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Intimate Partner Violence in Male Survivors of Child Maltreatment: A Meta-Analysis

Natacha Godbout[1], Marie-Pier Vaillancourt-Morel[2], Noémie Bigras[1], John Briere[3], Martine Hébert[1], Marsha Runtz[4], and Stéphane Sabourin[2]

Abstract

Intimate partner violence (IPV) is a major public health concern. Yet, despite an increasingly extensive literature on interpersonal violence, research on male victims of IPV remains sparse and the associations between different forms of child maltreatment (CM) and IPV victimization and perpetration in men remains unclear. The present meta-analysis evaluated five different forms of CM (sexual, physical, and psychological abuses, neglect, and witnessing IPV) as they predicted sexual, psychological, and physical IPV perpetration and victimization in men. Overall, most available studies examined men as perpetrators of IPV, whereas studies of victimization in men were relatively scarce. Results reveal an overall significant association ($r = .19$) between CM and IPV. The magnitude of this effect did not vary as a function of type (perpetration vs. victimization) or form (sexual, psychological, or physical) of IPV. Although all forms of CM were related to IPV, with effect sizes ranging from .05 (neglect and IPV victimization) to .26 (psychological abuse and IPV victimization), these associations varied in magnitude according to the type of CM. Findings suggest the importance of expanding research on CM and IPV to include a range of different kinds of abuse and neglect and to raise concerns about the experience of men as both victims and perpetrators of IPV.

Keywords

interpersonal partner violence, male, child maltreatment, meta-analysis

Although studies on the adverse long-term outcomes of child maltreatment (CM) have proliferated over the last several decades, the knowledge base for male survivors, in particular, remains relatively limited. Fortunately, there is growing scientific interest in CM experiences as a risk factor of perpetration of violent behaviors in men (Jespersen, Lalumière, & Seto, 2009), including intimate partner violence (IPV; Smith-Marek et al., 2015). IPV is a pervasive public health problem generating huge social and medical costs annually in North America, with around 22–42% reporting that they perpetrated at least one form of physical, sexual, or psychological violence in the context of a sexual/romantic relationship and between 7% and 29% of men reporting having experienced rape, physical violence, and/or stalking by an intimate partner (Abrahams, Jewkes, Laubscher, & Hoffman, 2006; Black et al., 2011; Desmarais, Reeves, Nicholls, Telford, & Fiebert, 2012a, 2012b; Tjaden & Thoennes, 2000). Although most studies confirm a relationship between CM and IPV in men, they focus mainly on the association between child physical abuse, either experienced or witnessed, and physical IPV (Smith-Marek et al., 2015; Stith et al., 2000). Yet, different forms of CM may contribute in different ways to the development, either as a victim or as a perpetrator, of different forms of IPV in men.

For example, meta-analytic studies by Stith et al. (2000) and Smith-Marek et al. (2015) found that gender differences in IPV perpetration and victimization, including that growing up in a physically violent home, is a stronger risk factor for IPV perpetration in men and for IPV victimization in women. These findings suggest differences in socialization processes between girls and boys that may result in different associations between CM and IPV for each gender. In particular, the possibility of gender-specific interactions between different risk factors for IPV, the potentially greater dangers associated with male IPV perpetration relative to female IPV and yet the absence of any meta-analyses focused solely on men, indicates the need for a detailed analysis of male IPV. Such analysis is likely to provide cues for the design of efficient prevention programs.

[1] Département de sexologie, Université du Québec à Montréal, Montréal, Québec, Canada
[2] École de psychologie, Université Laval, Québec, Québec, Canada
[3] Keck School of Medicine, University of Southern California, Los Angeles, CA, USA
[4] Department of Psychology, University of Victoria, Victoria, British Columbia, Canada

Corresponding Author:
Natacha Godbout, Département de sexologie, Université du Québec à Montréal, 455 René-Lévesque Est., local W-R165, Montréal, Québec, Canada H2L 4Y2.
Email: godbout.natacha@uqam.ca

