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Understanding the Use of Violence Among Men Who Sustain Intimate Terrorism

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Abstract

Researchers in the field of intimate partner violence (IPV) are paying increasing levels of attention to the notion that members of aggressive and violent relationships cannot always be dichotomized as *innocent victims* versus *blameworthy perpetrators*; nonetheless, no research has documented characteristics of IPV victims that may predict their use of abusive and aggressive behaviors in response to their partners' IPV. This study fills this gap and is unique because it uses a sample of 302 men who sustained intimate terrorism from their female partners and sought help. Results showed that victims who used physical IPV, in comparison with victims who did not, were younger and were more likely to abuse alcohol. In addition, in comparison with victims who used minor physical IPV, victims who used severe physical IPV were more likely to use—and use more frequently—other forms of IPV, and they were more likely to be substance abusers. Results are discussed in terms of possible theoretical implications, directions for future research, and practice implications.

Keywords

male victims; domestic violence; intimate terrorism; alcohol abuse; substance abuse

Researchers in the field of intimate partner violence (IPV) are paying increasing levels of attention to the notion that members of aggressive and violent relationships cannot always be dichotomized as *innocent victims* versus *blameworthy perpetrators* (e.g., Mills, 2008). For example, even if we can delineate that one member of the couple uses more IPV than the other, this latter individual may also engage in behaviors that are problematic and/or abusive. Nonetheless, researchers who have examined samples of IPV victims have not typically investigated the behaviors that those who were traditionally labeled as “victims” may engage in that could be perpetuating the IPV or be abusive in their own way, nor have the researchers examined the reasons, other than motives, for why victims of IPV may also use violent behavior in their relationships. This study represents the first study, to our knowledge, that has investigated several characteristics that differentiate victims of IPV who also use physical IPV against their partners, from those who refrain from using physical IPV in their relationships. Our study is also unique because our sample of IPV victims is comprised solely of heterosexual men who have sought help for their female partner's IPV perpetration.

Use of Intimate Partner Violence Among Victims in Clinical Samples

In a previous analysis of the men in the dataset used for this study (Hines & Douglas, 2010b), we established that our sample of men who sustained IPV from their female partners and sought help was comparable to samples of battered women in shelters in the level and frequency of physical IPV that they sustained. Moreover, we established that overall, the men in our sample sustained intimate terrorism (IT) from their female partners, a type of IPV described by Johnson (1995, 2006) and Johnson and Ferraro (2000) as violence that is one tactic in a general pattern of control of one partner over the other. The IPV is severe, occurring on at least a monthly basis; it is not likely to be mutual, but it is likely to involve serious injury and psychological abuse of the partner as well.

However, we also found that 55% of the men in our sample who sustained IT also used physical IPV in the previous year (Hines & Douglas, 2010b). This percentage is very similar to the percentages of battered women in shelters who report using physical IPV in the previous year. For example, Giles-Sims (1983) found that 50% of women in a shelter reported using physical aggression against their partner within one year prior to coming to the shelter, and Saunders (1988) found that 75% of women in a shelter stated that they engaged in nonsevere violence in the previous year. The use of physical IPV by battered women in shelters is typically attributed to a pattern of violent resistance (Johnson & Ferraro, 2000), and we were able to conclude that this was the case with our sample of male help-seekers. Violent resistance 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).

Even though the percentage of male victims of IT in our sample who used physical IPV is similar to the percentage of battered women in shelters who use physical IPV, it is important to understand why some of these men are engaging in violent resistance in their relationships, whereas others are not. In addition, it is important to understand why some men use more severe levels of physical IPV in relationships in which their partners use IT. We found that 19.5% of the men in our sample reported using at least one act of severe physical IPV in the previous year (i.e., an act that had a high likelihood of causing an injury, such as punching, kicking, or beating up; Hines & Douglas, 2010b); even higher rates have been found among samples of battered women in shelters. Specifically, Saunders (1988) found that 50%–60% of the women in his sample reported using severe violence, with 8% of the women saying that they beat up their partners or used a knife or gun, and with 12% saying that they threatened their partners with a knife or gun. McDonald, Jouriles, Tart, and Minze (2009) found that 67.1% of the women in their shelter sample used severe physical aggression in the previous year against their partners.

These high levels of both minor (e.g., pushing, grabbing, shoving) and severe (e.g., punching, beating up, using a knife or gun) physical IPV perpetration among victims of IT are important to understand for several reasons. The severity of the acts themselves is a concern because they could injure their partners and are dysfunctional to the health of relationship itself. In addition, the use of violence by both parties can lead to an escalation in the IPV that is used by both members of the relationship, and these high levels of violence can lead to both physical and psychological consequences for both parties. For example, the frequency of IPV tends to be higher in relationships in which there is reciprocal violence (Whitaker, Saltzman, Haileyesus, & Swahn, 2007), and studies that assess possible consequences of IPV have found that in relationships with reciprocal violence, both men and women are injured at higher rates (Straus, 2008; Whitaker et al., 2007) and have higher levels of depression (Straus, 2008), in comparison with relationships where only one member of the couple uses physical IPV.

Purpose of this Study

Despite the research reviewed thus far, to our knowledge, no one has investigated the characteristics and behaviors that differentiate IT victims who do not use physical IPV from those who do use physical IPV—in this case, either minor physical IPV or severe physical IPV. In fact, to our knowledge, only four studies (Giles-Sims, 1983; Graham-Kevan & Archer, 2003; McDonald et al., 2009; Saunders, 1988) have investigated the extent to which IT victims, in all cases of battered women in shelter samples, used physical IPV, and only one provided a possible indication as to why IPV occurs, concentrating on self-reported motives (Saunders, 1988).

