more likely to have ever used drugs. There were no differences in IPV victimization or perpetration. Further information on the phone and online community samples that is beyond the scope of the current analysis can be found in Hines et al. [2010].

The methods for this study were approved by the boards of ethics at the participating institutions. All the men participated anonymously, were apprised of their rights as study participants, and gave their consent to participate before beginning the survey. Steps were taken to ensure their safety: at the completion of the survey, the participants were given information about obtaining help for IPV victimization and how to delete the history on their Internet web browser.

Measures

Both the help-seeking and community samples were given the same core questionnaires regarding demographics, aggressive behaviors that they and their female partners may have used in the previous

TABLE I. Demographics, Intimate Partner Violence Sustained, PTSD, and Childhood Aggression Experiences

	Help-seeking sample ($n = 302$)	Community sample ($n = 520$)	
	% or *M* (*SD*)	% or *M* (*SD*)	χ^2 or *t*
Demographics			
Age (in years)	40.49 (8.97)	43.68 (10.88)	4.52***
Education[a]	4.40 (1.56) ($n = 300$)	4.04 (1.72) ($n = 514$)	3.13**
Income (in thousands)	\$50.44K (25.69) ($n = 296$)	\$48.98K (26.13) ($n = 508$)	0.77
% white	86.8	84.8	0.59
% currently in a relationship	56.3%	95.8%	193.70***
% with minor children	73.2%	45.3%	64.60***
Length of relationship (in months)	97.90 (82.06)	164.90 (131.01)	8.93***
% sustaining IPV			
% sustaining controlling behaviors	93.4	20.0	412.20***
% sustaining severe psychological aggression	96.0	13.7	526.31***
% sustaining physical aggression	100.0	16.3	536.60***
% sustaining injury in previous year	78.5	4.0	491.56***
Mean # of acts of IPV sustained among those sustaining IPV			
# of controlling acts in previous year	42.62 (36.25) ($n = 282$)	11.36 (16.31) ($n = 104$)	11.64***
# of severe psychological aggression acts in previous year	28.90 (26.20) ($n = 290$)	9.13 (13.26) ($n = 71$)	8.98***
# of physically aggressive acts in previous year	46.72 (53.48) ($n = 302$)	12.22 (33.29) ($n = 85$)	7.27***
# of injuries sustained in previous year	11.68 (15.61) ($n = 237$)	5.52 (11.42) ($n = 21$)	2.29*
% using IPV			
% using controlling behaviors	45.7	11.5	121.90***
% using severe psychological aggression	40.1	10.4	100.44***
% using physical aggression	55.0	13.8	159.19***
% using injury in previous year	26.2	4.6	80.90***
Mean # of acts of IPV used among those using IPV			
# of controlling acts in previous year	7.20 (8.99) ($n = 138$)	12.29 (16.99) ($n = 60$)	2.19*
# of severe psychological aggression acts in previous year	5.74 (8.59) ($n = 121$)	6.07 (14.49) ($n = 54$)	0.19
# of physically aggressive acts in previous year	7.71 (14.25) ($n = 166$)	8.68 (24.21) ($n = 72$)	0.40
# of injuries partner sustained in previous year	5.19 (6.40) ($n = 79$)	6.96 (12.01) ($n = 24$)	0.69
Levels of PTSD symptoms and childhood aggression experienced			
PCL score	46.56 (14.22)	20.43 (8.28)	29.19***
% sustaining child physical aggression	46.8	35.3	10.65***
% witnessing IPV between parents	21.5	14.3	7.03**

[a]Educational status: 1 = less than high school; 2 = high school graduate or GED; 3 = some college/trade school; 4 = 2-year college graduate; 5 = 4-year college graduate; 6 = some graduate school; 7 = graduate degree. $^{*}P < .05$; $^{**}P < .01$; $^{***}P < .001$.

year, more detailed information regarding their last physical argument (if applicable), their mental health, and various risk factors. The help-seeking sample was given additional questions pertaining to their specific help-seeking experiences in an aggressive relationship and what prevents them from leaving the relationship. Only the questionnaires used in the current analyses will be described below.

Demographic information. Men were asked basic demographic information about both themselves and their partners, including age, race/ethnicity, personal income, education, and occupation. Men were also asked about the current status of their relationship, the length of their relationship with their partners, how long ago the relationship ended (if applicable), and how many minor children were involved in that relationship, if any.

Revised conflict tactics scales. The revised conflict tactics scales (*CTS2*) [Straus et al., 1996] was used to measure the extent to which the men in the

study used and sustained psychological, physical, and sexual aggression, and injuries in their relationships. The items used for this study included five items assessing minor physical aggression (e.g., grabbing, shoving, slapping); seven items assessing severe physical aggression (e.g., beating up, using knife/gun) that were combined into a total physical aggression scale; and six items assessing injuries [e.g., having a small cut or bruise, broken bone, passing out). The eight *CTS2* items regarding psychological aggression were supplemented with seven items from the Psychological Maltreatment of Women Inventory [Tolman, 1995]. To investigate the factor structure of this combined psychological aggression scale, a factor analysis that combined the two samples was conducted using the victimization items [see Hines and Douglas, 2010, for further details on this analysis). The factor analysis revealed that there were three subscales: Minor Psychological Aggression (e.g., insulting/swearing, shouting/yelling, doing something to spite partner), Controlling Behaviors (e.g., not allowing to leave the house, monitoring time and whereabouts), and Severe Psychological Aggression (e.g., threatening to harm partner, intentionally destroying something belonging to partner). For this study, only the controlling behaviors and severe psychological aggression scales were used because they theoretically differentiate IT from CCV [Johnson, 1995].

Participants responded to items depicting each of the conflict tactics by indicating the number of times these tactics were used by the participant and his partner in the previous year. Participants indicated on a scale from 0 to 6 how many times they experienced each of the acts in the previous year, 0 = 0 times; 1 = 1 time; 2 = 2 times; 3 = 3–5 times; 4 = 6–10 times; 5 = 11–20 times; and 6 = more than 20 times. These data were then transformed in order to obtain an approximate count of the number of times each act occurred in the previous year, using the following scale: 0 = 0 acts in previous year; 1 = 1 act in the previous year; 2 = 2 acts in the previous year; 3 = 4 acts in the previous year; 4 = 8 acts in the previous year; 5 = 16 acts in the previous year; and 6 = 25 acts in the previous year.

The *CTS2* has been shown to have good construct and discriminant validity and good reliability, with internal consistency coefficients ranging from .79 to .95 [Straus et al., 1996]. Reliability statistics for these samples were .82 for both the Controlling Behaviors and Severe Psychological Aggression scales, .92 for the Physical Aggression scale, and .68 for the Injury scale.

Abusive childhood experiences of the participant. Childhood abusive experiences were assessed using two questions that condensed the eight items from the violence socialization (VS) scale of the *Personal and Relationships Profile* [Straus et al., 1999]. Participants indicated the extent to which they agreed or disagreed (1 = strongly disagree, 4 = strongly agree) with each statement: ''When I was less than 12 years old, I was spanked or hit a lot by my mother or father'' (sustaining child physical aggression), and ''When I was a kid, I saw my mother or father kick, punch, or beat up their partner'' (witnessed interparental IPV). Reports of the psychometric properties of the full VS scale indicate adequate validity and an overall α of .73 [Straus and Mouradian, 1999].

Posttraumatic stress symptoms. The *PTSD Checklist* (PCL) [Weathers et al., 1993] is a 17-item self-report measure of the severity of PTSD symptomology. Items reflect three symptom clusters: reexperiencing, numbing/avoidance, and hyperarousal. Consistent with the concept of PTSD and per the instructions of the PCL, questions were anchored to one potentially traumatic event: participants were asked to think about their worst argument with their female partner, and then indicate the extent to which they were bothered by each symptom in the preceding month using a 5-point scale (1 = not at all, 5 = extremely). The items were then summed to create a continuous measure of PTSD symptoms. One item, ''Feeling as if your future will somehow be cut short,'' was not included in the survey because participants reported that they did not understand the item during pilot testing of the instrument. The PCL has been validated for use in both combat and civilian populations and the civilian version was used for this study. The PCL has been shown to have excellent reliability [Weathers et al., 1993] and strong convergent and divergent validity [Blanchard et al., 1996; Ruggiero et al., 2003]. For these samples, the α was .97.

Alcohol and drug abuse. Alcohol and drug abuse were measured using a scale developed for the National Women's Study to assess the association between IPV victimization and alcohol/drug abuse among female victims [Kilpatrick et al., 1997]. The scale included up to 19 items asking respondents about their use and abuse of alcohol and illicit drugs (i.e., marijuana, cocaine, methamphetamines, crack, LSD, heroin, or other such drug) in their lifetimes and in the past year, and included items regarding

negative experiences resulting from alcohol abuse. Consistent with Kilpatrick et al.'s [1997] guidelines for scoring this scale, we measured alcohol abuse within the past year by two indicators that approximated the diagnostic criteria for the *Diagnostic and Statistical Manual of Mental Disorders IV* [American Psychiatric Association, 1994]: (1) participants who answered affirmatively to any of the six questions on negative experiences (e.g., getting in trouble with the police or a boss) within the past year because of alcohol were classified as meeting the criteria for alcohol abuse in the past year, and (2) frequency of intoxication within the past year: participants were asked to indicate how frequently they were intoxicated in the past year on a scale from 0 = never to 7 = every day/almost every day.

Similarly, according to the guidelines established by Kilpatrick et al. [1997], drug abuse was measured by two indicators that approximate the frequency of usage considered significant by the Diagnostic Interview Schedule substance abuse screen [Robins et al., 1988]: (1) if participants indicated they used any illegal drugs more than four times in the past year, they were considered nonexperimental users/drug abusers, and (2) actual frequency of drug use within the past year from 0 = never to 3 = more than ten occasions. This scale has demonstrated excellent construct validity [Kilpatrick et al., 1997].

RESULTS

Table I presents the demographics of the help-seeking and community samples, and descriptive information for all predictor, mediator, and outcome variables. A full discussion of these samples can be found in previous analyses of this dataset [e.g., Hines and Douglas, 2010].

Hypothesis 1: Differences in Proposed Conceptual Models

Bivariate correlations among IPV and alcohol/drug abuse. To test Hypothesis 1, we first performed a series of correlational analyses on the alcohol/drug abuse and IPV variables (Table II). For each sample separately, we correlated the frequency with which the participants sustained all four forms of IPV with the four alcohol/drug abuse variables: alcohol abuse in the past year, frequency of intoxication in the past year, drug abuse in the past year, and frequency of drug use in the past year. As shown,

TABLE II. Bivariate Correlations Among Sustained IPV and Alcohol/Drug Abuse for Both Samples

	Help-seeking sample ($n = 302$)				Community sample ($n = 520$)			
	Controlling behaviors	Severe psychological aggression	Physical aggression	Injuries	Controlling behaviors	Severe psychological aggression	Physical aggression	Injuries
Alcohol use/abuse								
Abused alcohol in past year	.08	−.03	−.05	−.04	.18***	.14***	.16***	.12**
Frequency of intoxication in past year	.00	−.08	.02	.04	.11*	.12**	.24***	.18***
Drug use/abuse								
Abused drugs in past year	.01	−.11	−.06	−.02	.21***	.13**	.13**	.01
Frequency of drug use in past year	.00	−.12*	−.05	−.05	.25***	.17***	.18***	.07

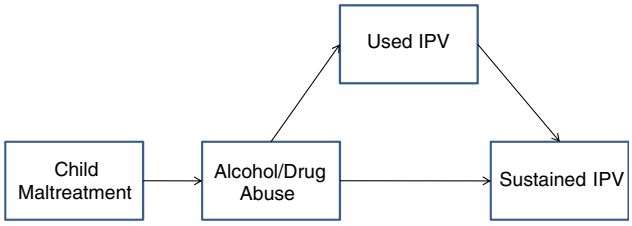
*$P < .05$, **$P < .01$, ***$P < .001$.

there was only one significant association for the help-seeking sample, and it was in the opposite direction hypothesized. For the community sample, all but two of the associations were significant. The results indicate that there is a dose–response relationship between alcohol/drug abuse and sustaining IPV for the community sample, but not the help-seeking sample.

Path models. Because only the community sample showed associations among alcohol/drug abuse and sustaining IPV, we then investigated the hypothesized path models for the community sample only (Fig. 1).[1] In the interest of parsimony, we combined the scores on the two childhood physical aggression measures (sustaining child physical aggression and witnessing interparental IPV) into a variable called *Child Maltreatment*. For sustaining IPV, we only used the frequency with which they sustained physical aggression because CCV, the type of IPV that occurs among a minority of couples in a community sample, is not theoretically tied to controlling behaviors and severe psychological aggression [1995, 2006; Johnson and Ferraro, 2000]. Finally, for the alcohol and drug abuse variables, we used the frequency of intoxication and frequency of drug use in the past year variables, respectively, to have continuous outcome measures for our path modeling.

As indicated, in the first model, we hypothesized that child maltreatment would predict alcohol/drug abuse, which would then predict sustaining IPV in adulthood; this latter association would be partially mediated by the use of IPV. In the second model, we predicted that child maltreatment would predict sustaining IPV, which would then predict alcohol/substance abuse, and this latter association would be partially mediated by levels of PTSD symptoms. These full models were tested for alcohol and drug abuse separately, and each model was evaluated using four fit measures—χ^2, RMSEA, NFI, and GFI—as recommended by Tabachnik and Fidell [2006]. This method ensures a model fit is tested

Model 1: Alcohol/Drug Abuse Predicts Sustaining IPV



Model 2: Sustained IPV Predicts Alcohol/Drug Abuse

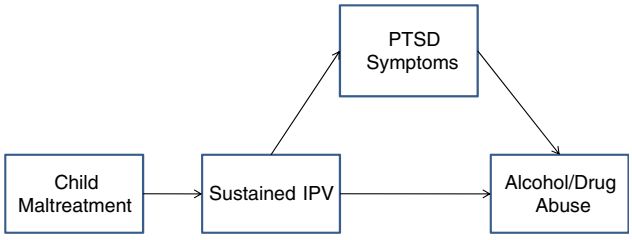


Fig. 1. Hypothesized path models for the associations between alcohol/drug abuse and sustaining IPV among community sample only. Model 1: alcohol/drug abuse predicts sustaining IPV. Model 2: sustained IPV predicts alcohol/drug abuse.

from several different perspectives [Meyers et al., 2006]. Nonsignificant paths were pruned one at a time until an excellent fitting model was achieved. This end model was compared with the original model on their AIC and ECVI; smaller AIC values represent better fitting models and smaller ECVI values represent the greatest potential for replication [Byrne, 2010].

Within the community sample, five cases (0.1%) were removed because of incomplete data on the child maltreatment measures. For the frequency of drug usage variable, two cases (0.4%) were missing and replaced with the mean on that variable. For the frequency of intoxication variable, seven cases (1.4%) were missing and replaced with the mean on that variable. For physical aggression used, there was one extreme outlier that was replaced with a value that was one act higher than the next closest value, as per Tabachnik and Fidell [2006]. Similarly, for physical aggression sustained, there were two extreme outliers that were replaced with values that were one and two acts higher than the next closest value. Models were tested both with and without the outliers replaced and there were some slight differences in the path estimates (but no differences in model fits or significance of path estimates); therefore, the results for the models with the outliers replaced are presented.

Initially, the full model for each analysis was evaluated for its adherence to the assumption of

[1]To be certain, we did run the same models with the help-seeking sample as we did with the community sample. As expected, none of the models were good fits to the data, even when nonsignificant parameters were pruned. In fact, for the models where we were using alcohol/drug abuse to predict IPV victimization, the only significant paths were from IPV perpetration to IPV victimization, and for the models where we predicted alcohol/drug abuse from IPV victimization, the only significant paths were from IPV victimization to levels of PTSD symptoms and from levels of PTSD symptoms to drug abuse.

multivariate normality. Mardia's [1970, 1974] normalized estimate of multivariate kurtosis equaled 258.39 for the model where alcohol abuse predicted IPV victimization, 98.89 for the model where IPV victimization predicted alcohol abuse, 271.65 for the model where drug abuse predicted IPV victimization, and 109.18 for the model where IPV victimization predicted drug abuse. All these values are well above the standard cut-off of 5 and indicated nonnormal distributions [Bentler, 2005]. Therefore, we employed the bootstrapping procedure for estimating standard errors and reducing bias in our estimates of parameters and their significance. Although not without its limitations, bootstrapping is a procedure that is routinely used when estimating path models with nonnormal data [Byrne, 2010].

For alcohol abuse predicting IPV sustained, the full hypothesized model achieved a moderate-to-good fit to the data (χ^2 (2) = 12.27, P = .002; NFI = 0.96; GFI = 0.99; RMSEA = .10, AIC = 28.27, ECVI = .06). The final parsimonious model achieved an excellent fit: χ^2 (1) = 0.05, P = .82; NFI = 1.00; GFI = 1.00; RMSEA = .00, AIC = 12.00, ECVI = .02. This final model represents a significant improvement in the χ^2 fit of the model ($\Delta\chi^2$ (1) = 12.23, P = .0005), and the parameter estimates for this model are shown in Figure 3. Child maltreatment dropped out of the model and the influence of alcohol intoxication on sustaining IPV was fully mediated by the use of IPV. Overall, this model explained 42.5% of the variance in sustaining physical IPV.

The full model for sustaining IPV predicting alcohol abuse also achieved a moderate-to-good fit (χ^2 (2) = 7.36, P = .03; NFI = 0.90; GFI = 0.99; RMSEA = .07, AIC = 23.36, ECVI = .05). After nonsignificant paths were removed one-by-one, the final model, shown in the bottom half of Figure 2, achieved an excellent fit (χ^2 (1) = 0.10, P = .76; NFI = 0.99; GFI = 1.00; RMSEA = .00, AIC = 10.10, ECVI = .02). This reduced model was a significant improvement over the full model ($\Delta\chi^2$ (1) = 7.26, P = .007), but explained only 4% of the variance in alcohol abuse. Overall, the model shows that sustaining IPV has direct influences on both frequency of alcohol intoxication and the level of PTSD symptoms, but that the level of PTSD symptoms does not serve as a mediator between sustaining IPV and alcohol intoxication.

To determine whether the final model predicting sustaining IPV from alcohol abuse was a better fit than the final model predicting alcohol abuse from sustaining IPV, we compared the two models' AICs and ECVIs. There were no differences in the ECVIs. The final model where alcohol intoxication predicted sustaining IPV had a slightly lower AIC than the final model where sustaining IPV predicted alcohol abuse; therefore, it was concluded that the best fitting model was one where alcohol intoxication predicts sustaining IPV. In addition, the differences in the percent of variance explained

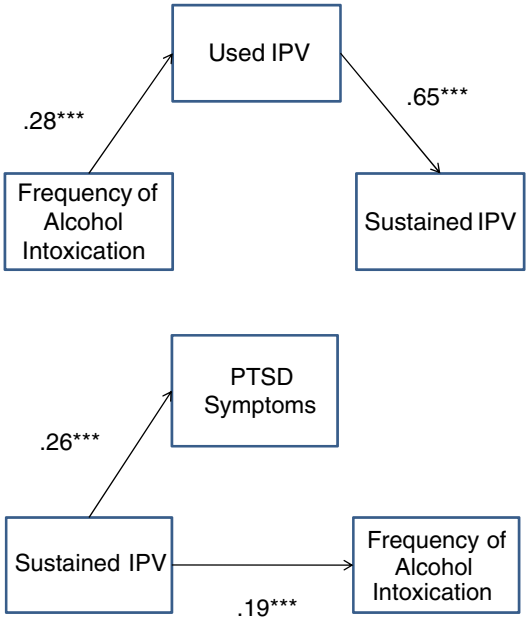


Fig. 2. Final models for the association among alcohol abuse and sustaining IPV among community sample only, ***P < .001.

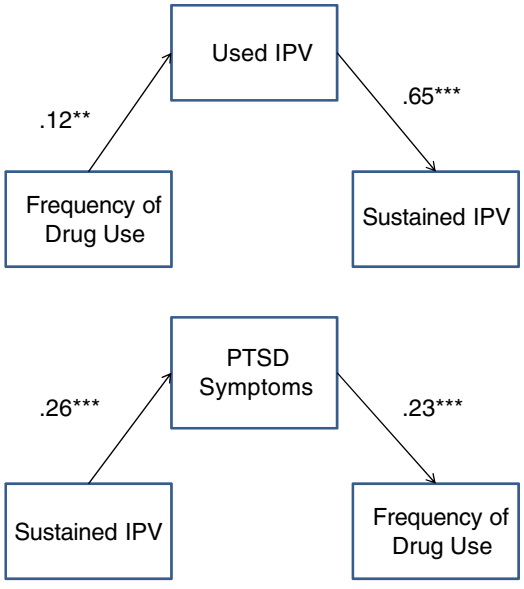


Fig. 3. Final models explaining associations among drug abuse and sustaining IPV among community sample only, **P < .01, ***P < .001.

(41 vs. 4%) provide further evidence that the model where alcohol intoxication predicts sustaining IPV is a better model.

The full model investigating drug abuse as a predictor of sustaining IPV achieved a moderate-to-good fit of the data (χ^2 (2) = 11.63, P = .003; NFI = 0.96; GFI = 0.99; RMSEA = .10, AIC = 27.63, ECVI = .05). After removing the nonsignificant paths one at a time, the final model achieved a good-to-excellent fit (χ^2 (1) = 2.94, P = .09; NFI = 0.99; GFI = 0.99; RMSEA = .06, AIC = 12.94, ECVI = .02). This reduced model was a significant improvement over the full model (χ^2 (1) = 8.69, P = .003), and showed that using IPV served as a full mediator of the relationship between frequency of drug use and sustaining IPV (Fig. 3). This model explained 42% of the variance in physical IPV sustained.

The full model predicting drug abuse from sustaining IPV was a moderate fit to the data (χ^2 (2) = 7.52, P = .02; NFI = 0.91; GFI = 0.99; RMSEA = .07, AIC = 23.52, EDVI = .05). The final model, also displayed in Figure 3, was a good-to-excellent fit (χ^2 (1) = 3.11, P = .08; NFI = 1.00; GFI = 0.99; RMSEA = .06, AIC = 13.11, ECVI = .023), and was a significant improvement over the full model ($\Delta\chi^2$ (1) = 4.41, P = .04). This model explained 5% of the variance in drug abuse, and showed that the level of PTSD symptoms was a full mediator between sustaining IPV and frequency of drug use.

To determine whether the final model predicting sustaining IPV from drug abuse was a better fit than the final model predicting drug abuse from sustaining IPV, we compared the two models' AICs and ECVIs. There were no differences in the ECVIs. The final model where drug abuse predicted sustaining IPV had a lower AIC than the final model where sustaining IPV predicted drug abuse; therefore, it was concluded that the best fitting model was one where drug abuse predicts sustaining IPV. In addition, the difference in the percent of variance explained (42 vs. 5%) provides further evidence that the model where drug abuse predicts sustaining IPV is a better model.

Hypothesis 2: Differences Among IT, CCV, and No Violence Groups in Alcohol and Drug Abuse

To test our second hypothesis, we divided the community sample into those who sustained IPV (CCV group) and those who sustained no IPV; the help-seeking sample was an indicator of IT. These divisions were in line with our previous analyses that established the no violence, IT, and CCV groups [Hines and Douglas, 2010].[2] We then performed χ^2 and ANCOVA analyses to investigate whether there were significant differences among the three groups in the variables assessing alcohol and drug abuse and the percentage of men meeting the criteria for alcohol and drug abuse.

As shown in Table III, the no IPV group was the group least likely to have abused alcohol in the past year. The IT group was significantly more likely to have abused alcohol than the no IPV group, but the CCV group had the highest rates of alcohol abuse in the past year. Similarly, the CCV group reported intoxication in the past year significantly more frequently than either the no IPV or IT groups, who were not different from each other in reported intoxication frequency within the past year. For drug abuse, the no IPV group had the lowest rates and frequency within the past year. Both the IT and

[2]A full description of how we determined that the help-seeking sample was a sample of IT victims can be found in Hines and Douglas (2010). Briefly, we did a series of comparisons between the help-seeking and community samples in the rates and frequencies of physical IPV, controlling behaviors, severe psychological IPV, and injuries reported by the male participants, to test Johnson's conceptualization of IT that it is physical IPV in the context of controlling behaviors and severe psychological IPV, whereas CCV is characterized by low-level mutual physical IPV without the same level of controlling behaviors as in IT. In comparison to the male help-seekers, the female partners of men in the help-seeking sample had significantly higher rates of all types of IPV, and just among those men and women who engaged in physical and psychological IPV, the female partners used 5–6 times the frequency of physical IPV, severe psychological IPV, and controlling behaviors. The help-seeking men also had significantly higher rates of injuries than their female partners, and among those men and women who sustained injuries, the men were injured at approximately twice the frequency. Finally, the frequency with which men sustained violence in the previous year (46.72 acts) is comparable to the frequency of violence sustained in samples of battered women (between 15 and 68 acts per year). Patterns of IT were also found when we compared the help-seeking with the community sample. In comparison to the female partners of community men, the female partners of help-seeking men engaged in significantly higher rates and frequency of all types of IPV: they were 54 (controlling behaviors) to 407 (minor physical IPV) times more likely to use IPV. Among just those women who used IPV, the female partners in the help-seeking sample had significantly higher frequencies of IPV, ranging from about 1.5 times (severe physical IPV) to more than 3.75 times (controlling behaviors, total physical IPV) the frequency of IPV than female partners in the community sample. Moreover, the men in the help-seeking sample were injured at higher rates and frequencies—they were close to 90 times more likely to have sustained an injury in the past year, and when comparing just those men who were injured, men in the help-seeking sample had about twice the frequency of injuries. Finally, the female partners in the help-seeking sample were significantly more likely to have used physical IPV first, in both the last physical argument (97 vs. 56.9%) and ever (91.7 vs. 53.0%).

TABLE III. AN(C)OVA and χ^2 Results on the Differences Among IPV Groups in Alcohol/Drug Abuse

	No violence % or *M* (*SD*)	CCV % or *M* (*SD*)	IT % or *M* (*SD*)	*F* or χ^2 (df)	η^2
Abused alcohol in past year	11.5[a]	30.6[a]	17.9[a]	21.00*** (2)	
Frequency of intoxication in past year	0.76 (1.35)[a]	1.80 (2.16)[a,b]	1.00 (1.46)[b]	11.33*** (2, 794)	.03
Abused drugs in past year	5.3[a,b]	15.3[a]	11.6[b]	14.29*** (2)	
Frequency of drug use in past year	0.20 (0.65)[a,b]	0.51 (1.06)[a]	0.43 (0.90)[b]	8.24*** (2, 783)	.02

Means in the same row sharing superscripts are significantly different from each other. For frequency of intoxication, means in the same row sharing superscripts are significantly different from each other after controlling for age and presence of children. For frequency of drug use, means in the same row sharing superscripts are significantly different from each other after controlling for age, presence of children, and educational level. For ANCOVA results, unadjusted means are presented and Tamhane post hoc tests (because they correct for heterogeneity of variance) were used to identify the locus of any significant differences. CCV, common couple violence; IT, intimate terrorism. ***$P < .001$.

CCV groups had significantly higher rates and frequencies of drug abuse in comparison to the no IPV group, but they were not different from each other on either measure of drug abuse.

DISCUSSION

The purpose of this study was to investigate the associations and possible mediators between alcohol/drug abuse and sustaining IPV among two samples of men: a help-seeking sample that sustained IT and a community sample, 16% of which sustained CCV. Our study showed support for the hypothesis that the predictors and mediators of any associations among sustaining IPV and alcohol/drug abuse would differ among the two samples; however, only the community sample conformed to any of the proposed models. Moreover, our study showed mixed support for the hypothesis that sustaining more severe types of IPV would be associated with higher levels of alcohol/drug abuse because the experience would be more traumatic.

Alcohol Abuse

Overall, and consistent with Simons et al. [2008], there was support for the hypothesis that sustaining IPV would be associated with higher levels of alcohol abuse. However, contrary to our prediction, the men who experienced CCV had the highest levels of alcohol abuse and frequency of intoxication within the past year. In addition, although in comparison to men who sustained no IPV, men who experienced IT had higher levels of alcohol abuse within the past year and they did not report a greater frequency of intoxication.

Men who experience CCV would be in relationships in which the incidence and frequency of all types of IPV would be about equal between them and their female partners [Johnson, 1995, 2006; Johnson and Ferraro, 2000], as was the case with the men in the community sample [Hines and Douglas, 2010]. Therefore, the reason that the CCV group had the highest levels of alcohol abuse and intoxication could lie in the fact that, perhaps in men, alcohol abuse is more predictive of the use of IPV rather than sustaining IPV. This is supported by the fact that in the help-seeking sample there were no associations between sustaining IPV and either alcohol abuse or intoxication. In addition, our best fitting path model for the men in the community sample showed that the association between alcohol intoxication and sustaining IPV was fully mediated by the men's use of IPV. This finding supports Kilpatrick et al.'s [1997] theory that perhaps alcohol abuse is a risk factor for sustaining IPV because alcohol abuse leads one into certain situations or relationships, or leads one to behave in a certain way, in which sustaining IPV is more likely. Thus, it seems that for the community men, alcohol intoxication led them to use IPV, which then led to them sustaining IPV from their partners, perhaps in retaliation or self-defense.

We tested an alternative explanation to this hypothesis (results not shown), in which we hypothesized that the association between alcohol intoxication and using IPV would be mediated by sustaining IPV. In this situation, alcohol intoxication would lead to the man sustaining IPV, which would then lead to him using IPV, perhaps in retaliation or self-defense. This model proved to be a poor fit to the data (χ^2 (1) = 23.45, $P < .001$, NFI = 0.93, GFI = 0.97, RMSEA = .21). Thus, it seems that alcohol intoxication has little to do with directly predicting men's victimization from IPV, but only indirectly predicts men's victimization from IPV through his perpetration of IPV. These results support studies on women who sustain IPV or violence [Kilpatrick et al., 1997; Martino et al., 2005; Testa et al., 2003], which show no evidence that alcohol intoxication leads to sustaining IPV or violence.

It is also important to note that among the community men there was support for Kilpatrick's et al. [1997] hypothesis that sustaining IPV is a risk factor for alcohol abuse. Although this model was an excellent fit to the data, it was not as good a fit as the model in which alcohol abuse predicted sustaining IPV, and it only predicted a small percentage of the variance in alcohol abuse. In addition, there was no support for the hypothesis that this association would be mediated by the level of PTSD symptoms. In fact, sustaining IPV directly predicted both levels of PTSD symptoms and alcohol intoxication, which were not significantly related to each other. We can only speculate as to why levels of PTSD symptoms did not serve as a mediator between sustaining IPV and alcohol intoxication, given the current literature that states that PTSD and alcohol/substance abuse are highly comorbid disorders that are functionally related [Chilcoat and Breslau, 1998; Jacobsen et al., 2001; Stewart, 1996; Stewart et al., 1998] because alcohol and other drugs seem to provide acute symptom relief of PTSD [Chilcoat and Breslau, 1998; Jacobsen et al., 2001; Stewart, 1996; Stewart et al., 1998].

Perhaps the differences in our findings are due to the fact that we were not able to make a definitive diagnosis of PTSD; we were assessing levels of PTSD symptoms on a continuous scale in our path models. Thus, we recommend additional research that explores the associations among alcohol intoxication and both levels of PTSD symptoms and actual diagnosis of PTSD in studies of IPV using men in community samples. In addition, because there was support for, and minimal differences between, both models—that alcohol intoxication predicted sustaining IPV through using IPV and that sustaining IPV predicted alcohol intoxication and levels of PTSD symptoms—we need to further investigate the associations among sustained IPV and alcohol intoxication in men, preferably with longitudinal data.

It is also worth speculating as to why there was no dose–response relationship between alcohol abuse and violence victimization (or perpetration) among the help-seeking sample of men. Past research suggests that men are more likely than women to abuse alcohol or other substances in response to a stressful event [Cooper et al., 1992], and being victimized by IT would certainly be considered a stressful event. However, the men in the help-seeking sample were no more likely to abuse alcohol than the men in the community sample who experienced less frequent and severe IPV, nor were they drinking more in response to increasing levels of IT victimization.

The answer to this contradiction may lie in the nature of the help-seeking sample. Men are less likely than women to seek help for a wide range of psychological, social, and physical health issues. Moreover, men are even less likely to seek help for an issue that is nonnormative for men (i.e., victimization from domestic violence is considered a women's issue) that others may perceive they should be able to handle themselves and that may cast them as being "deviant" [Addis and Mahalik, 2003]. Thus, the men in our sample had to overcome many social and psychological barriers to seeking help, in addition to any external barriers that they may have had to encounter after deciding to seek help (e.g., being told that a domestic violence agency only helps women) [Douglas and Hines, 2010]. Men who are able to overcome such barriers may have better coping mechanisms and be less likely to abuse alcohol in response to IT victimization. The fact that our help-seeking sample seems to be significantly better educated and have a slightly higher income, despite their younger age, than men in the community sample, lends support to the notion that these men are in some way different than a sample of average men—maybe their higher educational status allows them to psychologically break from traditional masculine norms and seek help for a nonnormative issue. Therefore, male victims of IT who do not seek help may indeed show a dose–response relationship between IPV victimization and alcohol/drug abuse, and may even evidence the highest levels of alcohol abuse among all male victims of IPV, because they do not seek help and may use other coping mechanisms, such as alcohol or other drugs. We recommend research that strives to study the associations between alcohol/drug abuse and IPV victimization among such a population.

Drug Abuse

Consistent with previous research [Kilpatrick et al., 1997, 2000; Salomon et al., 2002; Testa et al., 2003], we also found that men sustaining either CCV or IT had higher levels of drug abuse in the past year and higher frequencies of drug use in comparison to men who did not sustain IPV. However, contrary to our expectation that men who sustained IT would have higher levels of drug abuse than men who sustained CCV because their experiences would be more traumatic, we found no differences between men sustaining CCV and IT in either the percentage of men abusing drug in the past year or their frequency of drug use in the past

year. Thus, for men, it seems that sustaining IPV is associated with elevated levels of drug abuse, but it does not matter which type of IPV is sustained; they both have equally elevated levels of drug abuse. This is inconsistent with Johnson's [1995, 2006; Johnson and Ferraro, 2000] assertion that CCV and IT would necessarily have different predictors and consequences. However, as previously mentioned, this inconsistency could be due to the unique nature of our help-seeking sample, and Johnson's hypothesis may be borne out among a sample of male IT victims who do not seek help.

What is consistent with Johnson's [1995, 2006; Johnson and Ferraro, 2000] assertion is that the associations among sustaining IPV and drug abuse were different for the two samples. For men in the help-seeking sample, there was no dose–response relationship between sustaining any type of IPV and drug abuse or frequency of drug use. For the community sample, there was. Thus, perhaps once one reaches a certain level of IPV victimization, sustaining further acts of IPV would no longer increase one's risk for drug abuse. We performed three regression analyses with both samples combined (results not shown) to test this hypothesis—linear, cubic, and quadratic—and the only significant regression model was a cubic model that showed that initially frequency of drug use increased as IPV victimization increased, and then leveled off between 50 and 225 acts sustained in the past year; at about 225 acts sustained, there was again an increase in the frequency of drug use in the past year. Alternatively, the lack of a dose–response relationship for the help-seeking sample could be due to the uniqueness of such a sample, as discussed previously.

For the community sample, there was support for the hypothesis that drug abuse would predict sustaining IPV, which is consistent with both Kilpatrick et al.'s [1997] and Testa et al.'s [2003] findings among women. In addition, our findings expand upon these results by pointing toward a mediator that, to our knowledge, has never been tested among women. Specifically, among the community men, perpetrating IPV was a full mediator of the association between drug abuse and sustaining IPV. Thus, similar to our results with alcohol intoxication, among men, frequency of drug use predicts the use of IPV, which then predicts sustaining IPV, perhaps in retaliation or self-defense.

The opposite model that sustaining IPV would predict drug abuse was also a good fit to the data, which is consistent with previous research among women who sustain IPV and violence [Kilpatrick et al., 1997; Salomon et al., 2002] and among adolescent male victims of violence, in general [Kilpatrick et al., 2000]. In addition, this association was fully mediated by levels of PTSD symptoms, which is consistent with the self-medication model that posits that in an effort to cope with and reduce the overwhelming negative emotions that accompany a trauma like IPV, the person might abuse substances [Jacobsen et al., 2001; Simons et al., 2005; Stewart, 1996].

Thus, among the community sample, there was support for sustaining IPV predicting drug abuse and for drug abuse predicting sustaining IPV. The model showing that sustaining substance abuse predicts IPV was a better fitting model and also explained a much higher percentage of the variance in the outcome variable, but both were good-to-excellent fits to the data. These results are consistent with Kilpatrick et al.'s [1997] study of women who sustain violence. In addition to finding support for both models, using longitudinal analyses, they found evidence for a vicious cycle between drug abuse and violence, in which drug abuse increased the risk for violent victimization, which in turn led to increased risk for further drug abuse. Such a model could also be occurring among men as well, but because our data are cross-sectional, we are unable to test this hypothesis. Thus, future studies should aim to investigate the temporal associations among drug abuse and sustaining IPV in men using longitudinal designs.

Limitations and Future Research

The limitations of this study need to be addressed so that future research can replicate and expand on the findings reported here. First, as mentioned previously, this is a cross-sectional study, and therefore inferences about causality cannot be firmly established. In fact, for both alcohol and drug abuse, although we were able to distinguish which models fit the data the best, the models that predicted opposite effects were both excellent fits. Therefore, future research should aim to test these models in a longitudinal design. Second, it is possible that some of the men who were classified as IT victims were really victims of CCV and vice versa. Johnson [Johnson, 1995, 2006; Johnson and Ferraro, 2000] does not provide "cut-off" criteria to establish which *individuals* sustain IT vs. CCV; he only provides modest guidelines to establish whether a sample would be characteristic of IT or CCV. We agree with Johnson's efforts to distinguish types of

violence and find this differentiation useful; however, without existing cut-off measures, it is currently not possible to definitively categorize individuals into IT or CCV groups. It is important to note that if there are CCV victims in our IT group and/or IT victims in our CCV group, it would serve as error and would weaken all associations reported in this article.

Third, the study relies solely on the men's reports of their partners' aggressive behaviors and their own psychosocial characteristics. This limitation is important to consider for three primary reasons: (1) correlations between aggressive behaviors and psychosocial characteristics may be inflated because certain traits of the participant may influence how he answers both sets of questions [Cooper, 2002]; (2) it is possible that the men overestimated their female partners' use of IPV; however, studies of couples reporting on IPV show no difference between male and female partners in their estimates of women's use of IPV [Archer, 1999]; and (3) by using only the men's reports, we have no external validation of the authenticity of their reports. We were concerned, particularly for our help-seeking sample, about the confidentiality and safety of the participants if we asked their partners to participate in this study as well. Therefore, we opted not to obtain these data directly from the female partner, but note that such methodology has been used in most of the studies on IPV and on samples measuring IT that we cited in this article. Thus, we recommend that future studies, whenever possible, should strive to obtain information from multiple informants.

CONCLUSION

In closing, this study provides valuable information regarding our understanding of male IPV victimization. We can conclude that men who sustain IPV from their female partners engage in more alcohol and drug abuse than men who do not. However, among men who seek help for IT victimization, increased levels of victimization do not predict increased levels of alcohol or drug abuse, possibly because they have active coping mechanisms. Given that our help-seeking sample of men is a unique sample, it would be valuable to investigate whether such associations would be found among men who sustain IT and do not seek help. Among men who sustain CCV, increased levels of IPV victimization are associated with increased levels of alcohol and drug abuse as expected, and the best potential explanation for this association seems to be that alcohol/drug abuse leads to IPV perpetration, which then leads to IPV victimization.

The results of this study can be useful to alcohol and drug abuse providers and other service providers in the field of family violence. We encourage the screening of alcohol and drug abuse among male IPV victims and the screening of IPV among men who seek treatment for alcohol and drug use. Even though this article documents that alcohol and drug abuse among IT victims is not an overarching issue, we encourage family violence providers to have a method of providing alcohol and drug abuse treatment for men, even if this means making referrals to providers outside of domestic violence agencies. At the same time, men do not usually seek help for CCV, and thus we encourage the screening of IPV among men who seek help for alcohol and drug abuse, because for these men, it may be a red flag for other problematic behaviors that may otherwise go unnoticed.

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A Closer Look at Men Who Sustain Intimate Terrorism by Women

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Over 30 years of research has established that both men and women are capable of sustaining intimate partner violence (IPV) by their opposite-sex partners, yet little research has examined men's experiences in such relationships. Some experts in the field have forwarded assumptions about men who sustain IPV—for example, that the abuse they experience is trivial or humorous and of no consequence and that, if their abuse was severe enough, they have the financial and psychological resources to easily leave the relationship—but these assumptions have little data to support them. The present study is an in-depth, descriptive examination of 302 men who sustained severe IPV from their women partners within the previous year and sought help. We present information on their demographics, overall mental health, and the types and frequency of various forms of physical and psychological IPV they sustained. We also provide both quantitative and qualitative information about their last physical argument and their reasons for staying in the relationship. It is concluded that, contrary to many assumptions about these men, the IPV they sustain is quite severe and both mentally and physically damaging; their most frequent response to their partner's IPV is to get away from her; and they are often blocked in their efforts to leave, sometimes physically, but more often because of strong psychological and emotional ties to their partners and especially their children. These results are discussed in terms of their implications for policy and practice.

KEYWORDS: intimate partner violence; male victims; domestic violence; spouse abuse; battering; female perpetrators

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Although increasingly more researchers have been investigating women's use of intimate partner violence (IPV) (e.g., Carney, Buttell, & Dutton, 2007; Carney & Buttell, 2004; Dowd, Leisring, & Rosenbaum, 2005; Henning & Feder, 2004; Henning, Jones, & Holdford, 2003; Swan, Gambone, Caldwell, Sullivan, & Snow, 2008; Swan, Gambone, Fields, Sullivan, & Snow, 2005; Swan & Snow, 2006) and thus acknowledging that men can sustain IPV from their women partners, little systematic research has documented the experiences of men who sustain IPV from their women partners. What has been done has been limited primarily to case studies (Cook, 2009; Migliaccio, 2001), with only one larger-scale study of men seeking help because they sustained IPV (Hines, Brown, & Dunning, 2007). One reason for this lack of research has been attributed to the controversial nature of this topic (Hines & Douglas, 2009): Despite decades of research showing that women use IPV against their men partners (Catalano, 2007; Gelles, 1974; Straus & Gelles, 1988; Straus, Gelles, & Steinmetz, 1980; Tjaden & Thoennes, 2000) at rates and frequencies that often equal that of their men partners (Archer, 2000), there are some who argue that men do not sustain IPV from their women partners, unless it is because their partners are acting in self-defense or retaliation (Belknap & Melton, 2005; Dobash, Dobash, Wilson, & Daly, 1992; Loseke & Kurz, 2005; Saunders, 1988). These authors typically argue that, because IPV is an issue of men maintaining power and control over their women partners, it is not possible for women to be perpetrators of IPV.

Johnson (1995, 2006) attempted to resolve this controversy by theorizing that there are two distinct types of IPV: common couple violence (CCV) and intimate terrorism (IT). CCV, Johnson argued, was seen primarily in population-based and community surveys that showed that women and men used IPV equally. This type of IPV consists of conflicts that "get out of hand" and result in men and women using low levels of violence (e.g., pushing, shoving, or slapping) toward one another. The central feature of IT is that the violence is one tactic in a general pattern of control of the male partner over the female partner. The IPV occurs frequently and is severe, occurring at least monthly; it is not likely to be mutual, and it is likely to involve serious injury and emotional abuse of the female partner as well. Johnson argues that IT can be explained by patriarchal theory and is the sole domain of men. The primary shortcoming of Johnson's research is that he used only shelter samples of battered women, and men mandated into batterer treatment programs, to come to this conclusion.

In a previous article on the data set used in the current study (Hines & Douglas, in press), we established that, as a whole, the men in our sample were the victims of IT by their women partners and that the violence the men used against their women partners was characteristic of violent resistance. Violent resistance, as described by Johnson, is characterized by the victim sometimes reacting to the partner's IT with violence but not within a general pattern of trying to control the partner (Johnson & Ferraro, 2000). The purpose of the present article is to more closely examine the men who sustain IT and to evaluate some prevailing assumptions about who they are and what they experience. Specifically, we will provide data on their demographics, the

nature of their relationships, what types of abuse they experience, and what prevents them from leaving.

ASSUMPTIONS AND PREVIOUS RESEARCH ABOUT MEN WHO SUSTAIN INTIMATE PARTNER VIOLENCE FROM WOMEN PARTNERS

As mentioned, one well-noted assumption about women who use IPV against their men partners is that they are acting solely in self-defense or retaliation against their presumably violent men partners (Belknap & Melton, 2005; Dobash et al., 1992; Loseke & Kurz, 2005; Saunders, 1988). This assumption, held by a few researchers, has been refuted by studies assessing women's motives for IPV, which show that, although some women report self-defense or retaliation as a motive, most do not (see Hines & Malley-Morrison, 2001; Medeiros & Straus, 2006, for reviews). In a previous article (Hines & Douglas, in press), we provided evidence that refuted that assumption as well. The men in our sample are clearly the victims of IT, IPV that is characterized by severe violence and control, and any violence used by the men was consistent with the definition of violent resistance

Another assumption concerning woman-to-man violence held by some researchers (e.g., Pagelow, 1985) focuses on the relative size difference between most men and women. Because, on average, men are physically bigger and stronger than their women partners, some authors have argued that men would strike back or restrain a woman partner who becomes violent and that men presumably also have the ability to leave the premises without being forcibly restrained by their women partners (Pagelow, 1985). Some researchers who forward this assumption conclude that, because men can easily fight back, restrain their partners, and/or leave the premises, women's violence against men is trivial, humorous, or annoying (Currie, 1998; Pagelow, 1985; Saunders, 1988), and violence by women toward men has no social or psychological effects on the men who sustain it (Mills, 1984). Several anecdotal accounts (Cook, 2009; Migliaccio, 2001) and one larger-scale study (Hines et al., 2007) of men who sustain IPV from women partners indicate that women's violence can induce fear in men partners and is not viewed as trivial, humorous, or annoying, but as distressing. Many men report that they cannot and will not hit back, both because of moral objections to hitting a woman and because of fear that, if he hits her back, he may set himself up to be arrested and/or lose custody of his children (Cook, 2009; Migliaccio, 2001). Men victims are injured less frequently than women victims, but, men do, nonetheless, sustain injuries, which are sometimes very severe (Hines & Douglas, in press; McNeely, Cook, & Torres, 2001), and suffer socially and psychologically from their partner's aggression (e.g., Cook, 2009; Hines, 2007; Stets & Straus, 1990).

