Intimate Partner Violence: Strategies to Engage Male Victims

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Military REACH, a project of the DoD-USDA Partnership for Military Families, utilizes a multi-disciplinary approach integrating both research and outreach to support those who work with and on behalf of military families. Through our three-fold approach, we provide empirical research that identifies and addresses key issues impacting military families and the programs that serve them, offer outreach and professional development through online resources, and host a Live Learning Lab for program staff seeking constructive professional development feedback for their programs.

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Executive Summary

Among military and civilian communities, intimate partner violence (IPV) is a public health concern that impacts the well-being of individuals, couples, and families (Walters, Chen, & Breiding, 2013). Although much of the research and services are aimed at female IPV victims, data on the prevalence of male IPV victimization have led to increased recognition of male IPV victims in recent years (e.g., Reid et al., 2008). Given the rates of male IPV victimization, treatment and support services are needed to address male IPV victims’ and their families’ needs. However, despite the availability of resources, many male IPV victims do not engage in treatment or services (Tsui, Cheung, & Leung, 2010). Given the discrepancy between services and treatment for male IPV victims and their limited engagement in services, a better understanding of male IPV victims’ experiences, barriers to receiving help, and strategies that may encourage them to engage in services is needed.

To gain a better understanding of the research on male IPV victimization and strategies to engage male IPV victims in treatment and services, a comprehensive review of empirical articles, literature reviews, research reports, book chapters, and websites was conducted using databases such as PsychINFO, Google Scholar, PubMed, and Web of Science. A variety of search terms were utilized, including: male victims, male survivors, intimate partner violence, treatment, prevention, interventions, military, outcomes, domestic violence, prevalence, communication strategies, recruitment, help-seeking, engagement, theory, models, and risk factors. With a focus on research that was published since 2002, more than 3,500 resources (articles, book chapters, reports, etc.) were identified and reviewed in the writing of this report.

A review of the literature yielded several theories to explain the occurrence of IPV, and most theories propose that IPV is due to a combination of individual, environmental, and systemic factors (e.g., Bandura, 1978; Gelles, 1985; Heise, 1998). Moreover, most theories of IPV describe the contributing factors that lead to IPV perpetration (Lawson, 2012); however, newer variations of previous theories (e.g., social learning and ecological theories) have been applied to better understand IPV victimization (e.g., Cochran, Sellers, Wiesbrock, & Palacios, 2011) and victims’ help-seeking decisions and behaviors (e.g., Liang, Goodman, Tummala-Narra, & Weintraub, 2005). Newer theories that help to explain IPV victimization are crucial to understanding how to better assist victims, especially male IPV victims, as data suggest that the lifetime prevalence rates for male IPV victims may be nearly 30% for civilians (Walters et al., 2013) and Service members in select service branches (e.g., Air Force; Rabenhorst et al., 2012). As these rates suggest, male IPV victimization is a significant issue, which is complicated by numerous risk factors, such as age, childhood abuse, and childhood conduct problems. For example, men who are 45 years or older are less likely to have experienced IPV victimization in the past year (Caetano, Vaeth, & Ramisetty-Mikler, 2008). Further, substance abuse seems to be a risk factor (e.g., McKinney, Caetano, Rodriguez, & Okoro, 2010), but it is unclear to what extent (as a precursor or as an outcome) it is associated with male IPV victimization. However, several studies report negative mental and physical health outcomes in both civilian (e.g., Beydoun, Williams, Beydoun, Eid, & Zonderman, 2017) as well as military (e.g., Crouch, Thomsen, Milner, Stander, & Merrill, 2009) samples.

The prevalence rates as well as data on risk factors and outcomes for male IPV victims suggest that male IPV victimization is a complex issue that should be addressed by multiple systems, such as family
services, healthcare institutions, and law enforcement. To better engage male IPV victims, a public health approach (i.e., target all members of a group, including victims and non-victims) via social marketing campaigns may help to communicate the availability of support services (e.g., domestic violence shelters for men, helplines, hotlines, and advocacy services) and mental health treatment (e.g., individual or couples counseling) to address current or future male IPV victims’ needs (e.g., Wray, 2006). Furthermore, campaigns that also focus on psychoeducation (e.g., information and advice) may help the decision-making process for male IPV victims as they contemplate where and from whom to seek help. As one major goal of awareness campaigns is to engage victims, it will be vital to consider barriers to engagement as well as strategies to increase engagement. For example, rigid views of masculinity may negatively impact help-seeking among men, generally (Addis & Mahalik, 2003), and male IPV victims, specifically (Tsui et al., 2010), especially those in the military (e.g., Ashley et al., 2017). In addition, male IPV victims in the military may be worried about how disclosing victimization may affect future promotions (Taylor, Keeling, & Mottershead, 2017), and for male IPV victims in gay, bisexual, transgender, and queer/questioning (GBTQ) relationships, disclosure of sexual identity may be an additional barrier (Parry & O’Neal, 2015). In addition to social marketing campaigns, thorough screenings embedded in routine assessments and coordinated community responses may be helpful in improving education about: warning signs, indicators that male IPV victims are in an abusive relationship, and where and how to seek help as these factors are important precursors to engaging in services. As such, it is important for professionals who work with Service members and their families to consider diverse approaches to overcome barriers and increase the likelihood of engagement of male IPV victims and their families.
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Intimate relationships are often at the center of individuals’ lives and serve as the foundation for families. When intimate relationships are healthy, they consist of mutual support and respect for each individual and can be positive models for other family members, especially children. However, when intimate relationships are unhealthy, these relationships can include abusive behaviors that negatively impact each partner’s well-being and the wellness of the family unit. Furthermore, unhealthy relationships can be a precursor to intimate partner violence (IPV), which is a public health concern within both civilian and military communities (Foran, Slep, & Heyman, 2011; Sugg, 2015). Across all families, IPV has been associated with numerous adverse outcomes such as substance abuse (e.g., Hellmuth, Jaquier, Overstreet, Swan, & Sullivan, 2014), physical health issues (e.g., Bonomi, 2009), and mental health concerns (e.g., Ulloa & Hammett, 2016) among survivors as well as increased risks of poor developmental outcomes in children raised in households where IPV occurred (e.g., Harding, Morelen, Thomassin, Bradbury, & Shaffer, 2013; Maneta, White, & Mezzacappa, 2017). Among civilian and military couples, IPV research has predominately focused on female victims (e.g., Ahrens, Rios-Mandel, Isas, & del Carmen Lopez, 2010; Jones, 2012); however, emerging theoretical and empirical research has begun to include male victims as a topic of study (e.g., Stephenson, Rentsch, Salazar, & Sullivan, 2011; Straus, 2011). In particular, recent findings suggest that although the type of treatments and support services that are available are similar for male and female victims of IPV, male victims may experience different risk and protective factors as well as variations in accessibility and engagement in services.

Definitions of Intimate Partner Violence

Intimate partner violence (IPV) can encompass many aspects of unhealthy and abusive behaviors (e.g., physical violence and verbal insults; Forgey & Badger, 2006). Moreover, the definition of IPV varies across disciplines (criminology, psychology, family science; Bagwell-Gray, Messing, & Baldwin-White, 2015;
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Heyman, Slep, & Foran, 2015; Winstok, 2016). Although there are several variations of IPV definitions, IPV is routinely defined as:

Physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner, such as a spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner. (Breiding, Basile, Smith, Black, & Mahendra, 2015, p. 11)

An intimate partner is a person with whom an individual has a personal relationship that is often characterized by “partners’ emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other’s lives” (Breiding et al., 2015, p. 11). Of note, IPV can occur between individuals whose romantic relationship has ended. As listed in the definition, there are four primary types of IPV: physical violence, sexual violence, stalking, and psychological aggression (see Table 1; Breiding et al., 2015).

Table 1. Types of IPV (Breiding et al., 2015).