We have little guidance from the literature concerning what may predict or be associated with the use of violence among help-seeking samples of IT victims, but we can look to the research on men's use of physical IPV in general to guide our choice of variables. This literature indicates that in comparison to men who do not use IPV, men who use IPV are younger (Kessler, Molnar, Feurer, & Appelbaum, 2001; Rennison, 2001; Stith, Smith, Penn, Ward, & Tritt, 2004; Sutor, Pillemer, & Straus, 1990); are more likely to be Black or Native American and less likely to be Asian (e.g., Kessler et al., 2001; Malley-Morrison & Hines, 2004); have lower incomes and education (e.g., Kessler et al., 2001; Stith et al., 2004); are more likely to have a history of experiencing or witnessing abuse during childhood (e.g., Ehrensaft et al., 2003; Kalmuss, 1984; Stith et al., 2000); are more likely to have mental health issues (Kessler et al., 2001), including posttraumatic stress disorder (PTSD; Taft, Schumm, Marshall, Panuzio, & Holtzworth-Munroe, 2008); are more likely to abuse alcohol and other substances (Fals-Stewart, 2003; Fals-Stewart, Leonard, & Birchler, 2005; Leonard, 1993; Murphy, O'Farrell, Fals-Stewart, & Feehan, 2001; O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003; Stith et al., 2004); and are more likely to use other forms of IPV as well, including psychological and sexual IPV (e.g., Hines & Saudino, 2003; O'Leary & Maiuro, 2001; Stith et al., 2004). In addition, in comparison to the female partners of men who do not use physical IPV, the female partners of men who use physical IPV also use more physical IPV (Whitaker et al., 2007), which could also extend to other forms of IPV as well, including psychological and sexual aggression (Hines & Saudino, 2003; Stith et al., 2004). We will investigate in our sample of men who sustained IT whether any of the preceding variables differentiates men who do not use physical IPV, men who use minor physical IPV only, and men who use severe physical IPV.

In addition to testing the previous research questions, we will explore whether the physical size of the male victim and that of his female partner, the status of the relationship (current vs. former), and the disability status of either the man or his female partner influences the participant's use of physical IPV. We will also explore if there are differences between groups in the ways that the male participant responded to his partner's last instance of physical aggression (e.g., Did he try to get away from her, or did he yell and curse at her?) and in the male partner's help-seeking efforts (e.g., Did he seek help from the police or from a domestic violence hotline?).

METHODS

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 female partner ($n = 302$) was recruited from various sources, including the Domestic Abuse Helpline for Men and Women (DAHMW; a U.S. national IPV hotline specializing in male victims), and online websites, newsletters, blogs, and Listservs that specialized in the treatment of IPV, male 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 female 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 male 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 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, whereas 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, height, weight, personal income, education, and disability status. Men were also asked about the status of their relationship, the length of their relationship with their partners, and whether minor children were involved in that relationship.

Revised Conflict Tactics Scale—The *Revised Conflict Tactics Scale* (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 knife/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, 2010b).

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, where 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 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).

For this article, we calculated a dichotomous and a frequency variable for each 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 which the participant and his partner used each type of IPV. The *CTS2* has been shown to have good construct, 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 as follows: .45 (*severe injury*), .65 (*minor psychological*), .72 (*severe psychological*), and .90 (*minor physical aggression*).

Additional Information on Intimate Partner Violence—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 respondents 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.

Abusive Childhood Experiences of the Participant—Childhood abusive experiences were assessed using four questions that condensed the 16 items from the sexual abuse history (SAH) and violence socialization (VS) scales of the *Personal and the Relationships Profile* (Straus, Hamby, Boney-McCoy, & Sugarman, 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), “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 years old, 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 years old, 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 this study, we dichotomized each item: Participants who indicated that they agreed or strongly agreed with an item were coded as having sustained that type of childhood abuse; if they disagreed or strongly disagreed, they were coded as not having sustained that type of childhood abuse.

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 the particular female partner about whom they were reporting. For diagnoses, they were given the following forced 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 (ADHD)/attention deficit disorder (ADD), and other. If they chose *other*, we asked them to specify the diagnosis.

Posttraumatic Stress 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, respondents were asked to think about a potentially traumatic event, which for this study

was 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. Because a score of 45 or higher is considered to be indicative of PTSD (Weathers et al., 1993), the scores were also dichotomized to indicate the presence or absence of PTSD. 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 the 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, Del Ben, Scotti, & Rabalais, 2003). Furthermore, the PCL has been shown to have high diagnostic utility (.79–.90) when validated against the “gold standard” measures such as the structured clinical interview for *DSM-IV* axis 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.

Alcohol and Substance Abuse—Alcohol and substance abuse were measured using a scale developed for the National Women’s Study to assess the association between IPV victimization and alcohol/substance abuse among female victims (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). The scale included up to 19 items, asking respondents about their use and abuse of alcohol and illicit drugs in their lifetimes and in the past year, and included items regarding negative experiences resulting from alcohol abuse. Consistent with Kilpatrick et al. (1997), we measured alcohol abuse within the past year using two indicators: (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 (*everyday/almost everyday*). Similarly, substance abuse was measured by two indicators: (1) If participants indicated that they used any of the illegal substances more than four times in the past year, they were considered nonexperimental users/substance abusers, and (2) actual frequency of substance use within the past year from 0 (*never*) to 3 (*more than 10 occasions*). This scale has demonstrated excellent construct validity (Kilpatrick et al., 1997).