A related assumption is that men who sustain IPV from their women partners can leave their partners. Some researchers argue that men are not economically trapped in marriage or romantic relationships like women, because their incomes and occupational statuses tend to be higher (Saunders, 1988); they are not physically

or economically constrained from leaving (Pagelow, 1985), nor are they as psychologically invested in the children or household (Loseke & Kurz, 2005). Researchers who support this line of reasoning focus on concrete resources that are often available to men such as physical strength, employment, and transportation. Nonetheless, case studies show that men who sustain IPV often focus on these and other barriers to leaving an abusive relationship, including a commitment to marriage, lack of financial resources, and concern for their children. In such circumstances, men often worry that their women partners will obtain custody of their children. They have substantial concerns about leaving their children with a violent parent; if they stay in the household, they at least feel that they can protect the children (e.g., Cook, 2009; Steinmetz, 1977–1978). In our previous research on the sample in the current study, we also found that men encounter serious barriers to obtaining help from the social service system and from police when they seek such support, such as not being believed, being laughed at, and/or being accused of (or being arrested for) being the "real abuser" in the relationship (Douglas & Hines, 2009). Such barriers to seeking help from a system that is designed to help IPV victims creates further barriers to leaving an abusive woman partner.

In sum, despite increasing acknowledgement that men can sustain IPV from their women partners, some researchers embrace assumptions about the respective roles of men and women in troubled intimate relationships. Among these assumptions are that: (1) men are the primary perpetrators of abuse, and their women partners use violence in self-defense or retaliation; (2) men are physically dominant and can therefore easily strike back, restrain their partner, or leave the premises without being physically restrained; (3) the IPV that men sustain is trivial, humorous, or of no consequence; (4) men have greater socioeconomic resources than their women partners and thus have the ability to leave relationships that pose a danger to them; this ability is bolstered by their weaker psychological investment in their marriage and children as compared to women. Although these assumptions have been challenged by empirical studies on women who use IPV and case studies of men who sustain it, we still know little about men who sustain IPV from their women partners. The current article uses a large, national U.S. sample of men who sustained IPV from their women partners and sought help to investigate who these men are, the types and frequencies of abuse that they experience, their mental health status, and what prevents them from leaving the abusive relationships.

METHOD

Participants and Procedure

The boards of ethics at the participating institutions of higher education approved the procedures for this study. A help-seeking sample of men who had sustained IPV from a woman partner (N = 302) was recruited from a variety of sources, including the Domestic Abuse Helpline for Men and Women (DAHMW; a national IPV hotline

specializing in men victims) and online Web sites, newsletters, blogs, and electronic mailing lists that specialized in the treatment of IPV, men victims of IPV, fathers' rights issues, divorced men's issues, men's health issues, and men's rights issues. To be eligible, the men had to speak English, live in the United States, and be between the ages of 18 and 59; they also had to have been involved in an intimate relationship with a woman lasting at least one month in the previous year, in which they sustained a physical assault from their partner during the previous year, and they had to have sought help/assistance for their partner's violence. Help/assistance was broadly defined and included seeking help from formal sources, such as hotlines, domestic violence agencies, the police, mental health and medical health professionals, lawyers, and ministers, to more informal help-seeking efforts, such as talking with friends and family members and searching the Internet for information or support groups for men victims.

Men who called the DAHMW seeking assistance and who met the eligibility criteria were invited to participate in this study either by calling a survey research center to complete the interview over the phone or by visiting the study Web site to complete an anonymous, secure version of the study questionnaire online. Men who saw an advertisement for the study online were directed to the study Web site to complete the online version of the study. Screener questions regarding the study criteria were on the first page of the survey, and men who were eligible were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an exit page of the survey. Sixteen men completed the interview over the phone; the remaining 286 completed it online.

Measures

Demographic Information. Men were asked basic demographic information about both themselves and their partners, including age, race/ethnicity, personal income, education, and occupation. Occupation was coded according to the 1988 International Standard Classification of Occupations, a nine-point classification system developed by the International Labour Association that is updated every 20 years. Occupations were coded by two upper-level undergraduate research students, and interrater reliability was consistently above .90. Any discrepancies were resolved through conversations between the two coders. The nine categories are shown in the table note for Table 2. Men were also asked about the current status of their relationship, the length of their relationship with their partners, how long ago the relationship ended (if applicable), and how many minor children were involved in that relationship, if any.

Revised Conflict Tactics Scales (CTS2). The *CTS2* (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used to measure the extent to which the men in the study used and sustained psychological, physical, and sexual aggression and injuries in their relationships. The items used for this study included five items assessing minor physical aggression (e.g., grabbing, shoving, slapping), seven items

assessing severe physical aggression (e.g., punching, beating up, using a knife or gun), two items assessing minor injuries (e.g., having a small cut or bruise), four items assessing severe injuries (e.g., broken bone, passing out), and one item assessing sexual aggression (insisting on sex when the partner did not want to). The eight *CTS2* items regarding psychological aggression were supplemented with seven items from the Psychological Maltreatment of Women Inventory (Tolman, 1995). A factor analysis of these 15 items showed that there were three psychological aggression scales: controlling behaviors (e.g., not allowing to leave the house, monitoring time and whereabouts), minor psychological aggression (e.g., insulting/swearing, shouting/yelling, doing something to spite partner), and severe psychological aggression (e.g., threatening to harm partner, intentionally destroying something belonging to partner) (Hines & Douglas, in press).

Participants responded to each of the items by indicating the number of times these tactics were used by the participant and his partner in the previous year. Participants indicated on a scale from 0 to 6 how many times they experienced each of the acts in the previous year: 0 (0 times); 1 (*1 time*); 2 (*2 times*); 3 (*3 to 5 times*); 4 (*6 to 10 times*); 5 (*11 to 20 times*); 6 (*more than 20 times*). These data were then transformed in order to obtain an approximate count of the number of times each act occurred in the previous year, using the following scale: 0 = 0 acts in previous year; 1 (*1 act in the previous year*); 2 (*2 acts in the previous year*); 3 (*4 acts in the previous year*); 4 (*8 acts in the previous year*); 5 (*16 acts in the previous year*); 6 (*25 acts in the previous year*).

For the present article, we calculated a dichotomous and a frequency variable for each item in the *CTS2* and a dichotomous, a frequency, and a chronicity variable for each scale (i.e., minor psychological, severe psychological, controlling behaviors, insisting on sex, minor physical, severe physical, total physical, minor injuries, severe injuries, total injuries). We also created a new physical aggression scale that was comprised of the items that could be considered life-threatening (i.e., beating up, using a knife or gun, burning, choking), and we called this the very severe physical aggression scale. (The severe physical aggression scale contained these items as well, in addition to the items that Straus et al. outline in their description of the scale.) The dichotomous variable indicates the presence or absence of each type of IPV and thus can be used to indicate the prevalence of perpetration and victimization of each type of IPV. Frequency is the frequency with each type of IPV was used or sustained (including zeros when indicated). Chronicity is the frequency with which the participant and his partner used each type of IPV, among only those who indicated that a given type of IPV had been used. Thus, the lower bound of the chronicity variables would be one (indicating that that person used one act of that type of aggression in the past year) because participants and their partners who did not use that particular type of IPV would be removed from this particular calculation.

The *CTS2* has been shown to have good construct and discriminant validity and good reliability, with internal consistency coefficients ranging from .79 to .95 (Straus et al., 1996). Reliability statistics for the current sample ranged from .45 (severe

injury) to .65 (minor psychological) to .72 (severe psychological) to .90 (minor physical aggression).

Additional Information on IPV. Following the *CTS2*, we gathered specific information about the most recent violent episode. These questions included who used physical aggression first in the most recent physical altercation. If participants indicated that their partner used physical aggression first, they were then asked how they responded and were given eight responses, including hitting back, leaving the room, and calling the police. Participants were also asked whether they and/or their partner used alcohol or drugs during that incident, and we inquired about whether any children involved with the couple ever witnessed violence between the adults. These questions and answer choices provided were based on a review of the qualitative literature in addition to the experiences of the executive director of the DAHMW. A final choice of "other, specify" was provided for these questions in case a particular participant's experiences did not fit with the choices provided. These qualitative responses were coded independently by two upper-level undergraduate research assistants, and any discrepancies were resolved by the first author. A final question addressed who was the first to ever hit the other person in the relationship.

We also asked the participants whether their women partners ever did any of the following to them: filed a restraining order against him under false pretenses, falsely accused him of hitting or beating her, falsely accused him of physically abusing the children, and falsely accused him of sexually abusing the children. These last two questions were asked only of men who indicated they had minor children.

Mental Health Status. We asked men whether they were ever diagnosed with a mental illness. If they stated that they had been, we then asked them what their diagnosis was and whether they suffered from this mental illness for a long time or only since being involved with their partner. For diagnoses, they were given the following answer choices: depressive disorder, anxiety disorder, alcoholism/substance abuse, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, bipolar disorder, schizophrenia, eating disorder, attention deficit hyperactivity disorder/attention deficit disorder, and other. If they chose "other," we asked them to specify the diagnosis.

What Prevents Them From Leaving. We asked men whether they ever seriously considered leaving their partners. If they answered yes, we then asked why they had not left yet. Sample answer choices included: love, concern for the children, not enough money to leave, and embarrassment that others will find out that his partner abused him. Answer categories were based on a review of the qualitative literature and the experiences of the DAHMW. One final choice of "other, specify" was included in case a participant's experiences were not captured by the existing choices. Any qualitative responses were coded independently by two upper-level undergraduate research assistants; discrepancies were resolved by the first author.

RESULTS

Demographics

Table 1 presents the relationship characteristics. The majority of the men (56.5%) were currently in a relationship with their woman partners, the most common type of which was a marriage (47.5%), followed by separation (17.9%). Overall, 72.4% of the men were currently or had been married to their partners. The remainder were currently or had dated, cohabited with, or been engaged to their partners. These relationships lasted on average 8.2 years, and, of the relationships that had ended, they ended on average just over 6 months prior to the participants completing the survey. Almost three-quarters of the men said that minor children were involved in the relationship, and they reported an average of two children per relationship.

The demographics of the men and their women partners are presented in Table 2. In comparison to their partners, the men were significantly older, taller, and heavier and were more likely to be White, less likely to be Asian, had a higher income and educational status, and were more likely to be working. There was no difference in their occupational statuses. Overall, the men were a well-educated group, with an average educational attainment between a two- and four-year college degree. Their personal income was almost $52,000 per year, and, of those who provided an occupation, their average occupational code approached that of a technician/associate professional. More than three-quarters were working at least seasonally, but 13.2% were disabled in some way (7.0% of all men were not working because of a disability).

TABLE 1. Relationship Characteristics (*N* = 302)

	Percentage or *M (SD)*
Currently in a relationship	56.5%
Dating	3.6%
Ex-dating	7.3%
Engaged	1.7%
Ex-engaged	4.3%
Cohabiting (but not engaged)	6.0%
Ex-cohabiting	6.3%
Married	47.5%
Separated	17.9%
Divorced	7.0%
Length of relationship (in months)	97.90 (82.06)
Number of months since relationship ended (n = 112)	6.10 (7.69)
Have minor children	73.2%
Number of minor children (n = 217)	2.00 (1.01)

TABLE 2. Men Participants' and Their Women Partners' Demographics

	Men Help Seekers	Women Partners	
	Percentage or *M (SD)*	Percentage or *M (SD)*	χ^2 or *t*
Men participant demographics			
Age (*n* = 299)	40.49 (8.97)	37.91 (8.61)	7.11***
Height (in inches) (*n* = 293)	70.74 (2.94)	65.17 (2.88)	24.34***
Weight (in pounds) (*n* = 296)	195.41 (38.80)	153.21 (63.28)	10.39***
Body mass index (*n* = 291)	27.31 (4.76)	25.24 (10.25)	3.28***
Race/ethnicity			
White	86.8%	74.2%	26.33***
Black	6.0%	7.3%	0.75
Hispanic	5.0%	7.6%	1.75
Asian	4.3%	9.3%	7.84**
Native American	2.0%	2.6%	0.07
Income (*n* = 269)	$51,950 (24.46)	$30,130 (24.32)	10.38***
Educational status[a] (*n* = 299)	4.41 (1.56)	3.82 (1.90)	5.37***
Occupational status			
Working full-time	68.9%	47.7%	
Working one part-time job	4.6%	10.3%	
Working >1 part-time job	2.3%	1.7%	
Working seasonally	2.6%	1.3%	
Disabled, not working	7.0%	3.0%	
Retired, not working	1.3%	0.0%	
Unemployed, looking for work	7.9%	6.3%	
Not working, not looking for work	3.6%	27.5%	
Working at least seasonally (*n* = 294)	78.5%	60.6%	20.66***
Occupation code[b] (*n* = 107)	6.80 (2.13)	6.93 (1.60)	0.62
Has a disability	13.2%	8.6%	3.25

[a]Educational status: 1 = less than high school, 2 = high school graduate or GED, 3 = some college or trade school, 4 = two-year college graduate, 5 = four-year college graduate, 6 = some graduate school, 7 = graduate degree.

[b]Occupation code: 1 = elementary occupations, 2 = plant and machine operators and assemblers, 3 = craft and related trades workers, 4 = skilled agricultural and fishery workers, 5 = services workers and shop and market sale workers, 6 = clerks, 7 = technicians and associate professionals, 8 = professionals, 9 = legislators, senior officials, managers.

**$p < .01$. ***$p < .001$.

Of the men who provided occupations (n = 212), 25 were contractors or construction workers; 16 were in the military, police officers, or firefighters; 15 were lawyers, doctors, or engineers; and 10 were business owners or executives.

Experiences of Psychological and Physical Aggression in the Previous Year

As mentioned in Hines and Douglas (in press) and shown in Table 3, 100% of women partners were reported by their men partners to have used minor psychological aggression, 96.0% used severe psychological aggression, 93.4% used controlling behaviors, and 41.1% used sexual aggression. When examining their chronicity of aggression within the previous year, among those who used aggression, women partners were reported to have used 65.12 acts of minor psychological aggression, 28.90 acts of severe psychological aggression, 42.62 controlling behaviors, and 9.60

TABLE 3. Prevalence and Chronicity of Intimate Partner Violence by Women Partners (N = 302)

Types of Aggression	Percentage of Women Partners Who Perpetrated	Frequency of Aggression *M (SD)*	Chronicity of Aggression[a] *M (SD)*
Minor psychological	100.0	62.12 (24.15)	65.12 (24.15)
Severe psychological	96.0	27.75 (26.29)	28.90 (26.20)
Controlling behaviors	93.4	39.80 (36.60)	42.62 (36.25)
Insisting on sex	41.1	3.94 (7.20)	9.60 (8.48)
Minor physical	98.7	31.58 (34.30)	32.01 (34.33)
Severe physical	90.4	15.13 (21.54)	16.74 (22.06)
Very severe physical	54.0	4.03 (8.62)	7.46 (10.59)
Total physical (minor and severe)	100.0	46.72 (53.48)	46.72 (53.48)
Types of Injuries	**Percentage of Men Help Seekers Who Sustained an Injury**	**Frequency of Injuries to Men Help Seekers *M (SD)***	**Chronicity of Injuries to Men Help Seekers[a] *M (SD)***
Minor	77.5	7.54 (11.93)	9.73 (12.75)
Severe	35.1	1.63 (4.95)	4.64 (7.50)
Total (minor and severe)	78.5	9.16 (14.63)	11.68 (15.61)

[a]Chronicity is the average number of aggressive acts used by those women partners who were reported to have used any of the corresponding aggressive acts.

acts of sexual aggression. For physical aggression, 100% of women partners were reported to have engaged in physical aggression overall, with 98.7% engaging in minor physical aggression, 90.4% engaging in severe physical aggression, and 54.0% engaging in very severe (i.e., life-threatening) physical aggression. Moreover, within the previous year and among partners who were physically aggressive, women partners were reported to have used 46.72 acts of physical aggression overall, with a mean of 32.01 acts of minor, 16.74 acts of severe, and 7.46 acts of very severe physical aggression.

Almost 80% of men participants reported that they were injured by their women partners, with 77.5% stating they sustained a minor injury and 35.1% sustaining a severe injury in the previous year. Moreover, within just the men participants who did sustain injuries, the men participants reported that they were injured 11.68 times in the previous year (9.73 minor injuries and 4.64 severe injuries).

Table 4 presents the prevalence of each of the CTS victimization items by scale, along with the mean number of times that specific type of aggression happened in the past year (this mean includes those men who did not sustain that type of aggression). The items within each scale are arranged in order of prevalence rates, with the most prevalent item appearing first. For minor psychological aggression, the most prevalent types were shouting/yelling and insulting/swearing, with over 99% of men sustaining both of these at an average of over 20 times per year. For severe psychological aggression, the most prevalent items were threatening to hit or throw something at him and intentionally destroying something belonging to him, with approximately 75% of the sample sustaining both of these. More than 75% of the sample also had their time monitored by their partner, a type of controlling behavior, at a rate of over 12 times in the previous year. This type of controlling behavior was followed by the partner preventing him from seeing his friends or family, sustained by 68.2% of the sample at a rate of almost 8 times in the previous year.

For the minor physical aggression items, the most prevalent were pushing/shoving (93.0% sustained at a rate of 8.30 acts in the previous year) and throwing something at him that could hurt (82.5% sustained at a rate of 6.60 acts in the previous year). The most prevalent severe physical aggression items were punching/hitting him with something that could hurt, sustained by 84.4% of the sample at a rate of 6.08 acts in the previous year, and kicking, sustained by 56.3% of the sample at a rate of 3.08 acts in the previous year. Notably, 40.1% of the sample said they had been beaten up in the previous year, at an average of 2.68 times. This included 10 men (3.3%) who reported being beaten up 11 to 20 times in the previous year and 14 men (4.6%) who reported being beaten up more than 20 times in the previous year. In addition, 20.5% of men said their partners used a knife or gun on them in the previous year, which includes 9 men (3.0%) who said this happened 3 to 5 times, 2 men (0.7%) who said it happened 6 to 10 times, and 1 man (0.3%) who said this happened more than 20 times in the previous year. Almost 17% of the men reported being choked, which included 14 men (4.6%) who were choked 3 to 5 times, 2 men

TABLE 4. Rates and Frequencies of Women Partners' Aggression on All Conflict Tactics Scale Items (*N* = 302)

Item	Percentage	*M*	*SD*
Minor psychological aggression			
Shouted/yelled at him	99.3%	21.49	7.06
Insulted/swore at him	99.0%	21.12	7.36
Did something to spite him	90.4%	11.84	9.88
Stomped out of the room/house/yard during a disagreement	82.8%	10.67	9.77
Severe psychological aggression			
Threatened to hit or throw something at him	75.5%	8.46	9.46
Intentionally destroyed something belonging to him	73.8%	5.33	7.46
Called him a lousy lover	62.3%	6.71	8.96
Called him fat or ugly	57.9%	7.25	9.57
Controlling behaviors			
Monitored his time/made him account for his whereabouts	76.2%	12.40	10.68
Prevented him from seeing family or friends	68.2%	7.96	9.36
Prevented him from access to the household income	49.7%	5.68	8.73
Did not allow him to leave the house	45.0%	4.08	7.19
Restricted his use of the phone	36.1%	3.49	7.19
Restricted his use of the car	35.4%	3.90	7.83
Threatened to harm someone close to him	33.1%	2.28	5.79
Minor physical aggression			
Pushed or shoved him	93.0%	8.30	8.64
Threw something at him that could hurt	82.5%	6.60	8.03
Grabbed him	81.1%	7.24	8.60
Slapped him	71.9%	5.88	8.25
Twisted his arm or hair	46.7%	3.57	6.71
Severe physical aggression			
Punched him or hit him with something that could hurt	84.4%	6.08	7.86
Kicked him	56.3%	3.08	5.57

(*Continued*)

TABLE 4. (*Continued*)

Item	Percentage	*M*	*SD*
Beat him up	40.1%	2.68	5.94
Slammed him against a wall	38.4%	1.94	4.92
Used a knife or gun on him	20.5%	0.46	1.75
Choked him	16.9%	0.63	2.69
Burned/scalded him on purpose	7.0%	0.26	1.79
Minor injury			
He had a sprain, bruise, or small cut	69.5%	4.05	6.49
He still felt pain the next day	67.5%	3.49	6.17
Severe injury			
He needed to see a doctor, but didn't	29.1%	1.10	3.53
He went to the doctor because of a fight	14.2%	0.31	1.62
He had a broken bone	6.0%	0.08	0.40
He passed out from being hit on the head	5.6%	0.13	0.99

(0.7%) who were choked 6 to 10 times, and 3 men (1.0%) who were choked more than 20 times in the previous year.

The most common types of injury were having a sprain, bruise, or small cut, sustained by 69.5% of men on an average of 4.05 times in the previous year. Of the severe injuries, 29.1% of men said that they needed to see a doctor but did not in the previous year, and 14.2% actually did see a doctor. Over 5% of men reported sustaining a broken bone or passing out, with 15 men (5.0%) sustaining one broken bone, 1 man (0.3%) sustaining two broken bones, 2 men (0.7%) sustaining three to five broken bones, 10 men (3.3%) passing out once, 5 men (1.7%) passing out twice, 1 man (0.3%) passing out 3 to 5 times, and 1 man (0.3%) passing out 11 to 20 times in the previous year.

Finally, we asked the men about other behaviors that their women partners might have used that could be considered psychologically aggressive. Specifically, 67.2% reported that their partner falsely accused them of hitting or beating her; 38.7% reported that she filed a restraining order against him under false pretenses; 48.9% of the men with children reported that their partners falsely accused them of physically abusing the children, and 15.4% reported that they were falsely accused by their partners of sexually abusing the children.

What Happened During the Last Physical Argument

The men were then asked follow-up questions about their last physical argument. Table 5 presents those results. As shown, 93.0% of the men in the help-seeking sample reported that their women partners hit first during the last physical argument (4.0% reported that the man had hit first, and the remaining 3.0% did not

remember or did not answer the question). If the woman partner was reported to have hit first, we asked the men what their response was to her physical aggression. The most common response was to get away from her or go to another room (85.4%). The next common response was to yell or curse (62.8%), followed by calling a friend or family member (45.3%), crying (29.8%), calling the police (28.3%), and grabbing/shoving/pushing/hitting her back (19.5%).

Men were also given the opportunity to provide qualitative answers to the question concerning their response to their partner's physical aggression. The most common qualitative response was to ask her to calm down or attempt to reason with her (7.5%). Examples of this response include:

- "Tried to talk to her about it calmly, saying 'now, if I did that to you, you'd call it abuse.' She answered that she was defending her honor."
- "I tell her that it is not acceptable for her to hit me, or yell at me, especially in front of the children. I also ask her to apologize."

Next, 6.8% talked about trying to get away from her but being blocked in some way:

- "She refused to give me my cell phone and car keys and wouldn't let me leave the house. When I took the car keys from her she called the cops and I was arrested and convicted."
- "I tried to leave and she hit me in the head with a flower pot, then took the phone from me to prevent me from calling anyone."
- "Tried to leave but was prevented. I had been injured earlier that day and was not able to physically defend myself."

The next most common responses were to restrain her (5.3%) and to protect himself (4.6%):

- "She seemed to be panicking so I wrapped my arms around her . . . and tried to hold her still until she calmed down—she later said that my holding her that way was physically abusive."
- "Put my hands up to stop her hands from hitting my body and backed away."

Almost 4% talked about "taking it" or doing nothing in response to her aggression:

- "Mostly I just sat there and took it and tried to act like I was above it."

Finally, a small percentage discussed praying, meditating, or journaling in response to their partner's aggression (1.8%); attending to the children during the argument (1.4%), having someone else call the police (1.1%), hitting a wall or object (0.7%), and attending to their own injuries (0.3%).

We also asked the men about drinking and drug use during the last physical argument in which their partner hit first: 26.2% said their partner had been drinking, and 11.5% said they (the male partner) had been drinking; 17.2% said that their

TABLE 5. What Happened During the Last Physical Argument

	Percentage
Who hit whom first? (n = 302)	
Men participant	4.0%
Women partner	93.0%
Man's response when woman partner hit first (n = 281)	
Get away/go to another room	85.4%
Yell/curse	62.8%
Call friend or family member	45.3%
Cry	29.8%
Call police	28.3%
Grab/shove/push/hit back	19.5%
Qualitative responses	
Asked her to calm down/attempted to reason with her	7.5%
Failed attempts at getting away	6.8%
Restrained her	5.3%
Protected self	4.6%
Took it/did nothing	3.9%
Sought professional help	3.6%
Prayer/meditation/journaling	1.8%
Attended to children	1.4%
Tried to have someone else call police	1.1%
Hit a wall or object	0.7%
Attended to own injuries	0.3%
Drinking and drug use (n = 281)	
Woman partner drinking	26.2%
Man participant drinking	11.5%
Woman partner using drugs	17.2%
Man participant using drugs	1.4%
Children witnessing (n = 281)	
Yes	59.1%
Heard, but didn't see	11.3%
Maybe/don't know	9.3%
No	20.2%
Who was the first to ever hit? (n = 302)	
Man participant	2.6%
Woman partner	91.7%

partners had been using drugs, and 1.4% said that they (the male partner) had been using drugs.

We then asked the men whether their children had ever witnessed the violence between their parents. The majority of children had, with 59.1% witnessing it, 11.3% at least hearing it, and 9.3% possibly witnessing or hearing it.

Finally, we asked who was the first to ever hit the other person in their relationship. As shown, in 91.7% of the relationships, the woman partner was reportedly the first one to ever hit, with the man partner hitting first in 2.6% of relationships. In the remaining relationships, the man did not remember or did not answer the question.

Mental Health Status

As shown in Table 6, 71 of the 302 men (23.5%) indicated that they had been diagnosed with a mental illness. The most common types of mental illnesses among these 71 men were depressive disorders (64.8%), anxiety disorders (47.9%), attention deficit hyperactive disorder/attention deficit disorder (25.4%), bipolar disorder (16.9%), posttraumatic stress disorder (12.7%), and alcoholism/substance abuse (11.3%). About half of the men (49.3%) indicated that they had their mental illness(es) for a long time, and just under half (40.8%) indicated that they were diagnosed with this mental illness only since being involved in their abusive relationship.

TABLE 6. Mental Illness

	Percentage
Ever diagnosed with a mental illness	23.5%
Depressive disorder	64.8%
Anxiety disorder	47.9%
Attention deficit hyperactive disorder/attention deficit disorder	25.4%
Bipolar disorder	16.9%
Other: posttraumatic stress disorder	12.7%
Alcoholism/substance abuse	11.3%
Borderline personality disorder	4.2%
Schizophrenia	4.2%
Narcissistic personality disorder	2.8%
Antisocial personality disorder	1.4%
Histrionic personality disorder	1.4%
Eating disorder	1.4%
Had mental illness a long time	49.3%
Had mental illness only since being in this relationship	40.8%

What Prevents Them From Leaving?

Of 189 men who reported that they had not left their partners yet, 178 (94.2%) reported that they have seriously considered leaving. The issues that prevent them from leaving are presented in Table 7. As shown, commitment to the children and marriage, for those men who have children and/or are married, are the primary reasons they remain in the relationship. The third most common reason is love, followed by a fear that they may never see their children again. Over half of the men also reported that they think that their partners will change, they do not have enough money to leave, they have no place to go, and that they are embarrassed that others will find out that their partner abuses them. Just under 50% reported that they did not want to take the children away from their partners (presumably the children's mothers), and around 25% stated that the partner threatened suicide if they left and that they feared she might kill them or someone they love if they leave.

The types of qualitative responses and their frequencies are also shown in Table 6. The most common qualitative response concerned possible repercussions of leaving (12.7%):

- "She spends every penny that comes in and has racked up thousands in debt. I would lose everything I've tried to save. Or at least half including half my retirement." (financial)
- "She threatened to ruin me financially, ruin my professional reputation (we work together), lock me out of the house, and tell the police anything she wants to tell them (domestic situations being as difficult to ascertain as they are, men are guilty until proven innocent)." (financial and professional)
- "I was advised that if I leave, I would hurt my chances of gaining custody of the children in the long run." (personal repercussions)

This was followed by responses that indicated that he felt it was morally wrong to leave his partner (6.2%), as exemplified by this man's response:

- "'For better or for worse,' and, well, this was worse. I didn't care that she was too psychologically disturbed to love me back, I didn't care. I loved her. And I hoped I could get help for her condition before it was too late."

The third most common response concerned the men's fears for the safety of loved ones or pets (4.5%):

- "I stay around to protect the children!"

And 3.9% talked about how the partner threatened the men with false accusations:

- "She has promised to lie and accuse me of physical abuse against her, sexual abuse of our daughter, if that helps her win custody."

TABLE 7. What Prevents the Men From Leaving

Reason	Percentage
He is concerned about the children (n = 126)	88.9%
When he got married, it was for life (n = 113)	80.5%
Love (n = 178)	71.3%
He fears he may never see the children again (n = 126)	67.5%
He thinks she'll change (n = 178)	55.6%
He doesn't have enough money to leave (n = 178)	52.8%
He has nowhere to go (n = 178)	52.2%
He's embarrassed others will find out he's being abused (n = 178)	52.2%
He doesn't want to take the children away from her (n = 126)	46.0%
She threatened to kill herself if he left (n = 178)	27.5%
He fears she'll kill him or someone he loves if he leaves (n = 178)	24.2%
Qualitative responses (n = 178)	
Possible financial/professional/other/unspecified repercussions	12.7%
Feels it's morally wrong to split the family/abandon her	7.3%
Fears for the safety of loved ones or pets	4.5%
She threatened false accusations	3.9%
He says her behavior is not her fault (e.g., she's mentally ill or something in her past causes her to behave this way)	2.8%
She is dependent upon him and/or he's concerned about her well-being	2.2%
He didn't know he was being abused/thought it was normal	1.7%
He's dependent upon her in some way (e.g., disability, health insurance)	1.7%
He's afraid to leave	1.1%
The way the system would handle the situation would only make it worse	1.1%
The violence is mutual	1.1%
She discovered his plans to leave and is using tactics to stop him from leaving	1.1%
Thinks no one will believe him	0.6%

Just under 3% of men discussed how the partners' behavior was not their fault, that the partners were mentally ill, or that something in their past made them behave the way they did:

- "She's mentally ill. I know she's not doing this on purpose. I know she loves me."

Finally, 2.2% talked about concerns for their partners' well-being, with a particular emphasis on the partner being dependent upon him in some way:

- "Concern for her well-being, financially take care of herself."

The remaining qualitative responses were discussed by less than 2% of the sample and are listed in Table 6.

DISCUSSION

The purpose of this study was to provide an in depth investigation of the demographics, aggression experienced, and mental health status of men who sustained intimate terrorism; we also aimed to provide empirical descriptive data on why they sometimes choose to stay in relationships in which they are sustaining IT, intimate partner violence that is characterized by severe violence and controlling behaviors. In doing so, we tested many of the assumptions in the literature about men who sustain IPV, assumptions that were not always based on empirical research.

Upon entry into the study, the men and their women partners were, on average, in their late 30s to early 40s. Over half of them were still together, and were or had been in marital relationships lasting approximately 8 years. Almost three-quarters had children. Thus, on average, these were very serious, established relationships. The ethnic/racial composition of the relationships may be noteworthy—for the men who participated in this study, there was an overrepresentation of Whites in comparison to their representation in the population overall (U.S. Census Bureau, 2000) and an underrepresentation of Blacks and Hispanics; for their women partners, there was an underrepresentation of Whites and Blacks and an overrepresentation of Asians. This ethnic/racial disparity could be due to the possibility that men who sustain IPV and are Black or Hispanic or who have White or Black (but not Asian) women partners, may be less likely to seek help, less likely to seek help from the sources from which we recruited, or less likely to participate in research on men who sustain IPV. More research needs to be conducted to replicate these findings and explore the reasons why such ethnic/racial disparities might be occurring.

The men in our study were also relatively well educated, with good occupations and decent incomes. In fact, a substantial percentage of the men were employed in stereotypical masculine jobs, such as the military, police, firefighting, or construction, or at high-prestige jobs, such as doctors, lawyers, engineers, executives, or business owners, which is congruent with a previous study of a sample of men victims of IPV (Hines et al., 2007).

One assumption that some IPV experts have put forth is that men are bigger and stronger and can therefore easily strike back, restrain their partner, or leave the premises without being physically restrained (Pagelow, 1985). The analyses of our demographics provide evidence that the men are significantly taller and heavier than their women partners; however, based on the men's responses to what happened during the last physical argument, evidence for the belief that the men can strike back, restrain their partner, or leave the premises is mixed. When the woman partner hit first, the most common reaction that the participants reported was to get away from the partner or go to another room; the least endorsed reaction was to hit/grab/shove/push back. Thus, the men do seem to be able to leave the argument and violence if they want. However, there is also evidence that some are blocked in their efforts to leave, either through further violence or having their access to transportation blocked. In addition, they do not strike back in large numbers: 12 of the 59 men (20.3%) who reported that they hit/grabbed/shoved/pushed back stated in their qualitative accounts that it was to restrain her or defend himself. Thus, at most, 16.7% of the men reported striking back in retaliation, which is congruent with previous qualitative research that shows that men victims of IPV are reluctant to hit back either because of moral objections to hitting a woman or because of fear that if he hits her back, he may set himself up to be arrested and/or lose custody of his children (Cook, 2009; Migliaccio, 2001). This issue is exemplified by these quotes from men in our sample:

> I have never hit my wife, but today I came close to doing this. It should be noted she has hit me more times than I can remember and kicked me. I grabbed her arms in self defense and held her to the floor. I am a very big and strong man, my wife is tall but thin, not strong at all. I know I will be the one who goes to jail even though she is the one hitting and kicking.

> I asked her why she hit me, and she said, "because you're bigger than me." I just felt vengeful for a second and slapped her back. It was the only time I hit her, ever. I cried because I was raised not to hit women, and I felt disappointed in myself that I had crossed that line.

Our investigation of what happened during the last physical argument also raised issues that warrant further research. For example, according to the reports of the men participants, alcohol was used by 26% of the women partners and 11.5% of the men participants during the last physical argument. Previous studies do show a link between alcohol use and the perpetration of IPV among both men and women (e.g., Caetano, Schafer, & Cunradi, 2001; Hines & Straus, 2007; O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003); therefore, this association needs to be further explored in relationships in which the woman appears to be the intimate terrorist. Moreover, drug use may be a problem, because over 17% of the women partners were reportedly using drugs during the last physical argument; this is a noteworthy finding given that the extant research suggests that substance abuse is more of a problem

among men perpetrators of IPV than it is among women perpetrators (Henning et al., 2003; Medeiros & Straus, 2006), and it deserves further investigation.

The effect that this violence has on children is also something that warrants further exploration. With 70% of the men indicating that their children had either witnessed or heard the IPV, these rates are a cause for concern. The women partners in this sample are modeling violent and terroristic behaviors to their children, which can lead to psychological problems for children (Wolak & Finkelhor, 1998) and an increased likelihood of their involvement in violent relationships as adults (Stith et al., 2000). Moreover, there is evidence that the harm to children who witness IPV by their mothers is as strong as the harm they experience when witnessing IPV by their fathers (Holden, Geffner, & Jouriles, 1998; Moretti, Obsuth, Odgers, & Reebye, 2006; Straus, 1991). In addition, qualitative accounts from the men in this study show that the children are in direct physical danger from the violence that is perpetrated by the women toward the men participants, which is exemplified by this statement: "I had been holding the baby during the argument, when she threw the TV remote control towards my head just missing the baby." Future research should explore in more depth the possible consequences of children witnessing severe IPV and controlling behaviors by their mothers of the type that was found among the women partners of the men in this study.

Our analyses of the types of IPV these men experience and their mental health status addresses an additional assumption proposed by researchers: that the IPV such men sustain is trivial, humorous, or of no consequence (Currie, 1998; Mills, 1984; Pagelow, 1985; Saunders, 1988). We previously established that these men were sustaining IT from their women partners (Hines & Douglas, in press), which is a pattern of severe violence and controlling behaviors. A closer look at the types of violence they sustained showed that it was not trivial and could not be considered humorous. Between 93% and 96% of the men sustained both severe psychological aggression and controlling behaviors, with 50% to 76% of the men saying that their partners threatened to hit or throw something at them, intentionally destroyed something belonging to him, called him names, monitored his time and made him account for his whereabouts, and prevented him from seeing his family or friends. Over 90% sustained severe physical aggression (aggression that had a high likelihood of causing an injury), and over 50% sustained very severe physical aggression (aggression that could be considered life-threatening), which included being beaten up, having a knife or gun used on him, and being choked. Finally, the IPV they sustained was not inconsequential: 78.5% sustained an injury in the past year and were injured, on average, about once a month; these injuries included broken bones and passing out from being hit on the head.

In addition to the IPV mentioned above, over half of the men reported that their women partners made false accusations against them, which included that he hit or beat her, that a restraining order was filed against him under false pretenses, or that he physically and/or sexually abused the children. These findings are congruent with a previous study that showed that approximately 50% of men victims of IPV

stated that their partners gave false information to the court system in order to gain custody of the children or to obtain a restraining order (Hines et al., 2007). These findings are also consistent with a study of families undergoing custody disputes in the courts (Johnston, Lee, Olesen, & Walters, 2005), which showed that 21% of women made allegations of physical child abuse against their husbands, 23% of sexual child abuse, and 55% of IPV. Only 6%, 6%, and 41% of the accusations, respectively, were substantiated by the courts. (This study also showed similar rates of accusations and substantiations by men against their wives.) Such findings show that men who fear false accusations are justified in having such fears.

Moreover, it is possible that the mental health of the men in this sample may have suffered as a result of being involved in their relationship. Almost a quarter of the men had been diagnosed with a mental illness, and about 40% of these mental illnesses were diagnosed since being involved with their women partners. For all mental illnesses mentioned except posttraumatic stress disorder, it was equally likely that they were diagnosed with the mental illness before the relationship as it was after being involved with their partner; for posttraumatic stress disorder, 75% of the men were diagnosed since being involved with their partners. Although this analysis does not allow us to conclude that the relationship caused their mental illness, it does provide some indication that the IPV the men sustained may have had a psychological impact. In addition, even for those men who were diagnosed with mental illnesses before they became involved with their women partners, it is possible that the IPV they sustained may have worsened their symptoms. Finally, the fact that a large percentage of the children involved either witnessed or heard the IPV provides evidence that the social and psychological consequences of women's use of IPV may reach beyond just the men who sustain it.

Our final analyses provided data on why the men chose to stay in their relationships. Some researchers have argued that, in comparison to battered women, it is not difficult for men to leave their relationships, because they have the financial and occupational resources to leave (Pagelow, 1985; Saunders, 1988), and they are not as psychologically invested in their family (Loseke & Kurz, 2005). However, our study casts doubt on these assumptions. The overwhelming reason they chose to stay in the relationships typically involved their commitment to the marriage and their children. They stated that, when they married, it was for life and that they are concerned about their children—results that are congruent with a previous qualitative study that showed that men's primary reason for not leaving was a strong objection to what they perceived as abdicating their responsibilities to their marriage and children (Cook, 2009) but not congruent with researchers who argue that men are not that psychologically invested in their families.

In addition, the vast majority (71%) of men indicated that they stayed in the relationship because of love. Most of the literature on battered women focuses on external barriers to leaving, such as economic and housing needs and fears that their partners will escalate his abuse if they leave, with a deemphasis on more internal constraints, such as strong emotional attachments to one's partner (see Griffing

et al., 2002, for a discussion). However, studies of battered women that do consider love/emotional attachment as a possible constraint to leaving or returning to an abusive partner are consistent with our findings that the majority of victims cite this as a main reason for not leaving, with far fewer victims citing external constraints (e.g., Anderson et al., 2003; Griffing et al., 2002; Torres, 1987). Thus, love should not be overlooked or underemphasized as a real barrier for both men and women leaving abusive relationships, because by not acknowledging it, we may undermine our efforts to help women and men who may want to leave but feel emotionally tied to their abusers. Some researchers have discussed the bond that forms between battered women and their abusers as a form of traumatic bonding, in which the cycles of battering and reconciliation lead to a strong attachment that is difficult to break (Dutton & Painter, 1981; Walker, 2000). This bond seems to be strongest in the context of a relationship in which one partner is more powerful and when physical punishment and loving reconciliation are intermittently and alternately administered; this bond has been found in studies of prisoners and prison guards, captors and hostages, child abuse victims and parents, and battered women and their batterers (see Dutton & Painter, 1981, for a discussion). It is likely that many of the men in our study had this same type of bonding with their women partners. In addition, it provides further evidence that men's psychological investment in their families is a substantial barrier to leaving.

Also indicative of their psychological investment in their families are the fears that men indicated that they may never see their children again if they left, and they also discussed, in their qualitative accounts, their need to stay to protect their children. They expressed their fears that they will lose custody of their children, because women predominantly gain custody of children when families divorce or separate (Cancian & Meyer, 1998) and/or because of their women partners' threats to make false accusations against them so that they would have no possibility of getting custody. Half of the men in our study reported that such accusations had already been made against them.

Additionally, more than half of the men indicated that they did not leave because they had no place to go and did not have enough money to leave, results that do not support the assertion that men have enough resources to leave if they wish (Pagelow, 1985; Saunders, 1988). Other men, in their qualitative accounts, discussed the possible negative financial and professional repercussions of leaving through such issues as having their private life made public and/or having their women partners make false accusations against them that could ruin them. Overall, the men in our sample report substantial barriers to leaving.

The limitations of our study need to be considered in future research on men victims of women-perpetrated IT. Our sample was restricted to men who sustained IPV and sought help in some form. Although we broadly defined help seeking to include searching the Internet for resources and talking to friends or family members, it is likely that there is a large group of men who do not seek any type of help when sustaining IPV from their women partners because it is a nonnormative issue for

men (Addis & Mihalik, 2003). Moreover, the help seekers had to have either seen our advertisement on the Internet or called the DAHMW; therefore, help seekers without access to either of these resources were excluded. Future studies should aim to recruit men who may have sought help from other sources of support or who may not have sought help at all to investigate any possible differences in their experiences.

Second, we have no way to assess the legitimacy of the self-reported information in this study. It is possible that some of the men may have exaggerated or fabricated their experiences. However, it is unlikely that this problem is widespread, given that (1) the men reported about their experiences via an anonymous, 30-minute Internet or telephone survey with no incentives for participation, and (2) the men will have had to overcome several societal and internal barriers to seek help (Addis & Mihalik, 2003) and by this very factor are likely to be reporting legitimate concerns. However, as with any intimate relationship in which there is IPV, it is important to understand that, even if one person is more abusive than the other, both parties are often participating in hostile, dysfunctional means of communicating that cannot be ignored and should be addressed (Mills, 2008). Thus, to understand these dynamics better, future studies should strive to obtain information about men's experiences with IPV from multiple informants.

In sum, this in-depth analysis of men who are the victims of IT from their women partners provides empirical data on who they are and what they experienced. The men in this study sustained very serious IPV on an almost weekly basis and were injured approximately once a month. Over half of the men sustained violence that could be life-threatening. Although they do tend to be physically bigger and probably stronger than their women partners and are usually able to leave a violent confrontation, there are real barriers to striking back or using their size to their advantage; in fact, most men did not strike back, and some reported physical barriers to walking away from the violence. They are well-educated men who tend to have good, if not high-status, jobs, often in fields that can be considered masculine in nature, and they cited very real barriers to leaving, including a commitment to the marriage and children, having no place to go, and not having financial resources to support leaving.

These findings have important implications for practitioners and researchers in the field of IPV:

1. Assumptions about the circumstances of individuals who sustain IPV should be tested so that we have empirical data on their experiences, which can then inform the provision of services.
2. Given the serious level of the IPV that these men sustain, it is necessary to educate practitioners, researchers, and the public about men sustaining IT, their experiences, and their barriers to leaving.
3. All of the men in this study indicated that they had sought help of some form, and a previous article using this sample showed barriers to receiving help, particularly from domestic violence hotlines, domestic violence agencies, and

the police. These barriers included being turned away, ridiculed, accused of being a batterer, and arrested (Douglas & Hines, 2009). Because of the very serious nature of their victimization, it is important to educate and train front-line domestic violence workers about the existence of men victims and their needs.

4. Finally, it is important for all who work in the field of IPV, whether practitioner or researcher, to realize and acknowledge that both men and women can perpetrate even the most severe forms of IPV, and both men and women can be victimized by severe forms of IPV. Serious violence and controlling behaviors demand our attention, regardless of the gender of the perpetrator or victim.

