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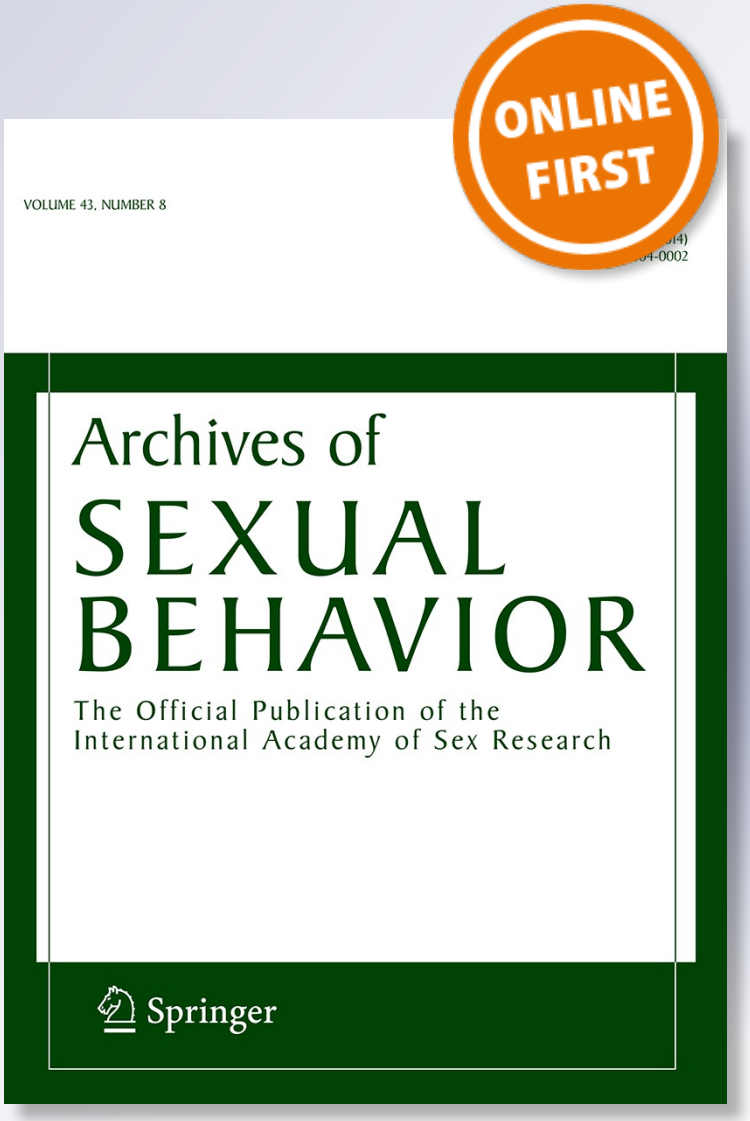
Archives of Sexual Behavior
The Official Publication of the
International Academy of Sex Research

ISSN 0004-0002

Arch Sex Behav
DOI 10.1007/s10508-014-0393-0



Springer

Arch Sex Behav
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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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Received: 26 November 2013 / Revised: 27 August 2014 / Accepted: 30 August 2014

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

Published online: 12 December 2014

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.

Acknowledgments The project described was supported by Grant Number 1R15HD071635 from the National Institute of Child Health and Human Development. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NICHD.

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