Help Seeking—We asked the men to indicate whether they had ever sought help from the following sources because of their partner’s IPV: the Internet, a domestic violence hotline, a local domestic violence agency, the police, a mental health professional, a doctor or emergency room, and/or a shelter for IPV victims. We did not include help-seeking from family or friends in these analyses because we gathered less data on these questions.

Analyses

We divided participants into three groups according to their reported use of physical IPV in the previous year: no physical IPV, used minor physical IPV only, and used severe physical IPV. Using chi-squares and ANOVAs, we compared the three groups on their demographics, childhood history of experiencing aggression, mental illness and PTSD, alcohol and substance abuse, their partner’s and their own use and frequency of various forms of IPV, their reactions to their partner’s physical aggression during their last physical argument, and their use of the various sources of help. Although we performed many analyses, we did not correct for inflated alpha levels that were a result of experiment-wise error. This is an exploratory study that has never been conducted with either women or men who sustained IT, and therefore, we were looking for patterns of differences and possible

areas of exploration in future research on the prediction of the use of physical aggression among individuals who sustain IT.

Because of unequal sample sizes across cells, Welch's variance-weighted one-way ANOVA was used, as recommended by Garson (2009). Tukey's post hoc tests were used to investigate the location of any significant differences, unless the homogeneity of variance assumption was violated, in which case Tamhane's T2 test was used as recommended by Meyers, Gamst, and Guarino (2006). Several variables were transformed, using either the natural logarithm or the natural logarithm plus 1, to correct for extreme multivariate kurtosis. These included partner's weight, partner's education, participant's income, relationship length, frequency of alcohol intoxication in the past year, frequency of substance use in the past year, frequency of participant's use of controlling behaviors, and frequency of participant's use of severe psychological aggression. However, when presenting the means and standard deviations of these variables, we present the non-transformed means and standard deviations. Finally, we did not analyze differences in the frequency of insisting on sex or the frequency of injuries, for either the men or their female partners, because of severe kurtosis that could not be corrected through transformations. As mentioned by Garson (2009), although ANOVAs are robust to violations of multivariate normality, they are still sensitive to extreme violations of kurtosis.

RESULTS

Table 1 presents the results in examining the differences between the three groups of men. Nearly half of the men reported that they had not used any physical IPV in the previous year ($n = 135$; 44.7%). Almost 36% ($n = 108$; 35.8%) reported that they used minor physical IPV only, whereas 19.5% ($n = 59$) reported that they used severe physical IPV in the previous year.

Demographic Differences and Differences in Childhood History of Experienced Aggression and Mental Illness/Posttraumatic Stress Disorder

There were few demographic differences between the groups, with the exception of age. Men who did not use physical IPV were significantly older than the other two groups of men, and men who used minor physical IPV only were significantly older than men who used severe physical IPV. Similarly, the female partners of the men who did not use physical IPV were significantly older than the female partners of the other two groups of men whose ages did not differ from each other.

There was also a significant difference in the reported weights of the female partners, with the female partners of men who did not use physical IPV being significantly heavier compared with the female partners of men who used minor physical IPV only. Further analyses showed that these differences remained even after controlling for the differences in the ages of the female partners ($F [2,291] = 3.83, p < .05$).

There were no significant differences between the groups in any of the measures of childhood experiences of aggression, in PTSD or any of its subscales, or in a history of being diagnosed with a mental illness.

Differences in Alcohol/Substance Abuse in the Past Year

Table 1 also shows that for all measures of alcohol and substance abuse, there were significant differences between the groups. Specifically, men who did not use IPV in the previous year were significantly less likely than either of the two other groups to have abused alcohol in the past year, and they were intoxicated significantly less often. Men who

used minor IPV only did not differ from men who used severe IPV in frequency of intoxication or abusing alcohol in the previous year.

Men who did not use IPV and men who use minor physical IPV only were significantly less likely than men who used severe physical IPV to have abused substances in the previous year, and they used substances at significantly lower frequencies in the past year than men who used severe physical IPV.

Differences in Partner's Use of Intimate Partner Violence

The three groups of men did not differ in their experiences of sustaining controlling behaviors, nor were there differences in the percentage of men who sustained severe psychological aggression. However, men who used severe physical IPV sustained more frequent acts of severe psychological aggression from their female partners within the past year than men in the other two groups who did not differ from each other. Men who used severe physical IPV also experienced more physical IPV from their female partners than men who did not use physical IPV in the previous year; they were more likely than the men in the other two groups to have sustained a severe injury in the previous year, and they were more likely than men who used minor physical IPV only to have sustained sexual aggression in the previous year.

Differences in Men's Use of Intimate Partner Violence

There were several significant differences in the men's use of various forms of IPV in the previous year. Men who used severe IPV were significantly more likely to have used controlling behaviors in the previous year and to have used these behaviors significantly more frequently, than men in the other two groups who did not differ from each other. They also used significantly more physical IPV, in terms of frequency, than men who used minor physical IPV only (men who did not report using IPV were not included in this analysis because there was no variability in their use of physical IPV). The female partners of men who used severe IPV were significantly more likely to have reportedly sustained a serious injury in the previous year than the female partners of men in the other two groups. On the other hand, men who did not use physical IPV were significantly less likely to have used severe psychological aggression and to use it significantly less frequently, than men in the other two groups who did not differ from each other in either the prevalence or frequency of severe psychological aggression. Similar results were obtained for the prevalence of sexual aggression in the previous year by the men.