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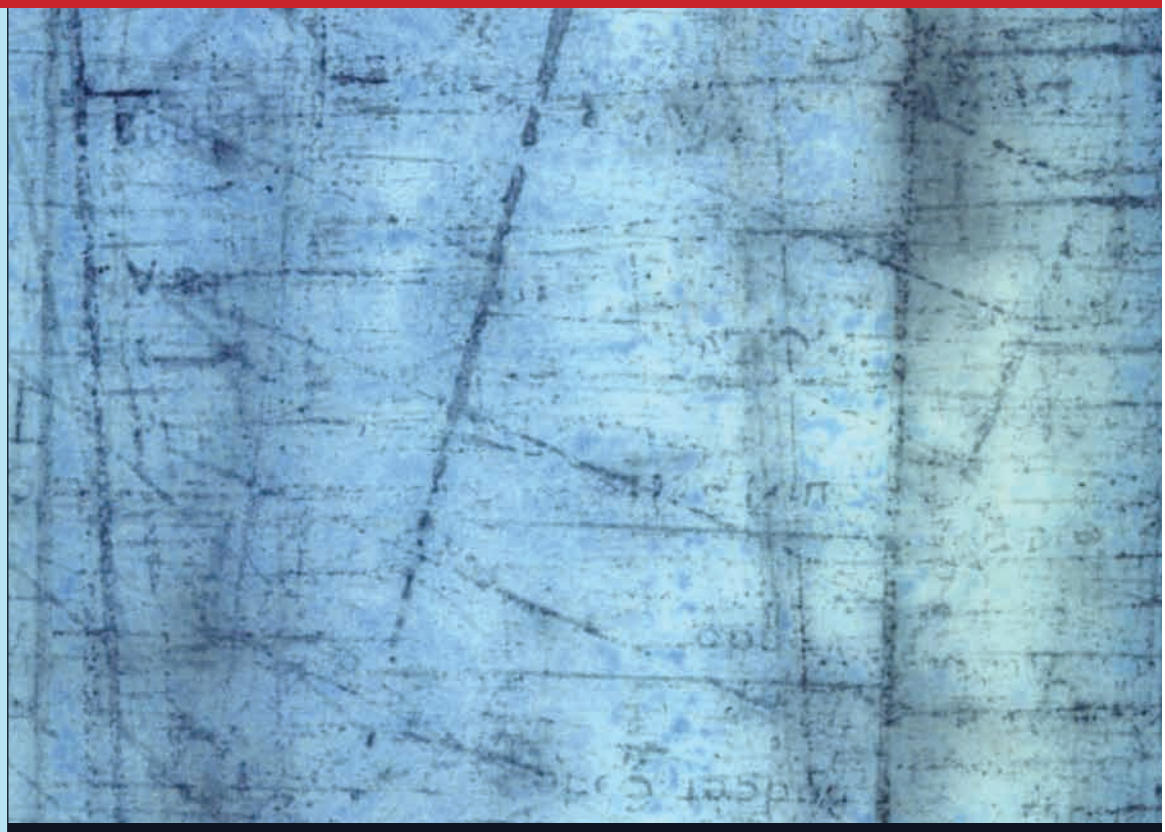

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Men Who Sustain Female-to-Male Partner Violence: Factors Associated With Where They Seek Help and How They Rate Those Resources

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Research since the 1970s has documented that men, in addition to women, sustain intimate partner violence (IPV), although much of that research has been overlooked. A growing body of research is examining the experiences of men who sustain female-to-male IPV, but there is still much to be learned. This exploratory study assesses the experiences of 302 men who have sustained IPV from their female partners and sought help from 1 of 6 resources: domestic violence agencies, hotlines, Internet, mental health professionals, medical providers, or the police. We examine what demographic characteristics and life experiences are associated with where men seek help and how they rate those experiences. We make recommendations for agencies, service providers, and first responders about how to tailor services for this specific population and their families.

Keywords: male victims; help seeking; female-to-male violence; service providers; emergency responders

Research since the 1970s has documented that men, like women, sustain intimate partner violence (IPV), which includes the physical, sexual, and psychological maltreatment of one partner against another (Gelles, 1974; Rennison & Welchans, 2000; Straus & Gelles, 1988; Tjaden & Thoennes, 2000). IPV against men is often a controversial issue (George, 2007); research on help seeking among men who have sustained IPV indicates that the domestic violence (DV) service system is not always able to serve them (Hines & Douglas, 2011) and that many men are turned away (Cook, 2009; Douglas, & Hines, 2011). Nonetheless, men attempt to find help for sustaining IPV through various resources, both formal (e.g., helplines, police, mental health professionals) and informal (e.g., friends, relatives, the Internet; Douglas, 2011). What remains unknown is what factors are related to (a) where men seek help and (b) how they rate the resources from which they seek help. This exploratory study will focus on the demographic, personal, and

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relationship characteristics that are associated with where men seek help for sustaining IPV and how they rate those experiences.

FEMALE-TO-MALE INTIMATE PARTNER VIOLENCE

Research reporting that women physically aggress toward their male partners first appeared in the 1970s (Gelles, 1974). More recently, the Department of Justice showed that in 2009, 117,210 men were physically assaulted by an intimate partner, most of whom were women, which represents 18% of all IPV victims that year (Truman & Rand, 2010). The same source of data for the period 1993–2004 showed a 61% decline of reported physical IPV toward women between 1993 and 2004, whereas the rates of IPV toward men only declined 19% (Catalano, 2007). The 1995–1996 National Violence Against Women Survey found that 40% of all IPV victims during a 1-year time period were men (Tjaden & Thoennes, 2000). The highest rates of IPV against both men and women have been found in national studies of family conflict, such as the 1975 and 1985 National Family Violence Surveys and the 1992 National Alcohol and Family Violence Survey (Straus, 1995). For example, female-to-male minor physical assaults (e.g., slapping, pushing) occurred at a rate of 75 per 1,000 in 1975 and 1985, and then increased to 95 per 1,000 in 1992. Rates of severe physical assaults (e.g., punching, beating up) by female partners remained constant at 45 per 1,000 in all study years (Straus & Gelles, 1988).

Help Seeking Among Men

Men who sustain IPV are often in need of assistance and support (Cook, 2009; Hines, Brown, & Dunning, 2007), yet may be reluctant to do so (Addis & Mahalik, 2003). One study of service providers found that reasons why men do not or might not seek help for IPV victimization include that IPV services are not targeted toward men and the men's own shame/embarrassment, denial, stigmatization, and fear (Tsui, Cheung, & Leung, 2010). Other research, however, has documented that some men do seek help for IPV victimization through established DV resources; however, they often encounter barriers, such as being blamed for the abuse, being sent to a batterer's program, and being laughed at (Hines et al., 2007).

In a previous investigation using the sample described in this article, we found that men who seek help for IPV victimization use various resources (Douglas, 2011). Men were most likely to seek help from family and friends, but about two-thirds also sought help via the Internet and from mental health professionals; about half sought help from the police and about half from a DV agency. With less frequency, men sought help from DV hotlines/agencies and medical professionals. The men also reported on the quality of the helpfulness that they received. Medical, followed by mental health and online resources, were the most helpful. DV hotlines, DV agencies, and the police were rated as being the least helpful. What remains unknown is what factors lead men to seek help from which resources.

Most research on male help seeking has focused on what characteristics indicate whether men will seek help (Addis & Mahalik, 2003), but there is a developing body of research addressing what factors are related to which services they seek once men actually *do* seek help. Lane and Addis (2005) found that willingness to seek help for depression and/or substance use varied not only by the degree of traditional masculine ideologies held by the individual and the type of problem but also by the source of help. Men who

embraced traditional masculine ideologies were less willing to seek help from a male friend, doctor, or partner and were more likely to consult an anonymous Internet group for depression. Also, these men were more likely to seek help for substance use from the Internet and, in some cases, from a parent. We do not have measures of adherence to traditional masculine ideologies; nonetheless, we aim to expand our knowledge of where men seek help by investigating a range of possible factors.

To our knowledge, only one study has documented factors associated with where men might seek help for IPV victimization (Ansara & Hindin, 2010). This Canadian study of male and female help seeking among IPV victims found that both genders sought help from health professionals and the police. Men were more likely to use both informal and formal sources of support when the IPV that they experienced was more severe than when it was less severe. We, too, will test, among our sample, whether severity of IPV is related to where men seek help.

Seeking Help for Intimate Partner Violence and Levels of Satisfaction Among Female Intimate Partner Violence Victims

Despite the limited research examining where male victims of IPV seek help, there is a growing body of research that predicts where female victims seek help. An Australian study of nearly 1,700 women who sought help for IPV found differences between women who used informal (e.g., friends, family, colleagues, neighbors) versus formal sources of support (e.g., law enforcement, specialized "walk-in" services, residential victim services; Meyer, 2010). Women who used formal sources of support had lower levels of household income and were more likely to be unemployed, to have children who witnessed the IPV, to be married to their abusive partners, to have used drugs or alcohol to cope with the abusive behaviors, to have been injured in the most recent violent episode, and to believe that their lives were in danger.

Women who experience higher levels of violence, do not live with their partners (Leone, Johnson, & Cohan, 2007), have filed protection orders, have higher levels of post-traumatic stress disorder (PTSD; Wright & Johnson, 2009), and are from urban locations (Shannon, Logan, Cole, & Medley, 2006) are more likely to contact the police. Those in shorter relationships, who have higher levels of PTSD symptoms, and were injured by the IPV are more likely to see a medical provider (Leone et al., 2007). Finally, women who are in shorter relationships, are older, have children, have access to financial resources (Leone et al., 2007), and have higher levels of education and income (Vatnar & Bjørkly, 2009) are more likely to see a mental health professional for IPV victimization.

Research also addresses their satisfaction with the services that they receive. Most research simply describes how female IPV victims rate their level of satisfaction/helpfulness with the resource (McNamara, Ertl, Marsh, & Walker, 1997; McNamara, Tamanini, & Pelletier-Walker, 2008; Molina, Lawrence, Azhar-Miller, & Rivera, 2009; Norton & Schauer, 1997; Refuerzo & Verderber, 1989). A small body of research does examine which factors are related to how IPV victims rate their experiences with resources. A study from the mid-1980s found no relationship between female IPV victims' demographic and relationship experiences and whether or not they rated a battered women's shelter as effective (Bowker & Maurer, 1985). Two decades later, similar results were found on another sample of IPV victims (Weisz, 2005), and another study showed no differences between White and African American women on their ratings of helpfulness among health providers and clergy members (El-Khoury et al., 2004).

Other research has found that victim characteristics and experiences can predict how victims rate the helpfulness of the resources they use for IPV victimization. Shannon et al. (2006) found that women from urban locations rated criminal justice resources as more helpful, whereas women from rural locations rated women's shelters as more helpful. Weisz (2005) found that women who had better experiences with victim advocates also had better experiences with the police and criminal justice system. Another study found that among women who wanted their partners arrested, women whose partners were ultimately not arrested were much less satisfied with the help that they received from the police compared with women whose partners were arrested (Apsler, Cummins, & Carl, 2003). This research will consider the demographic, relationship, and life experiences of male help seekers, as well as the nature of the response that they received from each resource in predicting how helpful they rated each resource. No research has examined whether women's own use of IPV is related to their help-seeking experiences even though samples of women in shelters show that most women do use IPV (Giles-Sims, 1983; Saunders, 1988). We will include a measure of men's own use of IPV in this study as a potential predictor of where they seek help and the helpfulness of that resource.

CURRENT STUDY

This study builds on the small body of research that examines factors related to where men seek help for IPV victimization and how they rate these resources. Specifically, this exploratory study addresses the following: (a) What demographic and life experience factors are related to where men who have sustained IPV seek help? and (b) What demographic and life experience factors are related to how men rate the helpfulness of these resources?

These questions were examined on a sample of 302 men who sought help for female-to-male physical, sexual, and psychological IPV victimization and who experienced physical IPV in the previous year. The men sought help from various resources: the police, medical and mental health providers, DV hotlines, DV agencies, and the Internet. The large dataset for this study permitted us to conduct exploratory analyses concerning men's help-seeking experiences.

METHOD

Procedure

The methods for this study were approved by the boards of ethics at the participating institutions. All of the men participated anonymously and were apprised of their rights as study participants. At the completion of the survey, participants were given information about obtaining help for IPV victimization and how to delete the history on their Internet Web browser.

In order to participate, the men had to speak English, live in the United States, and be 18–59 years old; they had to have been involved in an intimate relationship with a woman in the previous year lasting at least 1 month in which they sustained a physical assault within the previous year, and they had to have sought help for this IPV. Help seeking included seeking help from formal sources: hotlines, DV agencies, the police, mental and medical health professionals, lawyers, and ministers; and informal sources, such as friends/family and the Internet. The sample was recruited from multiple sources, including

the Domestic Abuse Helpline for Men and Women (DAHMW), a national helpline specializing in men who sustain IPV; and online Websites, newsletters, blogs, and e-mail lists that specialize in IPV, male IPV victims, fathers' and divorced men's issues, men's health, and men's rights. Potential participants were told and advertisements stated,

> Researchers at Clark University and Bridgewater State College are conducting a study on men who experience aggression from their girlfriends, wives, or female partners. If you are a man between the ages of 18–59 and have experienced aggression from your partner within the past 12 months, you may be eligible to participate in this study. We invite you to follow this link to the study Webpage where you can complete an Internet survey about your experiences.

Callers to DAHMW who had received assistance from the helpline staff and who met the eligibility criteria were invited to participate in the study by calling a survey research center to complete an interview over the phone or by visiting the study Website to complete the anonymous study questionnaire online. Screener questions regarding the study criteria were on the first page of the survey, and men who were eligible were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an "exit page" of the survey. Data were collected between December 2007 and January 2009. Sixteen participants completed the survey via phone, whereas 286 completed the online version of the study.

Sample

The sample consisted of 302 men from 45 states who sought help after sustaining IPV. Table 1 displays their characteristics. The average age was 40 years. This sample was well educated, with almost half having a college degree or higher; their mean income was $50,439. Their average occupational status was 6.7 (where 1 = *elementary occupations* and 9 = *legislators, senior officials, management*). The sample had limited ethnic and racial diversity, with 16.2% of the sample identifying with a minority group. The help seekers were in relationships lasting a mean of about 8 years. Approximately 75% were or had been married to the partner who used IPV against them. About half were currently still in the relationship; the remainder had ended the relationship within the past year. Almost 75% reported that minor-aged children were present.

The violence that the men in this sample sustained has been reported in detail in other papers (Hines & Douglas, 2010a, 2010b). A brief summary is provided in this article to orient the reader to the nature of the sample and of the types of IPV experiences reported by the study participants. The men in this study sustained serious violence: 96.0% reported sustaining severe psychological aggression in the past year (e.g., threats to physically harm the man or someone he cares about, destroying something belonging to him), 93.4% reported controlling behaviors (e.g., monitoring his time and whereabouts, not allowing him access to household income, isolating him from family/friends), 98.7% reported minor violence (e.g., pushing, shoving), 90.4% severe violence (e.g., punching, kicking), and 54.0% very severe violence (e.g., beating up, using a knife/gun). Of the men who reported each of these types of IPV, severe psychological aggression sustained a mean number of 28.90 times in the previous year; controlling behaviors, 42.62 times; minor violence, 32.01 times; severe violence, 16.74 times; and very severe violence, 7.46 times. The assaults often led to injuries—77.5% of the sample reportedly experienced minor injuries (e.g., bruise or cut) in the past year and 35.1% experienced severe injuries (e.g., broken bone, needing medical attention).

Measures

The survey contained questions about demographics, aggressive behaviors that both partners may have used, risk factors, and mental health. Help-seeking questions focused on where they sought help, that resources' helpfulness, and follow-up questions specific to each resource. Only questions used in the current analysis are described subsequently.

Demographic Information. Men were asked about their age, race/ethnicity (which we dichotomized as 1 = *minority*, 0 = *not a minority*), personal income, education, occupational status, and self-reported disability status (dichotomized as 1 = *yes*, 0 = *no*). Men were also asked about the current status (dichotomized as 1 = *currently married*, 0 = *not married*) and length of their relationship, if minor children were involved in the relationship (1 = *yes*, 0 = *no*), and if children had witnessed or heard the IPV in the relationship (1 = *yes*, 0 = *no*). We also inquired about the weight (in pounds) and height (in inches) of the help seeker and whether he had an existing diagnosis of mental illness (1 = *yes*, 0 = *no*). We asked to include the help seeker's locality (urban, rural, suburban) and region in the United States (North, South, Midwest, and West), which were coded as dummy variables in the analyses. These characteristics, along with all of the independent variables in this study, are summarized in Table 1.

Help-Seeking Questions. Men were asked if they had sought help from various resources, including DV agencies, DV hotlines, police, medical and mental health professionals, and online sources of support. We also asked whether they had talked with friends, family, clergy, and attorneys. For each of the sources used, we asked about the helpfulness of the resource (where 1 = *not at all helpful*, 2 = *somewhat helpful*, and 3 = *very helpful*). We also asked follow-up questions that were specific to each resource. For help seekers who used a DV agency, DV hotline, and/or the Internet, we asked if they were told that the resource only helps women, if they were accused of being the batterer in the relationship, and/or if they were given the impression that the staff was biased against men. For men who saw a mental health practitioner, we asked if the provider took their concerns seriously and if they were given information about how to get help for IPV victimization. For men who saw a medical provider for injuries, we asked if the provider inquired about the source of the injuries, if the men accurately answered these questions, and if they were given information by the provider about how to get help for IPV victimization. For men who sought help from police, we asked about how the police handled the complaint; who, if anyone, was arrested; who, if anyone, was put in jail; if the charges were dropped; and if the partner was determined to be the primary aggressor. All of the follow-up questions pertaining to seeking help were dichotomously coded (1 = *yes*, 0 = *no*). These questions were developed by the authors and were based on the literature and previous research by the second author (Hines et al., 2007). The results of these questions were discussed in detail in a previous paper using this same dataset (Douglas, 2011). The main results that are relevant to this article are summarized in Table 2.

Social Support. The Enhancing Recovery in Coronary Heart Disease (ENRICHD) Social Support Instrument (Mitchell et al., 2003) contains six items that measure emotional and instrumental support, such as "How often is someone available to you who shows you love and affection?" (emotional support) and "How often is someone available to help you with daily chores?" (instrumental support). Participants indicate on a 5-point scale the extent to which each statement is true of their situation (1 = *none of the time*, 5 = *all of the time*). This instrument has demonstrated excellent convergent and predictive validity and excellent internal consistency reliability (Mitchell et al., 2003). The mean for the current sample was 16; a = .90.

TABLE 1. Demographics of Sample and Predictor Variables ($N = 302$)

Variable	% or *M* (*SD*)
Help seeker demographic characteristics	
Age	40.49 (8.97)
Disabled	11.2
Educational status[a]	4.40 (1.56)
Height of help seeker (inches)	70.75 (2.93)
Income	$50.44K (25.69)
Locality: rural	20.8
Locality: suburban	50.2
Locality: urban	29.1
Mental illness diagnosis	24.0
Occupational status[b]	6.73 (2.14)
Race/ethnicity: White	86.8
Race/ethnicity: Black	6.0
Race/ethnicity: Hispanic	5.0
Race/ethnicity: Asian	4.3
Race/ethnicity: Native American	2.0
Region: Midwest	20.3
Region: North	21.7
Region: South	29.4
Region: West	28.4
Weight of help seeker (pounds)	195.22 (38.74)
Relationship demographics	
Currently in relationship	56.3
Minors involved in the relationship	73.2
Minors witnessed IPV[c]	70.4
Relationship length (months)	97.90 (82.06)
Relationship status: married	46.0
Time since relationship ended (in months)	6.10 (7.69)
Additional predictor variables	
False allegation made against help seeker	74.0
Physical assault perpetrated against partner: any	55.0

(Continued)

TABLE 1. Demographics of Sample and Predictor Variables ($N = 302$) (Continued)

Variable	% or *M* (*SD*)
Physical assault sustained: severe	90.0
Physical assault sustained: very severe	54.0
PTSD Checklist total score	46.56 (14.22)
Sexual Abuse in Childhood scale	2.94 (1.50)
Social Support scale	15.95 (5.91)
Violence Socialization in Childhood scale	4.12 (1.65)
Nature of help-seeking experience as predictor variable	
DV hotline—gave phone number, turned out to be for batterer's program[d]	25.4
DV hotline—gave references to local programs that helped[d]	27.0
DV hotline—referred to another hotline[d]	3.6
DV hotline—referred to batterer's program[d]	31.7
DV hotline—told "we only help women"[d]	63.9
Internet—gave phone number, turned out to be for batterer's program[e]	27.1
Internet—gave references to local programs that helped	25.8
Internet—refer helpseeker to batterer's program[e]	18.9
Internet—told "we only help women"[e]	42.9
Medical provider—ask about causes of injuries[f]	90.0
Medical provider—help seeker told about cause of injury[f]	59.2
Medical provider—give info about getting help for IPV[f]	14.3
Mental health provider—give info about getting help for IPV[g]	30.1
Mental health provider—took IPV concerns seriously	68.4
Police—arrest help seeker[h]	33.3
Police—arrest partner[h]	26.5
Police—put help seeker in jail[h]	29.7
Police—put partner in jail[h]	20.9
Police—determine partner was primary aggressor[h]	54.9

(Continued)

TABLE 1. Demographics of Sample and Predictor Variables ($N = 302$) (Continued)

Variable	% or *M* (*SD*)
Police—drop charges against help seeker[h]	16.2
Police—drop charges against partner[h]	15.8

Note. IPV = intimate partner violence; PTSD = posttraumatic stress disorder; DV = domestic violence.
[a]Educational status: 1 = less than high school; 2 = high school graduate or graduate equivalency degree (GED); 3 = some college/trade school; 4 = two-year college graduate; 5 = four-year college graduate; 6 = some graduate school; 7 = graduate degree.
[b]Occupational status, $n = 197$: 1 = elementary occupations; 2 = plant and machine operators and assemblers; 3 = craft and related trades workers; 4 = skilled agricultural and fishery workers; 5 = services workers and shop and market sale workers; 6 = clerks; 7 = technicians and associate professionals; 8 = professionals; 9 = legislators, senior officials, managers.
[c]Percentage is based on the number of help seekers who have children, $n = 203$.
[d]Percentage is based on the number who contacted a DV hotline, $n = 67$.
[e]Percentage is based on the number who used the Internet for help, $n = 144$.
[f]Percentage is based on the number who contacted a medical provider, $n = 54$.
[g]Percentage is based on the number who contacted a mental health professional, $n = 198$.
[h]Percentage is based on the number who contacted the police, $n = 139$.

Posttraumatic Stress Symptoms. The *PTSD Checklist* (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item self-report measure of PTSD symptomology and reflects three symptom clusters: reexperiencing, numbing/avoidance, and hyperarousal. Participants were asked to think about their worst argument with their female partner and then indicate the extent to which they were bothered by each symptom in the preceding month (where 1 = *not at all* and 5 = *extremely*). The items were summed to create a single score of PTSD symptoms and dichotomized to indicate the likely presence of PTSD, which

TABLE 2. Help-Seeking Experiences With Six Resources ($N = 302$)

Type of Resource Used	Percentage Used Resource	Rating of Helpfulness[a] *M* (*SD*)
DV agency	44.1	1.45 (0.67)
DV hotline	23.4	2.13 (0.81)
Internet	63.4	1.87 (0.67)
Mental health professional	66.2	1.99 (0.76)
Medical professional	18.1	2.06 (0.70)
Police	46.3	1.63 (0.78)

Note. DV = domestic violence.
[a]Scale of 1–3, where 1 = *not at all helpful*; 2 = *somewhat helpful*; 3 = *very helpful*.

equals 45 or higher (Weathers et al., 1993). The PCL has excellent reliability (Weathers et al., 1993), strong convergent and divergent validity (Ruggiero, DelBen, Scotti, & Rabalais, 2003), and high diagnostic use (.79–.90) when validated against the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) Axis I Disorders (First, Gibbon, Spitzer, & Williams, 1996). The reliability for the total scale for this sample was $\alpha = .92$. The mean for this sample was 46.56, with 57.9% of the sample meeting the cutoff for PTSD. We used to total scale score for all analyses.

Alcohol and Drug Abuse. Alcohol and drug abuse were measured using the scale developed for the National Women's Study (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). Participants answered up to 19 questions about their use of alcohol and illicit drugs and related negative experiences. Consistent with recommendations by Kilpatrick et al. (1997) and criteria established for the *DSM*, participants who answered affirmatively to any of the questions about negative experiences within the past year because of alcohol use (e.g., getting in trouble with family, the police) were classified as having abused alcohol; 17.9% met this classification. Participants who reported using illicit drugs four or more times in the previous year were considered to have abused drugs in the past year; 21.5% met this criteria. This scale has been shown to have excellent construct validity (Kilpatrick et al., 1997).

Childhood Experiences. We measured the potential impact of two types of childhood experiences—violent socialization and sexual abuse history—on help-seeking behaviors and experiences. Childhood violent socialization was measured with two items from the Violent Socialization scale of the Personal and Relationships Profile (PRP; Straus & Mouradian, 1999). Participants were asked the extent to which they agreed or disagreed (1 = *strongly disagree,* 4 = *strongly agree*) with each statement: "When I was less than 12 years old, I was spanked or hit a lot by my mother or father" and "When I was a kid, I saw my mother or father kick, punch, or beat up their partner." These two items were summed (range = 2–8, $M = 4.12$). Finally, two items from the Sexual Abuse History scale of the PRP were used to measure childhood sexual abuse. Participants were asked the extent to which they agreed or disagreed (1 = *strongly disagree*, 4 = *strongly agree)* with each statement: "Before I was 18, a family member did things to me that I now think might have been sexual abuse" and "Before I was 18, someone who was not part of my family did things to me that I now think might have been sexual abuse." These two items were summed (range = 2–8, $M = 2.94$). Both of these scales have demonstrated adequate validity and overall alphas of .73 (Violent Socialization scale) and .76 (Sexual Abuse History scale; Straus & Mouradian, 1999).

Intimate Partner Violence. We hypothesized that sustaining or perpetrating physical IPV might be related to where men do, or do not, seek help. All of the men in the sample had sustained a physical assault within the past year because it was a screening criterion for inclusion in this study. To partial out men's different experiences with sustaining violence, we included measures of having perpetrated *any* physical assault and having sustained a severe or very severe assault—all using the physical assault scale of the Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). We included these measures because we wanted to assess whether perpetrating IPV is related to help-seeking experiences and because previous research has documented that sustaining severe physical IPV can be a predictor of where victims seek help (Meyer, 2010). We did not include a measure of injury based on the rationale that in order to be injured, one must sustain a serious, or very serious, assault. Furthermore, one could seek help in immediate response to a severe assault, even if no injury results from the attack. Thus, using the physical assault scale may be a more accurate predictor of help seeking.

The physical assault scale of the CTS2 includes physical assault items that may take place in response to an argument. Respondents are asked if they did these acts to their partner *and* if their partner did them to the respondents. Our measure of perpetrating *any* physical assault was assessed using the entire physical assault scale, which includes 12 items ranging from minor to severe assault (e.g., pushing, slapping, beating up). Severe physical aggression victimization was measured with seven items (e.g., beating up, slamming partner against wall) and very severe physical aggression victimization with four items (e.g., using knife/gun, choking). Participants responded by indicating the number of times each of the behaviors occurred to them in the previous year and the number of times they used each of these behaviors as well (0 = *0 times*, 1 = *1 time*, 2 = *2 times*, 3 = *3–5 times*, 4 = *6–10 times*, 5 = *11–20 times*, 6 = *more than 20 times*). These data were then dichotomized into three variables: perpetrated a physical assault (1 = *yes*, 0 = *no*), sustained a severe assault (1 = *yes*, 0 = *no*), and sustained a very severe physical assault (1 = *yes*, 0 = *no*). The reliability for these scales is perpetrated any physical assault, $\alpha = .81$; severe physical assault victimization, $\alpha = .59$; and very severe physical assault victimization, $\alpha = .15$. Because of the low number of items on the latter two scales, the low base rates of these behaviors, and the constrained variance, the correlations were attenuated when calculating the alphas for these scales, which artificially reduced the magnitude of the alphas. On such scales, low alphas should not necessarily be considered indicative of low reliability (Garson, 2009) because many factors can influence alphas.

False Allegations. We asked the help seekers a series of yes/no response questions concerning whether they had been falsely accused of the following several abusive behaviors: beating his female partner, physically abusing the children, and sexually abusing the children. We also asked the help seekers if a restraining/protective order had been taken out against them under false pretenses. We combined these questions into one dichotomous variable (where 1 = *any false allegation* and 0 = *no false accusation*).

Analyses

We conducted bivariate analyses between the independent variables and the dependent help-seeking variables. We retained any variables for multivariate analyses where $p \leq .10$. For the questions concerning where help was sought, the variables are dichotomous (1 = *yes, used resource*, 0 = *did not*); thus, we used logistic regression to conduct these analyses. For the questions concerning the helpfulness of each resource that was used, the variables contain ordinal data (aka ranked data; 1 = *not at all helpful*, 2 = *somewhat helpful*, 3 = *not at all helpful*); thus, ordinal logistic regression was used. Statistical Package for the Social Sciences (SPSS) does not produce odds ratio estimates for ordinal regression. We used the exponent function in Excel to calculate the odds ratios from the log odds estimates provided by SPSS. For each regression analysis, we pruned nonsignificant predictors one-by-one until only significant or marginally significant predictors remained.

RESULTS

Factors Related to Where Men Seek Help

Table 3 summarizes the results of the logistic regressions which explore how the demographic and life experiences of men who seek help are related to where they seek help. The final column on the right displays the odds ratios (*ORs*), which show that the odds of

TABLE 3. Logistic Regression Summary of Predictors Concerning Where Men Seek Help ($N = 302$)

Independent Variable	*B*	*SE*	Odds Ratio	Wald
Seeking help from DV agency ($\chi^2[4] = 32.04$, $p < .001$), *Nagelkerke* $R^2 = .196$				
Abused alcohol in past year	−0.71	0.41	0.49^	3.00
Age of help seeker	0.07	0.02	1.08***	14.16
Children witnessed IPV	1.10	0.35	3.01***	9.93
False allegation made against help seeker	0.84	0.39	2.31*	4.59
Seeking help from DV hotline ($\chi^2[3] = 11.73$, $p = .008$), *Nagelkerke* $R^2 = .063$				
Abused drugs in past year	−1.01	0.57	0.36^	3.20
Region: south	−0.67	0.35	0.51*	3.73
Sexual abuse in childhood	0.21	0.09	1.23*	4.83
Seeking help via the Internet ($\chi^2[3] = 19.87$, $p < .001$), *Nagelkerke* $R^2 = .120$				
Physical IPV sustained: severe	−1.58	0.79	0.21*	4.00
PTSD total score	0.02	0.01	1.02*	4.34
Region: West	−0.93	0.31	0.40***	8.94
Seeking help from medical professional ($\chi^2[6] = 36.52$, $p < .001$), *Nagelkerke* $R^2 = .203$				
Disabled help seeker	0.95	0.46	2.59*	4.35
False allegation against helpseeker	1.44	0.56	4.20**	6.52
Physical IPV perpetrated against partner: any	−0.58	0.34	0.56^	2.88
Physical IPV sustained: very severe	1.07	0.38	2.92***	8.06
PTSD total score	0.03	0.01	1.03*	5.17
Region: Midwest	0.72	0.39	2.06^	3.49
Seeking help from mental health professional ($\chi^2[5] = 37.90$, $p < .001$), *Nagelkerke* $R^2 = .169$				
Children in home	0.90	0.30	2.47***	8.99
Education level of help seeker	0.24	0.09	1.27***	7.37
False allegation against help seeker	0.56	0.30	1.76^	3.46
Mental illness diagnosis	1.25	0.36	3.49***	12.16
Physical IPV perpetrated against partner: any	−0.54	0.27	0.59*	3.82
Seeking help from police ($\chi^2[8] = 48.13$, $p < .001$), *Nagelkerke* $R^2 = .202$				
Age of help seeker	0.03	0.02	1.03*	4.00
False allegation against help seeker	0.76	0.31	2.15**	6.21
Height of help seeker	0.11	0.05	1.11*	5.31

(Continued)

TABLE 3. Logistic Regression Summary of Predictors Concerning Where Men Seek Help ($N = 302$) (Continued)

Independent Variable	*B*	*SE*	Odds Ratio	Wald
Locality: rural	0.79	0.33	2.19*	5.73
Physical IPV perpetrated against partner: any	−0.74	0.27	0.48**	7.37
Physical IPV sustained: very severe	0.64	0.26	1.89**	6.01
Racial/ethnic minority	0.87	0.37	2.38*	5.61
Social support of help seeker	0.04	0.02	1.04^	3.35

Note. DV = domestic violence; IPV = intimate partner violence; PTSD = posttraumatic stress disorder.
^$p \leq .10$. *$p \leq .05$. **$p \leq .01$. *** $p \leq .001$.

seeking help from each source are either increased or decreased with each characteristic. All predictors displayed are significant or approaching significance. For every additional year in a man's age, the odds of him seeking help from a DV agency increased by 8%; men who reported that their children had witnessed the IPV were three times more likely to seek help from a DV agency than men who did not report children witnessing the abuse, and men who had had a false accusation made against them were 2.3 times as likely to seek help from a local DV agency. Regarding seeking help via a hotline, men who used this resource were 49% less likely to be from the South and 1.23 times more likely to have experienced sexual abuse in childhood.

Men who sought help via the Internet were about 80% less likely to have sustained a severe physical assault from their partner in the past year and were 60% less likely to be from the Western region in the United States. For every one point increase on the PCL (PTSD measure), men's odds of seeking help via the Internet increased by 2%.

Regarding seeking help from a medical professional, most of the characteristics that were significant increased the odds of using this resource. Men who sought help from a physician/emergency room were more than 2.5 times as likely to have a self-reported disability, 4.2 times more likely to have had a false allegation made against them, and 2.9 times more likely to have sustained a very severe physical assault in the past year. For every one point increase on the PCL scale, men's likelihood of seeking help from a medical professional increased by 3%. Men who reported seeking help from a mental health provider were 2.5 times more likely to have children in the home and 3.5 times more likely to have an existing mental illness. Every unit increase in their educational level raised their odds of seeking help from a mental health provider by 27%. They were also 41% less likely to have perpetrated any physical IPV against a partner.

In decreasing order of importance, men who sought help from the police for their partner's violence were 2.4 times more likely to be from a racial/ethnic minority, 2.2 times more likely to be from a rural location, 2.2 times more likely to have had a false accusation made against them, and 1.9 times more likely to have sustained a very severe assault. Each additional inch to the helpseekers' height increased their odds of calling the police by 11%; each additional year

of their age increased their odds of calling the police by 3%. The men who called the police were also about 50% less likely to have perpetrated physical IPV against their partners.

Factors Related to How Men Rate Those Resources

The results of the analyses predicting which factors are related to how men rate the helpfulness of the resources that they used are presented in Table 4. The *OR* represent how much an independent variable contributes to moving a help seeker between the ratings of 1 (*not at all helpful*) and 2 (*somewhat helpful*) or from 2 (*somewhat helpful*) to 3 (*very helpful*). For example, an "average" male help seeker might rate his experience with a DV agency as somewhat helpful. But, if he has children present in the relationship, his odds of giving this rating are decreased by 0.72. In other words, DV agency help seekers with children are 72% less likely to provide a favorable rating than help seekers without children. Similar results were found for men from a suburban location, as compared with rural or urban locations; they rated these services as significantly less helpful ($OR = 0.35$). Furthermore, the higher the levels of social support the men reported, the more positive their experiences with the DV agency were ($OR = 1.09$).

Men's experiences with DV hotlines greatly influenced how the men rated their level of helpfulness. The strongest predictor, with an $OR = 29.88$, was receiving a referral to a local DV agency that was helpful; men who received such a referral provided more positive ratings of the DV hotline. On the flip side, men who called DV hotlines and were told "we only help women" provided more negative ratings of the DV hotline ($OR = 0.09$). Regarding men's demographic characteristics and life experiences, the stronger the sexual abuse history ($OR = 1.9$) and the less they weighed ($OR = 0.97$), the more positive their ratings are. For seeking help on the Internet, men's experiences influenced their ratings of the degree of helpfulness of the resource. Men who were given referrals that were helpful rated this resource more positively ($OR = 3.37$); men who were told, "We only help women" rated it more negatively ($OR = 0.30$).

Men who sought help from a medical provider/emergency room and were given information about IPV victimization were much more likely to rate this resource as helpful ($OR = 5.84$). A strong association was also found between men who had a diagnosis of mental illness and ratings of helpfulness among medical providers. Among men who sought help from a medical provider, a diagnosis of mental illness was associated with a lower rating of helpfulness ($OR = 0.14$).

The nature of men's experiences with mental health providers was related to how they rated this resource. Men who said that their concerns about IPV were taken seriously ($OR = 20.71$) and who reported that the provider gave them information about getting help for IPV victimization ($OR = 2.16$) reported this resource more favorably than their respective counterparts.

A combination of personal characteristics and the nature of men's interactions with the police were related to how they rated this resource. Regarding personal characteristics, higher levels of sexual abuse as children ($OR = 0.67$) and higher levels of posttraumatic stress symptoms ($OR = 0.97$) were associated with less favorable rating of police helpfulness. Moreover, men who sustained very severe IPV from their partner ($OR = 0.33$) also rated their experiences with the police less favorably. Men whose partner was arrested by the police ($OR = 2.46$) and men whose partner was determined to be the primary aggressor ($OR = 5.31$) rated the police as being more helpful than their respective counterparts.

TABLE 4. Ordinal Logistic Regression Summary for Predictors of Ratings of Helpfulness

Independent Variable	Parameter Estimate	*SE*	*OR*	Wald
Helpfulness of DV agency (n = 132; $\chi^2[4] = 22.72$, $p < .001$), *Nagelkerke* $R^2 = .206$				
Children in home	−1.28	0.47	0.28**	7.56
Locality: suburban	−1.05	0.42	0.35**	6.10
Region: West	0.76	0.43	2.14^	3.06
Social support of help seeker	0.09	0.03	1.09**	6.90
Helpfulness of DV hotline (n =67; $\chi^2[4] = 49.27$, $p < .001$), *Nagelkerke* $R^2 = .724$				
Hotline gave referrals that were helpful	3.40	1.09	29.88***	9.68
Hotline said "we only help women"	−2.36	1.01	0.09*	5.46
Sexual abuse in childhood	0.63	0.26	1.88**	6.01
Weight of help seeker	−0.03	0.01	0.97*	5.18
Helpfulness of internet resources (n = 144; $\chi^2[3] = 25.12$, $p < .001$), *Nagelkerke* $R^2 = .212$				
Social support of help seeker	0.06	0.03	1.06^	3.42
Web resource gave referrals that were helpful	1.22	0.42	3.37***	8.20
Web resource said "we only help women"	−1.19	0.37	0.30***	10.35
Helpfulness of medical provider (n = 54; $\chi^2[2] = 12.72$, $p = .002$), *Nagelkerke* $R^2 = .263$				
Medical provider gave info on help for IPV victimization	1.76	0.87	5.84*	4.12
Mental illness diagnosis	−1.95	0.68	0.14***	8.26
Helpfulness of mental health professional (n = 198; $\chi^2[2] = 83.30$, $p < .001$), *Nagelkerke* $R^2 = .441$				
MH provider took IPV concerns seriously	3.03	0.43	20.71***	48.84
MH provider gave info on help for IPV victimization	0.77	0.35	2.16*	4.90
Helpfulness of police (n = 139; $\chi^2[5] = 44.07$, $p < .001$), *Nagelkerke* $R^2 = .359$				
Partner arrested	0.90	0.46	2.46*	3.83
Partner determined as primary aggressor	1.67	0.46	5.31***	13.02
Physical IPV sustained: very severe	−1.11	0.41	0.33**	7.33
PTS symptoms	−0.03	0.01	0.97*	4.07
Sexual abuse history	−0.41	0.20	0.67*	4.28

Note. DV = domestic violence; IPV = intimate partner violence; MH = mental health; PTS = posttraumatic stress.
^$p \leq .10$. *$p \leq .05$. **$p \leq .01$. *** $p \leq .001$.

DISCUSSION

The purpose of this study was to explore the demographic and life experiences that might be related to where men who experience IPV seek help and how they rate those experiences. This study is the first to take an in-depth examination of the predictive characteristics of help seeking for IPV among a large, nationally based sample of U.S. men who have sustained severe IPV and has important implications for each type of service or professional group featured in this study. The results also point to the importance of ensuring that agency policy supports and gives sufficient training for providers working with men seeking help for IPV victimization and that the local, state, and national policies parallel such efforts as well.

Understanding Where Men Seek Help

The men in this sample seek help in somewhat patterned ways. For example, men who had sustained a severe or very severe assault from their partner sought help from emergency personnel—emergency rooms (or physicians) and police officers—and were less likely to seek help through more passive means, such as the Internet. This pattern is probably because of the severe and criminal nature of the violence that warrants criminal justice and medical involvement. Similarly, in comparison to men with no mental illness, men with a diagnosis of mental illness were more likely to have sought help from a mental health provider. Men's reports that at least one false accusation was made against him by his partner was associated seeking help from four of the six help-seeking areas: local DV programs, medical providers, mental health professionals, and police. These men may be looking for ways to document their abusive experiences, which may be more possible through these resources than via the Internet or a hotline.

Our findings are also somewhat consistent with the literature on where female victims of IPV seek help. For example, we found that seeking help from a mental health practitioner was associated with having children in the home and having higher levels of education—results that are congruent with both Leone et al.'s (2007) and Vatnar and Bjørkly's (2009) studies of female victims. Moreover, our findings that sustaining severe levels of assault are associated with seeking help from the police are congruent with Leone et al. The unique contribution of this study is that the previous research was conducted almost solely on women, and this study confirms some of these findings on a sample of male help seekers. This research did not, however, find significant relationships with help-seeking behaviors and duration of the relationship or marital status, as did Leone et al. in their studies of female victims.

Help Seeking by Type of Resource

One of the most important contributions of this study is the findings because they relate to each type of service or provider. The results make it possible for providers to better understand who seeks their assistance and the conditions under which help seekers rate that assistance positively.

Domestic Violence Agency. Men who sought help for IPV victimization from a DV agency were more likely to have children who have witnessed IPV in the home and to have had a false allegation made again them. They were also older and half as likely to have abused alcohol in the past year. A substantive body of research has focused on children's exposure to IPV and the fact that victims (usually women) who seek help from DV

agencies or shelters often have children with them who have witnessed or heard the IPV (Becker et al., 2009; Heugten & Wilson, 2008; Litrownik, Newton, Hunter, English, & Everson, 2003; Meyer, 2010; Owen, Thompson, Shaffer, Jackson, & Kaslow, 2009; Rivett, Howarth, & Harold, 2006; Spilsbury et al., 2008; Wasilewski et al., 2010). This finding does not appear to vary by the gender of the help seeker, and thus, we recommend that DV agency personnel inquire about whether male help seekers have children who need help. Moreover, although no research has documented the extent to which female victims of IPV who have sought help from DV agencies have had false accusations made against them, the results from this study suggest that this is an avenue worth exploring.

Research has documented the connection between female IPV victimization and abuse of alcohol (Fowler, 2007; Poole, Greaves, Jategaonkar, McCullough, & Chabot, 2008; Wingood, DiClemente, & Raj, 2000). This research shows that, at least among men, alcohol abuse is less likely among help seekers of local DV agencies. This finding, in conjunction with the finding on age, is important so that DV agencies can be prepared to assist men who are likely to be older and not likely to have alcohol abuse problems.

Domestic Violence Hotlines. Men who sought help from a DV hotline were less likely to have abused drugs within the past year. This is consistent with other research, which has found that among callers to general hotlines, only 10% concern substance abuse issues (Levine, Wagner, & Wish, 1994). Others, however, have documented that substance use is a common problem among hotline callers (Goud, 1985), and research on IPV has shown a strong relationship between substance abuse and IPV victimization (Fowler, 2007; McClennen, Summers, & Vaughan, 2002; Poole et al., 2008; Stuart et al., 2008). Thus, it is important for hotline workers to know that men who call for help with IPV victimization are less likely to abuse substances. We also found that men who call hotlines are more likely to have a history of childhood sexual abuse. This is important information for DV hotline operators and managers because they may want to screen or be sensitive to the fact that male help seekers may have a history of sexual abuse.

Internet Resources. Men who sought help via the Internet had more symptoms of posttraumatic stress and were less likely to have sustained severe violence. Thus, providers who are working with clients via the Internet may want to assess for mental health problems or make referrals to mental health providers, if this is not already done, because of the elevated levels of posttraumatic stress symptoms among the men who sought help through this resource. If they do not already know, Internet-based providers might find it helpful to know that men who sustain severe violence are likely to seek help from emergency responders such as medical providers or the police, rather than through the Internet, which is consistent with our findings on seeking help through medical personnel and the police and previous research (Lempert, 1997; Meyer, 2010).

Medical Providers. Men who sought help from medical providers were more likely to have a disability, to have been severely assaulted by their partner, to have higher levels of posttraumatic stress symptoms, and to have had false allegations made against them. In addition, men who had physically assaulted their partners were about half as likely to seek help from a medical provider. Men who seek help from medical providers are vulnerable; they tend to have a disability, higher levels of posttraumatic stress symptoms, and have been very severely assaulted by their partner, which is probably the primary reason for their visit to the medical provider (Meyer, 2010; Phelan et al., 2005). The men are not likely to have assaulted their partners but are likely to have had been falsely accused of mistreating either their partners or their children; they may be seeking an opportunity to document the abuse that they experience.

Mental Health Providers. Men who sought help for IPV victimization were more likely to have children in the home, higher levels of education, to have had a false allegation made against them, and to have been diagnosed with a mental illness. Men who reported assaulting their partners were less likely to seek assistance through a mental health provider. Many of these findings are consistent with other research (Kernic et al., 2003; Meyer, 2010). This makes it necessary for clinicians to screen for the physical safety and psychological well-being of the children of their clients—something that has been routinely addressed in the literature (Augustyn & Groves, 2005; Rivett et al., 2006; Roseby & Johnston, 1995) and in practice (Wasilewski et al., 2010). It may be beneficial for mental health providers to understand the higher likelihood that false accusations are made against the male victims to which they provide services.

Police. Men who sought help from the police were older, taller, more likely to be from a racial/ethnic minority, and a rural location. They were more likely to have had a false allegation of mistreatment made against them and were more likely to have been very severely assaulted by their partners. Men who called the police were also less likely to have assaulted their partners.

Our findings are consistent with previous research, which shows that when victims contact the police, the IPV has become quite severe (Cattaneo & DeLoveh, 2008; Leone et al., 2007). Men who call the police are not likely to have used violence against their partner, possibly because of the very real possibility that they would be arrested for assault (Douglas, 2011). The men in this sample who called the police were likely to have had false allegations made against them and may be attempting to document the abuse that they experience in the relationship and the fact that they are not violent. Given our previous research, which shows that men in our sample who call the police are as likely to be arrested as are their female partners (Douglas, 2011), they may actually be doing their case further harm.

Minority men were more likely to call the police—a finding that is consistent with previous research showing that minority victims of IPV may be more likely to call the police than nonminority victims (Shermand, Schmidt, & Rogan, 1992). Men from rural areas may be more likely to call police because of a lack of services nearby or access to services.

Predictors of Helpfulness

We found that the quality of the experience that men had with the resource was strongly related to how they rated the helpfulness of the resources that they used. Resources that gave referrals that were helpful, validated the men's experiences, or provided information on how to get help for IPV were rated more favorably. Similarly, when a responder acted in accordance with a help seeker's expectations, the help seeker viewed the source as more helpful. When resources told men, "We only help women," the help seekers rated them less favorably. These findings are consistent with previous research on female IPV victims (Apsler et al., 2003).