Increasing attention to IPV in the scientific literature has generated a great deal of research on risk factors, including a rapidly evolving body of reviews and meta-analyses (Capaldi, Knoble, Shortt, & Kim, 2012; Fry, McCoy, & Swales, 2012; Gil-Gonzalez, Vives-Cases, Ruiz, Carrasco-Portino, & Alvarez-Dardet, 2008; Smith-Marek et al., 2015). Smith-Marek et al. (2015) recently published a meta-analysis of 124 studies on the effects of CM on adult IPV. In this extensively updated version of the landmark Stith et al.'s (2000) meta-analysis, Smith-Marek et al. (2015) found a small relationship between growing up in a violent home and IPV perpetration ($r = .26$) and victimization ($r = .16$) in men. However, both Smith-Marek et al. (2015) and Stith et al. (2000) focused solely on two forms of CM, witnessing parental IPV and physical abuse, and only examined physical IPV. However, IPV encompasses different forms of violence (physical, psychological, and sexual) and involves both victimization and perpetration (Breiding, Basile, Smith, Black, & Mahendra, 2015). To date, there has been no systematic review examining whether different forms of CM are associated with IPV, exploring all forms of CM as well as all forms of inflicted and sustained IPV.

The examination of different forms of CM in relation with IPV is consistent with trauma-focused theories such as the self-trauma model (Briere, 2002), suggesting that any form of CM may be detrimental to intimate relationships due to their impact on self-capacities (e.g., identity, affect regulation, and relational functioning). For example, different types of CM might affect the development of relational and affect regulation skills, potentially leading to a higher risk of experiencing interpersonal difficulties or conflicts, engaging in impulsive or violent behaviors, and vulnerability to revictimization in adult relationships (Berzenski & Yates, 2010; Gratz, Paulson, Jakupcak, & Tull, 2009). This perspective supports the importance of examining not only child physical abuse but also other forms of CM in relation to IPV.

Research suggests, in fact, that, in addition to child physical abuse, other forms of CM (e.g., psychological abuse, sexual abuse, neglect) may represent significant risk factors for IPV victimization and perpetration in adulthood. Previous studies have examined CM in general, across types of maltreatment, and reported a small but significant association between CM and IPV (Alexander, 2014; Gómez, 2011, Millett, Kohl, Jonson-Reid, Drake, & Petra, 2013), while other research did not find significant associations (Abdala, Shaboltas, Skochilov, & Krasnoselskikh, 2016; DiLillo, Lewis, & Loreto-Colgan, 2007; Widom, Czaja, & Dutton, 2014).

These inconsistent results might be explained according to which type of CM was evaluated. However, studies examining the relationship between specific forms of CM and IPV also report mixed results. For example, in a 30-year follow-up of 497 children with documented histories of abuse or neglect, compared with a matched control group, Widom, Czaja, and Dutton (2014) found that childhood physical abuse, sexual abuse, and neglect did not significantly predict psychological, physical, or sexual domestic violence victimization or perpetration in adulthood. In contrast, Brassard, Darveau, Péloquin, Lussier, and Shaver (2014) found that child sexual abuse predicted physical and psychological IPV perpetration in a clinical sample of 302 men, and Daigneault, Hébert, and McDuff (2009) found that child sexual abuse predicted physical and psychological IPV victimization in a national representative sample of 7,823 men. Moreover, Dardis, Edwards, Kelley, and Gidycz (2013) reported that neglect predicted physical IPV perpetration in a sample of 292 college men, whereas in Roberts, McLaughlin, Conron, and Koenen's (2011) study of a representative sample of 14,564 men, neglect was not a significant predictor of IPV perpetration when controlling for other childhood adversities.

These contradictory findings make it difficult to discern a general trend in the association between different forms of CM and IPV. Some discrepancies may be at least partly explained by differences in sampling and methodology. Stith et al.'s (2000) and Smith-Marek et al.'s (2015) meta-analyses indicated differences in the strength of the association according to the population under study (clinical vs. general population) and study quality. Moreover, varying designs (e.g., documented histories of CM vs. self-reported retrospective report) and examinations of only specific forms of CM or specific forms of IPV, without controlling for other CM experiences, may also play a role.