Differences in Responses to Partner's Physical Intimate Partner Violence and Help Seeking

When the men reported that their female partners were the first to use physical IPV in the previous year, there were a few differences in their responses. Although the groups did not differ in the extent to which they reported crying, calling a friend/relative, or calling the police in response to their partner's last instance of physical IPV, they did differ in the extent to which they reported yelling/cursing and getting away/going to another room. Specifically, men who did not use physical IPV were significantly less likely to have yelled or cursed at their partners than men in the other two groups, and they were significantly more likely to have gotten away/gone to another room than men who used minor physical IPV only.

There were also no differences between the groups in the extent to which they sought help from the Internet, domestic violence (DV) hotlines, local DV agencies, or mental health professionals. However, men who did not use physical IPV were significantly more likely to have called the police or tried to go to a shelter than men who used minor physical IPV only.

In addition, men who did not use physical IPV and men who used severe physical IPV were significantly more likely to have gone to a doctor or emergency room because they were injured than men who used minor physical IPV only.

DISCUSSION

This study is the first to examine the characteristics of IT victims that differentiate whether they do not use physical IPV, whether they use minor physical IPV only, and whether they use severe physical IPV. In addition to our study being unique in examining such characteristics, our study is also unique because we examined these characteristics among a sample of male IT victims. Results will be discussed in two main parts: What differentiated men who did not use physical IPV from those who did (either minor or severe) and then what further differentiated men who used minor only IPV from those who used severe physical IPV.

Differences Between Men Who Do Not Use Physical Intimate Partner Violence and Men Who Do

We found several characteristics that differentiated men who did not use physical IPV from those who used either minor or severe IPV. Consistent with the previous research on men who use IPV in general (Kessler et al., 2001; Rennison, 2001; Stith et al., 2004; Sutor et al., 1990), men in our sample who used physical IPV tended to be younger than men who did not; their partners tended to be younger as well. What was surprising was that there were no differences between men who used physical IPV and men who did not in ethnicity, education, income, or disability status of either the participant or his partner. This is contrary to our expectations, given the previous research on men who use physical IPV in general (Kessler et al., 2001; Malley-Morrison & Hines, 2004; Stith et al., 2004), and it could be because of our unique help-seeking sample of men who sustain IT.

One interesting finding was that men who did not use physical IPV had female partners who weighed significantly more than the female partners of men who used minor physical IPV only, a weight difference that could not be accounted for by the age differences between the groups. Perhaps these men fear their partners because of their partners' larger size—that is, their partners have greater strength and ability to physically harm them if the men engage them in physical IPV. Similarly, men with smaller partners may know that they can use physical IPV to retaliate or defend themselves, with a lesser likelihood of being injured. This is, of course, a speculation, and given the likelihood of experiment-wise error, this result should be replicated in future research.

Another interesting finding was the lack of differences between men who use physical IPV and those who did not (either minor or severe) in childhood history of abuse and mental illness. This is contrary to what we would expect given the previous research (Ehrensaft et al., 2003; Kalmuss, 1984; Stith et al., 2000) but points toward the possibility that although these histories may increase the risk of being in a relationship characterized by physical IPV, they may not differentiate the way that victims respond once involved. Perhaps a history of childhood abuse and mental illness may lead one to become involved in IPV, but for men at least, once involved, they do not predict whether he hits his female partner when she hits him. In addition, there are no differences between groups in PTSD scores. PTSD, in this study, was intended to be an outcome variable—we asked the men to reflect on their worst argument with their partners and report their symptoms in response to that argument. Thus, there are no differences between groups in their PTSD because of their worst argument, which may mean that no matter how the male victim of IT responds to his partner's IPV, he has a similar likelihood of suffering from symptoms of PTSD.

However, our study suggests that men who use physical IPV (either minor or severe) engage in other maladaptive behaviors with their female partners as well. Specifically, in comparison to men who did not use physical IPV, men who did use physical IPV engaged in significantly more severe psychological IPV (both in prevalence and in frequency) and were more likely to insist on engaging in sex when their partners did not want to. There were few differences, however, in the female partners' behaviors, which means that it may not be the women's IPV that drives the men's maladaptive behavior but something about the men that leads them to react with IPV.

This "something" seems to be alcohol abuse. That is, men who used both minor and severe physical IPV were intoxicated significantly more often and were more likely to be categorized as abusing alcohol in the past year than men who did not use physical IPV. This is consistent with prior research that suggests that alcohol is a risk factor for men's use of physical IPV (Fals-Stewart, 2003; Fals-Stewart et al., 2005; Hines & Douglas, 2010a; Leonard, 1993; Murphy et al., 2001; O'Farrell et al., 2003; Stith et al., 2004).

Several theories have been posited as to why alcohol may lead men to engage in physical IPV, which can be summarized by three subtypes of theories: the spurious effects model, the indirect effects model, and the proximal effects model (Leonard & Quigley, 1999). According to the spurious effects model, the association between alcohol abuse and the use of physical IPV would disappear once other associated variables are controlled. One such variable could be age, in that younger people have developed fewer social problem-solving skills and coping mechanisms and, therefore, use IPV and alcohol more frequently than older individuals do. In this study, follow-up analyses showed that the association between physical IPV and alcohol intoxication remained significant, even after controlling for age ($F[2,292] = 3.64, p < .05$).