The area in which the help seekers lived was also predictive of how the men rated the helpfulness of local DV agencies. We found an association between urbanicity and helpfulness; men who lived in the suburbs rated their experiences with local DV agencies less favorably than their counterparts in rural and urban areas. Similarly, women who live in urban locations have been found to rate the police as more helpful than women who live in rural locations; women from urban locations rated shelter use as less helpful than women from rural locations (Shannon et al., 2006). Men who lived in the Western United States rated their experiences with DV agencies as more positive, which seems inconsistent with

findings that DV agencies located in the West are the least likely to provide group counseling services for men (Hines & Douglas, 2011).

There were other factors associated with ratings of helpfulness. First, men who had children reported less favorable experiences with DV agencies, which is concerning because we also found that men with children who have witnessed IPV are, in fact, more likely to seek help from a DV agency. Second, men who are lighter in weight had more positive ratings of the help that they received from DV hotlines, potentially because men who are larger are not taken seriously regarding IPV victimization. Third, men with a diagnosed mental illness were less satisfied with the help that they received from medical personnel, which has been noted in other research in general (Clarke, Dusome, & Hughes, 2007; Hoff, Rosenheck, Meterko, & Wilson, 1999).

Research on male victims of IPV is still developing, and the field has much to learn concerning their life experiences, how these relate to their help-seeking behaviors, and their satisfaction with their help seeking. Given that service providers' responses were the strongest predictors of men's rating of helpfulness, it would be beneficial if service providers take steps to alter their practices with male victims. Given that repeated, negative help-seeking experiences have been linked to poorer mental health outcomes among these men (Douglas, 2011), the importance of providing appropriate help cannot be overemphasized.

Limitations and Future Research

There are several limitations of this study. First, we cannot assess the legitimacy of the accounts and reports of abuse and help seeking in this study. Because most men completed the survey anonymously on the Internet, we have no way to confirm the legitimacy of their reports. It is possible that some men may have "an axe to grind" and reported false information. That said, it is unlikely that most men in this study fabricated the experiences that they reported in this 30-minute Internet study. These men likely had to overcome several societal and internal barriers to seeking help (Addis & Mahalik, 2003); it is not unusual for the experiences of victims to be denied when they first surface (Schatzow & Herman, 1989). Nonetheless, future research should aim to gather data from multiple informants. On a related note, we do not know the recruitment source for most samples, which made it impossible to know whether this piece of information is related to their satisfaction with the services that they received.

Second, we were not able to recruit men who did not have access to the Internet or did not call the DAHMW. Thus, we likely missed the experiences of men who are potentially in need of help, who found help through other avenues, and whose experiences could differ from those of the men we surveyed. This may be especially true because men's access to these resources was limited by socioeconomic conditions. On a related and third note, the men in this study are primarily White and well educated. It is possible that men with less affluence might have different experiences with help seeking, or might even be less likely to seek help in the first place. Fourth, the men in this study were asked to recall not only the events that primarily occurred over the past year but also some events that happened in their childhood; those questions that dealt with childhood issues are subject to potential problems with recall. Nonetheless, adult recall is a standard method for assessing childhood trauma (Derevensky & Deschamps, 1997; Finkelhor, Hotaling, Lewis, & Smith, 1990; Ruggiero et al., 2004; Wonderlich, Wilsnack, Wilsnack, & Harris, 1996).

Fifth, this study was a cross-sectional, correlational study; therefore, inferences about causality are weak, and such inferences could be strengthened with longitudinal designs.

We used several demographic and life experiences variables to predict where the men seek help and the helpfulness of those resources, but we cannot conclude that those predictors were causal. For example, social support positively predicts men's ratings of the helpfulness of DV agencies and the Internet, which could also be interpreted as men feeling more supported *as a result* of their positive experiences with those resources. Sixth, in-depth experiences with more potential service providers, such as members of the clergy, social workers, and attorneys, should be assessed. Finally, we measured the help seekers' opinions concerning the helpfulness of services and understand that this is not a measure of the effectiveness of the services, only a measure of how helpful the men perceived the service provider to be.

CONCLUSION AND RECOMMENDATIONS

Previous research on male help-seeking behaviors indicates that many men have to overcome internal and external barriers to seeking help for mental and physical health problems (Addis & Mahalik, 2003; Lane & Addis, 2005). The men who seek help for IPV victimization likely overcome similar barriers to seeking help, especially because it is a problem that is framed, even in federal policy, as a "woman's issue" (Saunders, 1988), and research indicates that men are even less likely to seek help for problems that are non-normative (Addis & Mahalik, 2003). Our previous research on this population has documented the significant external barriers that men encounter in obtaining assistance from human/social services and first responders (Douglas, 2011). It is not unusual for nontraditional IPV help seekers to report negative experiences with resources in the community (Beaulaurier, Seff, Newman, & Dunlop, 2007; Donnelly, Cook, & Wilson, 1999; McClennen et al., 2002; Renzetti, 1989). This study contributes to a small body of research, which examines factors related to the quality of the experiences among a group of help seekers for IPV victimization (Apsler et al., 2003; El-Khoury et al., 2004; Shannon et al., 2006; Weisz, 2005), and it is the first to focus on men. Further research is needed to better understand how personal characteristics and life experiences are related to the quality of these experiences. In addition, although recent research has examined the characteristics of DV agencies and their ability to provide services to male (and other underrepresented) victims (Hines & Douglas, 2011), further research is needed to understand how characteristics of DV agencies and personnel are related to how male victims of IPV rate the experiences from these agencies and similar providers.

In this study, we elucidated several demographic characteristics and life experiences that might be related to where men seek help and how they rate those services; in addition, we found that service provider responses strongly influence how clients rate the services they received. We hope that these results will better prepare members of the human/social service sector and first responders to IPV for the types of victims who may seek their services and provide evidence that all policies—agency, local, state, and federal—that target IPV victimization should be inclusive of gender, regardless of gender or sexual orientation. In theory, any of the types of providers assessed in this study might tailor the types of resources and assistance that they provide to match client characteristics and history. We applaud the good and important work that most responders to IPV provide clients, and it is not our intention to criticize the work that has been and is being accomplished. Rather, we seek to supplement it by providing long overdue evidence that verifies that men often need assistance with IPV victimization and that the characteristics of those men and

the responses they receive may determine the type of assistance that is needed and their perceptions of the quality of help that they have obtained.

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services) either during or after the termination of a relationship in an abusive manner, and this can often involve false allegations against the victims. In our conceptualization and measurement of LA aggression, we measured both threats of aggression and actual aggression (Hines et al., 2014).

LA aggression can be perpetrated by men on female IPV victims as well (Hines et al., 2014; Miller & Smolter, 2011), and can involve frivolous lawsuits, false reports of child abuse, and other system-related legal manipulations. However, Tilbrook et al. (2010) suggested that this form of IPV may be more common among male than female IPV victims because the professional and legal systems responsible for intervening in cases of IPV often hold stereotypes that only men are capable of perpetrating serious IPV. This potential bias within the legal system and elsewhere coincides with the gender stereotype that men are predominately to blame for IPV which often results in outside parties failing to recognize when men are victims of IPV (Follingstad, Coyne, & Gambone, 2005; McHugh, Rakowski, & Swiderski, 2013). Furthermore, as a result of these societal misperceptions, male victims can be erroneously and unfairly blamed for IPV occurring in their relationship (Hamel, 2007). In addition, victim services are traditionally set up to assist women and not men (Douglas & Hines, 2011; Hines & Douglas, 2011a). Men's efforts to combat false allegations can become easily stifled due to these cultural biases, which in combination with gender stereotypes, can be used by women who perpetrate LA aggression on their male partners.

In an initial test of Tilbrook's hypothesis, Hines et al. (2014) found that within a population-based sample of men involved in heterosexual relationships, men sustained more instances of LA aggression than they perpetrated. Specifically, 12.9% of men reported that their partner threatened them with LA aggression, and 3.9% reported that their partner actually carried out a form of LA aggression against them. In contrast, 5.3% of the men reported that they threatened their partner with LA aggression, and 1.1% reported actually perpetrating at least one form of LA aggression against their partner. Although these gender differences could be due to the possibility that Hines et al. (2014) did not adequately measure the types of LA aggression that men use, these findings provide initial support for Tilbrook et al.'s (2010) hypothesis that men may be particularly vulnerable to sustaining LA aggression.

Tilbrook et al. (2010) discussed men who had been falsely accused of IPV, child maltreatment, and other crimes; these men spent substantial money, time, and other resources to prove their innocence in court and to address restraining orders that were based on false reports. Similarly, Cook (2009) provided qualitative evidence that some male IPV victims unjustly lost their homes, possessions, and children because of false claims of abuse made by their female partners. Cook noted that the male IPV victims felt helpless in the face of a judicial system that they believed was stacked against them because of their gender. For example, the men believed that during child custody proceedings, physical custody of their children would be granted to their female partners, and that any contact granted to them to see their children would be blocked by their partners in a continued effort to abuse them and manipulate the legal system. They also feared being falsely accused of mistreating or abusing the children in their partners' efforts to block them from having access to their children, and in several cases, Cook found that this happened.

Hines, Brown, and Dunning (2007) examined the concerns of male helpseekers who called the Domestic Abuse Helpline for Men. Just under half of the male callers (the large majority of whom were in heterosexual relationships) reported that their partners engaged in LA aggression by requesting a restraining order under false pretenses or manipulating the court system to gain sole custody of the children. Similarly, in another study of heterosexual male helpseekers for IPV, when asked what prevents men from leaving an abusive female partner, one of the most commonly cited reasons was a fear that they would never see their children again (Hines & Douglas, 2010a). Men also reported instances of being the victims of LA aggression by their female partners who used threats to ruin their reputation in the community and at work, in addition to using threats of false allegations of physical/sexual abuse against them and/or their children as a means of manipulating their partner. In fact, two-thirds of the men reported that false accusations had been carried out against them (Hines & Douglas, 2010b).

We developed a scale to measure LA aggression, and in our initial psychometric evaluation, we found good construct validity and reliability for the victimization scale (Hines et al., 2014). We also found that among male physical IPV victims who had sought help, 91.4% reported that their partner threatened to carry out at least one form of LA aggression, and 78.9% reported that their partner actually carried out at least one form of LA aggression. These findings suggest that a large portion of male physical IPV victims sustain LA aggression. It is, therefore, important to study the potential mental health consequences of this form of IPV. The field seems to be moving toward a recognition that LA aggression is a form of IPV, but IPV scholars have not yet explored whether there is a relationship between LA aggression and the mental health status of individuals who are

targeted and their children. We address some of these gaps in the current paper.

Partner Violence Victimization and Mental Health

Because there is no quantitative literature on the potential mental health consequences of LA aggression on victims and their children, we used the literature on other forms of IPV to guide our hypotheses for this paper. Most studies that evaluate potential mental health outcomes for men are community studies comparing men and women. Many use data from the National Violence Against Women Study, and show that for both women and men, IPV victimization is associated with depressive symptoms and chronic mental illness (Carbone-Lopez, Kruttschnitt, & MacMillan, 2006; Coker et al., 2002). Both men and women are affected by IPV victimization; after controlling for lifetime exposure to aggression, there are no gender differences in the influence of IPV on mental health outcomes (Pimlott-Kubiak & Cortina, 2003). Other research using community samples find that men who sustain IPV are at a greater risk of depressive symptoms (Chan, Straus, Brownridge, Tiwari, & Leung, 2008; Kaura & Lohman, 2007; Reid et al., 2008; Stets & Straus, 1990) and symptoms of PTSD (Hines, 2007). Finally, recent work focusing on male victims of more severe levels of IPV show that men who sustain severe IPV and seek help are at significantly higher risk for PTSD than men who sustain minor IPV or no IPV at all. Specifically, 2.1% of non-IPV-victims evidenced PTSD, 8.2% of minor IPV victims did, while 57.9% of severe IPV victims did (Hines & Douglas, 2011b). In the current study, we examine the associations between LA aggression victimization and mental health among a sample of male physical IPV victims who sought help in order to focus on this subset of the population.

Children of parents who engage in IPV also suffer from mental health problems (Sternberg, Baradaran, Abbott, Guterman, & Lamb, 2006) including externalizing (Kalil, Tolman, Rosen, & Gruber, 2003) and internalizing problems (Clements, Oxtoby, & Ogle, 2008; Heugten & Wilson, 2008). A study of children who were living in a shelter for battered women found 69% of the children met clinical cutoffs for mental health problems: 30% of the children met the clinical cut-off for both internalizing and externalizing problems, 21% met the cut-off for externalizing problems, and 18% met the cut-off for internalizing problems (Grych, Jouriles, Swank, McDonald, & Norwood, 2000). Others have found that children are more likely to exhibit externalizing problems. This was the case among children who lived in homes with police-reported IPV (Kernic et al., 2003; Spilsbury et al., 2008). Children and adolescents living in homes where their mothers are abused often demonstrate patterns of aggression, hostility, anxiety, somatic complaints, social isolation, and suicidal ideation (see Jaffe & Sudermann, 1995). Overall, the literature shows that children who live in homes where there is IPV show both internalizing and externalizing behavior problems; however, no research has investigated the potential consequences of LA aggression. The current study addresses this gap using a sample of male IPV victims who sought help and their report of the mental health status of their children.

The Current Study

The current study utilizes a new LA aggression scale (Hines et al., 2014) developed as an add-on to the Revised Conflict Tactics Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). We used this scale to investigate how LA aggression may be related to the mental health of male victims of IPV and their children. We predicted that female-to-male LA aggression would be related to poorer mental health for both the male victims and their children and that this would be the case for both threats of LA aggression and for actual LA aggression. We also investigated whether this association remained after controlling for demographic characteristics of the men and their children, other forms of IPV that may be occurring in the home, and other forms of life adversity and/or trauma that the male victims and/or their children may have experienced.

METHOD

Participants and Procedure

We recruited a help-seeking sample of male physical IPV victims ($n = 611$). To be eligible, the men had to speak English, live in the U.S., be between the ages of 18 and 59, and have been involved in an intimate relationship with a woman lasting at least one month in their lifetimes. In addition, the men had to have sustained a physical assault from their female partner at some point in their relationship, and they had to have sought help/assistance due to their partner's violence from at least one of the following sources: medical doctor or dentist, domestic violence agency, domestic violence hotline, the internet, a lawyer, the police, a clergy member, a family member, a friend, or a mental health therapist.

To recruit our sample, we posted advertisements on our study's webpage and Facebook page, and we posted ads on webpages and Facebook pages of agencies that specialize in male victims of IPV, the physical and mental health of all men and those specializing in minority men, fathers' issues, and divorced men's issues. We also sent announcements to a database of

researchers, practitioners, and other interested parties who signed up to be on an e-mailing list through our website which focuses on male victims of IPV; it has been in existence since 2008. The advertisement stated that we were conducting "a study on men who experienced aggression from their girlfriends, wives, or female partners." The ad then provided a link to the anonymous online questionnaire. After providing consent, the next two pages of the survey contained questions to assess for the above screening criteria. Men who were eligible were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an "exit page" of the survey. Demographics of the men and their eldest child are displayed in Table I. The eldest minor children ranged in age from infancy (0–6 months) to 17 years.

The methods for this study were approved by the boards of ethics at the participating institutions. All participants were informed of their rights as study participants, and participated anonymously. At the completion of the survey, participants were given information about seeking help for IPV victimization or psychological distress, and on how to delete the history on their Internet web browser.

Measures

Participants were given questionnaires assessing demographics, victimization and perpetration of IPV in their relationship, their mental and physical health, and various risk factors for IPV. Men who had children ($n = 408$; 66.8%) were asked to report information about their eldest child in terms of their child's mental health and other risk factors. Only the questionnaires used in the current analyses are described here.

Demographic information. Men were asked basic demographic information about both themselves and their partners, including age, race/ethnicity, personal income, and education. Men were also asked about the current status of their relationship, the length of their relationship with their partners, how long ago the relationship ended (if applicable), and how many minor children they parented with their abusive partner, if any. We asked the men to report on the eldest minor child in the relationship including the age, gender, the nature of his relationship with the child (e.g., adopted, biological), and where the child lived.

Revised conflict tactics scales (CTS2). The *CTS2* (Straus et al., 1996) was used to measure the extent to which the men in the study perpetrated and sustained psychological, physical, and sexual aggression, and injuries in their relationships. The items used for this study included four items assessing minor psychological aggression (e.g., swearing at partner, stomping out of the room during disagreement), four items assessing severe psychological aggression (e.g., threatening to hit or throw something at partner, calling partner fat or ugly), 12 items assessing physical aggression (e.g., slapping, beating up), six items assessing injuries (e.g., having a small cut or bruise, broken bone), and six items assessing sexual aggression (e.g., insisting on, threatening, or using force to have sex when the partner did not want to).

Similar to previous studies on male victims (e.g., Hines & Douglas, 2010a,b, 2011b), we added nine items from the Psychological Maltreatment of Women Inventory (Tolman, 1995) to the *CTS2* which focused on acts of controlling behavior. A prior factor analysis (Hines & Douglas, 2010a) showed that these items represented a unique factor that was distinct from both the minor and severe psychological aggression items of the CTS2.

Participants responded to items depicting each of the conflict tactics by indicating the number of times these tactics were used by the participant and his partner. Participants indicated on a scale from 0 to 7 how many times they used and sustained each of the acts, 0 = never; 1 = 1 time in previous year; 2 = 2 times in previous year; 3 = 3–5 times in previous year; 4 = 6–10 times in previous year; 5 = 11–20 times in previous year; 6 = more than 20 times in previous year; 7 = did not happen in the previous year, but has happened in the past.

In the current study, we coded each subscale on the CTS2 (i.e., perpetration and victimization of each type of aggression) in two different ways:

1. Whether any of the types of aggression ever happened (dichotomous yes/no variable).
2. The number of different acts of each type of aggression that ever happened (e.g., there were a total of 12 items of physical aggression, so participants could be victimized by up to 12 types of physical aggression). This method of scoring is recommended by Moffitt et al. (1997), who showed that it provided a reliable and valid assessment of the severity and frequency of the various forms of IPV, without violating statistical assumptions.

The *CTS2* has been shown to have good construct and discriminant validity and good reliability, with internal consistency coefficients ranging from $\alpha = .79$ to $\alpha = .95$ (Straus et al., 1996). In the current study, the internal consistency of the scales ranged from $\alpha = .69$ (perpetration of severe psychological aggression) to $\alpha = .94$ (victimization from physical aggression). The percentages of men who were victimized or perpetrated each of the forms of aggression measured by this scale are presented in Table I.

TABLE I. Demographic Information of the Male Helpseekers and Their Children ($n = 611$)

	% or *M* (*SD*)
Male participant demographics	
Age	43.89 (9.18)
White	75.5%
Black	4.1%
Hispanic/Latino	4.9%
Asian	4.3%
Native American	2.9%
Middle Eastern	1.1%
Income (in thousands)	52.7 (27.7)
Educational status[a]	4.71 (1.63)
Relationship demographics	
Currently in a relationship	26.3%
Relationship length (months)	112.33 (87.62)
Time since relationship ended (in months)	45.17 (54.33)
Minors involved in the relationship	67.7%
# of minors involved in relationship	1.12 (1.03)
Victimization from CTS2 scales (% ever)	
Threatened LA aggression	91.4%
Actual LA aggression	78.9%
Minor psychological aggression	100%
Severe psychological aggression	95.8%
Controlling behaviors	94.3%
Physical aggression	100%
Sexual aggression	48.1%
Injuries	72.3%
Perpetration of CTS2 scales (% ever)	
Threatened LA aggression	11.2%
Actual LA aggression	9.7%
Minor psychological aggression	89.4%
Severe psychological aggression	34.5%
Controlling behaviors	38.3%
Physical aggression	46.1%
Sexual aggression	14.6%
Injuries	21.1%
Eldest child demographics ($n = 405$)	
Age	9.90 (4.92)
Male	50.0%
Female	50.0%
Eldest child—living situation ($n = 405$)	
Primarily live with the male helpseeker	29.5%
Primarily live in another residence elsewhere	53.1%
Split time about equally between male helpseeker and someone else	17.4%
Male helpseekers relationship to eldest child ($n = 405$)	
Biological child of helpseeker	92.9%
Biological child of partner	44.6%
Adopted by male helpseeker	1.5%
Adopted by partner	0.5%

[a]Educational Status: 1 = less than high school, 2 = high school graduate or GED, 3 = some college/trade school, 4 = two-year college graduate, 5 = four-year college graduate, 6 = at least some graduate school.

Legal and administrative aggression scale. The LA Aggression scale (Hines et al., 2014) was divided into two components: (1) A 6-item scale that was an add-on to the CTS2, and (2) a 6-item scale comprised of yes/no questions. The first component contained six items asking participants how often they and their partners threatened to engage in various types of LA aggressive acts. These acts are aggressive, but to differentiate them from the second component of the scale, we refer to this component as the "threatened LA aggression" subscale. Using the same scale as the CTS2, participants indicated how often they and their partner threatened each of the following acts: make false accusations to authorities that the partner physically or sexually abused the other, make false accusations to authorities that the partner physically or sexually abused the children, leave and take the kids away, leave and take all the money and possessions, ruin the partner's reputation at work, and ruin the partner's reputation in the community. This scale was scored in the same manner as the other scales of the CTS2 (see above).

We refer to the second component of this scale as the "actual LA aggression" subscale. These yes/no questions were asked after the "threatened" items, and assessed whether the participant and/or his partner actually engaged in any of the six acts outlined above. The scale was scored by counting the number of "actual" acts of legal and administrative aggression the participant and his partner engaged in, and indicating whether the participant and/or his partner engaged in any of the six acts listed (1 = yes, 0 = no).

This scale was shown to be valid and reliable for measuring LA aggression victimization among the current sample of men who sought help for IPV in their relationship with adequate internal consistency of $\alpha = .89$ for the threatened LA aggression and $\alpha = .75$ for the actual LA aggression scale. The internal consistency in the current sample was lower for the perpetration scale: $\alpha = .47$ for threatened LA aggression and $\alpha = .44$ for actual LA aggression, which could be due to constrained variance and low base-rate for all of the items assessed. Rates of LA aggression victimization and perpetration in this sample can be found in Table I. In the current study, only the victimization scales for threatened and actual LA aggression, both of which demonstrated good reliability and validity, were used in the analyses to determine the potential impact of this behavior on male victims and their children.

Posttraumatic stress disorder. The *PTSD Checklist* (PCL;Weathers, Litz, Herman, Huska, & Keane, 1993) is a 16-item, self-administered instrument for assessing the severity of PTSD symptomatology. Items cover three symptom clusters: re-experiencing, numbing/avoidance, and hyperarousal. Participants indicate on a 5-point scale (1 = not at all, 5 = extremely) the extent to which they were bothered by each symptom in the previous month. The PCL has been used to evaluate PTSD symptomatology in a variety of populations, including female sexual assault victims,

(Blanchard, Jones-Alexander, Buckley, & Forneris, 1996) and male victims of IPV (Hines & Douglas, 2011b). The PCL has demonstrated excellent internal consistency, with alpha coefficients above .90 (Blanchard et al., 1996; Lang, Laffaye, Satz, Dresselhaus, & Stein, 2003; Weathers, Litz, Herman, Huska, & Keane, 1993) and test-retest reliability of .96 (Weathers et al., 1993). The measure has also shown strong convergent and divergent validity (Blanchard et al., 1996; Ruggiero, DelBen, Scotti, & Rabalais, 2003). Cronbach's alpha for the current sample was high ($\alpha = .97$).

Depression. Depression was measured with the Center for Epidemiologic Studies Depression Scale (CES-D). The CES-D is a 20-item self-report scale designed to measure depressive symptoms in the general population and has been used widely in epidemiological research. The scale has demonstrated good internal consistency both in the general population (approximately .85) and amongst a clinical population (approximately .90), and good discriminant validity between psychiatric patients and nonclinical cases (Radloff, 1977). Items pertain to depressed mood, feelings of guilt and worthlessness, feelings of hopelessness, loss of energy, and sleep and appetite problems. A four point Likert scale assesses the prevalence of these symptoms over the past week, 0 (*rarely or none of the time*) to 3 (*most or all of the time*). Cronbach's alpha for the current sample was high ($\alpha = .95$).

Child maltreatment experiences. Childhood maltreatment experiences were assessed using four items from Sexual Abuse History (SAH) and Violence Socialization (VS) scales of the Personal and Relationships Profile (PRP; Straus et al., 1996). These same 4 questions in previous studies of male IPV victims showed excellent psychometric properties (Hines & Douglas, 2011b). According to Straus and Mouradian (1999), both scales have adequate validity and demonstrate good internal consistency with alphas of $\alpha = .73$ (VS scale) and $\alpha = .76$ (SAH scale). Childhood neglect was measured using six items from the Multidimensional Neglectful Behavior Scale (Kantor et al., 2004), each of which measures a different dimension of childhood neglect (e.g., physical neglect, medical neglect, emotional neglect). Since these dimensions are not necessarily related, an alpha reliability statistic is not appropriate to calculate. However, the items do show face and predictive validity. For all child maltreatment items, participants were asked the extent to which they agreed (1-strongly disagree, 4 = strongly agree) with statements concerning their childhood experiences.

Previous trauma exposure. Previous exposure to trauma was assessed with the Traumatic Events Questionnaire (Vran & Lauterbach, 1994). The TEQ assesses 7 specific traumatic events, including violent crime victimization, combat, and natural disasters. We eliminated the item assessing adult abusive relationships, and scored the scale by adding together the number of items endorsed. The TEQ has demonstrated excellent test-retest reliability and validity (Lauterbach & Vran, 1996; Vran & Lauterbach, 1994). Cronbach's alpha was adequate in the current study ($\alpha = .71$).

Child behavior checklist (CBCL). To assess the mental health of children, the male participants completed the CBCL for their eldest minor child, which is a method used in other research investigating children in IPV families (Hines & Douglas, 2010a; Lang & Stover, 2008) and on research concerning fathers and their children (Douglas, 2003). The eldest child is the child most likely to have been exposed to IPV in the home. The CBCL (Achenbach, 1991; Achenbach & Rescorla, 2001) is the most widely used measure to assess the mental health of children (De Groot, Koot, & Verhulst, 1994; Konold, Walthall, & Pianta, 2004). It has demonstrated excellent reliability and validity (Achenbach & Rescorla, 2001a,b). The 2001 revision we used includes DSM IV-oriented scales which have demonstrated strong reliability and convergent and discriminative validity (Nakamura, Ebesutani, Bernstein, & Chorpita, 2009).

Two versions of the parent report were employed: (1) the CBCL/1½–5 is a 99-item measure for parents of children ages 1½–5 years of age; there are 5 DSM IV-oriented scales: affective problems, anxiety problems, pervasive developmental problems, attention deficit/hyperactivity problems, & oppositional defiant problems; and (2) the CBCL/6-18 is a 118-item measure for parents of children ages 6–18 and includes 6 DSM IV-oriented scales: affective problems; anxiety problems; somatic problems; attention deficit/hyperactivity problems; oppositional defiant problems; and conduct problems. Research on the ability of these scales to accurately identify DSM diagnoses shows moderate predictive ability for anxiety disorders and strong predictive ability for depressive disorders (Ferdinand, 2008). For each item, the men rated on a 3-point scale how true each statement was for his oldest child: 0 = not true (as far as you know); 1 = somewhat/sometimes true; 2 = very or often true. In the current study, the internal consistency of the scales ranged from $\alpha = .80$ (Anxiety Problems) to $\alpha = .92$ (Conduct Problems) for the school-age children, and from $\alpha = .72$ (ADHD Problems) to $\alpha = .84$ (Pervasive Developmental Problems) for the preschool children.

Things I have seen and heard (TIHSH). To assess the eldest minor children's exposure to other forms of violence or adversity outside their home, we used the parent version of TIHSH (Richters & Martinez, 1993). This 20-item tool measures events to which

children might have been exposed, such as hearing gun shots or witnessing an arrest, on a scale of 0–4 (0 = never, 4 = many times); we summed the items to capture children's exposure to other adverse events in their lives. TIHSH has demonstrated very good internal consistency across cultures (Richters & Martinez, 1993) and the parent version has been successfully used before in research on child witnesses of IPV (Spilsbury et al., 2008). For all items, we specified that the event had to have occurred outside of witnessing any violence between the male help-seeker and his female partner. Cronbach's alpha for the current sample was adequate ($\alpha = .77$).

RESULTS

We first examined the missing data patterns. Less than 5% of the data was missing for all the variables included in the present analysis. For the threatened LA aggression items, missing values were replaced according to the instructions for scoring the CTS2. Because the actual LA aggression items were dichotomous yes/no questions, missing values could not be replaced. Nonetheless, less than 5% of these items had missing values.

Associations Between Men's Mental Health and LA Aggression

Bivariate correlations were calculated to assess the relationship between the mental health variables (i.e., PTSD and depression symptoms) and LA aggression (Table II). For each LA aggression scale (i.e., threatened and actual), we used the total number of types of LA aggression ever sustained by the male partner (range = 0–6 for both scales). Both actual and threatened LA aggression were significantly correlated with PTSD and depression symptoms in male victims.

Hierarchical linear regression models were then used to investigate whether the association between LA aggression and mental health remained after controlling for other potential confounds. In separate models, actual and threatened LA aggression were used as the predictor variables and the mental health variables (PTSD and depression symptoms) were used as the outcome variables. Covariates in all models were added in steps. Step 1 controlled for the number of months since the end of the abusive relationship. Step 2 included traumatic/adverse experiences that were distal to the abusive relationship: number of past traumatic experiences (i.e., TEQ total), history of childhood sexual abuse, history of childhood violence exposure, and history of childhood neglect. Step 3 included traumatic/adverse experiences that were proximal to the abusive relationship: the total amount of other IPV occurring in the relationship. Specifically, the IPV covariates consisted of the number of types of each form of IPV (i.e., severe psychological aggression, controlling behavior, physical aggression, and sexual aggression) ever sustained by the male help-seeker. Step 4 included the number of types of LA aggression experienced (threatened and actual were assessed in separate models). At this step, changes in R^2 were evaluated to investigate whether this form of IPV victimization significantly predicted the male victims' mental health after controlling for other forms of IPV and trauma. Results of these analyses are shown in Table III.

In the final step of the hierarchical regression model, threatened LA aggression did not significantly improve the prediction models for either depression or PTSD after controlling for the other covariates. However, actual LA aggression did significantly improve the models for both PTSD and depression in the final step after controlling for the other covariates (see Table III).

In examining the potential impact of actual LA aggression on depressive symptoms, the final model that included all four steps of the hierarchical model significantly predicted depressive symptoms, $F(10,554) = 1.15$, $P < .001$, Adjusted $R^2 = .189$. Actual LA aggression was added as a predictor in the final step of this model, and significantly improved the model after controlling for the other covariates, $\Delta F(1,554) = 6.21$, $P = .013$, $\Delta R^2 = .009$. Actual LA aggression was a significant unique predictor and accounted for 0.9% of the variance after controlling for the other covariates. All other forms of IPV victimization as a whole accounted for 8.4% of the variance in depressive symptoms.

In examining the potential impact of actual LA aggression on PTSD symptoms, the overall model that included all four steps of the hierarchical regression model significantly predicted PTSD symptoms, $F(10,554) = 18.20$, $P < .001$, Adjusted $R^2 = .234$. Actual LA aggression was added as a predictor in the final step of this model, and significantly improved the model after controlling for the other covariates, $\Delta F(1,554) = 9.00$, $P = .003$, $\Delta R^2 = .012$. Actual LA aggression uniquely contributed to PTSD symptoms and accounted for an additional 1.2% of the variance. The other forms of IPV victimization as a whole, however, accounted for 15.2% of the variance in PTSD symptoms.

Associations Between Children's Mental Health Status and LA Aggression

Bivariate correlations were used to assess the relationship between the DSM mental health symptoms and LA aggression variables (see Table II). These initial correlations were carried out for pre-school (1½–5 years of age) and school age (6–18) children separately because the CBCL has two separate versions based on these two age groups. Neither actual nor threatened LA aggression were significantly correlated with any of the

TABLE II. Intercorrelations for LA Aggression and Mental Health of the Male IPV Victims and Their Children

Mental Health Problem	Number of Types of Actual LA Aggression	Number of Types of Threatened LA Aggression
Male helpseekers ($n = 611$)		
PTSD symptoms (PCL)	0.18***	0.19***
Depression symptoms (CES-D)	0.13**	0.12**
Preschool children ($n = 81$)		
ADHD symptoms	0.14	0.12
Affective symptoms	0.14	0.13
Anxiety symptoms	0.19	0.13
Oppositional defiant symptoms	−0.02	0.18
Pervasive developmental disorder symptoms	0.13	0.07
School-age children ($n = 298$)		
ADHD symptoms	0.08	0.09
Affective symptoms	0.20**	0.23***
Anxiety symptoms	0.16**	0.13*
Conduct symptoms	0.20***	0.21***
Oppositional defiant	0.20**	0.21***
Somatic symptoms	0.14*	0.17**

*$P < .05$; **$P < .01$; ***$P < .001$.

DSM outcome measures for pre-school children. However, both actual and threatened LA aggression were significantly correlated with affective, anxiety, conduct, oppositional defiant, and somatic problems in school-aged children.

Hierarchical linear regression models were used to investigate the associations between both threatened and actual LA aggression and school-age children's mental health symptoms. Covariates in these models were added in steps, and because of potential power issues, only those covariates that correlated with the outcome variable were entered into the model (bivariate correlations not shown but are available upon request). Step 1 included demographics of the children: age, gender, and time since the abusive relationship of their parents ended (in months). Step 2 included adversity they experienced that was distal to their home life, specifically their scores on the TIHSH scale. Step 3 included the adversity they experienced that was proximal to their home life, specifically other forms of IPV taking place within the parent's relationship (physical IPV, severe psychological IPV, controlling behaviors, and sexual aggression). The IPV covariates consisted of the number of types of each form of IPV ever sustained or perpetrated by the male participant (e.g., number of physical violence types ever sustained on a scale from 0-12 plus number of physical violence types ever perpetrated on a scale from 0-12). The final step consisted of the number of types of LA aggression their father reported experiencing (threatened and actual LA aggression were assessed in separate models). At this step, changes in R^2 were evaluated to investigate whether this form of IPV victimization significantly predicted the children's mental health after controlling for other forms of adversity. Results of these analyses are shown in Table IV.

Neither threatened nor actual LA aggression were significant unique predictors of anxiety, conduct, or somatic problems in school-age children after controlling for the other covariates. However, both actual and threatened LA aggression were significant unique predictors of affective and oppositional defiant problems in school age children after controlling for the other covariates (see Table IV).

In examining the potential impact of threatened LA aggression on affective problems, the overall model that included all four steps of the hierarchical regression model significantly predicted level of affective problems, $F(7,278) = 9.24$, $P < .001$, Adjusted $R^2 = .168$. Threatened LA aggression was added as a predictor in the final step of this model, and significantly improved the model after controlling for the other covariates, $\Delta F(1,278) = 6.57$, $P = .011$, $\Delta R^2 = .019$. Thus, threatened LA aggression victimization of the male help-seeker accounted for 1.9% of the variance in the oldest child's affective symptoms. The step of the model that accounted for the most variance in affective problems was adversity experienced by the child distal to the home environment as measured by the TIHHS, which accounted for 7.1% of the variance in the oldest child's affective symptoms.

Examining the potential impact of actual LA aggression on affective problems, the overall model that included all four steps of the hierarchical regression model significantly predicted affective problems, $F(7,280) = 8.74$, $P < .001$, Adjusted $R^2 = .159$. Actual LA

TABLE III. Hierarchical Regression Analysis Summary for Threatened and Actual Legal/Administrative Aggression Predicting Mental Health Symptoms in Men Seeking Help for Partner Violence Victimization

Step	Predictor	*B*	*SE*	*β*	*t*	*P*	ΔR^2
	Depression symptoms						
	Threatened LA aggression ($N = 562$)						
1	Time since relationship ended (in months)	−0.06	0.01	−0.23	−5.84	<0.001	0.072***
2	TEQ score	0.32	0.33	0.04	0.97	0.332	0.037***
	Childhood neglect	0.75	0.29	0.11	2.54	0.011	
	Childhood sexual abuse	−0.34	0.42	−0.04	−0.81	0.418	
	Childhood violence exposure	0.71	0.38	0.08	1.89	0.060	
3	# of types of sexual aggression in relationship	1.12	0.41	0.12	2.73	0.006	0.081***
	# of types of severe psychological aggression in relationship	0.87	0.62	0.07	1.40	0.163	
	# of types of controlling behaviors in relationship	0.82	0.30	0.13	2.70	0.007	
	# of types of physical aggression in relationship	0.25	0.25	0.05	1.01	0.312	
4	# of types of female-to-male threatened LA Aggression	0.41	0.34	0.05	1.19	0.236	0.002
	Actual LA aggression ($N = 565$)						
1	Time since relationship ended (in months)	−0.07	0.01	−0.24	−6.12	<0.001	0.073***
2	TEQ score	0.29	0.33	0.04	0.89	0.373	0.038***
	Childhood neglect	0.77	0.29	0.11	2.62	0.009	
	Childhood sexual abuse	−0.29	0.42	−0.03	−0.69	0.490	
	Childhood violence exposure	0.63	0.37	0.07	1.68	0.093	
3	# of types of sexual aggression in relationship	1.16	0.40	0.12	2.88	0.004	0.084***
	# of types of severe psychological aggression in relationship	1.05	0.59	0.08	1.78	0.076	
	# of types of controlling behaviors in relationship	0.78	0.30	0.13	2.60	0.009	
	# of types of physical aggression in relationship	0.21	0.24	0.04	0.86	0.388	
4	# of types of female-to-male actual LA aggression	0.78	0.31	0.10	2.49	0.013	0.009*
	PTSD symptoms						
	Threatened LA aggression ($N = 562$)						
1	Time since relationship ended (in months)	−0.04	0.01	−0.13	−3.42	0.001	0.034**
2	TEQ score	0.37	0.37	0.04	1.00	0.317	0.048***
	Childhood neglect	1.13	0.33	0.14	3.41	0.001	
	Childhood sexual abuse	−0.55	0.47	−0.05	−1.17	0.244	
	Childhood violence exposure	0.64	0.42	0.06	1.53	0.127	
3	# of types of sexual aggression in relationship	1.79	0.45	0.17	3.95	<0.001	0.150***
	# of types of severe psychological aggression in relationship	0.78	0.69	0.05	1.12	0.262	
	# of types of controlling behaviors in relationship	1.58	0.34	0.22	4.64	<0.001	
	# of types of physical aggression in relationship	0.26	0.27	0.04	0.95	0.342	
4	# of types of female-to-male threatened LA aggression	0.66	0.39	0.07	1.71	0.088	0.004
	Actual LA aggression ($N = 565$)						
1	Time since relationship ended (in months)	−0.05	0.01	−0.14	−3.74	<0.001	0.034***
2	TEQ score	0.33	0.37	0.04	0.91	0.365	0.049***
	Childhood neglect	1.12	0.33	0.14	3.43	0.001	
	Childhood sexual abuse	−0.51	0.47	−0.05	−1.09	0.277	
	Childhood violence exposure	0.58	0.42	0.06	1.39	0.164	
3	# of types of sexual aggression in relationship	1.80	0.45	0.17	4.02	<0.001	0.152***
	# of types of severe psychological aggression in relationship	0.99	0.66	0.07	1.50	0.134	
	# of types of controlling behaviors in relationship	1.55	0.33	0.22	4.67	<0.001	
	# of types of physical aggression in relationship	0.23	0.27	0.04	0.85	0.394	
4	# of types of female-to-male actual LA aggression	1.04	0.35	0.12	3.00	0.003	0.012**

*$P < .05$; **$P < .01$; ***$P < .001$.

aggression was added as a predictor in the final step of this model, and significantly improved the model after controlling for the other covariates, $\Delta F\ (1,280) = 4.16$, $P = .042$, $\Delta R^2 = .012$. Actual LA aggression accounted for 1.2% of the variance in affective problems. Children's exposure to adversity outside of the home accounted for the most variance, 7.2%.

In analyzing the potential impact of threatened LA aggression on oppositional defiant problems, the overall model that included all three steps of the hierarchical regression model significantly predicted oppositional defiant problems, $F(6,279) = 7.56$, $P < .001$, Adjusted $R^2 = .121$. Threatened LA was added as a predictor in the final step of this model, and significantly improved the model, $\Delta F\ (1,279) = 6.40$, $P = .012$, $\Delta R^2 = .020$. Threatened LA aggression was a significant unique predictor and accounted for 2.0% of the variance in oppositional defiant problems after controlling for the other

covariates. Again, experiences of adversity outside of the home provided the strongest prediction of oppositional defiant problems, explaining 7.6% of the variance.

Lastly, examining the potential impact of actual LA aggression on oppositional defiant problems, the overall model that included all three steps of the hierarchical regression model significantly predicted oppositional defiant problems, $F(6, 281) = 7.15$, $P < .001$, Adjusted $R^2 = .114$. Actual LA aggression was added as a predictor in the final step of this model, and significantly improved the model after controlling for the other covariates, $\Delta F\ (1,281) = 4.66$, $P = .032$, $\Delta R^2 = .014$. Thus, actual LA aggression explained an additional 1.4% of the variance in oppositional defiant problems after controlling for the other covariates. In addition, experiences of community adversity explained the largest percentage of variance, 7.6%.

Summary

Our regression analyses indicated that actual LA aggression remained a unique predictor of both depression and PTSD symptoms in male victims after accounting for the other forms of IPV occurring in the relationship, exposure to past traumatic experiences, and length of time since the end of the relationship. In addition, both threatened and actual LA aggression remained unique predictors of affective and oppositional defiant problems in school-aged children of male victims after accounting for exposure to adverse experiences outside of the home and other forms of IPV occurring in the relationship.

DISCUSSION

The purpose of this study was to examine the association between LA aggression as a form of IPV and the mental health of male victims of physical IPV who seek help and their children. LA aggression was associated with poorer mental health in adult male victims and the children who live or have lived in homes where LA aggression victimization was experienced by their fathers. Many of these associations remained after controlling for other forms of IPV between the male help-seekers and their abusive female partners, other adversity and trauma the men and their children may have experienced, and demographic variables.

Our results indicated that actual LA aggression, not threatened aggression, was uniquely associated with male IPV victims' PTSD and depression symptoms, above the influence of past traumatic experiences and other forms of IPV in the men's relationship. The fact that this form of IPV is uniquely associated with poor mental health in male victims represents a new finding, and the mechanisms for why this association exists requires further research. It is known that LA aggression can have dire consequences for male victims, such as losing custody of their children, jeopardizing their financial stability, and ruining their reputation at work or in their community (Cook, 2009). Major adverse life events (Kendler, Karkowski, & Prescott, 1999) and social shame are also associated with negative mental health outcomes, such as depression (Scheff, 2001). Thus, LA aggression can potentially lead to a plethora of negative social and legal secondary outcomes, and these secondary outcomes may primarily account for the effect of actual LA aggression on the mental health of male IPV victims.

The current findings also indicated that both threats and actual acts of LA aggression were uniquely associated with affective and oppositional defiant problems in school-aged children after controlling for other IPV between the parents, other types of life adversity, and demographic characteristics. The affective problems scale on the CBCL measures dysthymia and major depression, both of which are internalizing disorders. Oppositional defiant disorder represents a pattern of externalizing behavior characterized by tantrums, arguing with adults, actively disobeying rules set up by parents or other adults at school, and stubbornness and blaming others for one's own misbehavior (Achenbach, 1991). Prior research has shown that externalizing and internalizing problems often co-exist in children with parents experiencing IPV (Grych et al., 2000; Jaffe & Sudermann, 1995). These problems are not only likely to have long-term developmental consequences but can also have an impact on children's performance in school and interpersonal relationships (Jaffe & Sudermann, 1995).

Our findings concerning the relationship between LA aggression and children's mental health are consistent with previous studies showing that children are affected by living in homes where IPV is present (Spilsbury et al., 2008; Wasilewski et al., 2010). Further, our findings are in line with prior research, which has shown that children who live in homes where IPV is present can exhibit higher levels of both internalizing and externalizing mental health problems (Grych et al., 2000; Jaffe & Sudermann, 1995). The current study extends these findings to LA aggression as a form of IPV, and indicates that LA aggression can contribute to children's maladjustment beyond other forms of IPV occurring in the parental relationship.