A more detailed meta-analysis might help determine whether different forms of CM lead to specific types (perpetration or victimization) or forms (physical, psychological, sexual) of IPV in men. For example, it has not yet been demonstrated whether physical CM is most strongly related to physical IPV, as compared with psychological or sexual IPV, or whether psychological abuse is specifically associated with psychological IPV. In one of the few studies in this regard, Jespersen, Lalumière, and Seto's (2009) meta-analysis of the sexual abuse victim-to-perpetrator literature revealed that individuals who offended against children were more likely to have experienced sexual abuse as a child, while offenders against adults were more likely to have experienced physical abuse. Such findings are consistent with social learning, systemic, and psychodynamic theories suggesting that children who are exposed to violence are more likely to reexperience, replicate, or reenact violent behaviors in their adult intimate relationships. These phenomena also have been discussed as exemplars of the intergenerational transmission of violence and cycle of violence theoretical models (e.g., Godbout et al., 2016; Widom & Wilson, 2015). From a social learning perspective, children with different forms of CM may form conclusions and develop strategies based on their maltreatment experiences and then imitate, reenact, or tolerate similar experiences in adulthood, thereby perpetrating or becoming victims of relationship violence (Pears & Capaldi, 2001; Renner & Slack, 2006). Regardless of the basis for these behaviors or vulnerabilities, however, reviews of intergenerational transmission of violence studies have been constrained primary to physical violence, neglecting other forms of CM and IPV (Franklin, 2010; Hou, Fang, & Epstein, 2015) and thus require a more detailed assessment.

Objectives of the Current Study

We sought to clarify and expand the existing literature by performing a meta-analysis on the relationship between multiple forms of CM and IPV, exclusively in men, based on empirical articles published over the last decade. In order to achieve this goal, five forms of CM were targeted: sexual abuse, physical abuse, psychological abuse, neglect, and witnessing interparental violence. A global effect size was first determined for the association between CM and IPV. Three moderator variables were also examined: form of CM (physical, psychological, and sexual abuses, neglect, witnessing interparental violence), type of IPV (perpetration or victimization), and form of IPV (sexual, physical, and psychological). When the number of studies was sufficient, interactions between these three moderators, form of trauma and type and form of IPV, were examined.

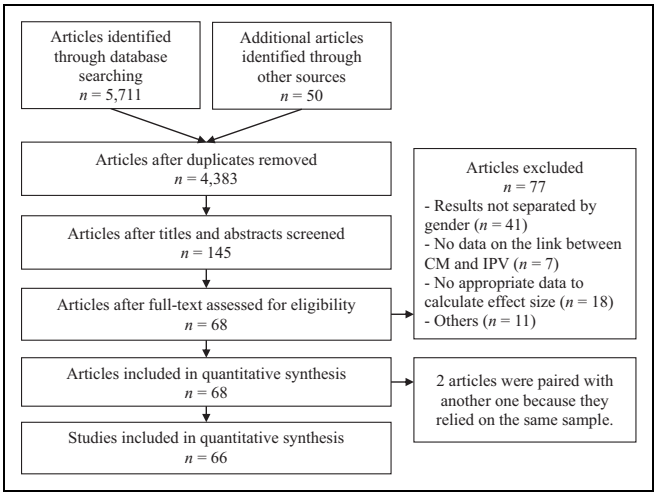

Figure 1. Flow diagram of information through the different phases of the meta-analysis.

Method

Literature Search

The selection of relevant published articles was based on a variety of strategies. First, electronic literature searches of American Psychological Association PsycNET (PsycINFO, PsycARTICLES) and PubMed were conducted using multiple combinations of various keywords, related to men ("men," "man," "males"), CM ("child* abuse," "victimization," "trauma," "maltreatment," "neglect," "sexual abuse," "physical abuse," "emotional abuse," "psychological abuse," "exposure to"), and IPV ("IPV," "domestic violence"). Second, to identify additional studies, the authors also manually searched issues of specific scientific journals that are focused on CM and IPV (*Journal of Interpersonal Violence, Child Abuse & Neglect*, *Journal of Traumatic Stress, Violence and Victims*, *Journal of Family Violence, Child Maltreatment*, *Journal of Aggression, Maltreatment & Trauma*). Finally, the reference sections of all selected studies were thoroughly examined for other relevant articles. When an article was identified, the title, abstract, and full text were read to identify appropriate studies based on the inclusion criteria described below. Whenever a potentially included study reported data that was insufficient to convert into an effect size, we e-mailed the first author to request additional information (14% positive response rate).