The indirect effects model would posit that alcohol abuse would be toxic to the intimate relationship, and this dysfunctional intimate relationship would then lead to physical IPV because of the increasing conflict that the alcohol abuse has caused (Leonard & Quigley, 1999). Thus, the association between the use of physical IPV and alcohol abuse would be fully mediated by measures of relationship quality and satisfaction. Although we did not have any measures of relationship quality and satisfaction, we did have measures of all types of IPV that both the male victim and his partner used. Increases in the male victim's intoxication by severity level of his physical IPV did not correspond with increases in the female partner's use of any type of IPV, nor were there any significant bivariate correlations between men's alcohol abuse and their female partner's use of any type of IPV (r 's = $-.08$ to $-.09$, ns). Thus, it does not seem that the male's intoxication led to an increase in the female partner's use of maladaptive conflict resolution behaviors, which would be expected if the male partner's intoxication led to increasing conflict and IPV in the relationship.

According to the proximal effects model, alcohol intoxication and abuse causes one to engage in physical IPV (Leonard & Quigley, 1999). One such theory that falls under this model is the "alcohol myopia" theory (Steele & Josephs, 1990). This theory suggests that under increased intoxication, the range of social problem-solving cues available to people may become limited because alcohol restricts the brain's ability to attend to and perceive cues in a given situation. Thus, if provoked, the intoxicated person may not be able to access higher order social problem-solving skills to resolve a conflict. In this situation, what could be happening is that when intoxicated, the man is attending to immediate cues (i.e., provocation by his partner) and is unable to attend to more distal, inhibitory information (e.g., possibility that he could be arrested for engaging in IPV) or to figure out alternative means to conflict resolution other than aggression.

Support for this theory would be in the form of evidence that the men are engaging in physical IPV when they are intoxicated and when they are provoked physically by their female partners. We do not have this specific information, although we do know that during the last physical argument that was instigated by the female partner, male participants who reported that they used any physical IPV in the previous year were significantly more likely to have been drinking than male participants who reported no use of physical IPV in the previous year (15.7% vs. 6.4%, $\chi^2 [1, N = 278] = 5.82, p < .05$). Thus, this is preliminary evidence that perhaps the man's intoxication contributed to his use of physical IPV when physically provoked by his female partner; however, the temporal associations do need to be investigated in more detail, such as through the diary studies conducted by Fals-Stewart (2003).

In addition to investigating the temporal association between alcohol intoxication and physical IPV, future research should investigate possible mediators and moderators in this association, such as impulsivity and deficits in executive cognitive functioning. For example, perhaps men with impulsivity issues are unable to control their drinking behaviors or their use of physical IPV (Field, Caetano, & Nelson, 2004; Schafer, Caetano, & Cunradi, 2004), especially when intoxicated. On a broader level, researchers have shown that deficits in executive cognitive functioning (i.e., skills such as attention, problem solving, planning, self-regulation, ability to abstract relevant information) help explain associations between impulsivity and aggression and between impulsivity and drinking problems (McMurran, Blair, & Egan, 2002; Ramadan & McMurran, 2005). Thus, it could be that male victims of IT who choose to use physical IPV as a response to their partner's aggression have deficits in executive cognitive functioning, which contributes to both their aggressive responses and their drinking problem.

Other differences between the groups of men are informative for our understanding of how they react to their partner's IPV. Specifically, men who do not use physical IPV are less likely to yell or curse at their female partner when she hits him and are more likely to get away from her or go to another room. Thus, men who do not use physical IPV are more actively trying to avoid their partners during a physical confrontation, whereas the men who use physical IPV are more likely to use other maladaptive means of responding to their partners' aggression, namely yelling and cursing at her. In addition, when seeking help, men who do not use physical IPV are more likely to call the police, go to the emergency room, or try to go to a shelter than men who used minor physical IPV only, but not more likely to use any other sources of help. This suggests that when men call the police or go to a shelter for help, it is unlikely that he is the *real abuser* in this relationship, an accusation that male help seekers often encounter by domestic violence agency workers and police (Douglas & Hines, in press). Instead, it is likely that such a help-seeker is trying to utilize sources of support to escape and avoid violence.

Differences Between Men Who Use Minor Physical Intimate Partner Violence Only and Severe Physical Intimate Partner Violence

In addition to differentiating male victims of IT who used physical IPV from those who did not, we also investigated what influenced whether men used minor physical IPV versus severe physical IPV: Why did some men cross the line and use a level of physical IPV that had a high likelihood of injuring his female partner? Age, once again, differentiated these two groups, with men who engaged in severe physical IPV being significantly younger than men who used minor physical IPV only, and there were no differences between the men on any of the remaining demographic traits, childhood history of abuse, or mental illnesses including PTSD.