As with the male victims themselves, this unique association between LA aggression victimization among their fathers and the children's mental health is a new finding, and we recommend that future researchers explore the mechanisms through which this association operates. For example, potential mediators include the

TABLE IV. Hierarchical Regression Analysis Summary for Threatened and Actual Legal/Administrative Aggression Predicting Mental Health Among School-Aged Children (6–18)

Step	Predictor	*B*	*SE*	*β*	*t*	*P*	ΔR^2
	Affective disorder symptoms						
	Threatened LA aggression ($N = 286$)						
1	Age of child	0.20	0.06	0.17	3.10	0.002	0.051**
2	Other childhood adversity (TIHSH score)	0.14	0.04	0.20	3.38	0.001	0.071***
3	# of types of sexual aggression between parents	0.43	0.15	0.17	2.92	0.004	0.047**
	# of types of severe psychological aggression between parents	0.17	0.17	0.07	0.97	0.331	
	# of types of controlling behaviors between parents	0.02	0.10	0.01	0.18	0.855	
	# of types of physical aggression between parents	−0.05	0.08	−0.04	−0.61	0.540	
4	# of types of female-to-male threatened LA aggression	0.35	0.14	0.16	2.56	0.011	0.019*
	Actual LA aggression ($N = 288$)						
1	Age of child	0.20	0.06	0.18	3.20	0.002	0.049**
2	Other childhood adversity (TIHSH score)	0.14	0.04	0.20	3.38	0.001	0.072***
3	# of types of sexual aggression between parents	0.40	0.15	0.16	2.68	0.008	0.045**
	# of types of severe psychological aggression between parents	0.23	0.17	0.09	1.36	0.174	
	# of types of controlling behaviors between parents	0.08	0.10	0.05	0.79	0.433	
	# of types of physical aggression between parents	−0.06	0.08	−0.05	−0.84	0.401	
4	# of types of female-to-male actual LA aggression	0.23	0.11	0.12	2.04	0.042	0.012*
	Anxiety disorder symptoms						
	Threatened LA aggression ($N = 289$)						
1	Other childhood adversity (TIHSH score)	0.06	0.03	0.14	2.22	0.027	0.038*
2	# of types of sexual aggression between parents	0.24	0.11	0.14	2.31	0.022	0.037*
	# of types of severe psychological aggression between parents	0.01	0.11	.00	0.04	0.967	
	# of types of controlling behaviors between parents	0.09	0.07	0.08	1.20	0.232	
3	# of types of female-to-male threatened LA Aggression	0.08	0.10	0.06	0.87	0.386	0.002
	Actual LA aggression ($N = 291$)						
1	Other childhood adversity (TIHSH score)	0.06	0.03	0.13	2.07	0.039	0.038*
2	# of types of sexual aggression between parents	0.23	0.10	0.14	2.21	0.028	0.037*
	# of types of severe psychological aggression between parents	0.01	0.11	0.01	0.10	0.924	
	# of types of controlling behaviors between parents	0.09	0.07	0.09	1.38	0.169	
3	# of types of female-to-male actual LA Aggression	0.13	0.08	0.10	1.62	0.107	0.008
	Conduct disorder symptoms						
	Threatened LA aggression ($N = 289$)						
1	Age of child	0.23	0.09	0.14	2.62	0.009	0.046**
2	Other childhood adversity (TIHSH score)	0.37	0.06	0.37	6.73	<0.001	0.175***
3	# of types of sexual aggression between parents	0.45	0.20	0.13	2.26	0.024	0.029*
	# of types of severe psychological aggression between parents	0.26	0.22	0.07	1.18	0.239	
	# of types of controlling behaviors between parents	0.01	0.14	0.00	0.05	0.961	
4	# of types of female-to-male threatened LA Aggression	0.22	0.19	0.07	1.17	0.243	0.004
	Actual LA Aggression ($N = 291$)						
1	Age of child	0.22	0.09	0.14	2.62	0.009	0.044**
2	Other childhood adversity (TIHSH score)	0.37	0.06	0.37	6.60	<0.001	0.176***
3	# of types of sexual aggression between parents	0.42	0.20	0.12	2.13	0.034	0.028*
	# of types of severe psychological aggression between parents	0.27	0.21	0.08	1.28	0.202	
	# of types of controlling behaviors between parents	0.03	0.13	0.02	0.26	0.792	
4	# of types of female-to-male actual LA Aggression	0.24	0.15	0.09	1.61	0.109	0.007
	Oppositional defiant disorder						
	Threatened LA aggression ($N = 286$)						
1	Other childhood adversity (TIHSH score)	0.09	0.03	0.20	3.31	0.001	0.076**
2	# of types of sexual aggression between parents	0.25	0.10	0.15	2.55	0.011	0.045**
	# of types of severe psychological aggression between parents	0.09	0.12	0.05	0.77	0.441	
	# of types of controlling behaviors between parents	−0.04	0.07	−0.04	−0.54	0.589	
	# of types of physical aggression between parents	0.05	0.05	0.06	0.89	0.375	
3	# of types of female-to-male threatened LA aggression	0.23	0.10	0.16	2.53	0.012	0.020*
	Actual LA aggression ($N = 288$)						
1	Other childhood adversity (TIHSH score)	0.09	0.03	0.20	3.33	0.001	0.076**
2	# of types of sexual aggression between parents	0.23	0.10	0.14	2.30	0.022	0.042*
	# of types of severe psychological aggression between parents	0.13	0.11	0.08	1.18	0.237	
	# of types of controlling behaviors between parents	0.00	0.07	0.00	0.05	0.964	
	# of types of physical aggression between parents	0.03	0.05	0.04	0.58	0.564	

continued

TABLE IV. (Continued)

Step	Predictor	*B*	*SE*	β	*t*	*P*	ΔR^2
3	# of types of female-to-male actual LA aggression	0.16	0.08	0.13	2.16	0.032	0.014*
	Somatic Symptoms						
	Threatened LA aggression ($N = 289$)						
1	Age of child	0.08	0.04	0.12	2.06	0.040	0.026*
2	Other childhood adversity (TIHSH score)	0.08	0.03	0.19	3.15	0.002	0.056**
3	# of types of sexual aggression between parents	0.19	0.10	0.12	1.97	0.050	0.023
	# of types of severe psychological aggression between parents	0.01	0.10	0.01	0.10	0.921	
	# of types of controlling behaviors between parents	0.04	0.06	0.04	0.61	0.540	
4	# of types of female-to-male threatened LA aggression	0.11	0.09	0.08	1.30	0.196	0.005
	Actual LA Aggression ($N = 291$)						
1	Age of child	0.09	0.04	0.12	2.09	0.037	0.025*
2	Other childhood adversity (TIHSH score)	0.08	0.03	0.19	3.12	0.002	0.057**
3	# of types of sexual aggression between parents	0.17	0.10	0.11	1.83	0.068	0.023
	# of types of severe psychological aggression between parents	0.02	0.10	0.02	0.24	0.812	
	# of types of controlling behaviors between parents	0.06	0.06	0.06	0.92	0.356	
4	# of types of female-to-male actual LA aggression	0.08	0.07	0.06	1.10	0.271	0.004

*$P < .05$; **$P < .01$; ***$P < .001$.

parent-child relationship or how much contact the children have with their fathers, both of which have been important in research concerning children whose parents are involved with the family court system (Holroyd & Sheppard, 1997; Pruett & Pruett, 1999). Another potential mediating variable may be parents engaging in behavior that contributes to children feeling alienated from one or both parents (see Johnston, Roseby, & Kuehnle, 2009), such as parents making negative comments to children about the other parent, threatening to remove the child from the home, or using tactics to control the child's behavior (Amato & Afifi, 2006; Hauser, 1985; Kurkowski, Gordon, & Arbuthnot, 1993). Another future step would be to explore the extent to which children are aware of the LA aggression occurring against their fathers and how that exposure may impact their mental health. Depending on whether children were directly exposed to certain forms of LA aggression, such as hearing arguments or knowing that their mother used legal or administrative resources to control or inflict harm on their father, could change the way LA aggression impacts a child's mental health.

We should note that the effect sizes for the unique association between LA aggression victimization and the mental health problems in male IPV victims and their children were small, explaining from 0.9%–2.0% of the non-shared variance in the participants' and their children's mental health symptoms. However, these effect sizes represent the unique influence of LA aggression victimization on the mental health outcomes, after controlling for other forms of traumatic and adverse experiences, and after controlling for all other forms of IPV in the home. Prior research shows that LA aggression victimization is highly correlated with other forms of IPV victimization among male IPV victims (Hines et al., 2014).

Limitations

This paper has some limitations that should be addressed in future research. First, only male victims were used to obtain data on both victimization and perpetration of IPV in their most recent abusive relationship. This can lead to shared method variance, which may cause inflated correlations because the same person reported on all scales in the study. In addition, it is also possible that there was a bias, wherein male victims were more likely to under-report instances of IPV perpetration. Typically, studies have shown a tendency for individuals to under-report in the case of their own undesirable behaviors, but not those of their partner (Woodin, Sotskova, & O'Leary, 2013). However, individuals have also been shown to under-report in relation to their partner's behavior due to feelings of embarrassment or humiliation about being abused (Follingstad & Rogers, 2013). All participants were guaranteed anonymity and this cautionary measure is likely to have mitigated under-reporting. Nonetheless, future research should strive to obtain information from multiple informants, and also pursue further research into how LA aggression can potentially manifest for female victims.

Second, the men in this study reported about their eldest minor-aged child. Research has rarely gathered child-based information from fathers because there is concern that fathers are not engaged enough with their children to be accurate assessors or reporters of their children's behavior and concerns, especially if their children do not live with them all of the time (Treutler &

Epkins, 2003). Previous research has shown that fathers may rate their children differently than mothers using the CBCL (Achenbach & Rescorla, 2001b), yet several studies show that fathers are as reliable and sometimes even more reliable as reporters than the child's mother (V. Phares, 1997; Van Hasselt, Ammerman, Hersen, & Reigel, 1991). Increasingly, researchers are calling to include fathers as informants of children's well-being (V. Phares, Fields, Kamboukos, & Lopez, 2005), which is what we have done in this study. Further, in the current study, the internal consistency of the CBCL scales were good, suggesting that fathers were reliable reporters of their children's mental health. In addition, the associations between the CBCL subscales and the various types of adversity assessed reflected what was predicted in terms of both the strength and direction of these associations, further supporting the validity of the men's reports on the CBCL.

Third, the current study only included men who sought help for IPV in their relationship, and therefore the results cannot necessarily be generalized to men who do not seek help, those who seek help through resources not included in the current study, or who may have sought help but do not wish to participate in research studies. Given that many men are reluctant to seek help for IPV, it can be difficult to obtain a more representative sample of male victims (Hines & Douglas, 2011b). However, future research should strive to include male IPV victims who seek help from a variety of sources and those who do not seek help at all.

A final limitation is that because this is a cross-sectional study we cannot draw causative conclusions about the effect of LA aggression on mental health issues. Without longitudinal designs, we cannot know whether LA aggression causes mental health problems in male victims and their children, whether having mental health problems makes men more vulnerable to LA aggression, or whether a third variable mediates the relationship between LA aggression and mental health problems in male victims and their children.

Implications for Practice

The results of this study carry important implications for practitioners. For example, it is important for men suffering from actual LA aggression to gain access to appropriate mental health treatment to address possible symptoms of PTSD and depression. Despite the availability of effective clinical treatments for a range of mental health issues (USDHHS, 1999), men have a low rate of help-seeking for mental health issues (USDHHS, 2002). A variety of contextual factors may be associated with why men are resistant to seek professional help (Addis & Mahalik, 2003), but these barriers include the need for control and self-reliance, minimizing the problem, concrete barriers to care, and privacy (Mansfield, Addis, & Courtenay, 2005). In the case of men suffering from LA aggression, it is important to understand the array of factors and barriers they may experience in seeking help from different sources of informal and professional help. Thus, devising effective modes of outreach to male victims is important.

Prior research on the factors associated with help-seeking for IPV related issues is associated with defining the problem, deciding to seek help, and selecting a source of support (Liang, Goodman, Tummala-Narra, & Weintraub, 2005). Individual, interpersonal, and sociocultural factors influence all of these stages of help-seeking. The sociocultural considerations in the case of male victims are particularly complex given the inherent bias found among both mental health professionals and the wider cultural context wherein men are often not recognized as victims of IPV (Cook, 2009; Follingstad, DeHart, & Green, 2004; Taylor & Sorenson, 2005). As a result there are not many outlets for male victims of IPV to seek help (Hines & Douglas, 2011a). Professionals in both the legal and mental health fields should become more aware of the issues surrounding male victims of LA aggression in order to identify the problem and provide needed mental health services for men and children when required. In the case of children, behavioral and mental health issues may manifest in school as well, and therefore, school psychologists and other professionals who have contact with children outside the home should also be aware of the implications of LA aggression.

Last, it is important to consider how men may be vulnerable to LA aggression in certain contexts, such as within particular administrative or legal contexts (Follingstad et al., 2005; McHugh et al., 2013). Men are likely to be fearful of threats of LA aggression perpetrated by their female partner because they may feel helpless to combat false allegations or other efforts by their female partner to gain custody of the children or demean them in a public forum (Cook, 2009). This could result in women threatening LA aggression in order to maintain control over their male partner while still in the relationship, and potentially make men less likely to leave an abusive relationship (Hines & Douglas, 2010b). Therefore, it is important to consider LA aggression for both men and women in conjunction with potential biases pertaining to IPV victimization and perpetration (Follingstad et al., 2005; McHugh et al., 2013). In the case of male victims, it may be important to determine whether interpretation of standing family policy and practice guidelines in any way contribute to men's experiences with LA aggression.

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ORIGINAL ARTICLE

The Helpseeking Experiences of Men Who Sustain Intimate Partner Violence: An Overlooked Population and Implications for Practice

Emily M. Douglas · Denise A. Hines

Abstract For over 30 years, research has shown that men can and do sustain intimate partner violence (IPV) from their female partners. This is the first large-scale, nationally-based, quantitative study to systematically detail the helpseeking experiences of men who have sustained IPV from their female partners. The sample is composed of 302 men who were recruited from resources specializing in men's issues. Results indicate that men who seek help for IPV victimization have the most positive experiences in seeking help from family/friends, and mental health and medical providers. They have the least positive experiences with members of the DV service system. Cumulative positive helpseeking experiences were associated with lower levels of abusing alcohol; cumulative negative experiences were associated with higher rates of exceeding a clinical cut-off for post-traumatic stress disorder. Results are discussed in terms of implications for the social service sector and for future research.

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Intimate partner violence (IPV), which includes physical, sexual, and psychological maltreatment of one partner against another, is a national social and health problem affecting hundreds of thousands of individuals and families a year (Centers for Disease Control 2006; Tjaden and Thoennes 2000). Most nations pay considerably more attention to and provide services for male-to-female IPV (National Center for Injury Prevention and Control 2003; World Health Organization 2005) than other types of IPV, even though for 35 years, research has consistently documented that men are often the targets of female-perpetrated IPV (Gelles 1974; Hines and Malley-Morrison 2001; Straus 2004b). Qualitative research of helpseeking among men sustaining IPV indicates that the domestic violence (DV) service system is not always able to provide them services and that many men are actually turned away (Cook 2009; Hines et al. 2007).

These qualitative studies have made important contributions to the field, but no study has systematically quantitatively examined the experiences of men seeking help for IPV. It is also unknown if positive or negative helpseeking experiences have implications for the male helpseeker's mental health. This study is the first quantitative study to employ a large sample, in that it is a U.S. national-based examination of the helpseeking experiences of men who have sustained, or been victimized by, IPV from their female partners. We document where such men seek help, how their requests for help are received and the correlations between positive and negative helpseeking experiences and their mental health status.

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IPV Against Men by Female Partners

Incidence reports of women physically aggressing toward their male partners have appeared since the study of IPV began in the early to mid-1970s (Gelles 1974). Recently, crime statistics from the Department of Justice (DOJ) showed that in 2004, 1.3 per 1,000 men were physically assaulted by an intimate partner, most of whom were women, which represents 20% of all IPV victims that year. In contrast to the 61% decline of reported physical IPV toward women between 1993 and 2004, the rates of IPV toward men only declined 19% (Catalano 2007). In the 1995–96 National Violence Against Women Survey, 0.8% of men reported being physically assaulted by an intimate partner in the previous year (Tjaden and Thoennes 2000), which represented approximately 40% of all IPV victims during that time period. The highest rates of physical, sexual, and psychological IPV against both men and women have been found in national studies of family conflict, such as the 1975 and 1985 National Family Violence Surveys (NFVS) and the 1992 National Alcohol and Family Violence Survey (Straus 1995). After controlling for age and SES, minor physical assaults (e.g., slapping, pushing) by females toward male partners occurred at a rate of 75 per 1,000 in 1975 and 1985, and then increased to 95 per 1,000 in 1992. Rates of severe physical assaults (e.g., punching, beating up) by females toward male partners remained constant at 45 per 1,000 in all study years, which projected into approximately 2.6 million men per year who sustained physical IPV that had a high likelihood of causing an injury (Straus and Gelles 1988). Consistent with the DOJ studies, in contrast to declining rates of male-to-female physical IPV, female-to-male physical IPV remained stable over the 17-year period that spans the time between the 1975 and 1992 surveys (Straus 1995).

Men Who Seek Help for IPV Victimization

Despite over 30 years of research documenting that men can sustain female-perpetrated physical, sexual, and psychological IPV, these findings remain controversial. Those that are especially controversial are statistics showing that women report using physical IPV at equal or higher rates than men, a finding that has been replicated in dozens of studies (Archer 2000). This finding of a high rate of violence by female partners has been challenged primarily on conceptual bases because it is inconsistent with the dominant theoretical perspective of the cause of IPV: the patriarchal construction of our nation (Ferraro and Johnson 1983; Marshall 1992; Miller and White 2003). This controversy may help explain why men may face difficulties when seeking help for IPV victimization.

The literature on male helpseeking, in general, indicates that men are less likely than women to seek help and that men who do seek help must overcome internal and external obstacles to do so (Galdas et al. 2005). Men are not likely to seek help for problems that their larger community deems non-normative or determines that they should be able to solve or control themselves (Addis & Mahalik, 2003). When seeking help for any type of IPV victimization, one can imagine that the obstacles must be great, given our gendered notions of male and female roles in heterosexual relationships (Lye and Biblarz 1993; Sweeney 2007) and the framing of IPV as a women's issue (Arndt 1982; Walker and Browne 1985).

Qualitative research has documented the experiences of men who seek help for female-to-male IPV (Cook 2009; Hines et al. 2007). For example, Cook (2009) performed in depth interviews of 30 men who sustained all types of IPV from their female partners and tried to seek help. This work shows that men often experience barriers when seeking help. When calling domestic violence hotlines, for instance, men who sustained all types of IPV report that the hotline workers say that they only help women, infer or explicitly state that the men must be the actual instigators of the violence, or ridicule them. Male helpseekers also report that hotlines will sometimes refer them to batterers' programs. Some men have reported that when they call the police during an incident in which their female partners are violent, the police sometimes fail to respond. Other men reported being ridiculed by the police or being incorrectly arrested as the primary aggressor. Within the judicial system, some men who sustained IPV reported experiencing gender-stereotyped treatment. Even with apparent corroborating evidence that their female partners were violent and that the helpseekers were not, they reportedly lost custody of their children, were blocked from seeing their children, and were falsely accused by their partners of IPV and abusing their children. According to some, the burden of proof for male IPV victims may be especially high (Cook 2009).

The qualitative experiences of male victims of IPV needs to be expanded to also quantitatively document the experiences of men who seek assistance from the DV service system, how many who seek help receive it, and whether or not this help is adequate. There is also little research on reactions of the medical or mental health professions to men who sustain any type of IPV, and there is no information concerning the implications to male helpseekers' mental health when they encounter barriers such as the ones described above.

Mental Health Concerns and Helpseeking Experiences

The experience of IPV is generally considered to be a traumatic event, and many men who sustain IPV and seek

help view their IPV experiences as traumatic (Cook 2009). People who experience traumatic events are at increased risk for a range of psychological disorders, with the more common types of traumatic responses including symptoms of post-traumatic stress disorder (PTSD) and alcohol/substance abuse (American Psychiatric Association 1994). Research has documented that that among battered women, about 30–60% evidence PTSD (Astin et al. 1993; Cascardi et al. 1995; Gleason 1993; Saunders 1994) and that greater severity of IPV experiences among men is associated with increased PTSD symptoms (Hines 2007; Hines and Malley-Morrison 2001). Our previous research has established that male helpseekers for IPV victimization are indeed at-risk for high levels of PTSD symptoms (Hines and Douglas 2010b); in fact, almost 60% of the men in our sample exceeded a clinical cut-off for PTSD.

Alcohol and substance abuse are also common means of coping with the experience of a traumatic event. Stress-coping models of alcohol and substance use suggest that increases in the use of these substances may be associated with the psychological sequelae of a traumatic experience (Jacobsen et al. 2001; Simons et al. 2005; Stewart 1996) Indeed, research consistently shows that victims of IPV have higher rates of alcohol and substance abuse than non-victims (Stewart 1996).

In addition to the IPV incident itself contributing to symptoms of PTSD and alcohol/substance abuse, it is also possible that the experiences that the victim has when seeking help can either ameliorate or further exacerbate the victim's mental health issues. Dobash and Dobash (1984) first commented on how important third party responses were to battered women seeking help—if that third party responds to her request for help in a manner that implicitly blames her for the abuse or implies that she in some way caused the abuse, that third party is also implicitly justifying the abuser's behavior, further isolating the victim, and leaving her vulnerable to further attacks. Renzetti's (1989) work on battered lesbians showed that third party responders were critical as well—the less helpful the third party was, the longer the victim stayed with her abuser; victims also reported that because many third parties were reticent to label her situation "battering", it left her confused, despairing, and frustrated. However, no studies, to our knowledge, have investigated the association between these helpseeking experiences and levels of PTSD symptoms and alcohol/substance abuse, and no one has studied these associations among male helpseekers.

The research that we have reviewed in this paper clearly suggests that men who sustain female-to-male IPV do seek help, and that when they seek help, these experiences are often negative. The extant research on this topic, however, has primarily been conducted on small samples, using qualitative methods, or methods that were not systematic. We studied men's experiences with helpseeking using a U. S. national-based, large-scale study with consistent methodologies. In this paper, we have also reviewed research which has documented that men who experience IPV often have lower levels of mental health; this research has not, however, examined the relationship between helpseeking experiences and mental health status. We also address this gap in the literature by mapping men's experiences with seeking help onto their mental health status, while also controlling for other important life events. The research questions for this paper address:

1. Where do men who have sustained IPV from their female partners seek help?
2. How helpful are these resources?
3. What types of experiences do the helpseekers have with each of these resources?
4. Do helpseekers have more positive or negative experiences when seeking help?
5. Is the nature of helpseeking experiences related to the mental health status (as measured by PTSD and alcohol/substance abuse) of male helpseekers, even after controlling for variables measuring demographics and other life experiences?

As the first of its kind, this study is exploratory in nature. That said, the research already reviewed in this paper provides enough of a foundation for advancing some hypotheses about these research questions. It is unknown where men seek help for IPV victimization, but research does suggest that men will largely have negative experiences in trying to seek help. We also know that men who experience IPV victimization have a number of mental health concerns, and that negative experiences when seeking help can further isolate victims and keep them in an abusive relationship for longer periods of time; these negative experiences may also be viewed as traumatic. Thus, it is likely that positive helpseeking experiences would be associated with better mental health, whereas negative helpseeking experiences would be associated with poorer mental health.

These questions will be examined on a sample of 302 men who sought help for female-perpetrated physical, sexual, and psychological IPV victimization and who were physically assaulted by their partners in the previous year. The violence that the men in this sample sustained has been reported in detail in other papers (Hines and Douglas 2010a, b). A brief summary is provided here to orient the reader to the nature of the sample and of the types of IPV experiences reported by the study participants . The men in our study sustained serious violence: 96.0% reported sustaining severe psychological aggression in the past year (e.g., threats to physically harm the man or someone he cares about; destroying something belonging to him),

93.4% reported controlling behaviors (e.g., monitoring his time and whereabouts; not allowing him access to household income; isolating him from family/friends), 98.7% reported minor violence (e.g., pushing, shoving), 90.4% severe violence (e.g., punching, kicking) and 54.0% very severe violence (e.g., beating up, using a knife/gun). Of the men who reported each of these types of IPV, severe psychological aggression was sustained a mean number of 28.90 times in the previous year, controlling behaviors 42.62 times, minor violence 32.01 times, severe violence 16.74 times, and very severe violence 7.46 times. The assaults often led to injuries: 77.5% of the sample reportedly experienced minor injuries (e.g., bruise or cut) in the past year and 35.1% experienced severe injuries (e.g., broken bone, needing medical attention).

Method

Sample and Procedure

The methods for this study were approved by the boards of ethics at the participating institutions. All of the men participated anonymously, were apprised of their rights as study participants, and gave their consent to participate before data collection was initiated. Steps were also taken to ensure their safety. At the completion of the survey the participants were given information about obtaining help for any type of IPV victimization and how to delete the history on their Internet web browser.

In order to participate, the men had to speak English, live in the U.S., and be 18–59 years old. To reduce costs of survey administration, we required that the men speak English. We sought men who were between the ages of 18–59 because reporting laws in various states would require us to report instances of child abuse (i.e., victims under 18 years of age) and elder abuse (i.e., victims over 59 years of age), and we wanted the survey to remain anonymous and free from any reporting clauses in the consent process, so that participants would feel comfortable being honest in their reporting. We restricted our sample to U.S. residents so that we could understand the experiences of men in a single nation.

Furthermore, to increase accurate recall of the IPV in the relationship and to be consistent with previous studies of IPV (e.g., (Straus 2004a), we required that the men had to have been involved in an intimate relationship with a woman in the previous year lasting at least one month. We also required that they sustained a physical assault from their female partner within the previous year. We required a physical assault because that is an objective indicator of IPV that is considered illegal under U.S. law. We restricted our sample to men in relationships with women because our focus is on men in heterosexual relationships and their experiences might differ from men seeking help for IPV in gay relationships. Finally, so that we can report on their experiences when seeking help, we required that the men sought help for their IPV victimization. Helpseeking included seeking help from formal sources—hotlines, DV agencies, the police, mental and medical health professionals, lawyers, and ministers—and informal sources, such as friends/family and the Internet.

The sample was recruited from multiple sources, including the Domestic Abuse Helpline for Men and Women (DAHMW), a national helpline specializing in men who sustain IPV; through ads on online websites, newsletters, blogs, and listservs that specialize in IPV, male IPV victims, fathers' and divorced men's issues, men's health, men's rights; and through a description of the study on the Wikipedia page about domestic violence. Potential participants were told and advertisements stated: "Researchers at Clark University are conducting a new study on men who experience physical aggression from their female girlfriends, wives, or partners. If you are a man between the ages of 18–59, have experienced physical aggression from your partner within the past 12 months, and have sought help for this problem, you may be eligible to participate in this study. We invite you to follow this link to complete an Internet survey."

Callers to DAHMW, who had received assistance from the helpline staff and who met the eligibility criteria were invited to participate in the study by calling a survey research center to complete an interview over the phone with a trained telephone interviewer at the research center, or by visiting the study website to complete the anonymous questionnaire online. Screener questions regarding the study criteria were on the first page of the survey, and men who were eligible were allowed to continue with the survey.

Men who did not meet the eligibility requirements were thanked for their time and were redirected to an "exit page" of the survey. Data were collected between December 2007 and January 2009. Sixteen participants completed the survey via telephone with the survey interviewers, while the vast majority, 286, completed the online version of the study. The helpseekers in this study participated anonymously; thus, we did not provide them with compensation, nor did we seek verification regarding the information that they reported.

The sample consisted of 302 men from 45 states who sought help after sustaining IPV from their female partners. Table 1 displays their characteristics. The average age was 40. This sample was well educated, with almost half having a college degree or higher; their mean income was $50,439.

Table 1 Demographic characteristics of sample (n=302)

Characteristic	*M* (*SD*) or%
Age	40.49 (8.97)
Income	$50,439 ($25,693)
Disabled	13.6
Education	
High school or less	8.7
Some college/2-yr degree	42.4
College degree	34.3
Graduate degree	14.7
Occupational Status[1]	6.7
Race/Ethnicity (respondents could choose more than one category)	
American Indian/Native American	2.0
Asian American/Pacific Islander	4.3
African American/Black	6.0
Euro American/White	86.8
Hispanic/Latino	5.0
Length of relationship in years	8.16 (6.84)
Type of relationship	
Dating/Former dating partner	10.9
Engaged/Formerly engaged	6.0
Cohabiting/Formerly cohabiting	12.3
Married	45.7
Separated/Divorced	24.9
Mental Health Status	
PCL Total Score	45.56 (14.2)
Met cut off for PTSD	57.9
Abused alcohol	17.9
Abused drugs	21.5

[1] Occupational Code: 1 = Elementary occupations, 2 = Plant and machine operators and assemblers, 3 = Craft and related trades workers, 4 = Skilled agricultural and fishery workers, 5 = Services workers and shop and market sale workers, 6 = Clerks, 7 = Technicians and associate professionals, 8 = Professionals, 9 = Legislators, senior officials, managers.

Their occupational status was 6.7, where 1 = elementary occupations and 9 = legislators, senior officials, management; the mean value for this variable roughly corresponds to a technician or associate professional. The sample had limited ethnic and racial diversity, with 16.2% of the sample identifying with a minority group. Furthermore, 13.6% of the sample positively endorsed the question "Are you disabled?" The helpseekers were in relationships lasting a mean of 8 years. About 75% were or had been married to the partner who used IPV against them. About half were currently still in the relationship; the rest had ended the relationship within the past year. Almost 75% reported that minor-aged children were a part of the relationship. More information about this sample can be found in previously published papers on this study and dataset (Hines and Douglas 2010a, b).

Measures

The survey contained questions about demographics, aggressive behaviors that both partners may have used, risk factors, and mental health. Helpseeking questions focused on where they sought help, that resource's helpfulness, and follow-up questions specific to each resource. Only the variables that are relevant to this present paper are reported here. For additional information about this study, please see other, previously published papers (Hines and Douglas 2010a, b; Hines et al. 2010).

Demographic Information Men were asked basic demographic information about themselves including age, race/ethnicity, personal income, education, and occupational status. Men were also asked about the current status of their relationship, the length of their relationship with their partners, and if minor children were involved in the relationship.

Helpseeking Questions These questions in this section were developed by the authors and were based on the literature (e.g., Cook 2009) and previous research by the second author (Hines et al. 2007). Men were asked if they had sought help from a variety of resources including DV agencies, DV hotlines, police, medical and mental health professionals, and online sources of support. We also asked about talking with friends, family, clergy, and attorneys. For each of the sources used, we asked about the helpfulness of the resource, where 1 = not at all helpful, 2 = somewhat helpful, and 3 = very helpful. We also asked follow-up questions that were specific to each resource. For helpseekers who used a DV agency and/or hotline, we asked if they were told that the resource only helps women, if they were accused of being the batterer in the relationship, and/or if they were given the impression that the staff was biased against men. For men who saw a mental health practitioner, we asked if the provider took their concerns seriously and if they were given information about how to get help for IPV. For men who sought help from police, we asked about how the police handled the complaint; who, if anyone, was arrested; and if the partner was determined to be the primary aggressor. For the DV agency, DV hotline, and police questions, helpseekers were able to provide qualitative accounts in open-ended text boxes regarding their experiences. We specifically asked them to provide information that was not already captured by the available response options. All open-ended answers were coded independently by two upper-level undergraduate research

students using thematic analysis. Any discrepancies in coding were resolved by the second author.

Posttraumatic Stress Symptoms The *PTSD Checklist (PCL)* (Weathers et al. 1993) is a 17-item self-report that measures PTSD symptomology and reflects three symptom clusters: re-experiencing, numbing/avoidance, and hyperarousal. Participants were asked to think about their worst argument with their female partner, and then indicate the extent to which they were bothered by each symptom in the preceding month, where 1 = not at all and 5 = extremely. The items were summed to create a single score of PTSD symptoms and then dichotomized to indicate the likely presence or absence of PTSD. Although there is currently debate regarding the exact cut-off score that is possibly indicative of PTSD (e.g., suggestions range from 44 to 50), we chose a cut-off score of 45 that was used in a study of breast cancer patients (Andrykowski et al. 1998). It is important to also note that Ruggiero et al. (2003) found little differences in the diagnostic efficiency of these various cut-points using a civilian sample. One item, "Feeling as if your future will somehow be cut short", was not included in the survey because, during the pilot testing of the instrument, interviewees reported that they did not understand the item. The PCL has been validated for use in both combat and civilian populations, and the civilian version was used for this study. The *PCL* has been shown to have excellent reliability (Weathers et al. 1993) and strong convergent and divergent validity (Blanchard et al. 1996; Ruggiero et al. 2003). Furthermore, the *PCL* has been shown to have high diagnostic utility (.79–.90) when validated against "gold standard" measures such as the Structured Clinical Interview for DSM-IV Axis Disorders (First et al. 1996). The reliability for the total scale for this sample was α=.92. The mean for this sample was 46.56, with 57.9% of the sample meeting the clinical cutoff for PTSD.

Alcohol and Drug Abuse Past-year alcohol and drug abuse were measured using a scale developed for the National Women's Study to assess the association between IPV victimization and alcohol/drug abuse among female victims (Kilpatrick et al. 1997). The scale included up to 19 items asking respondents about their use and abuse of alcohol and illicit drugs (i.e., marijuana, cocaine, methamphetamines, crack, LSD, heroin, or other such drug) in their lifetimes and in the past year, and included items regarding negative experiences resulting from alcohol abuse. Consistent with Kilpatrick et al.'s (1997) guidelines for scoring this scale, we measured alcohol abuse within the past year by an indicator that approximated the diagnostic criteria for the *Diagnostic and Statistical Manual of Mental Disorders IV* (American Psychiatric Association 1994): Participants who answered affirmatively to any of the six questions on negative experiences (e.g., getting in trouble with the police, family, or a boss) within the past year because of alcohol were classified as meeting the criteria for alcohol abuse in the past year, which was 17.9% of the sample. Similarly, according to the guidelines established by Kilpatrick et al. (1997), drug abuse was measured by an indicator that approximates the frequency of usage considered significant by the Diagnostic Interview Schedule substance abuse screen (Robins et al. 1988). If participants indicated they used any illegal drugs more than 4 times in the past year, they were considered nonexperimental users/drug abusers, which was 21.5% of the sample. Because of the nature of the questions on this scale (screener questions and largely dichotomous answer choices), reliability cannot be calculated; however, this scale has demonstrated excellent construct validity (Kilpatrick et al. 1997).

Traumatic Experiences Our outcome variables of alcohol abuse, substance abuse, and PTSD can be the result of many traumatic experiences (Jacobsen et al. 2001; Stewart et al. 1998); thus, we controlled for various traumatic events, including being injured by a partner, childhood violent socialization, and childhood sexual abuse. Injury was measured via the injury scale of the *Revised Conflict Tactics Scales (CTS2)* (Straus et al. 1996). This scale includes 6 items assessing both minor (e.g., having a cut or bruise) and severe injuries (e.g., broken bone, passing out). Participants responded by indicating the number of times injuries occurred to them in the previous year (0 = 0 times; 1=1 time; 2 = 2 times; 3 = 3–5 times; 4 = 6–10 times; 5 = 11–20 times; 6 = more than 20 times). These data were then dichotomized into a single variable where 1 = sustained injury in past year from partner and 0 = no injury in past year.The reliability of the frequency scale for the men in this sample was α=.73.

The remaining items measuring traumatic experiences were measured using items from two scales of the *Personal and Relationships Profile* (*PRP*) (Straus and Mouradian 1999). Childhood Violent Socialization was measured with two items from the *Violent Socialization Scale* of the PRP. Participants were asked the extent to which they agreed or disagreed (1 = strongly disagree, 4 = strongly agree) with each statement: "When I was less than 12 years old, I was spanked or hit a lot by my mother or father" and "When I was a kid, I saw my mother or father kick, punch, or beat up their partner." These two items were summed (Range: 2–8, M=4.12). Finally, two items from the *Sexual Abuse History Scale* of the PRP were used to measure childhood sexual abuse. Participants were asked the extent to which they agreed or disagreed (1 = strongly disagree, 4 =

strongly agree) with each statement: "Before I was 18, a family member did things to me that I now think might have been sexual abuse" and "Before I was 18, someone who was not part of my family did things to me that I now think might have been sexual abuse." These two items were summed (Range: 2–8, M=2.94). Both of these scales have demonstrated adequate validity and reliability, with overall alphas of .73 (*Violent Socialization* Scale) and .76 (*Sexual Abuse History Scale*) (Straus and Mouradian 1999).

Results

Where Do Men Seek Help?

Table 2 shows that men seek help for IPV victimization from a variety of resources. They sought assistance through informal types of support (84.9%), namely through friends/neighbors, relatives/parents and also the more formal support of (male) attorneys. Two-thirds of the men also used the informal resource of online support. Follow-up questions concerning the type of online resource they used last indicated that over half of the men (53.8%) used a website that provided information/support, and almost one-quarter (23.8%) used an online support group. On-line resources that were less frequently used included email (7.7%), blogs/message boards (7%), chatrooms (4.9%), and other web-based resources (2.8%). Overall, 44.9% used a resource that was specifically for men experiencing partner aggression, and 42.6% indicated that the resource they used was for anyone experiencing partner aggression. With regard to formal resources, two-thirds of the men sought help from a mental health professional. Almost half of the sample sought assistance from local DV agencies and police departments. Resources that were less frequently used included DV hotlines (23.4%) and medical professionals (18.1%).

Table 2 Where men seek help and the helpfulness of those resources

Type of Resource Used	% Who Used Resource	% Who Said Resource was Somewhat/Very Helpful
DV agency	43.7	44.8
DV hotline[1]	23.4	31.4
Friends/family/attorney/clergy	84.9 (total)	90.0[2]
Male friend/neighbor	76.7	
Female relative/parent	68.9	
Male relative/parent	60.9	
Female friend/neighbor	60.2	
Male lawyer	43.3	
Female lawyer	32.1	
Male minister	30.0	
Female minister	6.5	
Medical professional	18.1	78.4
Mental health professional	66.2	70.6
Online support	63.4	69.1
Police	46.3	44.0

[1] For DV hotline, n=286 people who did not report on the DAHMW, a hotline that specializes in male victims of IPV

[2] Respondents were asked: "Were *any* of these people helpful?"

Helpfulness of and Experiences with Resources

Helpfulness The men rated the helpfulness of the resources that they used on a 3-point scale (1 = not at all helpful, 2 = somewhat helpful, and 3 = very helpful). Table 2 shows that there was wide variation in satisfaction with the resources the men used. They were most satisfied with the support that they received from family and friends, followed by medical and mental health professionals. Between half and two-thirds of the men who contacted the police, a DV agency, or a DV hotline reported that these resources were "not at all helpful."

DV Hotlines, Agencies, and Online Resources Men seeking help from DV agencies, hotlines, and via the Internet answered questions that addressed the reception they received when seeking help. The results are displayed in Table 3. Between 25–33% reported being referred by a DV hotline or an online resource to a local program that was helpful. The remaining experiences were not as positive. A large proportion of those who sought help from DV agencies (49.9%), DV hotlines (63.9%), or online resources (42.9%) were told, "We only help women." Of the 132 men who sought help from a DV agency, 44.1% (n=86) said that this resource was not at all helpful; further, 95.3% of those men (n=81) said that they were given the impression that the agency was biased against men. Some of the men were accused of being the batterer in the relationship: This happened to men seeking help from DV agencies (40.2%), DV hotlines (32.2%) and online resources (18.9%). Over 25% of those using an online resource reported that they were given a phone number for help which turned out to be the number for a batterer's program. The results from the open-ended questions showed that 16.4% of the men who contacted a hotline reported that the staff made fun them, as did 15.2% of the men who contacted local DV agencies. Qualitative accounts provide a more in-depth understanding of their experiences with these resources.

> "They didn't really listen to what I said. They assumed that all abusers are men and said that I must accept that I was the abuser. They ridiculed me for not leaving my wife, ignoring the issues about what I

Table 3 Follow-up questions about experiences with specific resources

Experience with Resource	% Responding "Yes" for Each Resource		
	DV Agency (n=83)	DV Hotline (n=67)	Online Resource (n=132)
Referred to local program that has been helpful	[a]	27.0	25.8
Told: "We only help women."	78.3	63.9	42.9
Referred to batterer's program/Suggested helpseeker was batterer	63.9	32.2	18.9
Given number which turned out to be for a batterer's program	[a]	25.4	27.1

[a] Question was not asked about this resource.

would need to do to protect my 6 children and care for them." (Experience with a DV agency)
"[T]hey offered to listen if I wanted to recount what had happehed [sic], but indicated that no support services were available." (Experience with DV hotline)
"I was mostly just doing research after the occurrence [sic] to find out what I should do. I found mostly female help sites and was turned down by several so I gave up." (Experience using online resources)

Police Table 4 displays the experiences that helpseekers had with the police (n=129). Chi-square analysis found no difference between the proportion of helpseekers and partners who were arrested and those who were placed in jail. We could not conduct a chi-square analysis on those who had charges dropped because the expected count in some cells was below 5. In 54.9% of cases, the partner was determined to be the primary aggressor. Among those 62 men, 41.5% said the police asked the helpseeker if he wanted his partner arrested; 21% reported the police refused to arrest the partner, and 38.7% indicated the police said there was nothing they could do and left. The coding of the qualitative accounts found that 25.4% of the men told stories of the police doing nothing and ignoring or dismissing them. Qualitative accounts of their experiences with police include:

"They determined she was the aggressor but said since I was a man it was silly to arrest her."
"Told me to get her help. Told me to spend the night in a hotel."
"They saw mw [sic] as a large male and…took her side. I was at the hospital with bruising and burned eyes from hot coffee thrown in them. They didn't believe that she did this…and refused to arrest her… The next incident…the police…saw me bleeding they charged her with felony DV but later dropped it to misdemeanor assault because we are not married and do not live together."

Table 4 Follow-up questions about experiences with police (n=129 who called the police)

Item	Partner	Helpseeker	χ^2
Police arrested	26.5	33.3	0.83
Of those arrested:	n=35	n=43	
Placed in jail	81.8	88.4	[a]
Charges dropped	50.0	41.5	0.05

[a] The expected count for some of the cells was <5 and a chi-square analysis could not be performed.

Mental and Physical Health Resources Of the 198 men who sought help from a mental health professional, 68.0% reported that the mental health professional took their concerns seriously. Only 30.1% stated the mental health professional provided them with information about getting help for IPV. A smaller number, n=54, ever sought help from a medical provider (even though 106 men reported experiencing a severe injury in the previous year). Of those using this resource, 91.8% indicated that the medical provider asked how they obtained their injuries; 60.4% of the men reported that they were truthful when answering this question, and 14% reported receiving information from the medical provider about getting help for IPV.

Cumulative Helpseeking Experiences and Relationship to Mental Health Status

We created a scale that captured positive and negative helpseeking experiences so that we could investigate how cumulative positive or negative helpseeking experiences might be related to the men's mental health status. As a reminder to the reader, helpseeking experiences were rated as 1 = very helpful, 2 = somewhat helpful, and 3 = not at all helpful. To assess cumulative experiences with helpseeking, we created two count variables, where we summed, or "counted," the number of positive ("very helpful") and then the number of negative ("not at all helpful") helpseeking experiences for each study participant. In order to capture the positive and negative helpseeking experiences in their "cleanest" form, we did not include ratings of "somewhat helpful" in these scales. Both variables ranged from 0–6;

positive helpseeking had a mean of .45; negative helpseeking had a mean of 1.05; these differences were significantly different, t (602)=7.14, $p<.001$, indicating that the helpseekers had more negative than positive helpseeking experiences.

Next, we examined the relationship between the positive and negative helpseeking experiences and the current mental health status of the men; our goal was to examine whether cumulative positive or negative helpseeking experiences might be related to the helpseekers' mental health status. Bivariate correlations indicated significant relationships or trends toward significance in three instances: cumulative positive experiences and lower levels of alcohol abuse ($r=-.11$, $p=.07$) and substance abuse ($r=-.10$, $p=.09$) in the past year, and cumulative negative experiences and higher rates of PTSD ($r=.14$, $p<.05$). We then conducted three logistic regression analyses with these dichotomous mental health variables as the dependent variables and either the cumulative positive or negative helpseeking experiences, where appropriate, as the independent variable. The full regression model included demographics and the traumatic life experiences described in the methods section as possible covariates. Non-significant covariates were removed from the models one at a time, and the final models are displayed in Table 5.

Results of the regression models indicate that there is a significant relationship between cumulative positive helpseeking experiences and alcohol abuse. For each additional positive helpseeking experience, men were about 40% less likely to abuse alcohol in the previous year. There was also a significant positive relationship between cumulative negative helpseeking experiences and PTSD. For each additional negative helpseeking experience, men were 1.37 times more likely to meet the clinical cutoff for PTSD. The trend toward significance between positive helpseeking experiences and substance abuse dropped out in the full regression model. Thus, positive helpseeking experiences no longer predicted substance abuse, once we controlled for demographic and other traumatic experiences.

Discussion

This study is the first that utilizes a large, U.S. national-based sample to assess the experiences of men who sustained multiple types of IPV from their female partners and sought help. It is also the first that assesses the relationship between male experiences in seeking help for victimization and their mental health status. The findings emphasize the need for more education about male IPV victims who might need services, and of the potential consequences to the mental health of victims when they cannot obtain help.

Our first three research questions sought to answer where men who have sustained female-to-male IPV seek help, to answer how they rate these resources, and to document the nature of these experiences. We found that men who sustain IPV seek help from a variety of resources, most typically from informal resources, such as family, friends, and the Internet, and the formal resource of a mental health professional. Family and friends were overwhelmingly reported as being the most helpful resource, and mental health and medical professionals were rated as being among the most helpful of the formal resources. These professionals were reported to have taken the male victims seriously and to inquire about the origin of the men's injuries. The resources providing the least support to men seeking help for IPV victimization are

Table 5 Logistic regression analysis parsimonious summary statistics showing relationship between cumulative positive and negative helpseeking experiences on mental health status of helpseekers

Independent Variable	*B*	*S.E.*	Odds Ratio	Wald
Abused Alcohol in Past Year				
Racial/ethnic minority[1]	−1.166	.538	.312	4.702*
Education level	−.351	.110	.704	10.120***
Injured by partner in past year[2]	−.788	.376	.455	4.400*
Violent socialization in childhood	.356	.103	1.428	12.002***
Sexual abuse in childhood	−.239	.123	.788	3.758*
Total positive helpseeking experiences	−.550	.278	.577	3.919*
Abused Drugs				
Age	−.041	.017	.960	5.949*
Education level	−.188	.097	.828	3.795*
Total positive helpseeking experiences	−.352	.232	.704	2.303
PTSD Cutoff				
Age	−.032	.014	.968	5.090*
Violent socialization in childhood	.347	.082	1.415	17.992***
Total negative helpseeking experiences	.317	.109	1.373	8.534**

*$p\leq.05$; **$p\leq.01$; ***$p\leq.001$

[1] 1 = Racial or Ethnic Minority (16.2%), 0 = Non-Minority (83.8%)

[2] 1 = Injured in Past Year, 0 = Not Injured in Past Year

those that are the core of the DV service system: DV agencies, DV hotlines, and the police. On the one hand, about 25% of men who sought help from DV hotlines were connected with resources that were helpful. On the other hand, nearly 67% of men reported that these DV agencies and hotline were not at all helpful. Many reported being turned away. The qualitative accounts in our research tell a story of male helpseekers who are often doubted, ridiculed, and given false information. Thus, our hypotheses that men who would have largely negative experiences with formal resources were supported, which is consistent with prior qualitative research (Cook 2009; Hines et al. 2007).

These findings are in stark contrast to ratings of social services by battered women. For example, in a study of 119 women who sought services for DV-related concerns from a DV shelter, 89% of the clients believed that they were helped by the services that they received and 84% reported that they felt better because of these services (McNamara et al. 2008). These findings are similar to a study which examined women's impressions of a hospital-based DV support group (Norton and Schauer 1997). Of the 59 women in this study, 95% reported that they were mostly or very satisfied with the services that they received. Their reasons for satisfaction included that the group leaders were supportive, they were able to hear about other women's experiences with abuse and were supported by them, they received referrals for additional support/services and they were able to learn about DV. These findings are consistent with other literature which states that women are often very satisfied with the services that they have received for IPV (Bowker and Maurer 1985; McNamara et al. 1997; Molina et al. 2009). Similar results with regard to satisfaction among battered women have been found in relation to police assistance. For example, one study of 95 female IPV victims indicated that the female victims found the police to be very helpful and 80% would contact the police again for assistance (Apsler et al. 2003).