<table>
<thead>
<tr>
<th>Type of IPV</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Violence</td>
<td>The use of physical force with the potential for causing death, disability, injury, or harm (e.g., pushing, throwing, choking, hitting, use of a weapon, and use of restraints).</td>
</tr>
<tr>
<td>Sexual Violence</td>
<td>A sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse (e.g., intentional sexual touching, forced penetration, or victim is forced to penetrate someone else).</td>
</tr>
<tr>
<td>Stalking</td>
<td>A pattern of repeated, unwanted, attention and contact that causes fear or concern for one’s own safety or the safety of someone else (e.g., parent, child, friend, etc.).</td>
</tr>
<tr>
<td>Psychological Aggression</td>
<td>Acts committed against one’s partner or a partner’s family member with the purpose of controlling or exploiting one’s partner. Acts include, but are not limited to: expressive aggression (e.g., verbal insults and humiliation), coercive control (e.g., limited access to resources; making threats to harm self or others; monitoring partner’s whereabouts and communications), threats of violence or use of gestures or weapons to communicate the intent to cause harm, exploitation of vulnerability (e.g., immigration status, disability, etc.), and presenting false information with the intent of causing the partner to doubt their memory, perception, or capabilities.</td>
</tr>
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In the military, IPV is described within the definition of domestic abuse. Specifically, the DoD Instruction 6400.06 Domestic Abuse Involving DoD Military and Certain Affiliated Personnel describes violence between intimate partners as:

An offense under the United States Code, the Uniform Code of Military Justice, or State law involving the use, attempted use, or threatened use of force or violence against a person, or a violation of a lawful order issued for the protection of a person who is:
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1. A current or former spouse;
2. A person with whom the abuser shares a child in common; or
3. A current or former intimate partner with whom the abuser shares or has shared a common domicile. (U.S. Department of Defense, 2015a, p. 36).

In recent years, four categories of violent relationships have been put forth to describe the nature of IPV between couples: situational couple violence, violent resistance, intimate terrorism, and mutual violent control (Johnson, 2006). Within these categories, the perpetrators’ and victims’ behaviors are described as either violent or controlling. These categories are used to indicate the complexities of IPV relationships where victims might engage in violent behaviors, which should always be understood in the context of the perpetrators’ behaviors (see Table 2).

Table 2. Categories of Violent Relationships (Johnson, 2006).

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Intimate Terrorism</td>
<td>Perpetrator is violent and controlling; the victim is neither violent nor controlling.</td>
</tr>
<tr>
<td>Violent Resistance</td>
<td>Perpetrator is violent and controlling; the victim is violent, but not controlling.</td>
</tr>
<tr>
<td>Situational Couple</td>
<td>Perpetrator is violent, but not controlling; the victim is neither violent nor controlling.</td>
</tr>
<tr>
<td>Violence</td>
<td>Mutual Violent Control</td>
</tr>
<tr>
<td></td>
<td>Both partners are violent and controlling.</td>
</tr>
</tbody>
</table>

As indicated in the definitions and types of IPV (in Table 1), there are multiple factors to consider to correctly determine if behaviors meet criteria for intimate partner violence. In addition, the categories of IPV (in Table 2) are also important to consider as these reflect the nature of the dyadic context of the violence. Understanding this context can help identify the most appropriate services for the couple. Moreover, the complexities reflected in the definitions, types, and categories are reflected in the multiple theories and models that aim to explain the underpinnings of IPV.

Theories and Models of Intimate Partner Violence

Intimate partner violence is a result of a combination of complex factors that occur within and outside of the dyadic relationship between couples (Carlson, 1984). Given this complexity, there are several theories that describe how intimate partner violence occurs. Notably, many of the theories were developed to explain male-to-female violence in heterosexual couples (e.g., Lawson, 2012). However, more recently, variations of these models have emerged to be inclusive of female-to-male perpetrated violence and same-sex relationships. As such, for this report, theories and models that are gender neutral will be reviewed in order to maintain focus on IPV experienced by male victims. It is important to note that feminist theories will not be a focus of this review, as these theories do not provide a theoretical understanding of male IPV victims since these theories are based on male-to-female IPV relationships.
Social Learning Theory

Social learning theory states that individuals’ social behavior is a result of conditioning (through reinforcement and punishment) and modeling (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979; Cochran, Maskaly, Jones, & Sellers, 2017). Expanding on this theory, social learning theory of aggression states that individuals learn aggressive behaviors through direct experience and/or by vicarious observation of aggressive acts and related consequences (Bandura, 1978). In particular, origins of aggression include observational learning, reinforcement of behaviors and acts, and structural determinants (e.g., societal power and control structures). For example, aggression that is learned through modeling occurs when individuals, especially children, learn by observation to engage in specific aggressive acts, as well as, to apply general tactics and strategies in a similar situation in the future. Learning not only leads to imitation in the moment, but allows individuals to extrapolate beyond what they have seen and heard to exhibit aggressive behavior in multiple contexts and over time. Although aggressive behaviors are modeled primarily by family members and caregivers, many individuals also learn aggressive behaviors through subcultures and communities in which they have routine contact as well as via symbolic modeling through mass communications and other sources (Bandura, 1978). Once learned, individuals’ aggressive behaviors are elicited through a series of experiences and appraisals. Specifically, individuals’ negative experiences lead to emotional arousal. Based on individuals’ cognitive appraisal of these experiences and of their emotional responses, as well as appraisals of any anticipated consequences they perceive in their environment, they may react aggressively. Thus, individuals’ experiences, emotions, and appraisals related to aggression are directly and indirectly influenced by past learning. There are numerous studies that support social learning theory of aggression; specifically that aggression is higher among individuals who were exposed to violence during childhood (e.g., Reyes, Foshee, Tharp, Ennett, & Bauer, 2015) and experienced childhood abuse (e.g., Dardis, Edwards, Kelley, & Gidycz, 2013; Jennings, Richards, Tomsich, Gover, & Powers, 2013).

Although social learning theories are predominately used to understand IPV perpetration, they can also be used to understand IPV victimization. For example, the social learning theory of aggression states that defensive aggression, often used by victims of IPV, may be due to fear that failure to be aggressive may result in future victimization or another negative consequence (Bandura, 1978). More recent theories have expanded on the original social learning theories to include underpinnings of IPV victimization (Espinoza & Warner, 2016). Cochran, Sellers, Wiesbrock, and Palacios (2011) proposed a social learning theory of intimate partner victimization which predicts that IPV victimization will be more prevalent among individuals who:

1. Have witnessed others using aggression against a partner or tolerating their partner’s use of aggression;
2. Hold definitions that approve, tolerate, slightly disapprove, or are neutral with regard to the use of partner violence;
3. Associate with others who support definitions consistent with the use of partner violence and/or engage in partner violence themselves;
4. Anticipate a greater balance of rewards than costs from tolerating partner violence. (Cochran et al., 2011, p. 796).

Social learning theory indicates that, similar to perpetration, IPV victimization is a result of both observational learning and appraisals of reinforcements and punishments in the environment. Several studies have found support for the role of social learning on IPV victimization (e.g., Liu, Mumford, & Taylor, 2017). For example, individuals who experienced child abuse and witnessed parental IPV were more likely to be victims of IPV in adulthood than individuals who did not have these negative childhood experiences (McRae, Daire, Abel, & Lambie, 2017). However, within this model, there are mixed findings regarding the influence of gender. In one study, female victims’ reports of associating with a peer who they know has been a victim of IPV were positively related to current IPV victimization while male victims’ reports of associating with a peer who was a victim were not related to current IPV victimization (Powers, Cochran, Maskaly, & Sellers, 2017). Although more research is needed to better understand these relationships, initial findings suggest that certain aspects of social learning may differentially influence male and female victims.

**Social Exchange Theory and Resource Theory**

Similar to social learning theory, social exchange theory (Emerson, 1976; Homans, 1958) and resource theory (Goode, 1971) have been applied to numerous disciplines, including family violence (Gelles, 1985). Broadly, social exchange theory states that individuals’ satisfaction with their interpersonal relationships is due in large part to a comparison of various outcomes; mostly between the outcomes of staying in a relationship compared to outcomes of separating from the relationship (Heyman, Foran, & Wilkinson, 2013). These comparisons of outcomes in interpersonal interactions are guided by receiving rewards and avoiding punishments. In regards to IPV, individuals who perceive that the benefits and rewards of violence are higher than the costs will be more prone to use violence (Gelles, 1983, 1985). For perpetrators, costs of violence can be reduced by multiple factors, such as limited accountability from social institutions and reluctance of victims to disclose perpetrators. Similarly, costs can be increased by related factors such as more consequences for perpetrators and additional opportunities for victims to feel safe to disclose violence. Individuals’ comparisons of their costs and benefits/rewards within their interpersonal relationships is an important component of social exchange theory; according to resource theory, individuals tend to make similar comparisons by weighing their options regarding the resources they do or do not possess (Lawson, 2012).
Resource theory proposes that the use of violence depends on the resources individuals can influence or command within a given system, such as intimate relationships (Goode, 1971). Based on this theory, individuals who use the most violence tend to have the least amount of resources (e.g., income, educational resources, etc.). Specifically, individuals with more resources tend to use violence less as they presumably have sufficient resources and need to command less. However, those with fewer resources, either objectively or subjectively, are believed to use violence as a way to obtain more resources (Gelles, 1985). Resources can be financial or physical, or they may be interpersonal resources, such as agency or self-efficacy. An extension of resource theory is disempowerment theory (McKenry, Serovich, Mason, & Mosack, 2006), which states that those who feel as though they lack power (or resources) will be prone to use violent or controlling means to gain (or regain) power. There is empirical support for this theory (e.g., K. L. Anderson, 1997); for example, women who had at least a college degree and were in abusive marriages were more likely to divorce than women in abusive marriages who did not have a college degree (Kreager, Felson, Warner, & Wenger, 2013). Furthermore, these theories have been applied to both female and male victims in heterosexual and same-sex relationships (Burke & Follingstad, 1999). For same-sex partners that experience IPV, power or resources may be imbalanced by one partner who may not have disclosed their sexual identity to family, friends, or coworkers (Goldenberg, Stephenson, Freeland, Finneran, & Hadley, 2016).