However, there were significant differences between the groups of men in the other types of IPV that were occurring in these relationships. Specifically, in addition to using significantly more acts of physical IPV than men who used minor physical IPV only, men who used severe physical IPV also were more likely to use controlling behaviors and used them significantly more often in the previous year. Thus, their behavior was more likely to trend toward mutual violent control, a behavior that Johnson (2006) and Johnson and Ferraro (2000) described as two intimate terrorists battling each other for control. However, what is important to point out is that although men who used severe physical IPV engaged in controlling and physical IPV more frequently than their no IPV and minor IPV only counterparts, they still reportedly engaged in much fewer of these behaviors than their female partners (controlling behaviors: $M = 43.88$ acts in the previous year for the female partners vs. $M = 6.31$ acts for the male participants. physical IPV: $M = 65.56$ acts in the previous year for the female partners vs. $M = 15.29$ acts for male participants). Therefore, although these men engaged in severe physical IPV and controlling behaviors, they would still be considered victims of IT who engage in violent resistance, according to the classification criteria established by Johnson.

However, what is apparent is that their use of severe physical IPV is leading to many more injuries for both them and their partners. More than 50% of the men who used severe physical IPV sustained a severe injury in the previous year, as did almost 25% of their female partners—percentages that are significantly greater compared with men in the other two groups (who did not differ from each other). Thus, the high levels of physical IPV in these relationships, by both the participant and his partner, are causing high levels of severe injuries. These results are consistent with those by Straus (2008) and Whitaker et al. (2007) who found that when both partners use severe IPV, it leads to higher levels of injury. We hypothesize that when the men in our study respond to their partners with severe physical IPV, it escalates the violence and is more likely to cause an injury.

The major characteristic that seems to differentiate men who use minor physical IPV only from men who use severe physical IPV is substance abuse. Although both groups of men have engaged in more alcohol abuse than the men who used no physical IPV, they did not differ from each other in alcohol abuse. However, men who used severe physical IPV were more likely to engage in substance abuse and used substances significantly more often than the other two groups of men—no IPV and minor IPV groups (who did not differ from each other). These findings are consistent with research on typologies of male batterers, which show that men who engage in more severe battering behaviors (i.e., generally violent antisocial and borderline dysphoric batterers) are more likely to abuse substances than men who engage in more minor levels of IPV (i.e., family-only batterers; Hamberger & Holtzworth-Munroe, 2009). However, this research also shows that more severe male batterers are also more likely to abuse alcohol, have a diagnosable mental illness, and experience family-of-origin violence, which was not the case with our sample of male victims of IT who used physical IPV. These discrepancies between our sample and samples of male batterers show the necessity of studying male victims of IT and possible typologies in their own right, and this study represents a first step toward this end.

In addition, future research should investigate why alcohol abuse and drug abuse may differentially predict the levels of physical IPV among this sample of men. Currently, theories explaining the link between substance abuse and the use of physical IPV are the same as those that predict the link between alcohol abuse and the use of physical IPV, with findings from all such studies being combined to provide support for a given theory (see e.g., Fals-Stewart, Klostermann, & Clinton-Sherrod, 2009; for a review). However, this study shows that different theories may be necessary to explain the divergent ways that

alcohol abuse and substance abuse predict the use of physical IPV among a sample of male IT victims who seek help.

Limitations and Future Research

This study represents the first study, to our knowledge, to investigate a wide range of characteristics that could differentiate IT victims who use physical IPV in their relationships from those who do not. In addition, it is unique because our focus was on male victims of IT, who traditionally have been overlooked in the literature on IT victims and IPV victims who seek help. Nonetheless, several limitations should be considered in future research in this area. The first limitation was that we did not control for experiment-wise error. Thus, some of the significant differences we found may not truly be significant. Because this study is exploratory in nature, in that we wanted to investigate patterns of variables that might be predictive of the use of physical IPV among IT victims, controlling for experiment-wise error might have concealed these patterns. Nonetheless, results reported here should be viewed with caution and as preliminary results only, and future research should aim to replicate and expand on our findings.

Such expansions should include help-seeking samples of female victims of IT, such as those found in battered women's shelters. Thus far, only a handful of studies have reported on battered women's use of physical IPV (Giles-Sims, 1983; Graham-Kevan & Archer, 2003; McDonald et al., 2009; Saunders, 1988), and the only variable that has been investigated as a possible reason for their IPV is motives (Saunders, 1988), to ostensibly test the hypothesis that battered women use IPV primarily in self-defense or retaliation. More research needs to be conducted in this area to empirically support this claim, but in addition, future research needs to consider other possible predictors and correlates of battered women's use of physical IPV. The findings of this study suggest that it is not safe to assume that the female victim of IT does not engage in maladaptive behaviors that could perpetuate the IPV or be abusive in their own right (Mills, 2008). Similar to the men in our study, certain characteristics and behaviors, such as alcohol or substance abuse, might contribute to any maladaptive behaviors that female victims of IT may use. This information has important implications for prevention and treatment of IPV and the development of healthy coping and relationship behaviors.

A second limitation is that we have no way to assess the legitimacy of the self-reported information in this study. It is possible that some of the men will have exaggerated or even fabricated their experiences. We were concerned for the safety of the men in our sample, especially given prior research which showed that most male victims of IT fear retribution if their female partners learned of their help seeking (Hines, Brown, & Dunning, 2007), and therefore, we did not include the female partners in the study. That said, it is unlikely that the problem of fabrication is too widespread, given that (a) the men reported about their experiences on an anonymous, 30-minute Internet/phone survey with no incentives for participation; and (b) the men likely had to overcome several societal and internal barriers to seek help (Addis & Mahalik, 2003) and by these very factors are likely to be reporting legitimate concerns. Nonetheless, future studies should strive to obtain information about men's experiences with IPV from multiple informants.