Our findings concerning male victims of IPV seeking and receiving help are consistent with previous qualitative research and accounts (Cook 2009; Hines et al. 2007) of men who encountered barriers to obtaining help for IPV victimization. The men in these studies reported that service providers often failed to take action. Police did not respond to calls for help, and men's accounts of abuse were not believed by DV agencies or hotlines. Our findings about seeking help from police are consistent with other research which has showed that male victims are especially dissatisfied with this form of assistance. One study found that male victims did not feel that the police took their concerns seriously, and were significantly less satisfied with the police response than female victims of IPV (Buzawa and Austin 1993).

At the same time, men in heterosexual relationships are not the only population to have encountered barriers to helpseeking for IPV victimization. Older women, who also fall outside the established norm of being the target of any form of IPV, report having trouble gaining access to services for IPV, fear of police brutality, and a feeling that DV services are not available or tailored to their needs (Beaulaurier et al. 2007). Some lesbian women victims also find shelter and police services to be lacking, and their experiences with DV agencies, as of 10 years ago, range from lack of outreach to outright exclusion (Donnelly et al. 1999). In one study of battered lesbian women, 15 of the 19 women who had called the police found them not at all helpful or just a little helpful (Renzetti 1989). Our results also parallel those of a study of gay men seeking help for IPV victimization from a range of sources: friends, relatives, clergy, mental health and medical providers, DV service system, and the police (McClennen et al. 2002). The most helpful were relatives and neighbors. The gay men overwhelmingly and consistently rated the other sources as "not helpful at all" to "a little helpful." None of the formal resources were given an approval rating of higher than 25%.

Our fourth and final research questions concerned whether male helpseekers have more positive or negative helpseeking experiences, and then how these experiences are related to their mental health status. Male helpseekers in our sample had twice as many negative as positive experiences when searching for assistance with what we have documented as serious physical and psychological IPV victimization (Hines and Douglas 2010a, b). Moreover, the quality of their experiences seems to have lasting implications for their mental health. Our hypotheses concerning helpseeking experiences and mental health status were supported. Specifically, for each additional negative experience with helpseeking, men's odds of meeting the cut-off for PTSD increased 1.37 times. For each additional positive experience, these helpseekers were about 40% less likely to have abused alcohol in the previous year. These findings hold even after controlling for other traumatic experiences, such as childhood victimization and being injured by a partner.

These findings suggest that positive experiences may act as a protective factor against mental health problems and that the men may be traumatized or further traumatized by their negative experiences. At the same time, we cannot imply causality from these findings since this study is cross-sectional. It is possible that individuals with PTSD are more likely to conclude that they have had a negative experience, perhaps because their symptoms lead them to interpret their experiences negatively. It is also possible that individuals who consume less alcohol will have more positive helpseeking experiences,

possibly because there is a lesser likelihood that they will have consumed a large amount of alcohol prior to seeking help.

Limitations and Future Research

The limitations of this study need to be considered in future research. First, we cannot assess the legitimacy of the accounts and reports of abuse and helpseeking in this study. Since the men were recruited via the Internet we have no way to confirm the legitimacy of their reports. Moreover, it is possible that some men, especially those recruited through men's advocacy groups, may have "an axe to grind" and thus, reported false information. In addition, it is possible that such men would have been more likely to have had negative helpseeking experiences and therefore, joined such a group. That said, it is unlikely that the majority of the 302 men in this study fabricated the experiences that they reported in this 30 min Internet study. These men likely had to overcome several societal and internal barriers to seeking help (Addis & Mahalic, 2003) and by this very factor are likely reporting legitimate concerns. Also, it is not unusual for the experiences of victims to be denied when they first surface (Schatzow and Herman 1989), and we believe that given enough research, the service needs of this group will be recognized as a reality just as it has for other groups.

Second, we were not able to recruit men who could not access the Internet or the DAHMW. Thus, we are likely missing the experiences of important groups who are potentially in need of help and whose experiences could differ from those of the men we surveyed. Third, and perhaps on a related note, the men in this study are primarily White and well educated. It is possible that men with lower levels of education or from other ethnic backgrounds might have different experiences with help-seeking. Fourth, the men in this study were asked to recall events that primarily occurred over the past year, but also some events that happened in their childhood (e.g., childhood violence socialization). As with all retrospective studies, the questions that dealt with childhood issues are subject to potential problems with recall, in that people currently experiencing any form of IPV might overestimate their childhood experiences with aggression, while those not experiencing IPV might underestimate them. Nonetheless, adult recall is a standard method for assessing childhood trauma (Derevensky and Deschamps 1997; Finkelhor et al. 1990; Ruggiero et al. 2004; Wonderlich et al. 1996), and for this study, childhood trauma was used solely as a covariate. If childhood experiences of aggression were overestimated by the helpseekers, that would result in an underestimation of the association between helpseeking experiences and mental health outcomes, in which case, the associations we measured would be underestimated. Fifth, in-depth experiences with more potential service providers, such as members of the clergy, social workers, and attorneys, should be assessed to investigate the extent to which men find these resources helpful and how they may impact their mental health. And finally, a wider array of mental health outcomes should also be assessed, including depression and anxiety.

Recommendations for Practice and Future Research

This paper is the first to use a large, U.S. national-based, sample to quantitatively document the helpseeking experiences of men who sustain female-to-male IPV. The results indicate that men use a variety of resources when seeking help and that they more often have negative, rather than positive, experiences. More important, the nature of their helpseeking experiences has significant links to their current mental health status, even when controlling for other potentially confounding factors, such as other traumatic events. Our findings suggest the need for change in a number of different areas in order for all people who sustain any form of IPV and seek help to be able to receive the services that they need. Our research also has implications for future research. Thus, we recommend:

1. An increase in training about the diversity of IPV victims for members of the DV service system and all helping professionals who might come into contact with IPV victims.
2. A re-examination by faculty in the social sciences who prepare future social service practitioners concerning their family violence curricula. Education should include the common experiences of all IPV victims, regardless of victim and perpetrator gender, and the important role that frontline staff plays in validating those experiences and providing services to all who need assistance.
3. A re-examination by police departments with regard to how they handle incidents of IPV and how police officers respond when victims do not meet our gendered notions of the dynamics of IPV.
4. Screening of all clients for abusive experiences. Any client, male or female, who indicates that s/he is the target of aggressive behaviors should receive information on getting help for IPV.
5. Public education concerning IPV and outreach materials for potential victims be gender-inclusive, because previous research shows that men are often not the recipient of outreach materials concerning IPV victimization (Hines and Douglas 2011a, b).

6. Future research examining the effectiveness of any of the training, screening, and public education techniques already recommended in this study.
7. Future research on men who sustain partner violence from their female and male partners, especially to examine other potential correlates or consequences of IPV, such as other types of mental health problems and an examination of potential physical health problems.
8. Future research on how female-perpetrated IPV may have an impact on a family system, especially children who live in these households.

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Intimate terrorism by women towards men: does it exist?

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ABSTRACT

Research showing that women commit high rates of intimate partner violence (IPV) against men has been controversial because IPV is typically framed as caused by the patriarchal construction of society and men's domination over women. Johnson's (1995) typology of common couple violence (CCV) and intimate terrorism (IT) attempted to resolve this controversy, but he maintained that IT was caused by patriarchy and committed almost exclusively by men. This study investigates Johnson's theory as it applies to a sample of 302 men who sustained IPV from their female partners and sought help, and a comparison sample of community men. Results showed that the male helpseekers sample was comprised of victims of IT and that violence by the male victims was part of a pattern of what Johnson labels violent resistance. Men in the community sample who were involved in IPV conformed to Johnson's description of CCV. Results are discussed in terms of research, policy, and practice implications of acknowledging women's use of severe IPV and controlling behaviour against their male partners.

KEY WORDS

Intimate partner violence; male victims; intimate terrorism; common couple violence; female perpetrators; female-to-male violence; female violence.

Introduction

The findings of high rates of women's use of intimate partner violence (IPV) towards their male partners have been the source of much controversy since such results were first published in the 1970s (Gelles, 1974; Straus, 2004). Although IPV is typically considered to be a pattern of behaviours that can involve physical assault, psychological and emotional abuse, and/or sexual assault and coercion (Malley-Morrison & Hines, 2007), most of the findings on rates of women's use of IPV are related to their use of physical IPV. Because IPV was traditionally conceptualised as a consequence of patriarchy and men's deliberate use of violence to maintain power and control in their relationships (Dobash & Dobash, 1979; Loseke & Kurz, 2005), these findings of female-perpetrated IPV have been the source of substantial criticism, most of which concerns the notion that male power and control should be central to our understanding of IPV and, therefore, high rates of female-perpetrated IPV need to be evaluated within this context (eg. Loseke & Kurz, 2005). However, few critics have actually considered what men report about their IPV victimisation experiences. Moreover, the prevailing theory that attempted to resolve this controversy was Johnson's (1995; 2006) conclusion that there are at least two distinct types of IPV: common couple violence (CCV) and intimate terrorism (IT). Using the existing studies on IPV, Johnson asserted that the perpetration of IT was the domain of men, yet no literature existed that focused on men's possible victimisation from IT. Thus, Johnson's conclusions are worthy of reconsideration. The current study is the first

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systematic, large-scale study of men who are seeking help for IPV victimisation. We will test Johnson's theory of IT victimisation with regard to men who sustain IPV.

Prevalence and ensuing controversy

Incidence reports of women physically aggressing toward their male partners have appeared since the study of IPV began in the early- to mid-1970s. For example, in Gelles' (1974) groundbreaking study of IPV, he found that '*the eruption of conjugal violence occurs with equal frequency among both husbands and wives*' (p77). Since then, our best population-based studies show that between 25% and 50% of victims of IPV in a given year in the United States are men (Catalano, 2007; Straus, 1995; Tjaden & Thoennes, 2000). The lowest rates are found in the US Department of Justice's National Crime Victimization Survey (NCVS), which showed that in 2004, more than 1.3 per 1,000 men were assaulted by an intimate partner, most of whom were women (Catalano, 2007); these men represented 25% of victims of IPV in 2004. A second source of data from the US is from the National Violence Against Women Survey (NVAWS), which showed that 0.8% of men reported being physically assaulted by a current or former intimate partner in the previous year, most of whom were women (Tjaden & Thoennes, 2000); female-perpetrated violence accounted for 40% of all IPV during that time period. National surveys in other countries find the percentage of male victims to be in the same range, with men constituting approximately 43% of domestic abuse victims in Britain in a one-year time period according to the British Crime Survey (Walby & Allen, 2004) and 47% of partner violence victims in Canada in a five-year period according to Canada's general social survey (Laroche, 2005).

A final source of data on violence by women toward men in the US comes from family conflict studies, many of which use the Conflict Tactics Scales (CTS) (Straus *et al*, 1996). Studies using the CTS typically show that about 50% of all victims of IPV in a given year are men. National US studies, including the National Family Violence Surveys (NFVS) of 1975 and 1985, and the 1992 National Alcohol and Family Violence Survey, showed that after controlling for age and socioeconomic status, minor assaults (eg. slapping, pushing) by wives toward husbands were reported to have occurred at a rate of approximately 75 per 1,000 in 1975 and 1985, and then reports increased to approximately 95 per 1,000 in 1992. Rates of severe assaults (eg. punching, beating up) by wives toward husbands reportedly remained constant at approximately 45 per 1,000 in all study years. These rates of severe assaults projected into approximately 2.6 million men per year who sustained IPV that had a high likelihood of causing an injury (Straus, 1995; Straus & Gelles, 1986).

These results have been confirmed by dozens of studies since the 1970s (Straus, 1999), including a meta-analysis (Archer, 2000), and have been shown in other countries that use the CTS as well, including a national cohort study in New Zealand (Magdol *et al*, 1997); yet, the high rates of violence by women towards men have been the source of significant controversy. Traditionally, IPV has been framed from a patriarchal perspective, whereby men's need to maintain power and control in society and at home is at the root of IPV; men systematically and intentionally use violence to maintain a power system in which men are dominant and women are subordinate (eg. Dobash & Dobash, 1977-78). Therefore, the findings of high rates of violence by women have been criticised or explained by proponents of patriarchal theory through several arguments, most of which centre on the view that the CTS, the primary instrument used to measure IPV, typically does not measure the context in which IPV takes place. Patriarchal theorists argue that both sociocultural and relationship factors, in which men hold power due to patriarchal social systems, need to be considered when examining women's violence (eg. Loseke & Kurz, 2005). Examples of some of the more common arguments, and evidence supporting or refuting them, follow.

First, critics argue that although women have the capability of being violent, their violence against men needs to be considered within the broader sociocultural context (Das Dasgupta, 2001). Men have traditionally held power and control, both in society and in intimate relationships. Furthermore, given the physical size and strength differentials between men and women, expected outcomes of violence, and responses available to them if hit, it is likely that women's and men's motives for violence differ greatly (Dobash & Dobash, 1977-78). Researchers who support this theoretical

perspective typically conclude that women use violence in the context of defence of themselves or their children, or in retaliation against an abusive male partner (eg. Belknap & Melton, 2005; Dobash *et al*, 1992; Loseke & Kurz, 2005; Saunders, 1988). However, empirical studies do not support this conclusion and typically show that self-defence or retaliation are among the least cited reasons that women provide for their use of IPV (see Hines & Malley-Morrison, 2001). In fact, research has shown that predictors and motives for IPV are quite similar among men and women (see Medeiros & Straus, 2006, for a review).

A second argument is that men's violence towards women has much stronger effects than women's violence towards men. For example, men's violence strikes fear in their partners, whereas women's violence does not (Das Dasgupta, 2001; Loseke & Kurz, 2005); women are injured more frequently than are men (Berk *et al*, 1983; Dobash *et al*, 1992); and the '*alleged male victim*' is not subjected to the chronic intimidation that battered women sustain (Dobash *et al*, 1992, p80). Researchers who support this theoretical perspective often conclude that women's violence against men is trivial, humorous, or annoying (Currie, 1998; Pagelow, 1985; Saunders, 1988), and violence by women towards men has no social or psychological effects on the men who sustain it (Mills, 1984). However, several anecdotal accounts (Cook, 2009; Migliaccio, 2001) and one larger scale study (Hines *et al*, 2007) of male victims of IPV by female partners clearly indicate that women's violence can induce fear in the men and is not viewed as trivial, humorous or annoying, but as distressing and sometimes life-threatening. Although male victims are injured less frequently than female victims (Archer, 2000), men do sustain injuries that are sometimes very severe (McNeely *et al*, 2001), and suffer both socially and psychologically from the violence that they endure (eg. Cook, 2009; Hines, 2007; Stets & Straus, 1990).

A final argument suggests that focusing on physical assault is misguided. IPV consists of a range of acts, such as verbal abuse, psychological humiliation, sexual aggression, using or threatening violence against others, and coercive control within the relationship, which are largely ignored but are found to be the most damaging acts of IPV against women (Currie, 1998; Loseke & Kurz, 2005; Yllo, 2005). That said, we cannot ignore the fact that research consistently shows that verbal abuse, sexual aggression, threats and controlling behaviours are not the sole domain of men (eg. Felson & Messner, 2000; Hines *et al*, 2007; Hines & Saudino, 2003; Simonelli & Ingram, 1998; Straus & Sweet, 1992).

Common couple violence versus intimate terrorism

Johnson (1995) attempted to reconcile these two divergent viewpoints on IPV by women by asserting that each side was drawing their conclusions based on non-overlapping data gathered from two fundamentally different sources. The studies that showed high rates of violence by women were typically studies of community- or population-based samples that were unlikely to recruit women who were battered by their partners; on the other hand, researchers studying female victims typically recruit their participants from shelter or other clinical samples (eg. hospital, police) that focus on severe violence by men towards women. Thus, the two groups, according to Johnson, were analysing two distinctly different phenomena. He labelled the IPV found in community and population-based samples CCV, which is characterised by low-level (eg. slapping, pushing), low-frequency violence in a couple where both members are about equally violent; this IPV is not part of an overall pattern of control of one partner over the other, but is the result of a conflict 'getting out of hand'. Johnson labelled the violence found in shelter and other clinical samples 'intimate terrorism' or IT. The central feature of IT is that the violence is one tactic in a general pattern of control of one member of the couple over the other. The IPV is more frequent than what is found in cases of CCV, is less likely to be mutual, is more likely to involve serious injury, and involves emotional abuse as well (Johnson, 1995; Johnson & Ferraro, 2000).

Johnson (1995) reviews research that gives an indication of the relative frequency of violence in CCV versus IT couples. He cites Straus' (1990) analysis of the NFVS, which showed that women who experienced CCV sustained an average of six assaults per year, whereas women who experienced IT sustained an average of 15 assaults. Others have found that women from shelter samples may sustain an average of 65–68 assaults per year (Giles-Sims, 1983; Okun, 1986), and still others have found that the female IT victims sustain an

average of 18 violent acts per year (Johnson, 2006), whereas female CCV victims sustain an average of three violent acts per year. Thus, women who experience IT sustain an assault about once a week or once a month and the assaults are usually initiated by their male partners, whereas women who experience CCV are involved in assaults about once every two-to-four months, with an equal likelihood that either the women or their male partners initiated the assault.

Johnson later updated his theory to include the behaviour of the partner in IT relationships (Johnson, 2006; Johnson & Ferraro, 2000). When sustaining IT, the partner can react nonviolently, react violently in defence or retaliation, or participate in this general pattern of severe violence and controlling behaviours. When a partner reacts violently in defence or retaliation, Johnson asserts that this partner is engaging in 'violent resistance.' Violent resistance is characterised by the victim sometimes reacting to their partner's IT with violence, but not within a general pattern of trying to control their partner. If the partner is reacting with severe violence and controlling behaviours, Johnson would call this '*mutual violent control*'. This pattern is basically two intimate terrorists battling for control in a relationship and is very rare.

Johnson (1995; 2006; Johnson & Ferraro, 2000) asserts that IT is the almost exclusive province of men and can be explained by patriarchal theories in which men are trying to exert and maintain control over 'their' women. Violent resistance, on the other hand, is the almost exclusive province of women; it is characterised by battered women who sometimes use violence in retaliation or defence of themselves when their male partner is engaging in IT. However, Johnson's conclusions, much like the conclusions of the critics of female perpetration of IPV, were drawn without considering the experiences of men who sustain severe IPV and controlling behaviours from their female partners. Johnson asserts that these men represent only a few case studies, and therefore do not contradict his conclusions that IT is due to patriarchy. However, there is consistent evidence that not only do women use IPV but they also use controlling behaviours in their intimate relationships, at rates that represent more than merely a few case studies (eg. Felson & Messner, 2000; Graham-Kevan & Archer, 2005; Hines *et al*, 2007; Migliaccio, 2001; Straus, 2008). Furthermore, Johnson's conclusions were based on a qualitative review of the extant research that did not include clinical samples of men who had sustained IPV and controlling behaviours; this omission was due to the fact that at the time that he published his theory, there was no research on large samples of men who sustained severe IPV and controlling behaviours. However, he never called for such research either, and when he later tested his theory (Johnson, 2006), he preselected samples that conformed to his ideas that IT perpetrated by women was rare and was, therefore, able to conclude again that it could be explained exclusively by patriarchal theory.

Male victims of severe IPV and controlling behaviours

In 2007, the first larger-scale study of male victims of IPV was published (Hines *et al*, 2007). This was an exploratory analysis of data collected through 190 phone call logs, between January 2002 and November 2003, to the US national Domestic Abuse Helpline for Men and Women (DAHMW), a helpline that specialises in male victims of IPV. The results showed a pattern of victimisation that might be consistent with IT victimisation. Callers to the helpline sustained physical and psychological aggression from their female partners. The most common physical acts were hitting, pushing, kicking, grabbing and punching. Their female partners' physical aggression was sometimes severe enough to warrant calling the police or getting medical intervention. Over 20% of the sample reported violence that could be considered life threatening (eg. choking, using a knife). The callers reported that their female partners would target their genitals during physical attacks, and a majority of the callers reported living in fear of their partners' violence. The DAHMW callers reported that their female partners engaged in a variety of psychologically aggressive behaviours: close to 95% of the callers reported that their female partners used controlling behaviours, including threats and coercion (eg. threatening to kill herself or him, threatening to leave; 77.6%), emotional abuse (eg. calling him names, humiliation; 74.1%), intimidation (eg. instilling fear by smashing things, destroying property, abusing pets, displaying weapons; 63.3%), blaming the male caller for the violence, denying the violence (59.9%), misusing the judicial system (eg. using the court system to

gain sole custody of children; falsely obtaining a restraining order against the male caller; 49.0%), isolating the caller from family and friends (41.5%), controlling the household finances and not allowing the caller to see or use the chequebook or credit cards (38.1%) and using the children to keep the caller in the violent relationship (64.5%).

Although valuable in elucidating the experiences of men who sustain IPV from their female partners, this study is limited in a number of ways. For example, because the DAHMW is an advocacy helpline whose primary focus is not research, the data were not systemically collected (eg. the percentages of each type of IPV are based on men's spontaneous recall of their IPV experiences). Reliable and valid instruments were not used to gather data, and questions were not asked of the men in a systematic manner. Moreover, data from a comparison community sample were not collected, so no firm conclusions about CCV versus IT could be made. The current study improves on this research through the recruitment of a large number of men who were seeking help for IPV victimisation, and the use of reliable, valid, and consistent data collection instruments to gather information about their experiences of IPV. Moreover, we collected similar data on a community sample of men so that we could compare the IPV experiences of men seeking help for IPV victimisation with those of men in the community. These comparisons allowed us to draw conclusions about whether the male helpseekers in our sample can be considered victims of IT.

Given Johnson's (1995; 2006; Johnson & Ferraro, 2000) conceptualisation, we expect that:

1. CCV will mostly be found in the community sample of men. In other words, we expect that the community men's use of IPV and controlling behaviours will be similar to their female partner's use of IPV and controlling behaviours, that each partner will be equally likely to have initiated the last physical argument, and that their overall frequency of IPV will be less than that found in the helpseeking sample.
2. IT will be found in the helpseeking sample. Given that the female partners' use of IPV and controlling behaviours would theoretically resemble terroristic violence, the female partners of men in the helpseeking sample are expected to use more physical IPV, severe psychological IPV, and controlling behaviours than both their male partners and the female partners of the men in the community sample. In addition, the helpseeking men will be injured more frequently than their partners and men in the community sample. We also expect that the female partners in the helpseeking sample will be the initiators of the assaults in almost all of the cases.

Finally, we explored the male helpseekers' reaction to their female partners' IT. As theorised by Johnson (2006), there are three ways the men can respond: non-violently; with violence but no controlling behaviours (violent resistance); or with levels of violence and controlling behaviours equal to their female partners (mutual violent control). We explored the male helpseekers' reactions by comparing their levels of IPV and controlling behaviours to both their female partners and the men in the community sample. Although Johnson would assert that it is unlikely that men engage in violent resistance, we predict that any violence by the men would be consistent with that found in shelter samples of battered women, and would be violent resistance.

Method

Participants and procedure

Two separate samples of male participants were recruited for this study: a helpseeking sample and a community sample. For both samples, the men had to speak English, live in the US, and be between the ages of 18 and 59 to be eligible; they also had to have been involved in an intimate relationship with a woman lasting at least one month in the previous year. In addition, to be eligible for the helpseeking sample, the men had to have sustained a physical assault from their female partner within the previous year, and they had to have sought help/assistance for their partner's violence. Help/assistance was broadly defined and included seeking help from formal sources such as hotlines, domestic violence agencies, the police, mental health and medical health professionals, lawyers and ministers, to more informal helpseeking efforts, such as talking with

friends and family members and searching the internet for information or support groups for male victims.

The helpseeking sample of men (n = 302) was recruited from a variety of sources, including the DAHMW, online websites, newsletters, blogs, and listservs that specialise in treatment of IPV, male victims of IPV, fathers' rights issues, divorced men's issues, men's health issues and men's rights issues. Men who called the DAHMW seeking assistance and who met the eligibility criteria were invited to participate in this study either by calling a survey research centre to complete the interview over the phone or by visiting the study website to complete an anonymous, secure version of the study questionnaire online. Men who saw an advertisement for the study online were directed to the study website to complete the online version of the study. Screener questions regarding the study criteria were on the first page of the survey, and men who were eligible were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an 'exit page' of the survey. Sixteen men completed the interview over the phone; the remaining 286 completed it online. Demographics of the helpseeking sample can be found in ***Table 1***.

Participants also included 520 men from the community. Approximately half of the community sample (n = 255) was recruited to participate in a phone version of the survey by a survey research centre, using a random digit dialing technique and CATI administration. The interviewers attempted to reach each phone number on 15 different days, at different times of the day, and made call-back appointments whenever possible. They also made refusal conversion efforts when appropriate. Because of low response rates (8%) during the first two months, advance letters were sent to potential participants informing them that they had been randomly selected to participate in a study focusing on how men and women get along, sponsored by the National Institutes of Health, and that they would be contacted within a week by a survey research centre interviewer. The response rate for the participants who received an advance letter was 15.5%. The overall response rate was 9.8%. The other half of the community sample (n = 265) was recruited through a panel of survey participants maintained by Survey Sampling, Inc. (SSI), to complete an online version of the same survey. Email invitations were sent to 16,000 male SSI panel members inviting them to participate in a study on how men and women get along. They were directed to an anonymous, secure, online version of the survey. The first page of the survey included screener questions testing for eligibility. Eligible men were able to continue to the rest of the survey, whereas non-eligible men were thanked for their time. The survey was closed after we met our target sample size of 265 men. Because data collection was ceased when the target goal for the number of completed surveys was reached and we did not wait for all men who received invitations to complete the survey, response rates for the internet sample cannot be reliably calculated. Demographic information on the full community sample (n = 520) can be found in ***Table 1***, and further information on the differences between the phone and online community samples can be found in Hines *et al* (in press).

The methods for this study were approved by the boards of ethics at the participating institutions. All the men participated anonymously and were apprised of their rights as study participants. Steps were taken to ensure their safety: at the completion of the survey, the participants were given information about obtaining help for IPV victimisation and how to delete the history on their internet web browser.

Measures

Both the helpseeking and community samples were given the same core questionnaires regarding demographics, aggressive behaviours that they and their female partners may have used in the previous year, more detailed information regarding their last physical argument (if applicable), their mental health, and various risk factors. The helpseeking sample was given additional questions pertaining to their specific helpseeking experiences in an aggressive relationship and what prevents them from leaving the relationship. Only the questionnaires used in the current analyses will be described below.

Demographic information. The men were asked basic demographic information about themselves and their partners, including age, race/ethnicity, personal income, education and occupation. The men were also asked about the current status of their relationship, the length of their relationship with their partners, how long

Table 1: Demographics

	Helpseeking sample (*n* = 302) % or *M* (SD)	Community sample (*n* = 520) % or *M* (SD)	χ^2 or t
Male participant demographics			
Age	40.49 (8.97)	43.68 (10.88)	4.52***
White	86.8	84.8	0.59
Black	6.0	8.3	1.48
Hispanic	5.0	5.0	0.00
Asian	4.3	3.1	0.85
Native American	2.0	1.0	1.52
Income	$50.44K (25.69) (*n* = 296)	$48.98K (26.13) (*n* = 508)	0.77
Educational status[1]	4.40 (1.56) (*n* = 300)	4.04 (1.72) (*n* = 514)	3.13**
Occupational status[2]	6.73 (2.14) (*n* = 197)	6.05 (2.61) (*n* = 376)	3.32**
Female partner demographics			
Age	37.91 (8.61)	41.73 (11.37)	5.44***
White	74.2	83.3	9.85**
Black	7.3	6.0	0.56
Hispanic	7.6	6.5	0.34
Asian	9.3	4.6	6.99**
Native American	2.6	2.1	0.24
Income	$30.13K (24.32) (*n* = 269)	$31.43K (23.65) (*n* = 462)	0.71
Educational status[1]	3.82 (1.90) (*n* = 299)	3.78 (1.76) (*n* = 514)	0.32
Occupational status[2]	6.84 (1.68) (*n* = 195)	6.73 (1.69) (*n* = 360)	0.70
Relationship demographics			
Currently in a relationship	56.3%	95.8%	193.70***
Relationship length (months)	97.90 (82.06)	164.90 (131.01)	8.93***
Time since relationship ended (in months)	6.10 (7.69)	3.56 (2.16)	1.31
Minors involved in the relationship	73.2%	45.3%	64.60***
Number of minors involved in relationship	2.00 (1.01)	1.90 (1.01)	1.12

[1] Educational status: 1 = Less than high school; 2 = High school graduate or GED; 3 = Some college/ trade school; 4 = Two-year college graduate; 5 = Four-year college graduate; 6 = Some graduate school; 7 = Graduate degree

[2] Occupational status: 1 = Elementary occupations; 2 = Plant and machine operators and assemblers; 3 = Craft and related trades workers; 4 = Skilled agricultural and fishery workers; 5 = Services workers and shop and market sale workers; 6 = Clerks; 7 = Technicians and associate professionals; 8 = Professionals; 9 = Legislators, senior officials, managers

**$p < .01$, *** $p < .001$

ago the relationship ended (if applicable) and how many minor children were involved in that relationship, if any.

Revised Conflict Tactics Scales (CTS2). The CTS2 (Straus *et al*, 1996) was used to measure the extent to which the men in the study perpetrated and sustained psychological, physical and sexual aggression, and injuries in their relationships. The items used for this study included five items assessing minor physical aggression (eg. grabbing, shoving, slapping), seven items assessing severe physical aggression (eg. beating up, using knife/gun), two items assessing minor injuries (eg. having a small cut or bruise), four items assessing severe injuries (eg. broken bone, passing out) and one item assessing sexual aggression (insisting on sex when the partner did not want to). The eight CTS2 items regarding psychological aggression were supplemented with seven items from the Psychological Maltreatment of Women Inventory (PMWI-F; Tolman, 1995).

Participants responded to items depicting each of the conflict tactics by indicating the number of times these tactics were used by the participant and his partner in the previous year. Participants indicated on a scale from 0 to 6 how many times they experienced each of the acts in the previous year: 0 = 0 times; 1 = 1 time; 2 = 2 times; 3 = 3-5 times; 4 = 6-10 times; 5 = 11-20 times; 6 = more than 20 times. These data were then transformed in order to obtain an approximate count of the number of times each act occurred in the previous year, using the following scale: 0 = 0 acts in previous year; 1 = 1 act in the previous year; 2 = 2 acts in the previous year; 3 = 4 acts in the previous year; 4 = 8 acts in the previous year; 5 = 16 acts in the previous year; 6 = 25 acts in the previous year.

Because we supplemented the eight CTS2 psychological aggression items with seven items assessing controlling and monitoring behaviour, we conducted a principal axis factor analysis with varimax rotation to investigate subtypes of psychological aggression. We combined both

Table 2: Summary of items and factor loadings from principal axis factoring with varimax rotation of the 15 psychological aggression items

Item	Factor loading 1	2	3	Communality
Your partner restricted your use of the phone	.67			.48
Your partner did not allow you to leave the house	.64			.48
Your partner prevented you from having access to household income	.62			.45
Your partner restricted your use of car	.61			.40
Your partner did not allow you to see family/friends	.59			.50
Your partner threatened to harm someone close to you	.44			.28
Your partner monitored your time or made you account for your whereabouts	.43			48
Your partner shouted or yelled at you		.88		.75
Your partner insulted or swore at you		.79		.71
Your partner stomped out of the room during a disagreement		.59		.50
Your partner did something to spite you		.52		.60
Your partner called you fat or ugly			.69	.49
Your partner threatened to hit or throw something at you			.61	.55
Your partner called you a lousy lover			.57	.50
Your partner intentionally destroyed something belonging to you			.52	.49
Eigenvalues	3.02	2.85	2.18	
% of variance	20.11	18.99	14.55	

Note: Factor 1 = Controlling behaviours; Factor 2 = Minor psychological aggression; Factor 3 = Severe psychological aggression

the helpseeking and community samples to achieve greater stability of the factor solution and used the victimisation items because they had more variability than the perpetration items. The results of the factor analysis (***Table 2***) revealed three factors with eigenvalues greater than 1: controlling behaviours; minor psychological aggression; and severe psychological aggression. The existence of three factors was confirmed by investigation of the scree plot.

For the present article, we calculated both a dichotomous variable and a chronicity variable for each scale of the CTS2. The dichotomous variable indicates the presence or absence of each type of IPV and thus can be used to indicate the prevalence of perpetration and victimisation of each type of IPV. Chronicity is the frequency with which the participant and his partner used each type of IPV, among only those who indicated that a given type of IPV had been used. Thus, the lower bound of the chronicity variables would be 1 (indicating that that person used one act of that type of aggression in the past year) because participants and their partners who did not use that particular type of IPV would be removed.

The CTS2 has been shown to have good construct and discriminant validity and good reliability, with internal consistency coefficients ranging from .79 to .95 (Straus *et al*, 1996). Reliability statistics for the current samples, calculated using frequency scores that include all zeros, ranged from .60 (minor injury) to .76 (minor physical aggression) for the perpetration items and .26 (severe injury) to .93 (minor physical aggression) for the victimisation items. Lower alpha coefficients typically occurred in scales with few items and representing rare events (eg. injuries). For all other scales, alpha coefficients were typically above .75.

Follow-up questions. Following the CTS2, we gathered specific information about the most recent violent episode. These questions were asked of all men in the helpseeking sample and any men in the community sample who reported experiencing at least one violent episode within the previous year. Among the questions asked, the two that will be included in the present study are: who was the first to ever use physical aggression in the relationship and who hit whom first in the last physical argument.

Results

Comparisons of IPV perpetration between men and women within each sample

Our first series of analyses compared men and their partners on the men's reports of IPV perpetration by both partners. Because these are paired variables (ie. we are using the men's reports on both variables), McNemar's test statistic was used when comparing the prevalence of all types of IPV. However, caution should be taken when interpreting these results because, overall, studies show that although men and women tend to provide congruent reports on women's perpetration of IPV, individuals do tend to under-report their own perpetration of IPV (Archer, 1999). Note, though, that it is the difference between samples in the magnitude of the sex differences that is informative to the purpose of this study.

Among the helpseeking sample, female partners were reported by the male participants to have used all types of IPV at significantly higher rates than the male participants (see ***Table 3***). When examining their frequency of aggression within the previous year, we see that among those who used aggression, female partners were reported to have used these types of aggressive behaviours at 1.72 times (insisting on sex) to more than six times (physical IPV) the frequency of the male participants (see ***Table 4***). Note that significance testing cannot be conducted for these sex differences in frequencies, yet the magnitude of these differences, in comparison to the magnitude of the sex differences in the community sample (presented in the lower parts of ***Tables 3*** and ***4***), are meaningful when assessing whether the IPV is CCV or IT.

For the community sample, a different pattern emerged. Male participants and female partners engaged in minor psychological, severe psychological, sexual (ie. insisting on sex), minor physical and total physical aggression at relatively equal rates (bottom of ***Table 3***), although female partners were reported to have engaged in significantly higher rates of controlling behaviours and severe physical aggression. In addition, within male participants and their female partners who were reported to have engaged in any of these aggressive acts, the relative frequency of aggression within the previous year was approximately equal for all types of aggression (bottom of ***Table 4***).

Differences between helpseeking and community samples in rates and frequency of IPV

To investigate whether there were differences between samples in the prevalence of each type of IPV, logistic regressions were conducted using the presence and absence of each type of IPV as the dependent variable and sample type (helpseeking versus community) as the independent variable. Because there were demographic differences between the two samples, correlations were conducted to investigate possible covariates to include in the regression models. The only demographic variables that consistently correlated with the various types of IPV were participant's age, partner's age, whether the participant was currently involved in a relationship with his partner, the length of the relationship, and whether minor children were involved. Participant's age, partner's age, and relationship length were highly intercorrelated (*r*'s = .55-.85, $p < .001$); therefore, to maintain adequate power and avoid multicollinearity, only participant's age was used as a possible covariate because it is likely to be the most reliable variable. Thus, possible covariates in all logistic regressions included age, whether the participant was currently in a relationship, and whether minors were involved in the relationship. For each regression, nonsignificant covariates were removed to increase power to detect effects. To correct for multiple tests of the same hypothesis, Bonferonni corrections were employed.

To investigate whether there were differences between samples in the chronicity of IPV used by male participants and their female partners among those who used IPV, negative binomial regression analyses were conducted. Because the chronicity data represented counts of the number of aggressive acts used or sustained in the previous year, the data were positively skewed. Furthermore, as shown in ***Table 4***, the standard deviations

Table 3: Prevalence of intimate partner violence among both samples

	% of female partners who perpetrated	% of male participants who perpetrated	χ^2
Helpseeking sample			
Minor psychological	100.0	95.4[a]	12.07*
Severe psychological	96.0[a]	40.1[a]	163.15*
Controlling behaviours	93.4[a]	45.7[a]	134.53*
Insisting on sex	41.1[a]	13.6	58.47*
Minor physical	98.7[a]	53.3[a]	133.07*
Severe physical	90.4[a]	19.5[a]	208.12*
Total physical (minor and severe)	100.0	55.0[a]	134.01*
Community sample			
Minor psychological	73.7	73.1	0.10
Severe psychological	13.7	10.4	4.49
Controlling behaviours	20.0	11.5	29.82*
Insisting on sex	9.9	12.7	4.36
Minor physical	15.4	13.1	3.03
Severe physical	5.8	2.3	11.12*
Total physical (minor and severe)	16.3	13.8	3.35

Note: tests of significant differences between male participants and their female partners were conducted using McNemar's test. For each sample, a Bonferonni correction was employed to test for significant differences (.05/8 = .006).

[a] Indicates a significant difference between the helpseeking and community samples, after controlling for significant covariates and employing a Bonferonni adjustment, p < .006

** p < .006*

Table 4: Chronicity of intimate partner violence among both samples[1]

	Female partners' perpetration *M (SD)*	Male participants' perpetration *M (SD)*	Ratio (F/M)
Helpseeking sample			
Minor psychological	65.12 (24.15) (*n* = 302)	27.88 (23.40) (*n* = 288)	2.33
Severe pychological	28.90 (26.20) (*n* = 290)	5.74 (8.59) (*n* = 121)	5.03
Controlling behaviours	42.62 (36.25) (*n* = 282)	7.20 (8.99) (*n* = 138)	5.92
Insisting on sex	9.60 (8.48) (*n* = 124)	5.59 (7.31) (*n* = 41)	1.72
Minor physical	32.01 (34.33) (*n* = 298)	6.17 (11.83) (*n* = 161)	5.19
Severe physical	16.74 (22.06) (*n* = 273)	4.86 (6.52) (*n* = 59)	4.55
Total physical (minor + severe)	46.72 (53.48) (*n* = 302)	7.71 (14.25) (*n* = 166)	6.07
Community sample			
Minor psychological	16.82 (19.49) (*n* = 383)	15.38 (17.74) (*n* = 380)	1.09
Severe psychological	9.13 (13.26) (*n* = 71)	6.07 (14.49) (*n* = 54)	1.50
Controlling behaviours	11.36 (16.31) (*n* = 104)	12.29 (16.99) (*n* = 60)	0.92
Insisting on sex	6.82 (7.88) (*n* = 51)	7.41 (8.30) (*n* = 66)	0.92
Minor physical	8.66 (19.18) (*n* = 80)	7.01 (14.27) (*n* = 68)	1.24
Severe physical	11.54 (24.08) (*n* = 30)	12.35 (26.75) (*n* = 12)	0.93
Total physical (minor + severe)	12.22 (33.29) (*n* = 85)	8.68 (24.21) (*n* = 72)	1.41

Note: pairwise comparisons within samples cannot be conducted because only those pairs in which both members of the couple used a given type of aggression would be included.
[1] Chronicity is the average number of aggressive acts used by those participants who reported any of the corresponding aggressive acts.

were greater than the means for most of the aggression variables. Therefore, negative binomial regression analyses were conducted using the type of sample as the predictor and the chronicity of each of the aggression types as dependent variables (see Hutchinson & Holtman, 2005, for a discussion of the use of negative binomial regression to analyse count data of infrequently occurring events). As with the logistic regressions, possible covariates in all negative binomial regressions included age, whether the participant was currently in a relationship, and whether minors were involved in the relationship, and nonsignificant covariates were removed to increase power to detect effects. Goodness-of-fit of negative binomial regression models was evaluated by examining whether the deviance divided by

the degrees of freedom (ie. deviance/df) was close to 1.00. If so, the significance of the sample type was then evaluated.

Female partners' use of IPV. Logistic regression analyses showed that, according to the male participants' reports, female partners of men in the helpseeking sample were significantly more likely than the female partners of men in the community sample to use all types of IPV. (Logistic regression could not be performed on minor psychological aggression or total physical aggression because all female partners in the helpseeking sample reportedly committed those types of aggression.) For severe psychological aggression, χ^2 (2, N = 822) = 613.46, $p < .001$, controlling behaviours, χ^2 (2, N = 822) = 470.48, $p < .001$, insisting on sex, χ^2 (2, N = 822) = 152.62, $p < .001$, minor physical χ^2 (2, N = 822) = 655.34, $p < .001$, and severe physical aggression, χ^2 (2, N = 822) = 670.19, $p < .001$, the overall regression models were significant. After controlling for significant covariates, the type of sample significantly predicted women's use of severe psychological aggression, Wald = 240.33, $p < .001$, controlling behaviours, Wald = 240.72, $p < .001$, insistence on sex, Wald = 53.31, $p < .001$, minor physical, Wald = 133.57, $p < .001$, and severe physical aggression, Wald = 283.31, $p < .001$. Specifically, in comparison to female partners in the community sample, female partners in the helpseeking sample were reportedly 147.15 times more likely to use severe psychological aggression, 53.67 times more likely to use controlling behaviours, 5.28 times more likely to insist on sex when her partner did not want to, 406.84 times more likely to use minor physical aggression, and 122.39 times more likely to use severe physical aggression.

Moreover, negative binomial regressions showed that among women who reportedly used each type of IPV respectively, female partners in the helpseeking sample used significantly more minor psychological aggression, severe psychological aggression, controlling behaviours, minor physical aggression, severe physical aggression and total physical aggression in the previous year than female partners in the community sample (***Table 5***). However, when investigating the frequency with which female partners insisted on sex just among those who were reported to have done that, negative binomial regressions revealed that there were no significant differences between samples.

Male participants' use of IPV. For all types of psychologically and physically aggressive behaviours, logistic regression analyses showed that men in the helpseeking sample were significantly more likely to use aggression than men in the community sample. Specifically, for each type of aggression, the overall logistic regression models were significant (minor psychological: χ^2 (2, N = 822) = 77.89, $p < .001$; severe psychological: χ^2 (2, N = 822) = 105.16, $p < .001$; controlling behaviours: χ^2 (2, N = 822) = 130.03, $p < .001$; total physical: χ^2 (2, N = 822) = 192.15, $p < .001$, minor physical: χ^2 (2, N = 822) = 185.78, $p < .001$, and severe physical: χ^2 (2, N = 822) = 94.05, $p < .001$), and after controlling for significant covariates, the type of sample predicted men's use of minor psychological aggression, Wald = 44.65, $p < .001$, severe psychological aggression, Wald = 84.45, $p < .001$, controlling behaviours, Wald = 98.31, $p < .001$, any physical aggression, Wald = 129.44, $p < .001$, minor physical aggression, Wald = 126.47, $p < .001$, and severe physical aggression, Wald = 47.99, $p < .001$. Men in the helpseeking sample were 7.06 times more likely to use minor psychological aggression, 5.58 times more likely to use severe psychological aggression, 6.04 times more likely to use controlling behaviours, 7.46 times more likely to use any physical aggression, 7.43 times more likely to use minor physical aggression, and 9.93 times more likely to use severe physical aggression than men in the community sample.

However, when we look at differences in frequency of aggressive behaviours among just those men who reported using each type of aggression (***Table 5***), we find a mixed picture. Negative binomial regressions showed that among men who used minor psychological aggression, male participants in the helpseeking sample used significantly more minor psychological aggression than male participants in the community sample; for severe psychological aggression, there were no differences between samples in frequency; and among men who used controlling behaviours, male participants in the helpseeking sample used significantly *fewer* controlling behaviours than male participants in the community sample. For physical IPV, there were no differences between samples in the frequency with which they used total or minor physical aggression in the past year; moreover, among men who used severe physical aggression, men in the

Table 5: Negative binomial regression analyses predicting chronicity of IPV from sample type

Variable	*B*	*SEB*	Wald χ^2
Female partners' use of IPV			
Minor psychological: goodness-of-fit: deviance/df = .78			
Minors involved[1]	0.19	.08	5.19*
Sample type[2]	1.32	.08	264.89***
Severe psychological: goodness-of-fit: deviance/df = 1.04			
Sample type[2]	1.15	.14	69.18***
Controlling behaviours: goodness-of-fit: deviance/df = 1.03			
Sample type[2]	1.32	.12	124.06***
Sexual: goodness-of-fit: deviance/df = 0.83			
Sample type[2]	0.34	.18	3.72
Minor physical: goodness-of-fit: deviance/df = 1.18			
Age	-0.02	.01	9.81**
Sample type[2]	1.34	.13	102.63***
Severe physical: goodness-of-fit: deviance/df = 1.31			
Age	-0.03	.01	23.68***
Current relationship[3]	0.35	.13	7.91**
Minors involved[1]	-0.32	.14	5.19*
Sample type[2]	0.74	.21	12.11***
Total physical: goodness-of-fit: deviance/df = 1.35			
Age	-0.02	.01	17.17***
Sample type[2]	1.40	.13	120.14***
Male participants' use of IPV			
Minor psychological: goodness-of-fit: deviance/df = 1.02			
Age	-0.01	.01	7.62**
Minors involved[1]	0.19	.08	4.90*
Sample type[2]	0.54	.08	41.28***
Severe psychological: goodness-of-fit: deviance/df = 1.20			
Sample type[2]	-0.06	.18	0.10
Controlling behaviours: goodness-of-fit: deviance/df = 1.09			
Current relationship[3]	-0.55	.17	10.11***
Sample type[2]	-0.78	.18	19.13***
Sexual: goodness-of-fit: deviance/df = 1.24			
Sample type[2]	-0.28	.21	1.74
Minor physical: goodness-of-fit: deviance/df = 1.24			
Minors involved[1]	-0.48	.16	9.48**
Sample type[2]	0.02	.16	0.02
Severe physical: goodness-of-fit: deviance/df = 1.21			
Sample type[2]	-0.93	.33	7.89**
Total physical: goodness-of-fit: deviance/df = 1.42			
Age	-0.02	.01	5.03*
Minors involved[1]	-0.51	.15	11.17***
Sample type[2]	0.01	.16	0.01

Note: deviance/df indicates the goodness-of-fit of the model, with values close to 1.00 indicating a good fit.
[1] Minors involved: 1 = Yes, 0 = No
[2] Sample type: 1 = Helpseeking, 0 = Community
[3] Current relationship: 1 = Current, 0 = Past
** p < .05, ** p < .01, *** p < .001*

community sample used significantly more severe physical aggression in the previous year.

