

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

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

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

Tilbrook et al. (2010) discussed men who had been falsely accused of IPV, child maltreatment, and other crimes; these men spent substantial money, time, and other resources to prove their innocence in court and to address restraining orders that were based on false

reports. Similarly, Cook (2009) provided qualitative evidence that some male IPV victims unjustly lost their homes, possessions, and children because of false claims of abuse made by their female partners. Cook noted that the male IPV victims felt helpless in the face of a judicial system that they believed was stacked against them because of their gender. For example, the men believed that during child custody proceedings, physical custody of their children would be granted to their female partners, and that any contact granted to them to see their children would be blocked by their partners in a continued effort to abuse them and manipulate the legal system. They also feared being falsely accused of mistreating or abusing the children in their partners' efforts to block them from having access to their children, and in several cases, Cook found that this happened.

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

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

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

Partner Violence Victimization and Mental Health

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

Children of parents who engage in IPV also suffer from mental health problems (Sternberg, Baradaran, Abbott, Guterman, & Lamb, 2006) including externalizing (Kalil, Tolman, Rosen, & Gruber, 2003) and internalizing problems (Clements, Oxtoby, & Ogle, 2008; Heugten & Wilson, 2008). A study of children who were living in a shelter for battered women found 69% of the children met clinical cutoffs for mental health problems: 30% of the children met the clinical cut-off for both internalizing and externalizing problems, 21% met the cut-off for externalizing problems, and 18% met the cut-off for internalizing problems (Grych, Jouriles, Swank, McDonald, & Norwood, 2000). Others have found that children are more likely to exhibit externalizing problems. This was the case among children who lived in homes with police-reported IPV (Kernic et al., 2003; Spilsbury et al., 2008). Children and adolescents

living in homes where their mothers are abused often demonstrate patterns of aggression, hostility, anxiety, somatic complaints, social isolation, and suicidal ideation (see Jaffe & Sudermann, 1995). Overall, the literature shows that children who live in homes where there is IPV show both internalizing and externalizing behavior problems; however, no research has investigated the potential consequences of LA aggression. The current study addresses this gap using a sample of male IPV victims who sought help and their report of the mental health status of their children.

The Current Study

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

METHOD

Participants and Procedure

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

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

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

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

Measures

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

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

Revised conflict tactics scales (CTS2). The CTS2 (Straus et al., 1996) was used to measure the extent to which the men in the study perpetrated and sustained psychological, physical, and sexual aggression, and injuries in their relationships. The items used for this study included four items assessing minor psychological aggression (e.g., swearing at partner,

stomping out of the room during disagreement), four items assessing severe psychological aggression (e.g., threatening to hit or throw something at partner, calling partner fat or ugly), 12 items assessing physical aggression (e.g., slapping, beating up), six items assessing injuries (e.g., having a small cut or bruise, broken bone), and six items assessing sexual aggression (e.g., insisting on, threatening, or using force to have sex when the partner did not want to).

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

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

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

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

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

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

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

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

Legal and administrative aggression scale.

The LA Aggression scale (Hines et al., 2014) was divided into two components: (1) A 6-item scale that was an add-on to the CTS2, and (2) a 6-item scale comprised of yes/no questions. The first component contained six

items asking participants how often they and their partners threatened to engage in various types of LA aggressive acts. These acts are aggressive, but to differentiate them from the second component of the scale, we refer to this component as the “threatened LA aggression” subscale. Using the same scale as the CTS2, participants indicated how often they and their partner threatened each of the following acts: make false accusations to authorities that the partner physically or sexually abused the other, make false accusations to authorities that the partner physically or sexually abused the children, leave and take the kids away, leave and take all the money and possessions, ruin the partner’s reputation at work, and ruin the partner’s reputation in the community. This scale was scored in the same manner as the other scales of the CTS2 (see above).