Future studies should also investigate other possible variables that differentiate victims of IT who use physical IPV from those who do not. The original purpose of this study was to investigate the experiences and mental health of men who sustained partner violence and sought help. Therefore, we did not test for certain variables that may be informative in predicting which of the men would use physical IPV against their female partners. These variables could include personality dysfunction; attitudes and beliefs about violence, particularly violence against women; other mental illnesses, such as anxiety or depression;

anger/hostility problems; executive cognitive functioning; and attachment orientation (Dutton, 1995; Stith et al., 2004).

A final limitation concerns the generalizability of our findings. Because this study is preliminary and exploratory, results should be viewed with caution, and the generalizability to other victims of IPV should also be done with caution. Our sample was restricted to men who sustained IPV and sought help. 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 female partners because it is a nonnormative issue for men (Addis & Mahalik, 2003). Moreover, the help-seekers had to have either seen our advertisement on the Internet or called the DAHMMW; therefore, help-seekers without access to either of these resources were excluded. Future studies should aim to recruit both men and women 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

In all situations, whether the male partner used no physical IPV, minor physical IPV only, or severe physical IPV, the female partner reportedly used all forms of IPV at higher rates and frequencies than the male partners, and the male partners were reportedly more likely to be injured. The comparatively high rate of violence by females is because of the nature of the sample—men who were seeking help for IPV victimization.

The use of violence by both perpetrators and help-seekers in the sample is informative in several ways. First, the results are consistent with the few studies that have examined the use of violence among a clinical sample of female help-seekers, in that the findings do not appear to be related to gender. Second, the results of this study have important implications for the field of family violence. They help us to better understand the complexities within many relationships that are violent and can help providers shape screening questions and services to individuals seeking help. Third, the findings challenge our understanding and classifications of *victims* and *perpetrators* as unidimensional figures, who are either worthy of help (i.e., victims) or deserving of punishment (i.e., perpetrators).

Our findings are also consistent with research in several related fields. For example, research on bullying among children and adolescents has revealed that there are three *types* of players in bullying situations: (1) bullies, (2) victims, and (3) bully-victims—minors who both bully others and who are also the targets of bullying by their peers (Dukes, Stein, & Zane, 2009; Pontzer, 2010). In fact, bully-victims often have higher levels of psychosocial maladaptation (Estévez, Murgui, & Musitu, 2009). Similarly, research has shown that among some families involved with the child welfare system, parents who are victims of IPV are sometimes also perpetrators of child maltreatment (Dixon, Hamilton-Giachritsis, Browne, & Ostapuik, 2007). The findings of the extant research, in conjunction with the findings of this study, speak to the importance of examining more broadly the incidents of victimization and perpetration of violence; when these two can overlap; and how this evidence can inform efforts of prevention, outreach, and treatment among those involved in the field of family violence.

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TABLE 1
Differences Between Men Who Do Not Use Physical IPV, Men Who Use Minor Physical IPV, and Men Who Use Severe Physical IPV

	Men Who Did Not Use Physical IPV (<i>n</i> = 135) % or <i>M</i> (<i>SD</i>)	Men Who Used Minor Physical IPV Only (<i>n</i> = 108) % or <i>M</i> (<i>SD</i>)	Men Who Used Severe Physical IPV (<i>n</i> = 59) % or <i>M</i> (<i>SD</i>)	χ^2 , <i>F</i> , or <i>t</i>
Demographics of Men				
Age	43.15 (7.92)^a	39.69 (9.34)^a	36.03 (8.56)^a	15.67^{***}
Weight (in pounds) ^a	198.34 (40.65)	193.01 (36.01)	192.37 (39.40)	0.70
Height (in inches)	70.63 (2.99)	70.93 (2.86)	70.71 (2.95)	0.31
Ethnicity				
White	87.4	84.3	89.8	1.12
Black	6.7	6.5	3.4	0.87
Hispanic	2.2	8.3	5.1	4.75
Asian	4.4	5.6	1.7	1.39
Native American	0.7	2.8	3.4	2.02
Education ^b	4.55 (1.51)	4.37 (1.65)	4.14 (1.48)	1.60
Income (in thousands)	49.66 (26.29)	51.36 (25.75)	50.52 (24.58)	0.30
Disabled	15.6	13.1	10.2	1.06
Demographics of Partner				
Age	40.59 (7.56)^{a,b}	36.32 (8.50)^a	34.76 (9.37)^b	13.14^{***}
Weight (in pounds)	156.69 (42.28)^a	142.25 (32.87)^a	151.41 (43.60)	4.49[*]
Height (in inches)	65.05 (2.95)	65.25 (2.77)	65.12 (3.02)	0.14
Ethnicity				
White	76.3	70.4	76.3	1.27
Black	8.1	6.5	6.8	0.27
Hispanic	5.9	9.3	8.5	1.02
Asian	8.1	13.9	3.4	5.37
Native American	3.7	0.0	5.1	4.88
Education ^b	3.67 (1.85)	4.06 (1.88)	3.71 (2.03)	2.03
Income (in thousands)	30.56 (24.86)	31.36 (24.97)	26.89 (21.93)	0.71
Disabled	10.2	6.5	10.2	1.11
Relationship Demographics				