Criteria for Study Inclusion

The first and principal criterion for inclusion in the meta-analysis was that the study empirically examined the relationship between any form of CM and any type of IPV. Second, separate results had to be reported for men; studies examining this association in both men and women were included only if there were separate, usable male data. Third, in order to compute specific effects of CM as compared to the absence of CM, the study had to compare victims of CM to nonvictims. Studies involving only participants who experienced CM were excluded because they did not allow computation of effect sizes. Fourth, because this review focused on IPV outcomes in adult males, all studies had to examine participants aged 18 years or older. Fifth, only studies published in English in a peer-reviewed journal between 2005 and fall of 2015 were included. Smith-Marek et al. (2015), who reviewed the association between childhood physical violence and physical IPV from 1980 to 2013, found that as the publication date becomes more recent, or as the study quality increases, the strength of the reported effect size decreases. By restricting this meta-analysis to peer-reviewed studies published in the last decade, we aimed to increase the methodological quality of the investigations sampled and to provide a relatively contemporary synthesis of the data on the association between CM and IPV. Finally, selected articles had to have reported sufficient data to allow computation of effect sizes. If several articles reported results from the same sample for the same association, the effect was entered only once using the most comprehensive article. If they reported results for different associations, that is, for different levels of moderators, articles were combined to form one study. In line with the Preferred Reporting Items for Systematic Review and Meta-Analyses statement (PRISMA), each step of the process of study selection for inclusion in meta-analyses is presented in a PRISMA flow diagram in Figure 1 (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009). A total of 66 studies, reporting 363 CM–IPV effect sizes, were identified as appropriate for this meta-analysis. These studies involved a total *N* of 70,359 participants, and sample sizes ranged from 51 to 14,564.

Coding Procedures

Studies meeting inclusion criteria were coded by a member of the research team and independently verified by a second member. Because all variables coded were discrete and objective, there was a 94% agreement rate. Discrepancies were due to errors in transcription, misunderstanding of the study design/

results, or misreading of the articles. They were resolved through discussion among authors until a unanimous consensus was reached. A coding form was developed that included variables related to the study description (e.g., publication date and author), study characteristics (e.g., sample size, source of the sample, and method used to assess CM and IPV), and the statistics needed to compute estimates of effect size. Three potential moderators were coded: form of CM (i.e., physical abuse, psychological abuse, sexual abuse, neglect, or witnessing interparental violence), type of IPV (i.e., perpetration or victimization), and form of IPV (i.e., sexual, psychological, or physical). Some studies examined different forms of childhood neglect (i.e., physical or emotional) or different forms of interparental violence (physical or psychological), and a large proportion of studies did not provide specific information on the type of neglect or interparental violence. As a consequence, we regrouped all forms of childhood neglect and all forms of interparental violence to yield a sufficient number of studies with which to compute effect size coefficients. When no specific form of CM was mentioned, the study was coded as examining CM in general and included in the global effect size calculation but was not part of the moderation analyses of form of CM. Similarly, when the form of IPV was not specified, we included it in the calculation of the global effect size (coded as general IPV) but not in the moderation analyses examining the effects of the form of IPV.

Statistical Methods

The meta-analysis was conducted using Comprehensive Meta-Analysis, Version 2.0 (Borenstein, Hedges, Higgins, & Rothstein, 2009). Multiple effect sizes were calculated when studies provided results for different forms of CM or different types or forms of IPV. A mean effect size, using Pearson r, was computed for each study by averaging effect sizes within the study (Lipsey & Wilson, 2001). Effect size magnitude was estimated based on Cohen's (1988) guidelines, where $r > .10$ is considered small, $r > .30$ medium, and $r > .50$ large. Average effect sizes for each study were used to test for the global weighted relation between CM and IPV. When considering moderating effects, however, each effect size was used independently to ensure that different forms of CM or IPV were appropriately considered. Because of the variability within methods, settings, recruitment procedures, and sample types, all effect size results are reported for a random effects analysis (Borenstein, Hedges, Higgins, & Rothstein, 2010; Card, 2012). We used a mixed-effects model for the moderation analysis, a random-effects model within subgroups, and a fixed-effect model across subgroups (Borenstein et al., 2010). In the random-effects analysis, all combined effect sizes were weighted by study sample size, and the estimation of between-study variation used inverse-variance weighting methods (Borenstein et al., 2009). Heterogeneity was formally assessed with the Q and I^2 statistics.