For insisting on sex, after controlling for age and whether the relationship was current, logistic regressions revealed that the type of sample did not predict men's insistence on sex when his partner did not want to, Wald = 2.35, *ns*. In addition, among men who insisted on sex, negative binomial regression showed that there were no differences between samples in the frequency with which they did this (***Table 5***).

Comparisons between men and women within each sample of injuries sustained

In the helpseeking sample, McNemar's test showed that male participants reported that they were injured at significantly higher rates than their female partners in the previous year (***Table 6***). Moreover, within just the male participants and their female partners who reportedly sustained injuries, the male participants reported that they were injured at 1.52 times (severe injuries) to 2.25 times (total injuries) the frequency of their female partners (***Table 7***).

In the community sample, a different picture emerged, with McNemar's test revealing no significant differences between male participants and their female partners in the rates of overall, minor or severe injuries (bottom of ***Table 6***), and with female partners sustaining more injuries in the previous year than the male participants (bottom of ***Table 7***).

Differences between the helpseeking and community samples in injuries

Logistic regression analyses showed that men in the helpseeking sample were significantly more likely than men in the community sample to sustain injuries. For injuries overall, χ^2 (1, N = 822) = 532.34, $p < .001$, and for both minor, χ^2 (1, N = 822) = 534.64, $p < .001$, and severe injuries, χ^2 (2, N = 822) = 206.47, $p < .001$, the overall regression models were significant. After controlling for significant covariates, the type of sample significantly predicted men's total injuries, Wald = 287.57, $p < .001$, minor injuries, Wald = 272.20, $p < .001$, and severe injuries, Wald = 67.89, $p < .001$. Specifically, in comparison to men in the community sample, men in the helpseeking sample were 86.64 times more likely to sustain any injury, 95.97 times more likely to sustain a minor injury and 24.75 times more likely to sustain a severe injury. Negative binomial regression analyses showed that among men from both samples who were injured, men in the helpseeking sample sustained significantly

Table 6: Prevalence of injuries among both samples

	% of male participants who sustained	% of female partners who sustained	χ^2
Helpseeking sample			
Minor injuries	77.5[a]	25.2[a]	150.30**
Severe injuries	35.1[a]	7.3[a]	70.30**
Total injuries	78.5[a]	26.2[a]	150.30**
Community sample			
Minor injuries	3.5	4.2	0.75
Severe injuries	1.5	1.0	0.80
Total injuries	4.0	4.6	0.31

Note: tests of significant differences between male participants and their female partners were conducted using McNemar's test. For each sample, a Bonferonni correction was employed to test for significant differences (.05/3 = .02).

[a] Indicates a significant difference between the helpseeking and community samples, after controlling for significant covariates and employing a Bonferonni adjustment, p < .006

*** p < .001*

Table 7: Chronicity of injuries among both samples[1]

	Injuries sustained by male participants *M (SD)*	Injuries sustained by female partners *M (SD)*	Ratio (M/F)
Helpseeking sample			
Minor injuries	9.73 (12.75) (n = 234)	4.51 (6.22) (n = 76)	2.16
Severe injuries	4.64 (7.50) (n = 106)	3.05 (3.58) (n = 22)	1.52
Total injuries	11.68 (15.61) (n = 237)	5.19 (6.40) (n = 79)	2.25
Community sample			
Minor injuries	5.11 (11.36) (n = 18)	6.68 (12.28) (n = 22)	0.76
Severe injuries	3.00 (2.73) (n = 8)	4.00 (4.64) (n = 5)	0.75
Total injuries	5.52 (11.42) (n = 21)	6.96 (12.01) (n = 24)	0.79

Note: pairwise comparisons cannot be conducted within samples because only those pairs in which both members of the couple were injured would be included.
[1] Chronicity is the average number of injuries sustained by those participants and their partners where any of the corresponding injuries were reported.

more minor injuries and total injuries; however, they did not sustain more severe injuries (see top of ***Table 8***).

For injuries among women, the overall regression models were significant (any: χ^2 (2, N = 822) = 85.81, p < .001; minor: χ^2 (2, N = 822) = 84.85, p < .001; and severe: χ^2 (1, N = 822) = 25.57, p < .001) and after controlling for significant covariates, the type of sample significantly predicted any women's injuries, Wald = 67.48, p < .001; minor injuries, Wald = 59.76, p < .001; and severe injuries, Wald = 17.42, p < .001. Female partners of men in the helpseeking sample were reportedly 6.99 times more likely to sustain any injury, 7.25 times more likely to sustain a minor injury, and 8.09 times more likely to sustain a severe injury than female partners of men in the community sample. Among women from both samples who were injured, however, negative binomial regressions showed that there were no differences between the samples in the number of minor, severe or total injuries they sustained in the previous year (see bottom of ***Table 8***).

Initiation of IPV

Men in the helpseeking sample were significantly more likely than men in the community sample to report that their female partners hit first during the last physical argument (93.0% v. 56.9%), χ^2 (1, N = 404) = 20.58, p < .001. Men in the helpseeking sample were also significantly more likely to report that their female partners were the first to ever hit (91.7% v. 53.0%), χ^2 (1, N = 404) = 46.99, p < .001.

Discussion

This study is the first to provide a systematic, quantitative description of the IPV experiences of a large sample of men who sought help for IPV victimisation. Until now, this group has been largely overlooked in the discussion about women's use of IPV. Johnson's (1995) typology of CCV versus IT guided the conceptualisation of our methodology: by comparing the sample of men who sustained IPV and sought help with a community sample of men, we were able to gain a better understanding of the IPV experiences of both groups of men.

Table 8: Negative binomial regression analyses predicting chronicity of injuries from sample type

Variable	B	SEB	Wald χ^2
Male participants' injuries			
Minor injuries: goodness-of-fit: deviance/df = 1.07			
Age	-0.02	.01	6.76**
Minors involved[1]	-0.34	.16	6.76**
Current relationship[2]	0.37	.14	7.01**
Sample type[3]	0.88	.28	9.98**
Severe injuries: goodness-of-fit: deviance/df = 0.84			
Age	-0.02	.01	4.37*
Current relationship[2]	0.57	.21	6.99**
Sample type[3]	0.62	.44	2.04
Total injuries: goodness-of-fit: deviance/df = 1.13			
Age	-0.02	.01	9.92**
Minors involved[1]	-0.31	.15	4.24*
Current relationship[2]	0.34	.14	6.01*
Sample type[3]	0.94	.26	13.37***
Female partners' injuries			
Minor injuries: goodness-of-fit: deviance/df = 0.94			
Minors involved[1]	-0.58	.26	5.07*
Sample type[3]	-0.13	.29	0.21
Severe injuries: goodness-of-fit: deviance/df = 0.68			
Sample type[3]	-0.27	.56	0.24
Total injuries: goodness-of-fit: deviance/df = 0.96			
Sample type[3]	-0.29	.25	1.37

Note: deviance/df indicates the goodness-of-fit of the model, with values close to 1.00 indicating a good fit.
[1] Minors involved: 1 = Yes, 0 = No
[2] Current relationship: 1 = Current, 0 = Past
[3] Sample type: 1 = Helpseeking, 0 = Community
** p < .05, ** p < .01, *** p < .001*

The IPV experiences of the community sample closely resembled Johnson's description of CCV. The rates and frequencies of IPV perpetration and victimisation in this sample closely resemble other community and population-based surveys of IPV (eg. Morse, 1995; Straus, 1990; Straus & Gelles, 1986). Given that there were few differences reported between the men and their female partners in their use of all types of IPV, it is likely that their experiences are mostly reciprocal acts of IPV, what Johnson calls CCV (Johnson, 1995, 2006; Johnson & Ferraro, 2000).

A very different picture emerged with the helpseeking sample. The female partners of men in the helpseeking sample had significantly higher rates of all types of IPV. Johnson (1995) describes IT as physical aggression against one's partner that occurs within a general pattern of control. The female partners of the male helpseekers fit this definition: among those men and women in the helpseeking sample who engaged in physical and psychological aggression, the female partners used five-to-six times the frequency of physical and severe psychological aggression, and controlling behaviours; in addition, the female partners' rates of these types of aggression were twice as high as their male partners. Moreover, the helpseeking men had significantly higher rates of injuries than their female partners: among those men and women who sustained

injuries, the men were injured at approximately twice the frequency as their female partners. Moreover, the frequency with which men sustained violence in the previous year (46.72 acts) is comparable to the frequency of violence sustained in samples of battered women (between 15 and 68 acts per year) (Giles-Sims, 1983; Johnson, 2006; Okun, 1986; Straus, 1990).

Patterns of IT can also be found when we compare the helpseeking sample with the community sample: in comparison with the female partners of men in the community sample, the female partners of men in the helpseeking sample engaged in significantly higher rates and frequency of all types of IPV – they were 54 (controlling behaviours) to 407 (minor physical aggression) times more likely to use IPV. Among only those women who used IPV, the female partners in the helpseeking sample had significantly higher frequencies of IPV, ranging from approximately one and a half times (sexual aggression, severe physical aggression) to over 3.75 times (controlling behaviours, total physical aggression) the frequency of aggression of female partners in the community sample. Moreover, the men in the helpseeking sample were injured at higher rates and frequencies than men in the community sample – helpseeking men were close to 90 times more likely to have sustained an injury in the past year than men from the community sample. Finally, we also found that the female partners in the helpseeking sample were significantly more likely than female partners in the community sample to have used physical IPV first, in both the last physical argument and ever. Taken together, there is strong evidence that the female partners of men in the helpseeking sample conform to Johnson's (1995) conceptualisation of IT. This is not violence that can be viewed as trivial, humorous or merely annoying, as some have suggested (Dobash *et al*, 1992; Pagelow, 1985; Saunders, 1988).

The high rates of IPV by the men in the helpseeking sample deserve discussion as well. With the exception of insisting on sex, men in the helpseeking sample engaged in significantly higher rates of all types of IPV than men in the community sample. These rates of IPV perpetration among the helpseeking men are similar to the rates found in studies of battered women in shelters (Giles-Sims, 1983; McDonald *et al*, 2009; Saunders, 1988). Although rarely addressed, we found three studies in which researchers reported on the percentage of women seeking help in shelters who used physical IPV towards their partners. Giles-Sims (1983) found that 50% of helpseeking women in a shelter reported using physical aggression against their partner within one year prior to coming to the shelter. Saunders (1988) found that 75% of shelter women stated that they had engaged in nonsevere violence in the previous year; 50%-60% engaged in severe violence, with 8% saying they beat up their partners or used a knife or gun, and 12% threatened their partners with a knife or gun. Finally, McDonald *et al* (2009) found that 67.1% of the women in their helpseeking shelter sample had used severe physical aggression in the previous year against their partners. Our findings that 55% of helpseeking men used violence, with 19.5% using severe violence, are congruent with or lower than the rates of battered women in shelters, and indicate somewhat similar behaviour, regardless of sex, among individuals who are seeking help for IPV victimisation.

Why do the helpseeking men in our sample use violence at such high rates? Johnson's (2006) conceptualisation of the various types of IPV suggests that these helpseeking men are engaging in either violent resistance or mutual violent control; our findings suggest that the majority of IPV was likely a reaction to their female partner's violence, or violent resistance. The helpseeking men's rates of all types of IPV were lower than those of their female partners, and among just those men who used IPV, their frequencies of IPV were also much lower. The differences between the community and helpseeking men in the frequencies of different types of IPV are also informative. Among those men who used IPV, there were few differences between the helpseeking and community men in the frequency of IPV in the previous year, with the most notable differences being that the *community* men reported significantly higher frequencies of controlling behaviours and severe physical aggression, the types of IPV that are most pertinent to mutual violent control. Therefore, it is likely that the helpseeking men's IPV is characteristic of violent resistance and a reaction to their female partner's IT, and that their female partner's IT is the overarching problem in the relationship. We note that classifying the men's behaviour as violent resistance does not excuse their aggression; in addition, even though the

female partners' IPV is more severe, the male helpseekers, as a whole, were engaging in behaviours that are problematic, dysfunctional, and need to be addressed.

At this point, what we do not know is the prevalence of this type of relationship in the US. Our study only shows that these relationships, in which the woman is the intimate terrorist, exist, but we cannot draw any conclusions as to how prevalent these relationships are, in the same way that studies using shelter samples of battered women cannot be used to make inferences about how prevalent IT is against women. These inferences are difficult to make because IT against both men and women is relatively infrequent in comparison to CCV (eg. Ehrensaft *et al*, 2004; Straus, 1990). However, two population-based studies, one in New Zealand (Ehrensaft *et al*, 2004) and one in Canada (Laroche, 2005), show that women and men commit IT at similar rates. The New Zealand study, in particular, was a cohort study that encompassed almost the entire population of that cohort, and it showed that the prevalence rate of IT was 9%, with men and women equally likely to be intimate terrorists. This study was able to capture a sizeable proportion of 'clinical' cases in which the IPV had led to injury and/or intervention. This is significant because such epidemiological studies capture not only IPV that comes to the attention of authorities, but also serious cases that, for whatever reason, elude official detection and remain hidden in traditional clinical samples (Ehrensaft *et al*, 2004), such as Johnson's (2006). Nonetheless, more research needs to be conducted to replicate these findings and establish the prevalence of female IT, particularly in the US.

There are several limitations of our study that need to be considered in future research on male victims of female IT. Our first limitation is that the study relies solely on the men's reports of their own and their partners' aggressive behaviours. This limitation is important to consider for two primary reasons:

1. It is possible that the male helpseekers overestimated their female partners' use of IPV and underestimated their partners' injuries. Studies of couples reporting on IPV show little difference between male and female partners in their estimates of women's use of IPV (Archer, 1999), but it could be the case that when men seek help because of their partner's violence, they may overestimate their female partner's use of IPV and underestimate their partner's injuries. However, the magnitude of the differences between the male helpseekers' and their female partners' rates and frequencies of all types of IPV perpetration are so large that, even if the men exaggerated their female partners' use of IPV and underestimated their injuries, our classification of the helpseekers as victims of IT would still be valid. Studies also show that both men and women tend to underestimate their own use of IPV (Archer, 1999), but even if this occurred with our helpseeking sample of men, their actual use of IPV would still approximate the rates that are found in self-report studies using shelter samples of women seeking help for IPV victimisation (Giles-Sims, 1983; McDonald *et al*, 2009; Saunders, 1988).
2. By using only the men's reports, we have no external validation of the authenticity of their reports. We were concerned, particularly for our helpseeking sample, about the confidentiality and safety of the participants if we asked their partners to participate in this study as well. Therefore, we opted not to obtain these data directly from the female partners and note that methodologies similar to ours have been used in other social science research (Furstenberg *et al*, 1987; Lee, 1997; Seltzer, 1991; Seltzer & Bianchi, 1988; Walker, 2000). It is also important to consider that these men will have had to overcome several societal and internal barriers to seeking help (Addis & Mihalik, 2003) and by this very factor are likely to be reporting legitimate concerns.

Nonetheless, this limitation of using only the male participants' reports of IPV highlights the importance of replicating the findings reported here with studies using multiple informants.

A second limitation is that we restricted our sample of male victims to men seeking help for IPV victimisation, which most likely resulted in a large group of men being excluded because they did not seek help. In fact, men are reluctant to seek help in general and particularly for issues that society deems non-normative (Addis & Mihalik, 2003). Given that IPV is

typically framed as a women's issue, it is likely that many male victims of IPV do not seek help because they perceive their experiences as non-normative. We also were not able to recruit men who did not have access to the internet or to the DAHMW. Therefore, future studies should aim to recruit men who may have sought help from other sources of support or who may not have sought help at all, to investigate any possible differences in their experiences.

In sum, our study shows the existence of male victims of female-perpetrated IT. These men sustained very high rates and frequencies of psychological, sexual, and physical IPV, injuries, and controlling behaviours, the pattern of which is congruent with Johnson's (1995) conceptualisation of IT. And even though the male helpseekers had high rates of perpetrating IPV themselves, their rates are similar to or lower than those found in shelter samples of battered women (Giles-Sims, 1983; Saunders, 1988), and their violent behaviour conforms to Johnson's conceptualisation of violent resistance.

These findings represent important challenges to Johnson's (1995; 2006; Johnson & Ferraro, 2000) assertion that, with the exception of a few case studies, IT is committed almost exclusively by men and violent resistance is committed almost exclusively by women, with both conforming to the patriarchal notion that men use IT to maintain power and control over their female partners. These findings also have important implications for family violence researchers and practitioners, and we offer the following recommendations:

1. It is important that practitioners who engage in community outreach understand that both men and women can be victims of severe types and levels of IPV, including controlling behaviours.
2. All the men in this study indicated that they had sought help of some form. Training for members of the helping professions should include information about men's IPV victimisation.
3. Public awareness/education campaigns that address IPV should be sex inclusive. The public should understand that both sexes can be the instigators and recipients of IT.
4. In research concerning family violence, IPV perpetration and victimisation should be asked of both men and women in all relationships, regardless of sex.
5. The results of this study indicate that the adherence to the theory that patriarchy is the foundation of IT in Western, developed nations deserves reconsideration. Because IT can be perpetrated by both men and women, against both men and women, it is imperative that researchers, practitioners, and decision/policy-makers reconsider their conception of the causes of both IT and CCV so that all potential victims are addressed and provided with services.

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A Self-Report Measure of Legal and Administrative Aggression Within Intimate Relationships

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Although experts agree that intimate partner violence (IPV) is a multidimensional phenomenon comprised of both physical and non-physical acts, there is no measure of legal and administrative (LA) forms of IPV. LA aggression is when one partner manipulates the legal and other administrative systems to the detriment of his/her partner. Our measure was developed using the qualitative literature on male IPV victims' experiences. We tested the reliability and validity of our LA aggression measure on two samples of men: 611 men who sustained IPV and sought help, and 1,601 men in a population-based sample. Construct validity of the victimization scale was supported through factor analyses, correlations with other forms of IPV victimization, and comparisons of the rates of LA aggression between the two samples; reliability was established through Cronbach's alpha. Evidence for the validity and reliability of the perpetration scale was mixed and therefore needs further analyses and revisions before we can recommend its use in empirical work. There is initial support for the victimization scale as a valid and reliable measure of LA aggression victimization among men, but work is needed using women's victimization's experiences to establish reliability and validity of this measure for women. An LA aggression measure should be developed using LGBTQ victims' experiences, and for couples who are well into the divorce and child custody legal process. Legal personnel and practitioners should be educated on this form of IPV so that they can appropriately work with clients who have been victimized or perpetrate LA aggression. Aggr. Behav. 41:295–309, 2015. © 2014 Wiley Periodicals, Inc.

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INTRODUCTION

Experts on intimate partner violence (IPV) argue that it is a multidimensional and heterogeneous phenomenon that needs to be measured in multiple ways to increase knowledge of IPV, and capture its range, extent, and severity (e.g., Follingstad & Rogers, 2013; Woodin, Sotskova, & O'Leary, 2013). The U.S. Centers for Disease Control (CDC) have moved towards acknowledging this complexity by stating that there are four main types of IPV: physical violence; sexual violence; threats of physical or sexual violence; and psychological or emotional violence (Saltzman, Fanslow, McMahon, & Shelle, 2002). In their 2010 National Intimate Partner and Sexual Violence Survey (NISVS: Black et al., 2011), the CDC provided what many consider a model for measuring and surveying the U.S. population on these forms of IPV. Their data show that 47% of the victims of physical IPV in a 1-year time period are women. When sexual violence and stalking perpetrated by an intimate are added to this estimate, 57% of the victims in a 1-year time period are women. Finally, when psychological aggression is also added to the definition, 49% of IPV victims in a 1-year time period are women (Black et al., 2011).

Although this survey (Black et al., 2011) represents the largest and most comprehensive assessment of IPV to date in the United States, some may argue that it is still limited in its measurement of IPV, particularly non-physical forms of IPV. One notable absence is the measurement of legal and administrative (LA) aggression, which Tilbrook, Allan, and Dear (2010) define as occurring when "some perpetrators manipulate legal and administrative resources to the detriment of their… partners" (p. 20). The present study represents a first step

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toward the development and validation of a scale to measure this form of IPV.

WHAT IS LEGAL AND ADMINISTRATIVE AGGRESSION?

The basis for the development of our scale is Tilbrook et al.'s (2010) qualitative study of 15 male IPV victims and 5 significant persons in the lives of male IPV victims. Through the analysis of their interview data, Tilbrook et al. found that a distinct form of IPV emerged: LA abuse. We prefer the term "IPV" or "aggression" to "abuse" when considering the measurement of this concept because "abuse" connotes certain cut-offs or patterns of behavior that cannot adequately be captured by existing scales of IPV (McHugh, Rakowski, & Swiderski, 2013). LA aggression occurs when one partner uses the LA system to the detriment of the other partner. Tilbrook et al. (2010) postulated that this form of IPV may be unique to men as victims and women as perpetrators because employees of relevant non-governmental (e.g., domestic violence agencies) and governmental (e.g., family courts) agencies hold stereotypes that men are always the perpetrators of IPV and that women are always the victims. Tilbrook et al. provided supporting accounts from men who spent much money, time, and other resources to prove their innocence in a court of law because of restraining orders being filed against them under false accusations of abuse; men who said the police assumed the men were at fault; and men whose wives used domestic violence service agencies to further manipulate the men (e.g., by telling the services they were the victims and then using that against him in further legal battles).

Additional evidence of this type of IPV occurring against men appears in the scant literature on male IPV victims, and the perception that LA aggression can be carried out because of IPV stereotypes seems to be supported. For example, in a qualitative study, Cook (2009) provided case studies showing that male IPV victims unjustly lose their homes, possessions, and a continued relationships with their children because of false claims of abuse made by their female partners. For example, protective orders are sometimes used by their female partners as a means to get possession of the house and custody of the children. Cook noted that the male IPV victims in these cases believed that the judicial system was stacked against them because of their gender, and that gaining custody of the children would be difficult, if not impossible. The men in these cases also believed that physical custody of their children would be granted to their female partners, and that any contact with their children granted by the court would be blocked by their partners in a continued effort to control and abuse them. They also feared being falsely accused of sexually molesting the children, a tactic used by their partners to block them from having access to their children: in several cases, that actually happened.

Hines, Brown, and Dunning's (2007) study of male helpseekers to the Domestic Abuse Helpline for Men used the term "manipulating the system" to describe the behavior of some perpetrators who knew that the domestic violence system is less responsive to men and who use that to their advantage. Just under half of the male helpline callers in this sample reported that their female partners engaged in this type of behavior, which included filing for a restraining order under false pretenses or manipulating the court system to gain sole custody of the children. In addition, 67.3% of the men reported that their wives threatened to remove the children from the home. In qualitative accounts, men talked about false charges being filed against them with child protective services.

Similarly, in an analysis of what prevents men from leaving a female partner who uses more severe forms of IPV, Hines and Douglas (2010a) found that one of the top reasons was a fear that they would never be allowed to see their children again. In qualitative accounts, the men reported that their female partners threatened to ruin their reputation in the community and at work with false allegations of physical and/or sexual abuse against their partners and/or the children. In addition, a substantial percentage of male victims reported that such false accusations had been carried out against them: 67.2% reported that their partner falsely accused them of hitting or beating their partners; 38.7% reported that their partners filed a restraining order against them under false pretenses; 48.9% said that their partners falsely accused them of physically abusing the children; and 15.4% reported that their partners falsely accused them of sexually abusing the children.

Some may argue that this form of IPV is a form of psychological IPV; however, no measure of psychological IPV has captured this construct. For example, the Follingstad Psychological Aggression Scale (Follingstad, 2011) measures 17 categories of psychological aggression, none of which include the issues discussed thus far. The construct that seems to come closest is romantic relational aggression (Bagner, Storch, & Preston, 2007; Carroll et al., 2010; Goldstein, Chesir-Teran, & McFaul, 2008; Lento-Zwolinski, 2007; Linder, Crick, & Collins, 2002; Murray-Close, Ostrov, Nelson, Crick, & Coccaro, 2010). This construct has been assessed primarily among college students (Bagner et al., 2007; Goldstein et al., 2008; Lento-Zwolinski, 2007; Linder et al., 2002), and encompasses a range of tactics, such as shunning, purposeful ignoring, making one's partner jealous, cheating on one's partner for revenge, threatening to

break up with them to get one's way, and gossiping about them. Carroll et al. (2010) investigated this construct among married couples, and found that women engaged in relational aggression more than men. In their study, this construct consisted of: sharing private information about one's partner that the partner did not want shared, recruiting others to take one's side in an argument, gossiping about one's partner or spreading negative information when angry, embarrassing one's partner in front of others when angry, spreading rumors about one's partner to be mean, and threatening to disclose negative information to get one's partner to do what one wants the partner to do.

Romantic relational aggression is a construct that is close to LA aggression, but the behaviors that one engages in during LA aggression have potentially devastating consequences, in that the victims can lose their children, jobs, homes, financial stability, reputation, and so on. In other words, perpetrators who use romantic relational aggression target their partner's peer groups in their efforts to sully their partner's reputation, whereas perpetrators who use LA aggression target people in positions of power to exact these potentially devastating consequences on their victims. Therefore, LA aggression seems to be a different form of IPV that has not been adequately measured thus far. Moreover, it is likely that the perpetrator is able to engage in these behaviors because of existing widespread notions in both the public and legal sector that IPV is exclusively something that men do to women (Follingstad, Coyne, & Gambone, 2005; McHugh et al., 2013).

This widespread notion of IPV is well-documented in the literature. Male IPV victims state that their friends often laugh when they tell them about the severe and dangerous violence that their female partners use (Cook, 2009). Vignette studies show that when the public is asked about their perceptions of IPV, in which the characteristics of the victim, abuser, and incident are experimentally manipulated, judgments against female perpetrators are less harsh and more likely to take contextual information into account, whereas male perpetration is seen as more severe, regardless of whether it is physical or psychological IPV (Sorenson & Taylor, 2005). Similar findings exist with regard to the attitudes and perceptions of mental health professionals (Follingstad, DeHart, & Green, 2004).

There is evidence that domestic violence agency workers are not likely to believe or help men who are victimized by IPV (Cook, 2009; Douglas & Hines, 2011; Hines et al., 2007; Migliaccio, 2001; Tilbrook et al., 2010). These studies show that a majority of men who have sought help from these services have been turned away, told that the abuse must be his fault, that he did something to deserve it, that he must be the real abuser, or that he is lying. Some men report being laughed at and ridiculed. Police sometimes show these same tendencies. For example, when a male IPV victim calls the police because his female partner is being violent with him, he is just as likely to be arrested as is his partner (Douglas & Hines, 2011).

Research also shows that judges grant restraining orders 16 times more often in cases of female victims than in cases of male victims, even after controlling for the severity of violence (Basile, 2005; Muller, Desmarais, & Hamel, 2009). Further, several high-profile publications for child custody assessors (Bancroft & Silverman, 2002; Bancroft, Silverman, & Ritchie, 2011; Jaffe, Johnston, Crooks, & Bala, 2008; Jaffe, Lemon, & Poisson, 2003; Kelly & Johnson, 2008) provide guidelines for child custody evaluators that uniformly associate male gender with IPV perpetration and female gender with IPV victimization (see Dutton, 2006; Dutton, Hamel, & Aaronson, 2010, for more discussion). This combination of information suggests that men and women may be treated differently within the judicial system.

Thus, the evidence shows that women may be more able engage in this type of IPV because the public and legal system conceptualize IPV as something that men do to women. When writing the items for our scale, we reviewed the literature on male victims' accounts of the types of LA aggression that they said their partners enacted to (1) keep them in their relationships, and (2) punish them if they tried to leave or immediately after they left. In the first instance, we noticed that, in general, partners' threatened LA aggression functioned to keep men in their relationships, whereas actual LA aggression was used to hurt men who were in the process of leaving or who had already left. Thus, our scale is divided into two parts: six items containing threats and six items where those behaviors were actually carried out.

CAN THIS TYPE OF IPV HAPPEN TO WOMEN?

Although Tilbrook et al. (2010) argued that this type of IPV is unique to male victims of female perpetrators, a review of the literature indicates that male perpetrators engage in similar behaviors. For example, Beeble, Bybee, and Sullivan (2007) found that 69.9% of female IPV victims reported that their perpetrators had used the children to stay in their lives and 46.8% that their perpetrators tried to turn their children against them. Similarly, Eckstein (2011) found that some female IPV victims remained in their relationships because of fear that their abusers would take their children away from them.

Miller and Smolter (2011) discuss the term "paper abuse" with regard to battered women's experiences. The

types of behaviors included filing frivolous lawsuits, making false reports of child abuse, and threatening to take the children. Similarly, using emotionally abused women's experiences, Watson and Ancis (2013) discussed abusers seeking full custody of the children as a form of revenge, or if the ex-husbands had custody, limiting the extent of contact between the abused women and their children. Other tactics included: (1) failing to pay child support even when the fathers had adequate resources; (2) seeking changes in child support or filing other legal complaints in order to prolong the legal process and deplete the women of their financial resources; (3) hiding assets so that the fathers would not have to split them; (4) falsely accusing the mothers of being an incompetent or abusive parent, of being mentally ill, or abuse of substances; (5) falsely accusing the mothers of infidelity or sexual promiscuity; and (6) paying off witnesses to testify against her.

These studies indicate that men also use LA tactics to abuse their female partners, and thus, we tested the psychometric properties of the scale we developed in terms of men's victimization and perpetration. We investigated whether the items in our scale indicate a cluster of IPV behaviors that both men and women use against their partners, or whether a different scale may need to be developed to reflect female victims' experiences. Because we conceptualized this scale using male victims' experiences and as a form of IPV that takes advantage of people's stereotypes of men, women, and IPV, we expect to find different psychometric properties for victimization and perpetration.

THE CURRENT STUDY

To establish the psychometric properties of our LA aggression scale, we focused on establishing its construct validity and reliability. We established construct validity in several ways. First, we used the most common method of establishing construct validity: factor analysis (Follingstad & Rogers, 2013). Construct validity is further established through concurrent and criterion validity (Follingstad & Rogers, 2013), thus, we analyzed these two issues as well. For concurrent validity, we focused on establishing whether LA aggression was correlated with other forms of IPV because it is considered to be enacted particularly by controlling and violent partners (George, 2003; Miller & Smolter, 2011). For criterion validity, we followed Follingstad and Rogers (2013) and assessed whether known cases of greater severity (e.g., a sample of known IPV victims) have higher scores on the LA aggression scale than others (e.g., a population-based sample). Finally, we assessed the alpha reliability of the scales.

METHOD

Participants and Procedure

Two separate samples of male participants were recruited for this study: a helpseeking sample of physical IPV victims and a population-based sample. For both samples, the men had to speak English, live in the United States, and be between the ages of 18 and 59 to be eligible; they also had to have been involved in an intimate relationship with a woman lasting at least 1 month in their lifetimes. Also, to be eligible for the helpseeking sample, the men had to have sustained a physical assault from their female partner at some point in their relationship, and they had to have sought assistance for their partner's violence from at least one of the following sources: medical doctor or dentist, domestic violence agency, domestic violence hotline, the Internet, a lawyer, the police, a clergy member, a family member, a friend, or a mental health therapist.

We recruited the helpseeking sample of men ($n = 611$) from a variety of sources. We posted advertisements on our research webpage and Facebook page, and we posted ads on webpages and Facebook pages of agencies that specialize in male victims of IPV, the physical and mental health of men and minority men, fathers' issues, and divorced men's issues. We also sent out announcements to a database of researchers, practitioners, and other interested parties who signed up to be on our e-mailing list through our research webpage, which has been in existence since 2008. The advertisement stated that we were conducting "a study on men who experienced aggression from their girlfriends, wives, or female partners." The ad then provided a link to the anonymous online questionnaire. After providing consent, the next two pages of the survey contained questions to assess the above screening criteria. Men who were eligible were allowed to continue the survey. Men who did not meet the eligibility requirements were thanked for their time and were redirected to an "exit page" of the survey. Demographics of the helpseeking sample can be found in Table I.

Participants also included a population-based sample of 1,601 men. Their data were collected by the Internet survey research firm, Knowledge Networks (KN). KN offers the only Internet research panel of about 43,000 adults that is representative of the U.S. population. Panel members are chosen through an intensive, list-assisted random digit dial methodology, supplemented by traditional mailing addressed-based sampling to reach cell-phone only populations. They are invited to participate in the Web panel, and those who agree ($\sim$56%) are enrolled in the panel. Those who do not have Internet access are sent an Internet appliance and are provided with Internet access through KN. As incentives,

TABLE I. Demographics

	Population-Based Sample ($n = 1{,}601$)	Helpseeking Sample ($n = 611$)	
	% or *M* (SD)	% or *M* (SD)	χ^2 or *t*
Male participant demographics			
Age	41.77 (11.35)	43.89 (9.18)	4.52***
White	76.5%	75.5%	0.28
Black	10.2%	4.1%	21.09***
Hispanic/Latino	11.8%	4.9%	23.57***
Asian	1.9%	4.3%	10.16***
Native American	1.4%	2.9%	5.54*
Income (in thousands)	48.5 (27.6)	47.7 (27.7)	0.63
Educational Status[1]	3.68 (1.83)	4.71 (1.63)	12.90***
Female partner demographics			
Age	40.28 (11.60)	40.77 (9.53)	1.02
White	75.5%	67.4%	14.76***
Black	8.1%	4.1%	10.74***
Hispanic/Latina	9.9%	9.7%	0.02
Asian	4.0%	5.7%	3.10
Native American	1.4%	1.0%	0.71
Income (in thousands)	36.8 (23.5)	43.9 (29.6)	5.14***
Educational Status[1]	3.79 (1.78)	4.17 (1.77)	4.40***
Relationship demographics			
Currently in a relationship	86.5%	26.3%	730.93***
Relationship length (months)	150.09 (122.86)	112.33 (87.62)	8.05***
Time since relationship ended (in months)	6.55 (29.91)	45.17 (54.33)	16.63***
Minors involved in the relationship	41.6%	67.7%	118.83***
# of Minors involved in relationship	0.79 (1.12)	1.12 (1.03)	6.58***
Victimization from CTS2 Scales (% Ever)			
Severe Psychological Aggression	24.3%	95.8%	514.97***
Controlling Behaviors	18.9%	94.3%	571.57***
Physical Aggression	23.6%	100%	580.14***
Sexual Aggression	11.3%	48.1%	179.26***
Injuries	5.7%	72.3%	522.48***
Perpetration of CTS2 Scales (% Ever)			
Severe psychological aggression	20.5%	34.5%	25.73***
Controlling behaviors	16.5%	38.3%	61.13***
Physical aggression	17.1%	46.1%	102.55***
Sexual aggression	21.4%	14.6%	7.46**
Injuries	5.4%	21.1%	61.55***

[1]Educational status: 1, less than high school; 2, high school graduate or GED; 3, some college/trade school; 4, two-year college graduate; 5, 4-year college graduate; 6, at least some graduate school.

*$P < .05$.

**$P < .01$.

***$P < .001$.

panelists are enrolled in a points program where they accumulate points by completing surveys and then trade them in for prizes.

To increase the likelihood of the panel members' participation in our study, KN provided extra incentives and sent reminder emails three times during the month of data collection. KN's email was sent to male panel members between the ages of 18 and 59, and it informed them about a study, supported by the National Institutes of Health (NIH), on how well men and women get along, and men's health. Of the 3,536 men who were invited to participate, 2,174 (61.5%) entered the survey; 90% of them consented to participate, and of those who consented, 82.5% were eligible. Demographic information on this sample can be found in Table I.

The methods for this study were approved by the boards of ethics at our institutions of higher education. All participants were apprised of their rights as study participants. All of the men in the helpseeking sample participated anonymously. Participants in the population-based sample participated confidentially. KN links the data from each survey to the demographic and other information that it maintains on each participant. However, KN did not release any identifying information to the investigators on this project. Participants were informed that their responses would remain confidential,

that their confidentiality would be protected with a Certificate of Confidentiality obtained from the NIH, that KN would not release any identifying information to the investigators, and that they could not be personally identified in any reports that resulted from their participation. In addition, steps were taken to ensure all participants' safety: At the completion of the survey the participants were given information about obtaining help for IPV victimization or psychological distress, and on how to delete the history on their Internet web browser.

Measures

Both the helpseeking and population-based samples were given the same questionnaires regarding demographics, aggressive behaviors that they and their female partners may have used, their mental health, their physical health, various risk factors for IPV, and if applicable, their children's witnessing of IPV, their children's mental and physical health, and other risk factors for their children. Only the questionnaires used in the current analyses are described here.

Demographic information. Men were asked basic demographic information about both themselves and their partners, including age, race/ethnicity, personal income, and education. Men were also asked about the current status of their relationship, the length of their relationship with their partners, how long ago the relationship ended (if applicable), and how many minor children were involved in that relationship, if any.

Revised Conflict Tactics Scales (CTS2). The *CTS2* (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used to measure the extent to which the men in the study perpetrated and sustained psychological, physical, and sexual aggression, and injuries in their relationships. The items used for this study included four items assessing severe psychological aggression (e.g., threatening to hit or throw something at partner, calling partner fat or ugly), 12 items assessing physical aggression (e.g., slapping, beating up), six items assessing injuries (e.g., having a small cut or bruise, broken bone, passing out), and six items assessing sexual aggression (e.g., insisting on, threatening, or using force to have sex when the partner did not want to).

Consistent with our previous research on male victims (e.g., Hines & Douglas, 2010a, 2010b, 2011), we supplemented the *CTS2* with nine items from the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1995) that focused on controlling behaviors and could be applied to men as victims. A factor analysis (Hines & Douglas, 2010b) showed that these items represented a unique factor that was distinct from the severe psychological aggression items of the CTS2.

Participants responded to items depicting each of the conflict tactics by indicating the number of times these tactics were used by the participant and his partner. Participants indicated on a scale from 0 to 7 how many times they experienced each of the acts, 0 = never; 1 = 1 time in previous year; 2 = 2 times in previous year; 3 = 3–5 times in previous year; 4 = 6–10 times in previous year; 5 = 11–20 times in previous year; 6 = more than 20 times in previous year; 7 = did not happen in the previous year, but has happened in the past.

In order to obtain an approximate count of the number of times each act occurred in the previous year, we recoded the original items in the following way: 0 = 0 acts in previous year (includes never and did not happen in the past year but has happened before); 1 = 1 act in the previous year; 2 = 2 acts in the previous year; 3 = 4 acts in the previous year; 4 = 8 acts in the previous year; 5 = 16 acts in the previous year; 6 = 25 acts in the previous year. We also recoded each item according to whether it *ever* happened during the course of the relationship, where 0 = no, and 1 through 7 = yes.

Each subscale of the CTS2 (i.e., perpetration and victimization of each type of IPV) was then scored in four different ways:

1. Whether any of the types of aggression ever happened (dichotomous yes/no variable).
2. The number of different acts of each type of aggression that ever happened (e.g., there were a total of 12 items of physical aggression, so participants could be victimized by up to 12 types of physical aggression). This method of scoring is recommended by Moffitt et al. (1997), who showed that it provided a reliable and valid assessment of the severity and frequency of the various forms of IPV, without violating statistical assumptions.
3. Whether any of the types of aggression happened in the previous year (dichotomous yes/no variable).
4. Frequency of the different types of aggression within the past year (i.e., adding up the number of times each of the acts occurred in the past year for each of the items that comprised a given type of aggression).

The *CTS2* has been shown to have good construct and discriminant validity and good reliability (Straus et al., 1996). Reliability statistics for the current samples ranged from .69 (perpetration of severe psychological aggression) to .94 (victimization from physical aggression). The percentage of men who were ever victimized or ever perpetrated each of the forms of aggression, separated by sample type, is presented in Table I.

Legal and administrative aggression scale. The LA aggression scale was divided into two components: (1) A 6-item scale that we added on to the CTS2, and (2) a 6-item scale comprised of dichotomous yes/no questions. The first component

was added onto the end of the CTS2, and contained six items asking participants how often they and their partners threatened to engage in various types of LA aggressive acts. These acts are certainly aggressive, but to differentiate them from the second component of the scale, we refer to this component as the "threatened LA aggression" subscale. Using the same response options as the CTS2, participants indicated how often they and their partner threatened each of the following acts: (1) make false accusations to authorities that the partner physically or sexually abused the other; (2) make false accusations to authorities that the partner physically or sexually abused the children; (3) leave and take the children away; (4) leave and take all the money and possessions; (5) ruin the partner's reputation at work; and (6) ruin the partner's reputation in the community. This scale was scored in the same manner as the other scales of the CTS2 (see above). To conduct factor analyses and reliability analyses on this scale, any responses of 7 (did not happen in the past year, but happened before) were converted to 0.5, in accordance with Hines and Saudino (2004). This recoding allowed for a continuous scale that approximated how frequently each behavior occurred in the past year, from 0 = never happened to 6 = happened more than 20 times.

We refer to the second component of this scale as the "actual LA aggression" subscale. These dichotomous yes/no questions were asked after the "threatened" items, and assessed whether the participant and/or his partner actually ever engaged in any of the six acts we outlined in the preceding paragraph. We did not conduct factor analyses on these items because the data are dichotomous, but we did conduct reliability analyses. The scale was scored by counting the number of "actual" acts of LA aggression the participant and his partner engaged in, and indicating whether the participant and/or his partner engaged in any of the six acts listed (1 = yes, 0 = no).

RESULTS

The first series of analyses examined the missing data patterns. Less than 5% of the threatened LA aggression items had missing values, and missing items were replaced according to the instructions for scoring the CTS2: For participants who answered at least half of the items on the scale, their missing data was replaced with the mean of the other items on the scale. If they answered only 0 or 7, the missing value was replaced with a 0. Because the actual LA aggression items were dichotomous yes/no questions, missing values could not be replaced. Nonetheless, less than 5% of the dichotomous items had missing values.

Construct Validity: Factor Analyses of the Threatened LA Aggression Scale

Our next series of analyses focused on construct validity and consisted of factor analyses to assess whether our threatened LA aggression scale consisted of one or more subscales and whether all the items loaded onto the factor(s). To increase variability in the items and the reliability of the factor analyses, we conducted our initial analyses with both samples combined. In addition, we conducted separate analyses for the victimization and perpetration items. We used principal axis factoring with an oblimin rotation for both scales.

Table II displays the results. For both victimization and perpetration, a one-factor solution fit the data. For victimization, all items loaded strongly on the factor. However, for perpetration, the item "threatened to leave and take the children away" was a weak contributor to the factor, and as evidenced by its communality estimate, did not strongly correlate with the other items on the scale.

To further understand the perpetration of threatened LA aggression, we conducted factor analyses separately by sample type (see Table III). A one-factor solution emerged for the population-based sample, but a two-

TABLE II. Principal Axis Factor Analysis With Oblimin Rotation for the Six Items on the Threatened Legal and Administrative Aggression Scale ($n = 2{,}178$)

	Victimization		Perpetration	
	Factor Loading	Communality	Factor Loading	Communality
Threatened to make false accusations to authorities about physical or sexual abuse of partner	.87	.70	.74	.49
Threatened to make false accusations to authorities that partner physically or sexually abuses the children	.74	.56	.60	.43
Threatened to leave and take the children away	.69	.51	.31	.12
Threatened to leave and take all money and possessions	.78	.57	.56	.28
Threatened to ruin partner's reputation at work	.85	.72	.80	.60
Threatened to ruin partner's reputation in the community	.85	.72	.74	.61
Eigenvalue	3.83		2.50	
% of Variance explained	63.89		41.74	

TABLE III. Principal Axis Factor Analysis for the Six Items on the Perpetration of Threatened Legal and Administrative Aggression Scale: Separated by Sample Type

	Population-Based ($n = 1,579$)		Helpseeking[1] ($n = 599$)		
	Factor Loadings	Communality	Factor 1 Loadings	Factor 2 Loadings	Communality
Threatened to make false accusations to authorities about physical or sexual abuse of partner	.81	.62		.78	.35
Threatened to make false accusations to authorities that partner physically or sexually abuses the children	.79	.69		.70	.31
Threatened to leave and take the children away	.49	.31	—	—	.01
Threatened to leave and take all money and possessions	.71	.62	—	—	.04
Threatened to ruin partner's reputation at work	.90	.76	.80		.56
Threatened to ruin partner's reputation in the community	.84	.75	.93		.60
Eigenvalue	3.55		1.55	1.13	
% of Variance explained	59.08		25.79	18.75	

[1]At first, we tried a principal axis factoring with an oblimin rotation, which yielded a two-factor solution. However, the two factors were only correlated .14, so an orthogonal (varimax) rotation was used instead. The results presented here are from the varimax rotation.

factor solution emerged for the helpseeking sample. For both samples, "threatening to leave and take the children away" is the weakest contributor. Although it emerges as a moderate contributor (.49) to the factor for the population-based sample, it is not nearly as strong as the next weakest contributor, which has a factor loading of .71. In addition, its communality is quite low, suggesting that it is not adequately correlated with the remaining items. This trend is starker with the helpseeking sample, in which there is no correlation with the remaining items, and it does not emerge in the factor solution as contributing to either factor.

For the helpseeking sample, two factors emerged with two items each. The first factor encompassed the items regarding making false accusations of abuse, whereas the second encompassed ruining the partner's reputation. However, when alpha reliabilities were conducted, the first factor had a reliability of only .67, while the second was better at .85. In addition for the helpseeking sample, the item "threatened to leave and take all the money and possessions" did not contribute to factor solution, and it was not correlated with the other items.

Construct and Concurrent Validity: Factor Analyses of the Controlling Behaviors and Threatened LA Aggression Scales

Our next analysis focused on further establishing construct validity and on assessing concurrent validity. We tested whether this new scale is a measure of a separate form of IPV or is merely a component of controlling behaviors. To do so, we conducted a principal axis factor analysis with an oblimin rotation on the six items of the threatened LA aggression scale and the nine items of the controlling behaviors scale. To increase variability and the reliability of the analyses, we combined both samples. Table IV presents the results. For victimization, the factors were as expected, with clear delineation between the controlling and LA aggression items. However, for perpetration, the results were not as clear. Here "preventing partner from getting needed medical care" and "threatening to harm someone close" emerged with the LA aggression items. Again, "threatening to leave and take the children away" did not emerge as a form of LA aggression perpetration, nor did it emerge as a means of controlling perpetration. For both victimization and perpetration, the correlations between the factors ranged from .63 to .70, indicating that although two factors emerged, they are highly correlated, which is expected given that all forms of IPV should be correlated with each other. Thus, for victimization, both construct and concurrent validity are supported. However, for perpetration, the picture is more complicated.

