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

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

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

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

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

Theoretical and Empirical Associations Between PV and Health Indicators

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

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

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

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

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

Need for a Multidimensional Assessment of PV

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

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

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

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

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

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

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

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

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

Current Study

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

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

Method

Participants and Procedure

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

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

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

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

Table 1
Descriptive Information of the Sample, n = 611

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

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

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

Measures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Results

Bivariate Associations With Health Indicators

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

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

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

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

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

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

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

Correlations Among the Forms of Partner Violence

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

Multivariable Analyses

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

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

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

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

*** $p < .001$.

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

Limitations and Future Research

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

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

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

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

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

Implications

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

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

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