There are a myriad of factors (e.g., relationship quality, influence of peers) that can impact individuals’ assessments of the costs and benefits of interpersonal relationships as well as the comparative resources in their relationships. In particular, victims of IPV may behave in what seem to be unrewarding ways (i.e., not engage in behaviors to end their abusive relationships) based on their interpretations of costs/benefits and resources (e.g., Copp, Giordano, Longmore, & Manning, 2015). For example, some male victims may not leave their partner because of the impact the separation might have on their identity and self-esteem or the perceived consequences of admitting they are a victim of an abusive relationship would have on their masculinity.

Additionally, male victims may not leave their partner because of the impact the separation might have on their identity and self-esteem or the perceived consequences of admitting they are a victim of an abusive relationship would have on their masculinity. An extension of resource theory is disempowerment theory (McKenry, Serovich, Mason, & Mosack, 2006), which states that those who feel as though they lack power (or resources) will be prone to use violent or controlling means to gain (or regain) power. There is empirical support for this theory (e.g., K. L. Anderson, 1997); for example, women who had at least a college degree and were in abusive marriages were more likely to divorce than women in abusive marriages who did not have a college degree (Kreager, Felson, Warner, & Wenger, 2013). Furthermore, these theories have been applied to both female and male victims in heterosexual and same-sex relationships (Burke & Follingstad, 1999). For same-sex partners that experience IPV, power or resources may be imbalanced by one partner who may not have disclosed their sexual identity to family, friends, or coworkers (Goldenberg, Stephenson, Freeland, Finneran, & Hadley, 2016).

Ecological Theory

Ecological theories have also been applied to many fields of human behavior, such as child development (e.g., Bronfenbrenner, 1977) and family violence (e.g., Carlson, 1984). Ecological theory proposes that development is a product of four systems (microsystem, mesosystem, exosystem, macrosystem) that influence behaviors, interactions, and relationships. From the microsystem to the macrosystem, these...
four systems vary in proximal influence to the individuals and their development. For example, the microsystem describes the relationship between an individual and the environment while the mesosystem is the relationship between an individual and the settings they regularly encounter (e.g., school, work, church). Furthermore, the exosystem refers to the social structures and institutions that impact the individual’s environment (e.g., neighborhood, government) while the macrosystem is the overall culture of the society as expressed by the economic, educational, political, legal, and social systems (Bronfenbrenner, 1977). From this perspective, IPV occurs as a result of interactions and influences among individual (e.g., personality), family (e.g., familial roles and values), community (e.g., neighborhood characteristics), and societal (e.g., cultural norms and expectations) factors (Little & Kantor, 2002). Moreover, this model allows for these factors to not only be conceptualized as determinants, but also as maintaining IPV (Carlson, 1984). In considering IPV from an ecological perspective, research on the many aspects of the microsystem and mesosystem can be easily applied to all victims of IPV, while exosystem and macrosystem factors have predominately related to structures in societies that center on patriarchy and male dominance (e.g., Heise, 1998) and are most applicable to female victims. In particular, feminist theories, which are dominant in the IPV theoretical literature, have evolved from ecological theories and center on men’s power and control over women. Furthermore, according to feminist theories, male dominance is reinforced among all four systems within the ecological theory (e.g., Dobash & Dobash, 1979). For example, couples are impacted by gender roles and expectations that are taught to individuals (microsystem), and that are reinforced within families (mesosystem), communities (exosystem), and larger societies (macrosystem). Moreover, feminist theories are centered on historical and contemporary limitations women have faced related to participating in various political, economic, and social arenas (e.g., careers, ownership of property, etc.; Dobash & Dobash, 1979); as such, the theoretical understanding of male IPV victims is not explained by feminist theories since these theories are based on male-to-female IPV relationships and are not covered in this review.

Regardless of the victim’s gender, ecological theories generally focus on why one partner in a couple perpetrates IPV against the other; however, newer research is applying ecological theories to frameworks to better understand why the victim of IPV may or may not seek help (e.g., Tsui, Cheung, & Leung, 2012). For example, Liang, Goodman, Tummala-Narra, and Weintraub (2005) propose that help-seeking has three non-linear stages: defining the problem, deciding to seek help, and choosing a source of support. Specifically, within this framework, victims must first define their situations as abusive. Second, they must decide to seek help because they view their current circumstance as undesirable and unlikely to resolve without assistance. Third, they must identify formal and/or informal sources of support; the most compatible sources of help are ones that match the victims coping needs and situation. Victims’ experiences and decisions throughout the three stages in this framework are influenced by individual (microsystem), interpersonal (mesosystem), and sociocultural (exosystem and macrosystem) factors (Liang et al., 2005). Although initially developed to explain female victims’ help-seeking, this framework can be applied to male victims, with variations in the specific sociocultural factors (e.g., values related to masculinity) that likely impact male victims’ decisions to seek help.
There are aspects of the aforementioned theories that allow them to be used when understanding IPV among male victims. First, they are gender neutral, and unlike feminist theories or theories of power and control, they do not propose that IPV is based on gender roles (although most ecological perspectives include descriptions of patriarchal structures that impact male perpetrators and female victims; Lawson, 2012). Second, they can be applied to male victims in both heterosexual and same-sex relationships. Third, within all four theories, understanding the nature of IPV from the perspective of male victims can be tailored to the circumstances that are most applicable to the couple. For example, within military couples, male victims of IPV may perceive different costs/benefits to staying or leaving an abusive relationship than male victims in civilian couples. Given this, understanding theories of IPV is a vital part of becoming more aware of the experiences of male victims. In addition, an analysis of the prevalence rates as well as the risk factors and outcomes associated with male IPV victims is important to review.

**Prevalence Rates of Male Victims of Intimate Partner Violence**

Although prevalence rates of male IPV victims vary significantly (e.g., Crouch et al., 2009; Finneran & Stephenson, 2013), recent data suggest that despite the wide ranges, male IPV victimization is an issue that needs to be addressed. In a review of the literature on the prevalence of IPV victimization among men, Nowinski and Bowen (2012) found rates of lifetime male heterosexual victimization that ranged from 0.2% to 93%, and rates of male homosexual victimization that ranged from 1.8% to 93.7%. One explanation for a wide prevalence range is overall estimates of IPV often include multiple forms of violence, including physical, sexual, psychological, and verbal, each of which carry different prevalence rates when assessed individually. Specifically, higher overall prevalence rates tend to reflect the inclusion of milder forms of abuse, including name-calling, swearing, and unwanted phone calls. The severity of incidents within a single domain of abuse can also vary according to authors’ definitions of IPV, which ultimately affects reports of prevalence. For example, Crouch et al. (2009) defined moderate physical IPV as being pushed, shoved, or grabbed by a partner, while Rosen et al. (2002) defined the same behaviors as minor physical IPV.

Another reason why prevalence rates vary widely is due to the sampling frame used by studies: it has been suggested that community samples tend to capture situational couple violence, while clinical samples reflect much higher rates of intimate terrorism (Johnson, 2006), an assessment that has since been supported in studies of the IPV experiences of men from both community and clinical samples. Hines and Douglas (2010b) found that men in a help-seeking sample who had sought support services from a professional after sustaining physical assault from a partner sustained much higher rates of violence as well as more types of IPV (i.e., physical, psychological, emotional) than those in a community
sample. Men in the help-seeking sample were injured at significantly higher rates and reported on average nearly 47 acts of physical violence perpetrated against them in the last year, statistics that are in line with samples of women experiencing intimate terrorism (Johnson, 2006).

For these reasons, this report will forgo reporting overall rates of IPV given the imprecision of definitions associated with how these estimates are determined. Instead, prevalence estimates will be presented according to the different forms of violence (i.e., physical, sexual) in order to present a more accurate representation of the true rates of male IPV victimization.