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

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

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

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

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

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

Previous trauma exposure. Previous exposure to trauma was assessed with the Traumatic Events Questionnaire (Vran & Lauterbach, 1994). The TEQ assesses 7 specific traumatic events, including violent

crime victimization, combat, and natural disasters. We eliminated the item assessing adult abusive relationships, and scored the scale by adding together the number of items endorsed. The TEQ has demonstrated excellent test-retest reliability and validity (Lauterbach & Vran, 1996; Vran & Lauterbach, 1994). Cronbach's alpha was adequate in the current study ($\alpha = .71$).

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

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

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

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

RESULTS

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

Associations Between Men's Mental Health and LA Aggression

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

Hierarchical linear regression models were then used to investigate whether the association between LA aggression and mental health remained after controlling for other potential confounds. In separate models, actual and threatened LA aggression were used as the predictor variables and the mental health variables (PTSD and depression symptoms) were used as the outcome variables. Covariates in all models were added in steps. Step 1 controlled for the number of months since the end of the abusive relationship. Step 2 included traumatic/adverse experiences that were distal to the abusive relationship: number of past traumatic experiences (i.e., TEQ total), history of childhood sexual abuse, history of childhood violence exposure, and history of childhood neglect. Step 3 included traumatic/adverse experiences that were proximal to the abusive relationship: the total amount of other IPV occurring in the relationship. Specifically, the IPV covariates consisted of the number

of types of each form of IPV (i.e., severe psychological aggression, controlling behavior, physical aggression, and sexual aggression) ever sustained by the male help-seeker. Step 4 included the number of types of LA aggression experienced (threatened and actual were assessed in separate models). At this step, changes in R^2 were evaluated to investigate whether this form of IPV victimization significantly predicted the male victims' mental health after controlling for other forms of IPV and trauma. Results of these analyses are shown in Table III.

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

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

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

Associations Between Children's Mental Health Status and LA Aggression

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

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

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

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

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

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

predicted the children's mental health after controlling for other forms of adversity. Results of these analyses are shown in Table IV.

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

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

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

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

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

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

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

In analyzing the potential impact of threatened LA aggression on oppositional defiant problems, the overall

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

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

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

Summary

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

DISCUSSION

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

Our results indicated that actual LA aggression, not threatened aggression, was uniquely associated with male IPV victims' PTSD and depression symptoms, above the influence of past traumatic experiences and other forms of IPV in the men's relationship. The fact that this form of IPV is uniquely associated with poor mental health in male victims represents a new finding, and the mechanisms for why this association exists

requires further research. It is known that LA aggression can have dire consequences for male victims, such as losing custody of their children, jeopardizing their financial stability, and ruining their reputation at work or in their community (Cook, 2009). Major adverse life events (Kendler, Karkowski, & Prescott, 1999) and social shame are also associated with negative mental health outcomes, such as depression (Scheff, 2001). Thus, LA aggression can potentially lead to a plethora of negative social and legal secondary outcomes, and these secondary outcomes may primarily account for the effect of actual LA aggression on the mental health of male IPV victims.

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

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

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

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

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

continued

TABLE IV. (Continued)

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

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

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

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

forms of IPV victimization among male IPV victims (Hines et al., 2014).

Limitations

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

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

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

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

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

Implications for Practice

The results of this study carry important implications for practitioners. For example, it is important for men suffering from actual LA aggression to gain access to appropriate mental health treatment to address possible symptoms of PTSD and depression. Despite the availability of effective clinical treatments for a range of mental health issues (USDHHS, 1999), men have a low rate of help-seeking for mental health issues (USDHHS, 2002). A variety of contextual factors may be associated with why men are resistant to seek professional help (Addis & Mahalik, 2003), but these barriers include the need for control and self-reliance,

minimizing the problem, concrete barriers to care, and privacy (Mansfield, Addis, & Courtenay, 2005). In the case of men suffering from LA aggression, it is important to understand the array of factors and barriers they may experience in seeking help from different sources of informal and professional help. Thus, devising effective modes of outreach to male victims is important.

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

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

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