	Men Who Did Not Use Physical IPV (<i>n</i> = 135) % or <i>M</i> (<i>SD</i>)	Men Who Used Minor Physical IPV Only (<i>n</i> = 108) % or <i>M</i> (<i>SD</i>)	Men Who Used Severe Physical IPV (<i>n</i> = 59) % or <i>M</i> (<i>SD</i>)	χ^2 , <i>F</i> , or <i>t</i>
Relationship length	103.92 (84.29)	96.34 (83.44)	86.66 (74.01)	0.41
Currently in the relationship	55.6	58.9	54.2	0.42
Children involved	77.3	75.5	66.1	2.77
Childhood History				
Experienced physical abuse	42.2	51.9	48.3	2.29
Witnessed interparental violence	19.3	21.3	27.1	1.51
Sexually abused by a family member	14.1	10.2	15.3	1.16
Sexually abused by a nonfamily member	20.7	11.1	20.3	4.40
Mental Illness				
PTSD total score	45.79 (13.49)	46.94 (15.08)	47.61 (14.37)	0.40
Reexperiencing	14.69 (4.72)	15.48 (5.49)	14.74 (5.47)	0.73
Avoidance/numbness	16.99 (5.79)	17.26 (6.28)	17.85 (6.07)	0.43
Hyperarousal	14.12 (4.88)	14.20 (5.34)	15.01 (4.85)	0.74
Scored above clinical cutoff	54.8	58.3	64.4	1.56
Ever diagnosed with mental illness	22.7	21.3	30.5	1.92
Alcohol/Substance Abuse in Past Year				
Frequency of alcohol intoxication	0.68 (1.21)^{a,b}	1.28 (1.75)^a	1.24 (1.37)^b	8.36^{***}
Abused alcohol	11.1 ^{a,b}	24.1 ^a	22.0 ^b	7.73 [*]
Frequency of substance use^a	0.26 (0.72)^a	0.42 (0.91)^b	0.78 (1.11)^{a,b}	6.25^{**}
Abused substances	6.7 ^a	11.1 ^b	23.7 ^{a,b}	11.70 ^{**}
Partner's Use of IPV in Past Year				
Controlling behaviors—prevalence	94.1	91.7	94.9	0.84
Controlling behaviors—frequency ^a	40.42 (36.03)	36.78 (37.21)	43.88 (36.90)	0.73
Severe psychological IPV—prevalence	95.6	95.4	98.3	1.00
Severe psychological IPV—frequency	26.59 (26.78)^a	24.08 (23.34)^b	37.11 (28.41)^{a,b}	4.57[*]
Physical IPV—frequency^a	38.51 (52.39)^a	46.69 (50.02)	65.56 (58.00)^a	4.72^{**}
Insisting on sex—prevalence	42.2	31.5^a	55.9^a	9.56^{**}
Male sustained severe injury	28.9^a	32.4^b	54.2^{a,b}	12.12^{**}
Men's Use of Other IPV in Past Year				

	Men Who Did Not Use Physical IPV (<i>n</i> = 135) % or <i>M</i> (<i>SD</i>)	Men Who Used Minor Physical IPV Only (<i>n</i> = 108) % or <i>M</i> (<i>SD</i>)	Men Who Used Severe Physical IPV (<i>n</i> = 59) % or <i>M</i> (<i>SD</i>)	χ^2 , <i>F</i> , or <i>t</i>
Controlling behaviors—prevalence	34.8 ^a	46.3 ^b	69.5 ^{a,b}	19.92 ***
Controlling behaviors—frequency	2.21 (5.61) ^a	3.00 (6.02) ^b	6.31 (10.31) ^{a,b}	8.75 ***
Severe psychological IPV—prevalence	20.0 ^{a,b}	50.9 ^a	66.1 ^b	44.60 ***
Severe psychological IPV—frequency ^a	0.91 (4.67) ^{a,b}	2.69 (5.73) ^a	4.76 (8.50) ^b	22.15 ***
Physical IPV—frequency	—	3.51 (7.61)	15.29 (19.50)	4.46 ***
Insisting on sex—prevalence	4.5 ^{a,b}	16.7 ^a	28.8 ^b	21.95 ***
Female sustained severe injury	2.2 ^a	4.6 ^b	23.7 ^{a,b}	29.87 ***
Responses to Partner's Physical IPV				
Yell/curse	45.3 ^{a,b}	77.6 ^a	75.0 ^b	24.99 ***
Get away/go to another room	92.6 ^a	75.8 ^a	86.0	12.15 **
Cry	33.6	37.1	44.7	1.71
Call friend/relative	43.3	41.6	58.1	3.52
Call police	32.7	23.0	27.7	2.28
Help Seeking				
Internet	60.2	65.0	63.4	0.98
Hotline	27.6	18.5	23.6	2.67
DV agency	48.1	43.5	36.2	2.35
Police	54.1 ^a	37.0 ^a	45.8	7.02 *
Mental health professional	71.4	61.7	62.7	2.92
Emergency room/medical doctor	22.6 ^a	10.2 ^{a,b}	22.4 ^b	7.09 *
Shelter	12.1 ^a	2.8 ^a	6.8	7.20 *

Note. Items in bold are the variables on which the groups significantly differed. Results sharing the same subscript are significantly different from each other, according to Tukey's post hoc test or Tamhane's T2 post hoc test for variables with unequal variances (partner's age, frequency of substance use in past year, frequency of participant's controlling behavior, frequency of participant's severe psychological aggression) for ANOVA.

^aResults for these variables should be viewed with caution because of extreme kurtosis in the no-violence group.

^bEducational 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.

* $p < .05$.

.100 > d

.10 > d
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