**Civilian Rates**

For civilian families, there is no one program that can serve the needs of IPV victims, especially male IPV victims. Therefore, civilian males who are not married to a Service member and who experience IPV must seek help from a variety of sources, including formal sources such as domestic violence agencies and hotlines, medical professionals, and police, as well as from informal sources, including friends, family, clergy, and lawyers (Douglas & Hines, 2011). In addition, the absence of a centralized program may make it difficult to monitor and assist civilian IPV victims. As a way to assess rates of IPV among civilian families, the Centers for Disease Control issues an ongoing, nationally representative survey of IPV among adult women and men in the U.S using random-digit-dialing known as the National Intimate Partner and Sexual Violence Survey (NISVS; Walters et al., 2013). The most recent survey, conducted from 2010-2012, found a lifetime prevalence of total physical IPV victimization among heterosexual males of 28.3% and among homosexual males of 25.2%. The lifetime prevalence of severe physical IPV victimization (i.e., beaten, hit with a closed fist) was 13.9% among heterosexual males and 16.4% among homosexual males. There were no significant differences between the rates of IPV victimization for heterosexual males and homosexual males with regards to physical IPV. The lifetime prevalence of psychological aggression by an intimate partner (i.e., name-calling, swearing, or being humiliated by an intimate partner) was 47.3% among heterosexual males, and 59.6% among homosexual males. Homosexual males reported significantly higher rates of expressive aggression (i.e., name-calling and swearing) than heterosexual males. Finally, the lifetime prevalence of sexual IPV (i.e., rape, unwanted sexual contact) was 7% for all males (S. G. Smith et al., 2017); there were an insufficient number of homosexual men who reported lifetime sexual IPV to report differences according to sexual orientation.

Other national surveys of IPV among heterosexual males have recorded lower estimates of lifetime physical IPV, ranging from 5.9% (Coker et al., 2002) to 17.6% (Reid et al., 2008), with one national survey reporting an estimate similar to the NISVS of severe physical IPV among heterosexual males (14%; Breiding et al., 2014). Rates of reported sexual IPV victimization among heterosexual males in other national samples are higher than those reported in the NISVS, ranging from 9.5% (Breiding et al., 2014) to 18.5% (Houston & McKirnan, 2007).
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No other national surveys of homosexual male victims of IPV exist; therefore studies reporting prevalence rates among homosexual males reflect smaller, non-probability samples, so results should be interpreted with caution given that the samples they are drawn from may not be representative of the population as a whole. Reports of lifetime physical IPV victimization among homosexual males range from 13% (S. D. Rhodes, McCoy, Wilkin, & Wolfson, 2009) to 31.2% (Conron, Mimiaga, & Landers, 2010), while rates of lifetime sexual IPV victimization reported in two studies were between 18-19% (Conron et al., 2010; Houston & McKirnan, 2007).

Lifetime prevalence rates are generally higher than 12-month prevalence rates, due to the wider range of time captured by the former period (Nowinski & Bowen, 2012). According to the NISVS, 12-month prevalence of physical, sexual, and psychological IPV victimization among all males was 4.7%, 1.8%, and 18.2% respectively (S. G. Smith et al., 2017). The NISVS did not have a large enough sample size to report 12-month prevalence rates according to sexual orientation; however, rates of past year physical IPV victimization among heterosexual males in other national surveys ranged from 0.7% (Breiding, Black, & Ryan, 2008) to 2.9% (Reid et al., 2008), whereas rates of past year physical IPV victimization among homosexual males in community samples ranged from 11.8% (Stephenson, Khosropour, & Sullivan, 2010) to 23.6% (Stephenson & Finneran, 2017).

Military Rates

Active Duty military couples who experience IPV receive support, advocacy, and intervention services from the DoD Family Advocacy Program (FAP). The FAP is a congressionally mandated DoD program and the Service FAPs are present at all military installations where families are located (U.S. Department of Defense, 2017). The FAP investigates all known incidents of IPV between military personnel and their current or former intimate partners. In addition, the FAP communicates all unrestricted reports of domestic violence to civilian law enforcement agencies (U.S. Department of Defense, 2015b). All incidents of domestic abuse that are reported to the FAP are entered into a central registry to track occurrences of abuse and to determine the incidence and prevalence rates in the military. Different service branches may also maintain a central registry. For example, two prevalence studies of IPV victimization among males in the military used substantiated reports of abuse from the Army’s Central Registry (ACR). One study assessed the rate of first-time reports of IPV during a 10 year period between 1991-2000, which found that 3.7% of males were first-time victims of IPV, while 12.9% were involved in incidents of bidirectional violence for the first time (Bell, 2009). The other study focused on trends in substantiated reports of abuse on the ACR over a five-year period from 1998-2002, finding the rate of male victimization decreased from 9.5/1,000 Soldiers in 1998 to 5.4/1,000 Soldiers in 2002 (McCarroll, Ursano, Fan, & Newby, 2004). Information from these registries also inform what types of IPV occur among military samples. For example, in a population-based study utilizing all married Air Force members with at least one combat-
related deployment between 2001-2008 and at least one case of substantiated physical or emotional abuse against a spouse, a quarter of abuse incidents were bidirectional while 28% of the unidirectional cases involved a female offender only (Rabenhorst et al., 2012). However, because these studies only use officially reported and substantiated cases of abuse to assess the prevalence of IPV victimization among males within the military, they likely underreport the true occurrence of abuse (Clark & Messer, 2006). In order to gather a more accurate representation of the prevalence of IPV among males in the military, it is important to look to community samples where Service members can self-report abuse anonymously.

To date, no studies using military populations have reported on prevalence of IPV victimization among homosexual males. Only three studies have assessed the prevalence of past-year IPV victimization among community samples of male Service members in three branches of the military: the Army (Rosen et al., 2002), the Navy (Crouch et al., 2009), and the Air Force (Foran et al., 2011). Similar to civilian community samples, self-reported rates of mild or moderate IPV were higher than self-reported rates of severe IPV. When measuring mild or moderate IPV victimization, characterized by lesser physical acts (i.e., shoving, pushing, slapping, and grabbing) than severe IPV, rates of male victimization in the past year were 19.6% (Foran et al., 2011), 23.8% (Crouch et al., 2009), and 38.0% (Rosen et al., 2002). In assessments of more severe physical violence (i.e., choking, punching with a closed fist, beaten up by partner, threatened or attacked with gun or knife), rates of victimization in the past year were 10% (Rosen et al., 2002) and 16.7% (Crouch et al., 2009), while Foran et al. (2011) found that 3.54% of their sample reported IPV victimization so severe it resulted in injury or was considered an act of high danger (i.e., including weapons). Only one, small prevalence study was conducted with a clinical sample of 100 OEF/OIF veterans who were seeking marital therapy. Results indicated that 51.5% of male veterans reported being victims of physical IPV in the past year. However, the authors noted that very few participants endorsed the most severe forms of violence, including beating up a partner, which suggests that this study reflects mild or moderate acts of IPV (Tharp, Sherman, Bowling, & Townsend, 2014). Given the established occurrence of IPV among male victims in both civilian and military populations, it is important to review the documented risk factors and outcomes associated with victimization among males.

Risk Factors and Outcomes for Male Victims

While risk factors and outcomes associated with IPV have been studied extensively in male and female perpetrators (e.g., Cesur & Sabia, 2016; Foran, Heyman, Slep, & Snarr, 2012; Rabenhorst et al., 2012) and in female victims (e.g., Creech, Macdonald, & Taft, 2017; Hellmuth, Gordon, Stuart, & Moore, 2013), fewer studies have assessed the risk factors and outcomes associated with male victimization by an intimate partner. Further, results among male victims are confounded because individuals in violent relationships are often both victims and perpetrators (Caetano et al., 2008). In addition, many studies utilize cross-sectional data, including retrospective reports of abuse, making it difficult to determine which variables are risk factors for victimization, which are outcomes of having sustained abuse, or both. Given the difficulty with determining whether a variable preceded or followed occurrences of IPV, results from studies of the risk factors and outcomes associated specifically with male victims of IPV victimization are presented together in this section.
**Demographic Characteristics.** There are mixed findings regarding the effects of varying demographic characteristics on male victims of IPV. However, younger age is one of the demographic variables most consistently implicated in male IPV victimization (e.g., Bell, 2009; Lipsky, Caetano, Field, & Bazargan, 2005). While older men are more likely to have experienced lifetime IPV victimization (e.g., Schneider, Burnette, Ilgen, & Timko, 2009), one study found they are less likely to have experienced IPV within the past year (Caetano et al., 2008). There is some evidence that current socioeconomic status (SES) may be associated with male victimization (e.g., Chan & Cavacuiti, 2008). In a large sample of Active Duty U.S. Airmen, lower current family income was strongly associated with clinically significant emotional abuse for male victims (Foran, Heyman, & Slep, 2014). Employment status of the male victim may also play a role in IPV: one study using a random sample of female U.S. Army Soldiers found that Soldiers reported higher levels of aggression towards their male civilian spouses if they were unemployed compared with Soldiers whose husbands were currently employed (Newby et al., 2003). Findings with regards to the impact of race on male victimization have been mixed: in a large study of male U.S. Army Soldiers with a documented history of spouse abuse by their partners, male victims were significantly more likely than non-victims to be of minority race and to have less than a college education (Bell, 2009). However, in three prospective studies utilizing community samples, race was not found to be associated with victimization for males (Ehrensaft et al., 2003; O’Donnell et al., 2006; C. A. Smith, Ireland, Park, Elwyn, & Thornberry, 2011).