Concurrent Validity: Correlations of the Threatened LA Aggression Scale With Other CTS2 Scales

To further establish the concurrent validity of the threatened LA aggression scale, we conducted a series of correlations to investigate its relationship to the other types of IPV assessed by the CTS2. The correlations were conducted with the "number of types ever" variables to increase the variability in the analyses. Table V presents the results. For the population-based sample, the victimization from threatened LA aggression was significantly correlated with all forms of IPV victimization and with all forms of IPV perpetration. Similarly, the perpetration of threatened LA aggression was significantly correlated with all forms of IPV victimization and with all forms of IPV perpetration. Thus, concurrent validity is supported for the population-based sample.

However, a different picture emerged for the helpseeking sample. Victimization from threatened LA aggression was

TABLE IV. Principal Axis Factor Analysis With an Oblimin Rotation on the Threatened Legal and Administrative Aggression and Controlling Behaviors Items ($n = 2,178$)

	Victimization			Perpetration		
	Factor 1	Factor 2	Communality	Factor 1	Factor 2	Communality
Threatened to make false accusations to authorities about physical or sexual abuse of partner		.74	.719	.71		.587
Threatened to make false accusations to authorities that partner physically or sexually abuses the children		.86	.604	.55		.470
Threatened to leave and take the children away		.74	.544	—	—	.163
Threatened to leave and take all money and possessions		.58	.620	.47		.395
Threatened to ruin partner's reputation at work		.71	.730	.83		.650
Threatened to ruin partner's reputation in the community		.70	.737	.80		.652
My partner threatened to harm someone close to me	.38		.479	.67		.725
My partner prevented me from knowing about or having access to the family income	.55		.547		.39	.310
My partner prevented me from seeing my friends or family	.66		.648		.74	.590
My partner restricted my use of the car	.70		.436		.64	.459
My partner restricted my use of the telephone	.87		.580		.52	.494
My partner monitored my time and made me account for my whereabouts	.60		.555		.57	.291
My partner did not allow me to leave the house	.83		.572		.69	.606
My partner prevented me from getting needed medical care	.58		.403	.80		.796
My partner followed me to check on what I was doing	.56		.457		.56	.265
Eigenvalue	8.04	1.31		6.63	1.42	
% of Variance explained	50.85	5.90		41.15	6.04	

Note. Used pattern matrix for the factor loadings because of its ease of interpretation. For victimization, Factor 1, controlling behaviors; Factor 2, legal and administrative aggression. For perpetration, Factor 1, legal and administrative aggression; Factor 2, controlling behaviors.
Correlations between factors: victimization: $r = .70$, perpetration: $r = .63$.

correlated with only the victimization from other forms of IPV, and perpetration of threatened LA aggression was correlated with only the perpetration of other forms of IPV. Thus, there is some evidence of concurrent validity in that the victimization items were correlated with other forms of IPV victimization and the perpetration items were correlated with other forms of IPV perpetration.

Because victimization and perpetration are highly correlated for other forms of IPV, we next analyzed the overlap between the victimization and perpetration of the LA aggression scales to further establish concurrent validity. Table VI presents the correlations between victimization and perpetration for both samples. For the population-based sample, the results consistently showed

TABLE V. Correlations Between the Number of Types of Threatened Legal and Administrative Aggression and the Number of Types of Other Forms of IPV

	Population-Based Sample ($n = 1,601$)		Helpseeking Sample ($n = 611$)	
	Perpetration of LA Aggression	Victimization from LA Aggression	Perpetration of LA Aggression	Victimization from LA Aggression
Perpetration				
Severe psychological aggression	.54***	.56***	.30***	.06
Controlling behaviors	.74***	.68***	.25***	.06
Physical aggression	.68***	.64***	.19***	−.02
Sexual aggression	.62***	.54***	.19***	−.02
Injuries	.75***	.63***	.18***	.00
Victimization				
Severe psychological aggression	.48***	.60***	.05	.41***
Controlling behaviors	.64***	.73***	.10*	.39***
Physical aggression	.60***	.67***	.05	.30***
Sexual aggression	.65***	.57***	.02	.05
Injuries	.72***	.65***	.07	.23***

*$P < .05$.
**$P < .01$.
***$P < .001$.

TABLE VI. Correlations Between Victimization and Perpetration of Legal and Administrative Aggression

	Population-Based	Helpseeking
Threatened aggression		
Ever happened	.41***	.11**
# of Types that ever happened	.71***	.06
Happened in past year	.26***	.27***
Frequency in past year	.81***	.15***
Actual aggression		
Prevalence	.38***	.10*
# of Types	.45***	.06

*$P < .05$.
**$P < .01$.
***$P < .001$.

that perpetration and victimization of LA aggression were significantly and at least moderately correlated. However, for the helpseeking sample, victimization and perpetration were not always significantly correlated.

Criterion Validity: Comparisons Between the Samples on the LA Aggression Scale Items

We compared the population-based sample with the helpseeking sample on all items (see Table VII); criterion validity would be supported if the sample with expected higher severity of victimization on LA aggression (i.e., helpseeking sample) indeed had higher severity. As expected, victimization rates for all items were high for the helpseeking sample, and were significantly higher than men in the population-based sample. Specifically, while 91.4% of helpseeking men reported victimization on at least one of the threatened LA aggression items, 12.9% of the population-based sample of men did. Men in the helpseeking sample experienced on average about two different forms of threatened LA aggression ever, compared to less than one form experienced by men in the population-based sample. The past-year frequency of victimization was vastly different, with helpseeking men experiencing threatened LA aggression almost 32 times on average, in comparison to just over 4.5 times for the population-based sample of men. Moreover, while 78.9% of the helpseeking men reported that their partners engaged in at least one of the "actual" forms of LA aggression items, only 3.9% of the population-based sample of men did. Helpseeking men experienced more than 2.5 forms of actual LA aggression on average, whereas men in the population-based sample experienced on average, close to zero forms.

When comparing the population-based and the helpseeking sample on perpetration, we see that, overall, the helpseeking sample (11.2%) was significantly more likely to threaten at least one of the forms of LA aggression than the population-based sample was (5.3%). However, there were no differences between the samples on the number of types of threatened LA aggression they engaged in or in the past-year frequency of LA aggression. Moreover, on the item level, we see very few differences in threatened LA aggression. The only item-level difference is in threats to leave and take the children away (Helpseeking: 5.8%, Population-based: 2.0%). This difference stays the same and remains significant when only men with children are considered (Helpseeking: 8.7%, Population-based: 4.9%, $\chi^2 = 6.16$, $P = .013$). On the other hand, men in the helpseeking sample were significantly more likely to have actually perpetrated all of the forms of LA aggression, except for ruining their partner's reputation at work. Overall, 9.7% of helpseeking men engaged in at least one form of actual LA aggression—on average 0.13 types, whereas 1.1% of the population-based sample of men did—on average 0.02 types.

The differences between victimization and perpetration within samples are illustrative for criterion validity purposes as well. As expected given the nature of the sample, helpseeking men were victimized by significantly more threatened and actual LA aggression than they perpetrated. This was true when looking at prevalence, number of types, and past-year frequency, and when looking at every item of the scales. The same pattern emerged for the population-based sample, although the differences between victimization and perpetration were smaller and there were a few exceptions. Men in the population-based sample were significantly more likely to have been victimized by (than having perpetrated) all forms of threatened LA aggression, with the exception of threats to make false accusations to authorities that the partner physically or sexually abuses the children. They were victimized by more types of threatened LA aggression than they perpetrated, and in comparison to the frequency with which they perpetrated, they were victimized more frequently in the past year. For actual forms of LA aggression, they experienced aggression more than they perpetrated it for all forms, except threats of false accusations to authorities.

Reliability Analyses

We first computed Cronbach's alpha for the threatened LA aggression scales. When both samples were combined, both the perpetration ($\alpha = .79$) and victimization ($\alpha = .91$) scales achieved acceptable levels of reliability. Item analyses showed that the alpha for the perpetration scale increased to .81 if the item "threatened to leave and take the children away" was removed. Moreover, when we computed the Cronbach's alpha separately by sample type, we found that reliability was equally good for the population-based sample ($\alpha = .89$ for both victimization and perpetration), but not for the helpseeking sample, where it was excellent for

TABLE VII. Descriptive Information on Each Item of the Legal and Administrative Aggression Scale by Sample Type

	Population-Based $n = 1{,}601$			Helpseeking $n = 611$			Differences Between Population-Based and Helpseeking Samples	
			Differences Between Victimization and Perpetration			Differences Between Victimization and Perpetration		
	% Victimization	% Perpetration	McNemar's Test *P*-value	% Victimization	% Perpetration	McNemar's Test *P*-Value	χ^2 for Victimization	χ^2 for Perpetration
Threatened aggression items								
Ever threatened to make false accusations to authorities about physical or sexual abuse of partner	2.7	1.3	<.001	73.3	1.2	<.001	1261.75***	0.08
Ever threatened to make false accusations to authorities that partner physically or sexually abuses the children	0.8	0.6	.219	40.3	0.8	<.001	659.52***	0.49
Ever threatened to leave and take the children away	6.6	2.0	<.001	57.9	5.8	<.001	696.18***	21.41***
Ever threatened to leave and take all money and possessions	7.4	4.0	<.001	63.3	3.2	<.001	774.67***	0.75
Ever threatened to ruin partner's reputation at work	3.0	1.3	<.001	62.8	2.5	<.001	1000.44***	3.80
Ever threatened to ruin partner's reputation in the community	3.2	1.3	<.001	66.1	1.5	<.001	1064.21***	0.11
Any of the threatened types of legal and administrative aggression ever	12.9	5.3	<.001	91.4	11.2	<.001	1191.87***	13.55***
Any of the threatened types of legal and administrative aggression in the past year	7.3	2.6	<.001	45.0	5.8	<.001	424.22***	13.55***
Actual aggression items								
Did make false accusations to authorities about physical or sexual abuse of partner	0.8	0.5	.359	55.7	3.5	<.001	985.45***	30.08***
Did make false accusations to authorities that partner physically or sexually abuses the children	0.3	0.0	.125	25.9	1.5	<.001	424.95***	24.58***
Did leave and take the kids	1.5	0.1	<.001	44.4	2.9	<.001	696.96***	37.80***
Did leave and take all the money and possessions	1.5	0.6	.004	44.8	2.7	<.001	701.65***	17.22***
Did ruin partner's reputation at work	0.8	0.3	.039	40.6	0.8	<.001	671.76***	3.63
Did ruin partner's reputation in the community	1.4	0.2	<.001	52.1	1.7	<.001	866.31***	16.41***
Did do any of the actual types of legal and administrative aggression	3.9	1.1	<.001	78.9	9.7	<.001	1337.99***	95.81***
	M (SD)	*M* (SD)	*t (p)*	*M* (SD)	*M* (SD)	*t (p)*	*t*	*t*
# of types of threatened aggression ever	0.78 (0.02)	0.10 (0.58)	9.54 (<.001)	1.92 (0.08)	0.15 (0.47)	43.81 (<.001)	42.27***	1.91
Past year frequency of threatened aggression	4.61 (0.12)	2.56 (0.06)	4.78 (<.001)	31.93 (1.30)	3.24 (0.13)	11.60 (<.001)	11.32***	1.56
# of types of actual aggression	0.06 (0.36)	0.02 (0.17)	5.64 (<.001)	2.56 (1.93)	0.13 (0.43)	30.78 (<.001)	31.77***	6.19***

***$P < .001$.

victimization ($\alpha = .89$), but unacceptable for perpetration ($\alpha = .47$).

Cronbach's alpha reliability was also calculated for the actual LA aggression items for both samples combined, and then separately by sample type. The reliability for the victimization items was excellent for the combined samples ($\alpha = .88$), acceptable for the helpseeking sample ($\alpha = .75$), and adequate for the population-based sample ($\alpha = .67$). Alpha reliabilities for perpetration were consistently poor for the population-based (.52), helpseeking (.44), and combined (.48) samples.

DISCUSSION

The purpose of the present study was to test the construct validity and reliability of a new scale to measure LA aggression within the context of intimate relationships. This scale's format was based on the CTS2 and is intended as an add-on to that scale. It focuses specifically on LA aggressive tactics within an ongoing intimate relationship or shortly after it ends. It was developed using the experiences of male IPV victims, but both victimization and perpetration scales were tested on two samples of men: male IPV victims who sought help and a population-based sample. We found initial support for both the validity and reliability of this scale.

Victimization Scale

We found evidence to support both the construct validity and reliability of the victimization scale across both samples and within each sample of men. We found strong alpha reliabilities, a one-factor solution that is separate from, but correlated with a controlling behaviors scale, significant correlations with other forms of IPV victimization, and much higher rates among the helpseeking men than among the population-based sample of men.

The only possible exception to the strong psychometric properties of this scale was that there was little overlap between victimization and perpetration of LA aggression in the helpseeking sample. Similarly, there was little overlap between the victimization of LA aggression and the perpetration of other forms of IPV within the helpseeking sample. However, these findings may not be evidence of a lack of validity. Instead, they may reflect something unique about the helpseeking sample. Although there is evidence for an overlap between victimization and perpetration for other forms of IPV (e.g., Hines & Saudino, 2003; Straus, 2008; Whitaker, Haileyesus, Swahn, & Saltzman, 2007), little research has been conducted to assess whether this applies to helpseeking samples. We also do not know whether this should apply to this particular type of IPV among helpseeking samples.

Within the current study, we saw that for both the population-based and helpseeking samples, victimization was more common than perpetration. This finding with the population-based sample may suggest that LA aggression is perpetrated more by women than by men, although there are other potential explanations. For example, the psychometric properties of the perpetration scale were not that strong, and therefore, we might not be adequately measuring men's perpetration of LA aggression. If a different measure were developed that was more robust, we may not see any differences between perpetration and victimization in the population-based sample.

There was also little overlap between the victimization of LA aggression and the perpetration of other forms of IPV for men in the helpseeking sample. Because we are adequately measuring victimization from LA aggression and the perpetration of other forms of IPV, this lack of association cannot be due to poor reliability. This finding is important, however, because it would suggest that men in the helpseeking sample were unlikely to be perpetrators who "got what they deserved" in the legal system. They were recipients of another type of IPV, LA aggression. However, because the findings are based solely on self-reports, multiple informants are needed in future research to confirm this conclusion.

Perpetration Scale

The psychometric properties of the perpetration scale are more complicated. For both samples, the item "threatened to leave and take the children away" is not an item that emerges as a contributor to this scale, nor does it emerge as a contributor to the controlling behaviors scale. Thus, although a small minority of men used this tactic against their female partners, we found that it is not something that is used within the context of other forms of LA aggression or controlling behaviors. Perhaps men are more likely to believe that the other parent should be involved in their children's lives, and do not use this behavior to control or punish their partner. Future research should strive to understand why this particular behavior of men does not correlate with other types of LA aggression or controlling behaviors.

We also found different factor structures for the two samples, neither of which were completely unique from the controlling behaviors scale. We found two factors for the LA items for the helpseeking sample, but just one for the population-based sample. Moreover, the alpha reliabilities were—for the most part—unacceptable for both samples. Thus, there is little evidence that this is a valid or reliable scale for men as perpetrators, and work needs to be done to further analyze and revise this scale for assessing perpetration before it can be used in empirical studies.

This finding parallels research on psychological IPV. For example, McHugh et al. (2013) point out that the PMWI (Tolman, 1995) was developed using a sample of battered women, and therefore, many of its behaviors cannot be applied to male victims simply by changing the pronouns. In fact, men and women seem to use different forms of psychological IPV (Follingstad & Rogers, 2013; McHugh et al., 2013). Thus, scales developed to measure a construct among female IPV victims are often inadequate to measure that same construct among male IPV victims (McHugh et al., 2013). Given that we developed this LA aggression scale with male IPV victims' experiences, it is unlikely that the scale would apply to men as perpetrators just by changing the pronouns.

Thus, an important area of future research would be to develop a LA aggression scale using female IPV victims' experiences. We know from the current study that men report using all of the forms of LA aggression we assessed; however, they did not form a unifying construct as they did for victimization. We also know from previous studies that female IPV victims report experiencing various form of abuse that are related to legal issues—for example, falsely accusing them of abusing the children, falsely accusing them of having a mental illness or substance abuse problems: thus, it is important to develop a similar scale using female victims' experiences.

On the other hand, the weak psychometric properties of the perpetration scale may be due to a lack of variability in the items assessed and the skewness of the data. Lack of variability can degrade the factor solution (Meyers, Gamst, & Guarino, 2013), while skewed data reduces alpha reliability estimates (Ryan, 2013). Thus, both the factor analyses and the alpha reliability estimates may be inaccurate measures of whether this is a good measure. It is possible that our perpetration measure is a good measure of men's use of LA aggression; it just needs to be tested on samples with greater variability in experiences.

Limitations and Future Research

In addition to the issues discussed previously, the current study has several limitations that should be addressed in future research on LA aggression. For example, because we intended this scale to be an add-on to the CTS2, we limited the number of items. Thus, the scale might not be comprehensive enough, and important forms of LA aggression may be missing. Future research should test additional potential items. Such items should go beyond measuring threats and various forms of false allegations. Similarly, our scale focused on LA aggression that occurs within the context of an ongoing relationship or shortly after it ends. However, research shows that for both male (e.g., Cook, 2009; Hines et al., 2007; Hines & Douglas, 2010a) and female (e.g., Watson & Ancis, 2013) IPV victims, LA aggression can continue to occur throughout and long after a divorce or relationship disruption and child custody procedures are completed. Thus, assessing this form of IPV among couples who are ending or have ended an intimate relationship is necessary, and additional items would need to be considered. Such items could include preventing the non-custodial parent from seeing or having access to the children, failing to pay child support even when the perpetrator has sufficient assets to do so, filing frivolous lawsuits and claims, and alienating the non-custodial parent from the child's affection.

Future studies should also assess additional forms of validity to further establish the psychometric properties of this scale. For example, discriminant validity ought to be established with constructs that should be conceptually distinct from LA aggression. In addition, convergent validity should be established through the associations of this scale with similar constructs. Although the high correlation between our LA aggression measure and controlling behaviors provides initial support for convergent validity, LA aggression's correlations with other similar constructs, such as romantic relational aggression, should also be tested (Carroll et al., 2010; Murray-Close et al., 2010). Such research could also investigate whether LA aggression is a separate construct from romantic relational aggression. Because romantic relational aggression involves similar techniques to sully one's partner's reputation, it should be correlated with LA aggression. On the other hand, romantic relational aggression and LA should be distinct concepts because with romantic relational aggression, the perpetrator uses their partner's peer groups, but with LA aggression, the perpetrator uses people in positions of power to exact potentially devastating consequences on their victim, such as the loss of the victim's children, job, home, and financial stability.

We were unable to address this issue in the current study because of the overarching goal of the grant under which this study was supported. This goal was to investigate the physical and mental health problems of male victims of PV and their children. Thus, our measures were carefully chosen to address this goal, and we were unable to include a measure of romantic relational aggression in the current study due to concerns about participant burden.

Another important issue is to assess how this form of IPV should be operationalized among LGBTQ couples. Our LA aggression scale may not apply to their experiences because the legal system in many states is not structured to consider their unique family circumstances, and thus, a perpetrator may be able to use tactics that are not common among heterosexual couples. As an example, if one member of a lesbian couple were to have a baby and the other member was not legally allowed to

adopt that child by the state, custody could be fully denied to the non-biological parent upon relationship disruption by the biological parent. Moreover, some of the items developed for our scale (e.g., ruining reputation) may encompass different tactics (e.g., outing a partner who is not out to family, workplace) than what is found among heterosexual couples.

Finally, like most measures of IPV, this scale is limited because it is a self-report measure. Research shows that the typical pattern is under-reporting of one's own use of undesirable behavior, but not of one's partner's undesirable behavior (Woodin et al., 2013). There could also be a potential for over-reporting of one's partner's aggressive behaviors (e.g., due to wanting people to see them in a negative light; revenge; needing to feel superior). However, under-reporting is typically more common, as victims tend to feel embarrassed or humiliated by being abused, and the tendency to embellish is likely more related to one's own personality traits (Follingstad & Rogers, 2013). Moreover, as with psychological IPV, the subjective nature of some of the items assessed in a LA aggression scale contribute to the difficulty of fully establishing the validity of the scale. We do not know the context in which these threats took place or the temporal sequence of events, particularly when a participant reported both perpetration and victimization. We also do not know if the participant is misinterpreting events. Thus, more multidimensional and context-specific measures of this construct need to be developed. This scale represents a first step towards that end.

Implications

More work needs to be conducted on further developing and testing our LA aggression scale, but our work has important implications for the legal system because it is within this institution where many of these tactics play out. Previous research shows that IPV victims may be especially vulnerable to LA aggression; because of the psychological trauma of being abused, the victim is vulnerable to acquiescing to the abuser's threats or staying in an abusive relationship (Watson & Ancis, 2013).

The findings of our research suggest that legal system personnel (e.g., judges, attorneys, custody evaluators) should be informed of these types of abuse tactics and that they can be utilized by both male and female perpetrators to gain advantages within a relationship and in divorce, relationship disruption and child custody cases. Clinical and social service practitioners will likely benefit from knowing that the legal system can be an arena for an abuser to further her or his abuse against a victim, and thus, they could prepare their clients for potentially experiencing such abuse (Watson & Ancis, 2013). Furthermore, some suggest that judges should punish offenders who file false and frivolous claims (Miller & Smolter, 2011) to send a clear message that this type of behavior will not be tolerated.

Another potential implication is that this form of IPV can potentially keep victims in unhealthy relationships; thus, we need to identify the nuances of how this form of IPV functions in both marital, custody and non-marital relationships. By understanding this form of IPV in more detail, it could have implications for mental health practitioners being able to more readily identify this form of IPV, how it works in relationships, how it is perpetrated, how it relates to other forms of IPV, and to help victims identify it and remove themselves from unhealthy relationships.

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Male victims of female-perpetrated partner violence: A qualitative analysis of men's experiences, the impact of violence, and perceptions of their worth.

Machado, A., Hines, D., & Douglas, E. M. (2020). Male victims of female-perpetrated partner violence: A qualitative analysis of men's experiences, the impact of violence, and perceptions of their worth. *Psychology of Men & Masculinities, 21*(4), 612–621. https://doi.org/10.1037/men0000285

There has been a recent increase in the amount of research on male victims of female-perpetrated partner violence (PV), but research needs to be conducted to understand how the patterns of abuse persist in these relationships. In the current study, the experiences of 59 male PV victims in the United States, recruited through online advertisements in professional networks and websites (e.g., agencies that specialize in male victims of PV), were explored through a thematic analysis. Analyses suggested that the help-seeking process of male PV victims is complex and heterogeneous and can often lead to further negative consequences due to various structural, cultural, social, and organizational factors. The findings also highlight the potential societal issues that male victims perceived as contributing to male victimization and lack of available resources for them. The results are discussed in terms of its implications for agencies, service providers, and general societal attitudes that are relevant to raising awareness about this phenomenon. (PsycInfo Database Record (c) 2020 APA, all rights reserved)

Impact Statement

Public Significance Statement: A qualitative analysis of abuse and help-seeking experiences of men who are victims of PV reveals that men report being underacknowledged, mistreated, and penalized when trying to seek help or address the patterns of abuse in their intimate relationships. The findings also highlight the potential societal issues that male victims perceived as contributing to male victimization and the lack of available resources for them. (PsycInfo Database Record (c) 2020 APA, all rights reserved)

Dear Legislators:
My name is Joan Kloth-Zanard. I am an expert in the field of custodial interference where one parent falsely impedes the relationship between the children and the other parent. I have spent over 35 years working with not only victims of abuse but victims of this horrific form of psychological abuse. In my oldest case, the son, now 40 years old, finally had an epiphany about what happened to him at his other parent's hands. He is finally realizing that his other parent lied to him and abused him physically and psychologically, it nearly destroyed his life and ability to be a functioning adult. Just a few days ago, he reached out to his good parent to ask them to please tell him what really happened.

You have worked hard on this legislation and I want to thank you for removing any rhetoric about Parental Alienation not being real and junk science. With over 35 years of research, study and peer-reviewed articles, it is clear that custodial interference that uses the coercive control of parental alienating behaviors and domestic violence by proxy is not healthy for the children and their family relationships.

Sadly, there are still major issues with the bill. First, Custodial Interference and Coercive Control are criminal felony acts. The act of alienating and impeding the relationship between the children and the other parent is a form of custodial interference, so long as there is no criminal conviction for abuse or adjudication as an unfit parent. Any person who impedes the relationship between the children and the other parent through the use of these alienating tactics, is therefore committing a criminal act. We need to recognize that this causes serious damages to the children's psychological makeup and in fact is child psychological abuse.

Below I have numerous areas of concern that I would like to see if you would consider inputting into the bill to avoid these issues.

First, there is the issue of false allegations. 99% of all custodial interference cases and cases of coercive control contain alienating behaviors used impede and interfere with a child's relationship with one parent. False allegations are a serious issue as they take time and money from true victims of abuse. False allegations also cause serious harm to children who are raised to believe they were victims of abuse that never happened. This sets a horrible psychological trauma for them that never occurred and follows them for life. They live their lives as if victims of abuse and this sets them up for a plethora of self-esteem, attachment and abandonment issues.

Below are various resolutions that can be taken as whole or in parts to fix this and many of the others.

A RESOLUTION/BILL/ACT CONCERNING STANDARDS RELATED TO COURT PROCEEDINGSWHERE THERE ARE ACCUSSATIONS/ALLEGATIONS OF ABUSE AND NEGLECT.

Accusations of Abuse or neglect

Any allegations of abuse or neglect are criminal acts that cannot be adjudicated in family court as family court does not allow for public defenders, or pro-bono attorneys and thus violates due process rights under the 5th and 14th amendments of the United States. All such allegations must be made in the appropriate criminal court where the accused can be

guaranteed protection under the color of the law and where the accusing is also properly protected.

Alternate Option:
Family court must provide due process protection for the accused including but not limited to Pro-bono attorney or Public Defender where allegations of abuse or neglect are claimed.

Use of a Guardian Ad Litem(GAL) or Attorney for the Minor Child (AMC):
A GAL or AMC will only be used where one or both parents are suspected of being unfit. But once the parent or parents are deemed fit, the GAL or AMC will be removed.

To address the excessive legal abuse of excessive filings of motions or allegations.

In most cases of custodial interference, there is a preponderance of false and misleading allegations against one parent or both. To avoid further false allegations, an order such as a Strobel order – Strobel vs Strobel, a CT appellate case, could be issued; wherein a judge orders that litigants are barred from filing motions, complaints or allegations without express permission of the courts.

Penalties for repeated false unsubstantiated charges

If a person files two or more allegations accusing a parent of abuse and neglect, penalties must be swiftly enacted to ensure cessation of this behavior and continued delays of the case. Such penalties to include:

1. $500 fine that triplicates with each new false allegation; and/or
2. 5 extra days with the aggrieved parent that triplicates with each new allegation; and/or
3. 5 days of community service for the impeding parent that triplicates with each new allegation

After the 4th false allegation, the accusing parent risks loss of custody permanently or at the very least, a restraining order allowing them only therapeutic supervised visitation.

Next, the UN has NOT made any such statement about this being only Women and Children. They have made it clear that it is genderless. When we create legislation that discriminates against one gender, we take our government back to the dark ages. There is a massive amount of research and study, including from the Federal Government that shows women abuse men and children at the same rate as men supposedly do. If we ignore this fact that women are just as abusive, then boys will never be safe in our words and will continue to suffer including feeling forced to change their gender identity to avoid be considered part of the tainted gender as a male figure. Think of the implications down for the road for all male children who see their father's and all men seen as abusers.

Next, without specialized training that includes the identification of Cluster B personalities such as narcissism, bi-polar and other such diagnoses, the professionals put in place to make judgements was to the children's relationship with the parents is a dangerous game. It is a statistical fact that lack of proper training and the use of Traditional family therapy instead of Structural and Systems family therapy causes more harm than good. In fact, the wrong therapy

and improper evaluations cause the children to self-harm, suicidal and in some cases so hypervigilant about being perfect that they cannot handle the stress and anxiety in their homes. This last group of children actually appear to be doing well in school, but when you really get down to the heart of it, these children barely have any true close friends, they are terrified of not being perfect. This leads to other issues that eventually cause serious in adulthood.

Next, as to sufficient age and maturity issues, if our own federal government does not believe children are mature enough to vote until 18, drink or smoke until 21 or rent a car until 25, then how is it even possible that these same children can make a decision so momentous as to remove one parent from their lives permanently? They cannot!!

Next, custodial interference and coercive control are the hallmarks of Stockholm Syndrome. To refresh your history of this syndrome, Stockholm syndrome, psychological response wherein a captive begins to identify closely with his or her captors, as well as with their agenda and demands and comes from the Stockholm Bank robbery of 1973. It is sometimes called Patty Hearst Syndrome related to her kidnapping and finally falling in line with her captures to psychologically protect herself. In fact, when debunking cults like the Moonies, Jim Jones, Wacko and other religious organization that kidnap a person's mind and life, the treatment is the same as Stockholm syndrome. This treatment for Stockholm syndrome is very specialized and exactly what is being used in cases where one parent falsely impedes the relationship between the children and the other parent. To claim this treatment does not exist or cannot be used, would mean that any person who has been kidnapped, cannot get treatment. I implore you to consider the following resolution to address this issue of treatment instead of banning something that is standard to the mental health field when a person, no matter their age, has been brainwashed and programmed.

RESOLUTION CONCERNING STANDARDS RELATED TO COURT PROCEEDINGS WHERE THERE IS CUSTODIAL INTERFERENCE AND NO CRIMINAL CONVICTION FOR ABUSE OR NEGLECT OR LEGAL ADJUDICATION AS AN UNFIT PARENT EXISTS AND THE TREATMENT FOR CUSTODIAL INTERFERENCE

Bill Summary:
Under federal and state law, custodial interference is a felony, barring there is no criminal conviction for abuse or adjudication of a parent being unfit. Custodial is defined as:

> The act of custodial interference violates a parent's legal rights to parent. It is a felony and thus a criminal act that uses the concept of Stockholm syndrome and coercive control to interfere and/or impede an evaluation or report to the court concerning disputed issues relating to the parental responsibilities' allocation.

The bill further defines "custodial interference" in two ways.

> **Direct Interference with Custody**
> Direct interference with custody can include physically obstructing visitation, not returning the child, relocating the child without authorization, and annulling visitation time, which can lead to legal consequences. Examples of direct interference with custody

include physically preventing visitation, refusing to return the child, moving the child without permission, and canceling visitation time by one or both of their parents.
If one or both parents believe there are valid grounds to alter the parenting time order, it is recommended that they file a motion in court. It is also advised that they seek legal advice before making any changes to the parenting time schedule independently.

Indirect Interference with Custody
Indirect parenting time interference involves disrupting communication, preventing participation in activities, disparaging the targeted parent, and encouraging the child to refuse visits. Examples of interference with custody may include disrupting communication via text or phone or email, preventing participation in activities that the child is involved in, badmouthing the other parent, and coaching the child to refuse visits.

In severe cases, contacting law enforcement may be necessary to address the interference. Refusal to permit a child to contact the non-custodial parent via telephone and hindering a parent from engaging in a child's educational or extracurricular activities may be viewed as unacceptable interference with custody.

The bill defines "coercive control"

The bill requires that if allegations of domestic violence, child abuse or neglect, or child sexual abuse have been made, a child or youth must not be forced into an allocation of parental responsibilities arrangement, and the court is required to give strong consideration to the child's or youth's preference, if the preference is consistent with protecting the child's or youth's safety and the child has not been found to be compromised, influenced or otherwise parroting the other parent.

The bill defines a "deficient parent" as:

The bill defines a "deficient parent" as one who has been adjudicate as unfit through an evidentiary hearing and psych evaluation by a therapist specifically trained in cult-like behaviors, Stockholm syndrome and psychological abuse.

Harm caused by Custodial Interference:

Custodial interference as it pertains to alienating behaviors and the impact to the parent-child relationship create psychological harm to the children and their targeted extended family. Custodial interference sets the child up to believe that they are victims of the other parent usually for related to domestic violence. When a child is raised to believe that they are victims of abuse, when they are not, they live their lives as victims and this changes how they view the entire world as well as themselves. Psychological abuse causes further physical and behavioral issues.

2014-2015 Study about the Adverse Childhood Experiences was done based on the 10 areas of concern: or verbal abuse

- Physical or emotional neglect
- Separation or divorce
- A family member with mental illness

- A family member addicted to drugs or alcohol
- A family member who is in prison
- Witnessing a parent being abused

Below are a list of just some of the issues that affect children who are falsely withheld from a parent.

- Disrupted Neurodevelopment
- Social, emotional and cognitive impairment
- Adoption of health risk behaviors
- Impacts on life potential
- Disease, disability and social programs
- Early Death

Sources:
-2015, Nuruis, Paula S, Sara Green, Patricia Logan-Greens, Sharon Borja. Adverse Childhood Experiences Study"
-CDC, 2019, Adverse Childhood Experiences Prevention, https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf.

It has been recommended by the CDC and ACE's Study, that the following areas of concern be ensured for all children who score high on the ACES's testing.

- Strengthening economic supports for families
- Promoting social norms that protect against violence and adversity
- Ensuring a strong start for children and paving the way for them to reach their full potential
- Teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges
- Connecting youth to caring adults and activities
- Intervening to lessen immediate and long-term harms

Sources:

*2015, Nuruis, Paula S, Sara Green, Patricia Logan-Greens, Sharon Borja. Adverse Childhood Experiences Study"
*CDC, 2019, Adverse Childhood Experiences Prevention, https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf.

Remediation for Custodial Interference:

As Custodial Interference is a felony misdemeanor federally and, in all states, penalties f or this criminal act must be adjudicated in the proper court of law, that of Criminal Court.

A transfer of physical or legal custody of the child may be necessary to ensure the children are given a fighting chance to re-establish a relationship with the targeted parent.

Where necessary, and because of the impeding parent refusing to cooperate, therapeutic supervised visitation for the impeding parent should be required.

And where the courts have given temporary to one parent due to custodial interference, and based on the HIPAA rights of the parent and children, the temporary custodial parent,

who has been appointed by the courts due to custodial interference, may choose an out-of-state or multiday stay program in any state.

If a party/parent has been found to be impeding the children's relationship with a parent and/or extended family, the offending party will be given the opportunity to get therapy to help with their hostile aggressive parenting (HAP). They will be given one month to fix their ways and stop impeding before more drastic measures are required.

During this time the targeted parent and children will in therapy 3-days a-week, with overnights on each of the days they have been in therapy and every other weekend. If the party continues to impede this process and not endorse the child(ren)'s relationship and follow the directions of the therapist, penalties will be enacted.

If after 4 weeks of tri-weekly therapy with overnights after each therapeutic appointment, treatment is not progressing because of impediments by the HAP parent including the children continue to parrot, denigrate, and disrespect the targeted parent, running away, refusing to come to therapy or do overnights, and despite these penalties, the offending party will lose custody on a temporary basis and only allowed therapeutic supervised visitation in order that the children and other parents relationship can be repaired.

Standard language for all therapy that is court ordered should include holding the alienating parent responsible and liable for any and all impediments to the reunification process including transferring of the children to the targeted parent. Whether it be the alienating parent or a 3rd party, the aggressive alienating parent will be responsible to ensure that all aspect of the reunification process including transfer of the children. Failure to do sue will result in the alienating parent going to jail.

Standard language in all court ordered therapy should also include immunity for the therapists.

Further, as the targeted parent is the victim of the aggressive parents creating a break in the relationship between the parent and children, the targeted parent shall be the identified patient as they are the victims of domestic violence by proxy through the children's aggressive behavior. The children therefore cannot be the identified patient as they are part of the cause of the targeted parents relationship problems spurred on by the alienating parent.

Therapeutic Treatment for Custodial Interference

The therapeutic treatment such as would be used in Stockholm syndrome or other such cult-like behaviors is considered the appropriate therapy to debunk the trauma of this form of coercive control. No court will dictate the type or amount of therapy required to heal a person or family from this form of psychological abuse.

This bill defines and ascribes the following parameters for safe effective family reuniting therapy where no criminal convictions or adjudications as an abuser have been found.

- Notwithstanding any other law, consent of only one parent is all that is necessary, to ensure the children's welfare is not endangered, a court may order family reunification/reintegration, a court may order family reunification therapy, which is a medical treatment, as a condition of enrollment or participation, and requires any of the following:
- A no-contact order with the aligned parent will only be issued if the offending parent refuses to participate in therapeutic supervised visitation with a therapist of the reunification programs choice.
- Any allegations of abuse must be adjudicated swiftly and no later than 2 weeks after the report to ensure timely process for the family.

The bill includes publication of.

The bill clarifies that, pursuant to a chief justice directive, the office of the state court administrator is authorized to accept complaints regarding investigators and evaluators, and administer appropriate sanctions.

The office of the state court administrator shall publish information on its website regarding judges and magistrates who complete domestic violence and child abuse training.

No court will:

Prohibit investigators and evaluator from doing their job including providing information based on theories that are evidence-based or peer-reviewed in a report to the court. The key here is evidence based and peer-reviewed. Any research that is questionable and has been found to have errors and cannot be replicated should be considered suspicious as invalid. Once a theory has been proven to be evidence-based and peer-reviewed by a court, it shall follow forward for all cases of custodial interference where custody has been impeded with and where no criminal conviction of abuse or adjudication of being an unfit parent have been found. In other words, once a state or federal court has deemed the concept of custodial interference with alienating behaviors to be evidenced-base and peer-reviewed, it shall apply this to all subsequent cases involving this form of child abuse.

Courts will:

- Require investigators and evaluators to provide options for the court to consider;
- Require investigators and evaluators to adhere to certain interviewing and forensic reporting standards as determined by the medical community related to psychological abuse; and having standards for treatment protocols;
- Require investigators and evaluators to provide certain written disclosures to each party before performing duties;
- Allow the implementation of caps on charges for duties performed by evaluators;
- Requires investigators and evaluators to include all information obtained concerning domestic violence and child abuse; or lack thereof;
- Amends training requirements for investigators and evaluators to include specialized training in child psychological abuse that includes custodial interference, Stockholm syndrome, religious cult-debunking and other such isolation methods.

Testimony by Children:

In all proceedings, a child or youth must have the opportunity to be heard but due to the nature of Stockholm syndrome and custodial interference and coercive control, the mental maturity of the child must be evaluated to determine if they are emotionally and mentally mature enough to understand the responsibility and consequences of dismissing one parent. Interviews must be conducted by appropriately trained mental health professionals or social workers with a minimum of a Masters in Marriage and Family Therapy, Structural Therapy and Systems therapy. The child's statements will be entered into the record and sealed if the child or youth is of sufficient age and maturity and able to express an opinion.
The court will be considering information based on theories that are evidence-based or peer-reviewed in determining the best interests of the child or youth when determining parenting time.

Payment for treatment:

Payment for court ordered treatment will be 100% the responsibility of the offending parent. Failure to do so, will result in further charges and other possible penalties to encourage compliance with the orders. Parent may attempt reimbursement for family therapy services through their medical provider.

Penalties:

No aligned parent or associate or extended family member of the aligned parent or any other party will attempt to impede the transition of the children to the other parent. Any person who impedes this transition will be considered to have endangered the life and welfare of the chiler4n and shall be charged as such.\

No aligned parent or associate or extended family member of the aligned parent or any other party will use threats of physical force, undue coercion, verbal abuse or isolation for the child's family, community or other sources of support.

For the purposes of this section, "Family Reunification treatment" means a treatment, therapy, program or service that is aimed at reuniting or re-establishing a relationship between a child and an estranged or rejected parent.

Senate Judiciary

04/29/2024 01:30 PM

HB24-1350 Parental Responsibilities Proceedings Child Safety

Typed Text of Testimony Submitted

Name, Position, Representing	**Typed Text of Testimony**
Noella Elias For themself	Hello my name is Noella Elias. I am representing myself and I am in support of House build 24–1350. I am a mother of two girls whom are suffering the consequences of a neglectful PRE where the PRE concluded for my children to relocate with the abusive parent of domestic violence and coercive control. Being in support of of Bill 24–1350 there are parts of this bill that are fantastic - but other parts that will open a door for more abuse by manipulative parents while placing the children in the middle of parental conflict. I strongly believe that PRE's, CFI's, court evaluators and any other voice to the court based on the children's best interest should be trained on domestic violence and coercive control and use those findings in their conclusions and suggestions. I see where you did increase the training requirement from 15hour to 20 hours. TRAINING SHOULD BE 200 HRS+ AND SPECIFIC TO FAMILY DYNAMICS 20 hrs of training is not near enough to understand the subtleties of coercive control, and antisocial behavior, which are the underlying behaviors in many of these situations, and often confused as "protective parenting". An accused parent/person is often very defensive and hysterical - and that is often used against them by evaluators who do not understand this is a normal reaction, it's a form of C-PTSD, a triggered response from prior and/or ongoing IPV, and taking children away compounds the trauma.

	To this day it is very difficult for a person to find any information or licensure of any PRE. Dora is to hold this information but yet they have no documentation or listing for any PRE or any licensure. The parties that are involved should be given the PRE and or CFI licensure at their first meeting. I am disappointed there were no modifications made regarding “accusations”, and still no punishment for false accusers. The bill ignores false allegations and how to prevent them, in fact it may encourage them going forward with this bill. I appreciate your time and consideration, I thank you for all the support and hope you are providing to those whom are suffering at the hands of a broken system placing the children into the hands of the abuser while alienating the safe parent. Thank you so much from the bottom of my heart for all the work the time the effort and dedication you bring to the children and the parents. Great Regards, Noella Elias

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Jeremy Atkins Against themself	I am a caring, father and I strongly oppose this bill as written. I have not seen my daughter in over a year. I am a victim of Domestic violence, but as a man I was afraid to come forward, I had to go to work many times were cover-up to cover bite marks, bruises, and other wounds, There were times that I fought back and as a result, the mother of my child is claiming that she is a domestic violence survivor. She has put my child and her eldest minor child in danger

	multiple times Including being arrested For shoplifting, while my daughter who was two years old at the time was in her care. I am in a fight for custody for my child right now, and if this is allowed to pass as written, the gender bias will give the mother the upper hand in my case, and put my daughter at risk by allowing her mother who refuses to work or do anything to provide for my child Blanche to abuse, my child further and further alienate my daughter. The bill in its current form will not allow for deeper investigations into abuse, but allow whoever accuses first of domestic violence, the right to continue to abuse, the children and hurt the other parent.
Madison Welborne Against The Anti-Alienation Project	I am a survivor of severe child psychological abuse and an advocate for children's rights representing The Anti-Alienation Project, an organization I created to support adult children of parental alienation. Parental alienation is severe psychological child abuse where one parent manipulates their child to reject their other loving parent without true justification. This abuse is real. It has become highly politicized, and I'm not sure why. Further, because the alienating parent convinces the child that their other parent is bad, abusive, and unloving, the common, destructive effects on that child are SIMILAR, PREDICTABLE, and SPECIFIC. The child, realizing that they are half of each parent, internalizes this hatred and comes to believe that half of themselves is bad. This internalized hatred is why the effects of this abuse are similar, predictable, and specific. All members of our support group, which I only created 3 months ago, have suffered poor self-esteem and symptoms of complex ptsd. Many have experienced addiction or alcoholism to try to numb their emotional pain. The self-destructive effects can extend into adulthood or last a lifetime. We know that these effects are PREDICTABLE due to excellent research in the field by professionals like Dr. Ben Hine, Dr. Karen Woodall and more.

	Last, parental alienation is a worldwide epidemic. According to expert Dr. Harman, there are 22 million parents affected by this abuse in the US today. I believe we need to protect all children. If this bill had been in effect when I was a kid, it would have taken away treatment options for me, as the bill wants to outlaw reunification therapy. It would have failed to train professionals, and would have denied expert witnesses in court that could have fought for my actual best interest. Worst of all, this bill denies the abuse that I, along with millions of others, have experienced…. To what end? I'm aware that the signing of this bill is an effort for Colorado to be eligible for the Stop Fund Grant. You will be voting on a law that will have a permanent, far-reaching impact on not only one child or one childhood, but many lives and lifetimes... in exchange for 4 years of a small amount of funding from a Stop Grant. I ask that you please consider your votes carefully. I respectfully urge you to vote NO on this bill. I would be happy to help others learn more about the alienated child's experience. Thank you for your consideration. —Madison Welborne
Julia Purchase Amend themself	I have been a CFI for over ten years and 90% of my practice is CFI appointments. Over the past three years, I have issued an average of forty reports a year and a total of over 300 in my career. With this background in mind, I wanted to share my opinions. I have tried my best to understand the bill and the proposed changes thus far. I understand the goal of the bill and agree protections should be in place; however, I have sincere concern that these new protections, especially combined with the amendments in 2023, will come at the cost of Courts (and therefore families) no longer having any experienced evaluator feedback.

	The forensic interviewing requirements are concerning, and I am unclear on the training requirements for the same going forward. Also, the requirement regarding "options" for the court based on evidence-based or peer-reviewed theories seems unclear and burdensome. More pressing, however, is how these new requirements are inconsistent with existing law for CFIs in particular. Two main issues stand out: (1) The expectations conflict with the CJD's requirement of a limited scope investigation. Further, the cap on CFI fees is already difficult to meet, and the additional requirements of this bill will make it impossible in many cases. (2) The above is exacerbated by the appointed evaluator's loss of quasi-judicial immunity in 2023. In essence, we have more specific requirements and expectations with the same pay and, now, a risk of being sued. Personally, I devote my time and practice to CFI work because I feel I am helping children and families in a way I was not able to do as a litigator. I do this work with significantly lower pay than what I would likely earn as a family law attorney. Further, it comes with a high degree of stress. As anyone in the family law field knows, every case presents unique challenges, and, as CFI, I take the impact of my investigation and reports on families seriously. All this to say, the current trend in legislation, while certainly well intentioned, leads me to question whether I can realistically continue to do this work. Unfortunately, I have no great solutions to offer instead, but I hope my concerns as an active CFI are helpful. Thank you.