**Experience of Abuse during Childhood.** Childhood abuse is one of the most consistent predictors of IPV perpetration in males and females (e.g., Gil-González, Vives-Cases, Ruiz, Carrasco-Portiño, & Álvarez-Dardet, 2008) and IPV victimization with females (e.g., Bensley, Van Eenwyk, & Simmons, 2003). Evidence suggests it is likewise associated with victimization of males, both in community samples (e.g., Afifi et al., 2009; Hines & Douglas, 2011) and in clinical samples (e.g., Hines & Douglas, 2011; Schneider et al., 2009). In a national survey of U.S. adults, childhood sexual abuse was associated with male IPV victimization (Afifi et al., 2009). Similarly, Richards, Tillyer, and Wright (2017) found that both physical and emotional abuse in childhood were related to male victimization, while childhood sexual abuse was also implicated in experiencing IPV as both a victim and a perpetrator. A history of child abuse has also been found to be associated with high posttraumatic stress symptoms among male victims of IPV (Coker, Weston, Creson, Justice, & Blakeney, 2005; Hines & Douglas, 2011). In at least one study, differences in IPV victimization among childhood abuse survivors were noted according to race: in a sample of married, U.S. Army Soldiers, a history of physical and emotional abuse during childhood was a predictor of severe IPV victimization only for Black males, with no significant effects detected for abuse during childhood for White or Latino males (Rosen, Kaminski, Parmley, Knudson, & Fancher, 2003). Beyond direct experiences of abuse, individuals exposure to parental IPV during childhood (Ehrensaft et al., 2003) and adolescence (C. A. Smith et al., 2011) has been implicated as an additional risk factor, with one prospective study finding that exposure to parental violence during childhood was the single greatest independent risk for IPV victimization as an adult (Ehrensaft et al., 2003).

**Conduct Problems in Childhood.** Childhood conduct problems may also be implicated as a risk factor in adulthood IPV.
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victimization, although there is limited research. Specifically, one study followed economically disadvantaged children prospectively from eighth grade into adulthood. Results indicated that aggressive behaviors measured in males during eighth grade, including carrying a knife or gun, getting into physical fights, or threatening bodily violence to another person, were positively associated with IPV victimization at 19-20 years old after controlling for demographics and exposure to violence during childhood (O’Donnell et al., 2006). However, more research is needed to better understand the potential relationship between childhood aggression and conduct problems and later adulthood victimization.

Substance Abuse. The available evidence suggests that substance abuse, and in particular alcohol abuse, is associated with male IPV victimization. However, there have been mixed findings about the exact contribution, including whether victim or perpetrator use contributes more, as well as the timing, frequency, severity, and consequences of the substance use. Furthermore, much of the existing evidence identifying alcohol abuse as a risk factor for male IPV victimization, particularly those focused on the contribution of race and ethnicity, utilize the same national sample of civilian U.S. couples (e.g., Cunradi, Caetano, & Schafer, 2002; McKinney et al., 2010; Schafer, Caetano, & Cunradi, 2004). Given these limitations, results should be interpreted with caution.

There is evidence that problem drinking in men serves as a risk factor for male IPV victimization. In a longitudinal community sample of U.S. adults, self-reported alcohol problems in men in the last 12 months were associated with male IPV victimization by their female partners for White, Black, and Latino couples (Schafer et al., 2004). Similarly, in a community sample of adolescents followed into adulthood, White and Chen (2002) found that problem drinking during the last three years predicted IPV victimization during the previous year in men. Alcohol misuse may also serve as a predictor of more severe cases of male IPV victimization: in a sample of married U.S. Army soldiers, alcohol problems in male Soldiers were associated with severe physical violence, but not with mild physical violence or psychological aggression by Soldiers’ spouses (Rosen et al., 2003). There is limited evidence that drug abuse is associated with IPV victimization among males: one study compared a help-seeking sample and community sample of male IPV victims and found elevated levels of drug abuse were associated with sustaining IPV for both samples (Hines & Douglas, 2012). However, other studies have found no association between men’s substance use and their IPV victimization after adjusting for other factors, including race, ethnicity and household income (Beydoun et al., 2017; Lipsky et al., 2005; McKinney et al., 2010).

Mental and Physical Health. Ample evidence exists to suggest that male victims of IPV have significantly worse mental and physical health outcomes than non-abused controls, a finding that has been replicated in military samples (Crouch et al., 2009), community samples (e.g., Hines & Douglas, 2011;
Various mental health disorders have been found to be significantly associated with victimization among males, including posttraumatic stress disorder, depression, anxiety, and lifetime suicide attempts (Beydoun et al., 2017; Schneider et al., 2009). After controlling for pre-military levels of trauma symptoms in a sample of male Navy personnel surveyed during their second year of service, Crouch et al. (2009) found that experiencing IPV in the last year was associated with significantly higher levels of many trauma symptoms, including anxious arousal and anger/irritability. With regard to physical health, IPV victimization among males has been associated with a wide range of physical health ailments, including obesity, respiratory problems (i.e., asthma), circulatory problems (i.e., high blood pressure, heart disease), and reductions in cognitive functioning (Houston & McKirnan, 2007; Schneider et al., 2009; Williams, Murphy, Dore, Evans, & Zonderman, 2017). In a sample of male Army Soldiers, victims of IPV were more likely to be hospitalized with mental health or substance abuse treatment disorders than non-victims. Furthermore, victims were at increased risk for future hospitalizations occurring five or more years after the initial IPV event, suggesting adverse health effects that persist over time (Bell, 2009).

There is also evidence that the type of violence experienced may differentially contribute to a victims’ mental and physical health. For example, male IPV victims seeking non-urgent health care reported higher levels of depression, posttraumatic stress disorder (PTSD), and suicidal ideation relative to non-victims, while those who reported bidirectional IPV reported the highest levels of adverse mental health symptoms relative to non-victims (K. V. Rhodes et al., 2009). In addition, men who experienced intimate terrorism reported significantly greater physical and mental health concerns than those who experienced situational couple violence (Hines & Douglas, 2015).

While no studies to date have directly compared male victims of IPV in the military to non-military affiliated civilian male victims, one study with the U.S. Air Force compared Active Duty male victims to civilian male spouses of Active Duty Service members to identify correlates of emotional abuse. Results indicated that clinically significant emotional abuse tends to affect military and civilian males similarly, with the only significant difference in the correlates of emotional abuse between Active Duty and civilian male spouses being that poor family coping was more strongly associated with emotional abuse among Active Duty male victims compared to civilian male spouses (Foran et al., 2014). While this suggests that military and civilian male victims of IPV may be more similar than different in the risk factors and outcomes associated with IPV victimization, more studies comparing the populations are needed to better understand potential similarities and differences.

### Services and Treatments for Male Victims

Given the documented negative effects of IPV victimization among both military and civilian males, interventions are needed that are effective for male victims of IPV. Currently, support services and treatments for male victims of IPV are similar to those...
for female victims; however, there are very few studies investigating the efficacy or effectiveness of services and treatments for male victims (Barner & Carney, 2011; Eckhardt et al., 2013). Support services that are commonly used to address IPV for all victims include hotlines and helplines, community sources of support (e.g., emergency shelters), and psychoeducation, such as through awareness campaigns or information given by a medical provider (e.g., Sullivan & Virden, 2017a; Wallace, 2014). Also, treatment options for male and female victims usually include individual, couples, family, or group interventions (Arroyo, Lundahl, Butters, Vanderloo, & Wood, 2017; McCollum & Stith, 2008; Murphy & Meis, 2008). Within different treatment modalities, some victims seek out therapy specifically focused on IPV, while others engage in therapy due to other reasons (e.g., marital counseling, substance abuse treatment, etc.) where IPV is then addressed. Most of the outcomes assessed in studies that investigate treatments and services for IPV victims tend to focus on victims’ use of safety behaviors, mental health symptom reduction and improved functioning, and utilization of community and other resources.

**Support Services.** Similar to female IPV victims, many male IPV victims seek services from organizations, medical centers, and online resources that provide emergency shelters, legal services, and support groups (Douglas, Hines, & McCarthy, 2011). Examples of easily accessible support services for male IPV victims are helplines and hotlines. There exist national online and telephone resources for male victims of IPV in urgent and non-emergent circumstances (Cheung, Leung, & Tsui, 2009), such as Domestic Abuse Helpline for Men (The National Domestic Violence Hotline, n.d.), Male Survivor (“Male Survivor,” n.d.), and Help 4 Guys (Help 4 Guys, n.d.), which offer support services and resources to assist male IPV victims in a crisis. Although, there is limited empirical research on the effectiveness of hotlines and helplines with male IPV victims, there is emerging research on male IPV victims’ preferences regarding help-seeking and which services they seek (Tsang, 2015). In a national study of IPV male victims, most male victims sought counseling (90%) or legal services (70%) for help while nearly 20% of male IPV victims also reported seeking help for IPV-related concerns among services related to substance abuse treatment (Tsui, 2014). In addition, services that were rated as least helpful were domestic violence shelters and legal services. Furthermore, when male IPV victims sought support, resources, or other services, from most to least often, they sought help from: friends, family, online, mental health professionals, police, clergy, and medical providers. Although most male victims (78%) preferred to seek help from informal sources (i.e., friends and family), web-based resources were popular and male victims reported high use of the internet to seek help due to the flexibility and anonymity of access. Notably, most male victims (82%) reported that they were not aware of formal services (e.g., domestic violence shelters that assisted male victims) or the services they knew were not aimed to help men who were victims in IPV relationships (Tsui, 2014). Support services for IPV are still predominantly aimed at serving women, and there is evidence that male IPV victims may be more likely to have negative experiences when using general domestic violence agencies and hotlines (e.g., Tsui, 2014). For example, in a nationally-based qualitative study of the experiences of men seeking help for IPV, nearly half of those who sought help from a domestic violence agency and two-thirds of those who called a domestic
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violence hotline reported that the resource was not only unhelpful, but that they got the impression that the resource was biased against male victims. More than a third of these men reported accusations that they were the batterer in the relationship, while 16% reported that staff made fun of them for reporting being victims of abuse (Douglas & Hines, 2011).

Psychotherapy. Psychotherapy has been found to be effective in reducing mental health symptoms and improving general functioning of IPV victims (Arroyo et al., 2017; Eckhardt et al., 2013) and was one of the most used services in a national study of male IPV victims (Tsui, 2014). The variations of psychotherapy that have been found to be effective include short-term, individual, cognitive behavioral therapy (e.g., Zlotnick, Capezza, & Parker, 2011), couples therapy (e.g., Mendez, Horst, Stith, & McCollum, 2014; Stith & McCollum, 2011), and group-based couples interventions (e.g., Taft et al., 2014). However, most of the outcome data on psychotherapy for IPV relationships focuses on male-to-female IPV (Barner & Carney, 2011). For example, Mendez et al. (2014) found that heterosexual couples (male perpetrator, female victim) who participated in 12 couples IPV therapy sessions experienced insights about themselves and their partners regarding their own behaviors and attitudes towards each other and their relationships. In addition, some victims felt empowered after these sessions, including feeling more confident to express their points of view and initiate changes in their relationships (Mendez et al., 2014). Among an intervention group consisting of IPV female victims, trauma-focused psychotherapy was effective in reducing PTSD, depression, and anxiety symptoms (Beck et al., 2016).

Psychotherapy has also been found to be effective for male victims of various forms of non-IPV violence. Specifically, cognitive behavioral therapy has been found to reduce PTSD and depressive symptoms in male Veterans who were victims of military sexual assault (Mullen, Holliday, Morris, Raja, & Surís, 2014), while cognitive processing therapy has also been found to be effective in reducing PTSD symptoms among Veteran victims of military sexual assault (Voelkel, Pukay-Martin, Walter, & Chard, 2015). In both of the previously mentioned studies, male victims were patients of Veterans Affairs Medical Centers and data were taken from participants of a clinical trial (Mullen et al., 2014) or archival data (Voelkel et al., 2015). In addition to therapy, crisis counseling has also been found to be effective to help reduce emotional distress immediately following an act of violence for male sexual assault victims who presented in an emergency room for care (Du Mont, MacDonald, White, & Turner, 2013).

Psychoeducation. Psychoeducation refers to interventions that consist of information, education, feedback, and advice that are delivered verbally or in writing (Donker, Griffiths, Cuijpers, & Christensen, 2009). For IPV interventions, psychoeducation ranges from health care staff providing information during medical visits (Bair-Merritt et al., 2014) to local, state, and national awareness campaigns (Du Mont, Forte, Cohen, Hyman, & Romans, 2006). Psychoeducation that includes information about IPV, mental health resources, and assistance in coordinating services has been found to be more effective in connecting victims with help than providing information about mental health resources alone (Wolff, Cantos, Zun, & Taylor, 2017). Notably, web-based psychoeducation has also yielded positive therapeutic
effects in that heterosexual couples with mild to moderate levels of IPV reported that information on healthy relationship skills, communication, and emotional acceptance via an online intervention was effective in improving relationship satisfaction (Roddy, Georgia, & Doss, 2017). Psychoeducation may also be useful as a preventative approach to reducing IPV victimization by providing individuals with accurate depictions of IPV for them to recognize in their relationships. For example, non-victims of IPV were better able to correctly identify IPV scenarios after a psychoeducation intervention that included education about what constitutes IPV than individuals who did not receive the intervention (Bridges, Karlsson, & Lindly, 2015). While more information is needed regarding the effectiveness of the available support services for male victims of IPV, it is also important to address the barriers to engagement that may be unique among men in order to increase male victims’ engagement in treatment.

**Engagement and Communication Strategies for Male Victims**

Engaging male victims of IPV in treatment and support services is complex due to factors that include embarrassment, shame, and stigma (Turchik et al., 2013). Moreover, these factors may be influenced by individuals’ views on masculinity, cultural norms, and issues related to general barriers to help-seeking (Addis & Mahalik, 2003; Calton, Cattaneo, & Gebhard, 2016). For example, in one study of male IPV victims who completed narratives as part of an application for an order for protection, victims’ accounts were presented in ways where they were not described as a victim or powerless in their relationships. Specifically, the order of protections focused on wanting legal intervention to control their partners’ behavior and to prevent them from taking action against their partners; however, men did not mention being afraid or concerned about their safety (Durfee, 2011). Given this, male IPV victims’ views that minimize the severity of the violence may not provide sufficient information to uphold an order of protection. Therefore, beliefs and behaviors that serve as potential barriers to male IPV victims’ engagement in support, legal, and medical services are important to review in conjunction with strategies to address the potential barriers.

**Barriers to Engagement**

Regardless of gender, there are numerous barriers for IPV victims to seek and receive services that include individual factors such as shame and denial, and practical factors such as lack of transportation or other limited accessibility to services (Simmons, Lindsey, Delaney, Whalley, & Beck, 2015). For male IPV victims, factors that may decrease the likelihood of seeking help include not viewing themselves as victims and culture-based stigma with seeking help, generally, and for IPV, specifically.

**Masculinity and conflicted identity as a victim.** Male IPV victims are very diverse demographically (i.e., race, age, sexual orientation; Breiding et al., 2015) and they represent varying attitudes about IPV victimization: some data suggest male IPV victims see themselves as victims (e.g., Eckstein, 2009; Morgan & Wells, 2016), while other data indicate that they do not (e.g., Durfee, 2011). It may be that norms and expectations related to
masculinity make it difficult for some male IPV victims to identify as a victim and, as a result, to seek help (Addis & Mahalik, 2003; O’Brien, Hunt, & Hart, 2005). Moreover, this may cause some male IPV victims to separate their identities as men and as victims in order to preserve their masculinity (Corbally, 2015). In particular, Taylor et al. (2017) described retired male IPV victim Service members who minimized their IPV experiences and wanted to avoid the label of victim due to public stigma. Furthermore, male IPV victims in the same sample also reported that disclosing IPV victimization contradicted their expectations of themselves to be tolerant, resilient, and “a peace-keeper;” all characteristics they reported learning from their service in the military (Taylor et al., 2017). As such, it was difficult for male IPV victims in this sample to reconcile their identities as a victim of IPV and retired Service member who was trained to have “hardened responses.”

However, civilian male victims of sexual assault (e.g., Masho & Alvanzo, 2010) and IPV (Simon & Wallace, 2017) who were physically injured were more likely to seek professional help than those who were not injured, which may be due in part to their identity as a “victim” being defined by the severity of the injury. Therefore, to better engage male IPV victims, it may be beneficial to gather information as to how they identify themselves as communication strategies that identify male IPV victims as “victims” may not elicit disclosure (except in cases of severe injuries). Furthermore, in a study that examined male help-seeking related to a broad range of topics such as seeking help related to health and careers, men reported they were more likely to seek help if doing so allowed them to keep their job or if not doing so compromised their sexual performance (O’Brien et al., 2005). Specifically, O’Brien et al. (2005) stated that firefighters were “unusually open” about their personal concerns so as to receive prevention or early intervention services in order to have minimal disruptions to their careers. As such, it may have been that being labeled as a “victim” was not as aversive if doing so and receiving help maintained their career identity.

**Homophobia and disclosure of sexual identity.** Among gay, bisexual, transgender, and queer/questioning (GBTQ) male IPV victims, many barriers to help-seeking center around ramifications of disclosing sexual identity (which would result from disclosing occurrences of IPV) of not only the victim but his partner, and becoming vulnerable to prejudice and discrimination (Parry & O’Neal, 2015). Disclosure of sexual identity in an unsafe place may lead to experiences of homophobia, internalized oppression, loss of community ties, and negative impacts on career; all of which may also result in re-victimization (Duke & Davidson, 2009). Furthermore, male IPV victims’ abusers may threaten disclosure of sexual identity, especially to an employer or family member, as a way to silence victims, which may be particularly impactful in a relationship between a male IPV victim who is a Service member and their partner who is a civilian perpetrator. However, emerging research suggests that GBTQ males may be more likely to seek help for IPV victimization because of subscribing less to gender role stereotypes and norms (R. E. Anderson, Wandrey, Klossner, Cahill, & Delahanty, 2016).

**Strategies for Increased Engagement**

Acknowledging the unique barriers to treatment engagement that exist for male victims is an important first step towards utilizing resources to effectively reach a population of victims of IPV that has been traditionally underserved. The following strategies have either already been shown to be successful at engaging male victims of IPV in treatment (e.g., screening for IPV during visits for other complaints,
either medical or non-medical), or have shown success at engaging female victims of IPV (e.g., coordinated community responses and social marketing campaigns) and could be adapted for male victims through targeted changes to messaging.

**Screenings.** Screening has been conceptualized as an intervention, especially when used in medical settings (Eckhardt et al., 2013), but can also be viewed as a method to engage male IPV victims in treatment or services. Most of the research on screenings for IPV is based in medical settings (e.g., Chan & Cavacuitti, 2008). Victims of IPV are more likely to disclose experiences of IPV and participate in interventions when they are asked directly (as opposed to engaging in services by disclosing past IPV experiences without being prompted); therefore, screenings may be one of the most important ways to identify and engage victims (e.g., Feder et al., 2011; McFarlane, Groff, O’Brien, & Watson, 2006). For example, approximately 25% of male patients reported either current or past IPV victimization when asked by their primary care provider during an office visit (Jaeger et al., 2008). Of those who reported either past or current victimization, most received an intervention (a safety assessment and counseling) by their provider. Notably, Jaeger et al. (2008) reported that male victims of IPV were most likely to report current victimization in written measures, followed by reporting past victimization in an interview, and least likely to report current victimization in an interview. However, among female victims there are mixed findings regarding methods of screening; victims were more likely to disclose a history of IPV victimization via computer assisted self-report as compared to reporting directly to their health care provider (Klevens, Sadowski, Kee, Trick, & Garcia, 2012) while other results suggest in-person interviews were more effective than self-report computer assessments at eliciting information on IPV victimization history (Frazier & Yount, 2017). Furthermore, research suggests providers in a medical setting can be trained effectively to screen for IPV and refer to appropriate services (O’Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Another approach to identifying and engaging male victims of IPV is separately screening couples when they enroll in family services, such as parenting education classes or psychotherapy (Stith, McCollum, Amanor-Boadu, & Smith, 2012). This may be particularly important as data indicate lifetime prevalence rates of male IPV victims around 25% (Walters et al., 2013) and many may not present in medical settings (or may do so sporadically). For example, training of security forces or staff in the Office of Special Investigations on how to effectively screen for male IPV victimization may allow for increased opportunity to reach male IPV victims in the military (Ashley et al., 2017). However, more research is needed to evaluate how effective IPV victim screenings might be in non-medical settings.

**Coordinated community response.** One approach to encourage victims to utilize services is coordinated community response projects, funded by the Center for Disease Control (CDC). The goal of these projects is to integrate primary and secondary prevention initiatives that target community attitudes and beliefs about IPV as well as increase assistance and services for victims and accountability for perpetrators. Although the findings on the effectiveness of this approach have not indicated significant
reductions in prevalence rates (Garner & Maxwell, 2008) or significant increases in knowledge, attitudes, or beliefs related to IPV (Post, Klevens, Maxwell, Shelley, & Ingram, 2010), there is evidence that some characteristics of coordinated community response projects (e.g., disseminating information on the frequency of IPV in the community) were correlated with higher rates of contact with IPV services among female victims (Klevens, Baker, Shelley, & Ingram, 2008). As such, it may be useful to consider communication strategies that include increased exposure to information on treatment and support related to male IPV victimization to increase male victims’ contact with services.

Social marketing campaigns. As IPV is considered a public health concern, an important approach to address limited engagement of male IPV victims in services and treatment may be through a social marketing campaign via multiple forms of media. Social marketing and public awareness campaigns can not only increase the discourse around a particular topic, but can also provide information to those who are the target of the campaigns, and those who are not, about topics such as warning signs, potential outcomes, and how to seek help (e.g., Boles, Adams, Gredler, & Manhas, 2014; Randolph, Whitaker, & Arellano, 2012). For IPV, awareness and marketing campaigns have focused on male-to-female relationships (e.g., Cismaru & Lavack, 2010); however, there are emerging data to suggest a different approach may be more successful with female-to-male or male-to-male IPV relationships. For example, authors reported a “backlash” from both men and women in a focus group while evaluating the “Open your Eyes” campaign about awareness of IPV. Both men and women (although endorsed by more men) had negative reactions to men being assumed to be the abusers in the fictional couple from the campaign (Keller & Honea, 2015). Furthermore, the focus group suggested that the perpetrators are depicted asking/receiving help and that men are portrayed as victims as well. Moreover, Keller and Honea (2015) recommend avoiding gender-specific marketing strategies that may alienate couples who do not identify with traditional gender roles. Given this, marketing and public awareness campaigns that target male IPV victims might also consider depictions of diverse couples, but also resolutions and services that benefit both partners (i.e., perpetrator and victim receiving treatment).

In order to develop a successful social marketing campaign to engage IPV victims, one social marketing and media campaign model, the Integrated Model of Social Marketers (Cismaru, Lavack, Hadjistavropoulos, & Dorsch, 2008), proposes four important variables to consider: (1) stage of change, (2) characteristics of individuals in each stage of change, (3) important variables within each stage of change, and (4) campaign objectives appropriate to each stage of change. These four variables are based on factors that are believed to influence individuals’ decision-making about health behaviors: vulnerability, severity, response efficacy, self-efficacy, and costs (Cismaru et al., 2008; Rogers, 1975). Specifically, individuals who perceive themselves as having minimal vulnerability to negative consequences, understand the severity of the issue, identify the recommended behaviors as effective while seeing themselves as able to be effective, and perceive minimal costs to their livelihood will be motivated to act and follow recommendations.
recommendations (Cismaru et al., 2008). When developing social marketing campaigns, it is important to target content that addresses these five factors (vulnerability, severity, response efficacy, self-efficacy, and costs), regardless of individuals’ stage of change (i.e., precontemplation, contemplation, preparation, action, maintenance, or relapse) or their personal characteristics (e.g., extrovert, introvert, etc.). For example, social marketing campaigns that aim to encourage male IPV victims who are in the contemplation stage (i.e., individuals have acknowledged that they are in an abusive relationship and would like to receive support) to seek help might focus content and messaging on the perceived benefits and decreased costs of asking for help. However, for male IPV victims in the preparation stage (e.g., individuals have decided to seek assistance and are seeking information to act on their decision), social marketing campaigns might focus on reinforcing male IPV victims’ self-efficacy and providing them concrete actions to find help (Cismaru & Lavack, 2010).

Although this comprehensive literature search did not yield any empirical data on marketing or communication strategies that have been successful at prompting male IPV victims to engage in services, one study found that using branding strategies such as inclusive language, incorporation of visual diversity, and online communication channels may increase male victims’ awareness and engagement in IPV services (Dewey & Heiss, 2015). Furthermore, there are several studies regarding male IPV victims’ decisions to communicate about the abuse and to whom that may inform practitioners and researchers on how to best engage male victims (e.g., Douglas et al., 2011; Hines, Douglas, & Mahmood, 2010; Tsui, 2014). In one study, male IPV victims disclosed information about the abuse to informal supports, predominately close friends and family members and each victim discussed the importance of having respect for the individual with whom they disclosed (Eckstein, 2009). In addition, victims in this sample reported disclosing information primarily for an emotional release, and not necessarily to receive services (which may be due in part to disclosing to family and friends as opposed to professionals). Furthermore, most victims reported “incremental disclosure” which involved disclosing information in stages, based on their comfort level and their perception of privacy management (i.e., how much the person whom they trusted would maintain confidentiality; Eckstein, 2009). As such, in awareness campaigns, it may be effective to encourage male IPV victims to emphasize they may disclose IPV at their discretion and will not be forced to share information. Even though there is limited research about how to effectively engage male IPV victims in treatment and support services, strategies that have had limited success have approached IPV victimization from a public health perspective by applying a systemic, coordinated response between the legal system, family services, and healthcare providers that has included mass communications and outreach for victims as well as non-victims (Garner & Maxwell, 2008; Klevens et al., 2012).
Conclusions and Recommendations

Although male IPV victimization has received less media attention and only recently become more of an interest of academic research, it is also a public health concern similar to female IPV victimization in scope (e.g., Tjaden & Thoennes, 2000; Walters et al., 2013), risks (e.g., Caldwell, Swan, Allen, Sullivan, & Snow, 2009; Goldenberg et al., 2016), and outcomes (e.g., Hines & Douglas, 2010a; Miller & Irvin, 2017). As such, it is important that male IPV victims are engaged in treatment and supportive services to not only ensure their safety and well-being, but also to improve the health of their intimate relationships. Among military couples, it may be particularly difficult to engage male IPV victims due to the potential for additional experiences of shame, embarrassment, and threats to masculinity when compared to civilian male IPV victims (Addis & Mahalik, 2003; Taylor et al., 2017). In order to address concerns with engaging male IPV victims in the military, several recommendations are offered, followed by potential areas of future research.

Programs could:

- **Continue to develop both print and web-based resources as part of social media marketing and awareness campaigns for Service members and their families with information on IPV and where to obtain help.** Web-based psychoeducation has been shown to improve relationship satisfaction in couples with mild to moderate IPV (Roddy et al., 2017), and may be particularly useful given the large number of military families living in civilian communities who are unable to access centralized resources offered on or near military bases.

- **Consider incorporating measures of current and past IPV victimization into existing assessments and surveys given to all Service members and their spouses.** Evidence suggests that screening for IPV victimization may be the best way to identify victims and engage them in treatment (e.g., Feder et al., 2011; McFarlane et al., 2006). However, common phrasing such as, “Do you feel safe at home?” may be less effective with men as many male IPV victims may not feel unsafe, despite experiencing IPV (Peralta & Fleming, 2003). Although incorporating screening tools into existing assessments may be an effective way to begin to identify Service members and spouses who could benefit from IPV services and resources, it will be important to modify screening measures to engage male victims. For example, asking questions with specific, behavior-based content, such as, “Are you being hit/slapped/punched/kicked by your spouse?” may yield more accurate data (e.g., Shakil, Donald, Sinacore, & Krepcho, 2005).

- **Develop materials that discuss the importance of help-seeking to protect the well-being of military families and maintain operational readiness.** Previous research (e.g., O’Brien et al., 2005) suggests that men may be more likely to seek help if the support services or treatment allow them to preserve their role in the family or maintain their occupation. It may be beneficial to discuss help-seeking for male IPV victims in the context of receiving support to help them obtain assistance for their families and maintain their operational readiness.

- **Disseminate information normalizing the prevalence of IPV victimization among males in the military to Service members.** Previous research has established that past-year rates of male IPV
victimization may be as high or higher than rates for civilian males (e.g., Crouch et al., 2009; Foran et al., 2011; Rosen et al., 2002). Embarrassment, shame, and stigma have likely interfered with Service members seeking help. Circulating information regarding the pervasiveness of this problem within the military may be the first step towards letting male Service members who are or have been victims of IPV know that they are not alone, increasing the likelihood that they will seek help in the future.

Policies could:

- **Encourage the development of comprehensive media campaigns in an effort to: normalize the occurrence of IPV with male victims within the military and distinguish between military violence and domestic violence.** Targeting the beliefs and attitudes about male victimization is of particular importance with military populations given that it is a culture that values strength and masculinity (e.g., Taylor et al., 2017). In addition, among an international sample of male IPV victims, severity and uniqueness of victimization impacted disclosure in that the more severe the “physical or psychological” injuries were, the more likely male victims were to disclose to helping professionals. However, the more unique male victims perceived their situation, the less likely they were to disclose (Simon & Wallace, 2017). Therefore, educating male IPV victims on the prevalence of IPV victimization among males through broad-reaching media campaigns is one way to begin breaking down the barriers to help-seeking related to stigma and shame. Furthermore, social awareness campaigns and specific programming to reinforce the distinction between military and domestic violence may help male IPV victims better understand the danger of IPV and assist in their decision-making efforts to seek help.

- **Consider providing training for professionals who work with military families on alternative theoretical frameworks of IPV.** There may be unique risk and protective factors for male victims that are unaccounted for in traditional feminist theories of IPV. Expanding practitioners’ theoretical understanding of some of the differences between male and female victims of IPV may improve practitioners’ understanding of male victims, and ultimately lead to the development of more useful outreach strategies and treatment plans. In particular, male victims of IPV indicated that helping professionals who understood the intersection of IPV, masculinity, and culture helped them to feel comfortable in disclosing their experienced abuse (e.g., Simon & Wallace, 2017; Taylor et al., 2017; Tsui, 2014).

- **Recommend integrating information regarding IPV victimization among males into existing service delivery systems for military families.** Pre- and post-deployment programs, as well as other events for Service members and their families, may serve as an important platform through which information regarding men seeking help for IPV victimization can be delivered and normalized.

- **Encourage partnerships among military-based and community-based programs to help male IPV victims feel more comfortable seeking help and engaging in services that may not be present on installations.** When they do seek and engage in services, many male IPV victims use more than one resource or service (e.g., hotlines/helplines, mental health counselor, legal
services, etc.) to address their complex needs (e.g., Douglas et al., 2011; Tsui, 2014). Strong collaborations between military and community-based IPV victims’ services and treatment may increase the likelihood that male IPV victims have adequate awareness of their options and feel empowered to select services of their choice.

**Future Research**

While an increasing number of research studies have included samples of male victims of IPV in recent years (e.g., Afifi et al., 2009; Douglas et al., 2011), few have utilized military populations (e.g., Bell, 2009). To address this gap in the literature, the following recommendations are offered:

1. **Continue to examine the prevalence, risk factors, and outcomes associated with male victims of IPV within military samples.** There are currently no studies comparing male victims of IPV within the military to a civilian sample, therefore it is unknown to what degree the populations differ. This information could help identify Service members at risk for abuse, as well as those currently experiencing abuse within an intimate relationship, thus providing another avenue where screening for IPV can occur.

2. **Investigate the efficacy and effectiveness of services and treatments for male victims of IPV.** While many support and treatment services exist for victims of IPV, few have been empirically validated with samples of male victims (Barner & Carney, 2011). In order to ensure the services offered to male victims are useful, more research is needed to determine if existing programs can be adapted successfully for male victims, or if new programs need to be developed.

3. **Gather data on demographic factors, abuse characteristics, and other variables that may impact help-seeking among male IPV victims.** Although there are studies that examine variables that are predictive of help-seeking among civilian female (e.g., Fleming & Resick, 2016) and male (e.g., Hines & Douglas, 2015; Tsui, 2014) IPV victims, few studies have assessed demographic factors, abuse characteristics among male IPV victims in the military (e.g., Bell, 2009). Given this, future studies that explore the variables that are correlated with help-seeking of male Service members who are IPV victims can help to determine which subtypes of male IPV victims may be least likely to disclose IPV.

4. **Assess what types of messaging and the ways in which the messages are delivered that are most successful among male victims in the military regarding treatment engagement.** While broad screening for IPV among males has shown success (e.g., Jaeger et al., 2008), little is known about how to then successfully engage males identified as victims in treatment services, or if male victims in the military respond differently than civilian male victims to different types of messaging. Information about the most successful communication strategies is crucial in order to ensure more male victims obtain the support and treatment services they need.

Male IPV victimization is an important public health issue that impacts not only individuals, but families and communities. Coordinated intervention and prevention efforts by family services, medical personnel, and law enforcement to engage military and civilian male IPV victims in services can help to mitigate the impact of IPV on individuals and improve the well-being of their families.
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Intimate Partner Violence: Strategies to Engage Male Victims

184. https://doi.org/10.1080/08974454.2013.802271


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