Results

Publication Bias

All meta-analyses can suffer from publication bias, which occurs when studies with statistically or clinically significant results are more likely to be published than studies with nonsignificant or unfavorable results. To estimate the likelihood of this effect, we first examined a funnel plot of studies, which is a graph designed to check for the existence of publication biases (Sterne & Egger, 2001). The funnel plot was distributed symmetrically, suggesting an absence of publication bias. To quantify this observation, we then conducted a trim and fill test with a random effect. This test estimates the robustness of the mean effect size against a possible publication bias by estimating how the effect size would shift if the bias was removed (Duval & Tweedie, 2000). The trim and fill result suggested that no studies were missing in the funnel plot, indicating a symmetrical distribution and suggesting that the mean effect size was robust against bias. Finally, the classic fail safe N was also computed to determine the number of missing studies that would be required to nullify the effect (Rosenthal, 1979). A total of 1,136 null studies would be necessary to reduce the effect size to a nonsignificant value. Rosenthal's (1979) proposed threshold to disprove publication bias ($\geq 5k + 10$) was considerably greater than the current value of 340 ($5 \times 66 + 10$). Together, these findings indicated that the global effect size reported here was not significantly skewed by publication bias.

Study Characteristics Analysis

Moderator analyses were conducted to explore six study characteristics that might affect the strength of the association between CM and IPV: study design, method for evaluating CM, method for evaluating IPV, IPV data source, sample source, and publication date.

Study design. Although all the studies employed retrospective reports of CM, some studies used a longitudinal design in which CM experiences were evaluated before the measurement of IPV (e.g., during childhood using parent reports or official records). Analyses revealed that studies using a longitudinal design ($k = 6$; $r = .10$, 95% confidence intervals [CI] [.03, .18], $p = .005$) led to a significantly smaller effect size than studies with a cross-sectional design, $k = 61$; $r = .20$, 95% CI [.18, .23], $p < .001$; $Q_B(1) = 6.27$, $p = .012$.

CM evaluation. Different types of CM evaluation were observed within the studies: questionnaires, official reports, and interviews. The majority of studies used self-report questionnaires to assess CM and measures varied too widely between studies to examine the effect of employing specific instruments. Results indicated that the association between CM and IPV varied significantly between methods used to assess CM, $Q_B(2) = 13.55$, $p = .001$, yielding a smaller effect size for studies using official records ($k = 2$; $r = .08$, 95% CI

Table 1. Association Between CM and IPV in Men for Global Effect Sizes and as a Function of Moderators.

	k	*n*	*r*	95% CI	*z*	*Q* Value	I^2
All Studies	66	70,359	.19	[.17, .22]	15.14***	200.24***	67.54
Form of CM							
Physical abuse	43	52,890	.22	[.18, .26]	10.59***	257.51***	83.69
Psychological abuse	11	17,648	.21	[.14, .27]	6.01***	27.26**	63.32
Neglect	11	33,018	.09	[.04, .14]	3.37**	38.09***	73.75
Sexual abuse	25	51,103	.19	[.12, .26]	5.31***	322.40***	92.56
Witnessing IPV	35	29,693	.19	[.16, .23]	9.99***	118.68***	71.35
Type of IPV							
Perpetration	58	53,132	.19	[.16, .22]	13.60***	185.00***	69.19
Victimization	27	30,055	.17	[.13, .21]	8.66***	66.80***	61.08
Form of IPV							
Physical	52	55,609	.20	[.17, .23]	11.20***	171.17***	70.21
Psychological	21	14,171	.15	[.12, .17]	10.01***	21.63	7.52
Sexual	15	12,036	.16	[.11, .22]	6.25***	42.68***	67.20

Note. CM = child maltreatment; IPV = intimate partner violence; CI = confidence interval.
**$p < .01$. ***$p < .001$.

[.02, .14], $p = .006$), as compared to studies using interviews ($k = 6$; $r = .22$, 95% CI [.14, .30], $p < .001$) or questionnaires ($k = 58$; $r = .19$, 95% CI [.16, .22], $p < .001$).

IPV evaluation. Analyses revealed that the association between CM and IPV varied significantly according to the method used to assess IPV, $Q_B(3) = 14.72$, $p = .002$, with a lower effect size for studies using official records ($k = 1$; $r = .07$, 95% CI [.02, .13], $p = .014$), compared with studies using interviews ($k = 3$; $r = .24$, 95% CI [.13, .35], $p < .001$), the Conflict Tactics Scale ($k = 42$; $r = .19$, 95% CI [.16, .22], $p < .001$), or other questionnaires ($k = 20$; $r = .20$, 95% CI [.15, .25], $p < .001$).

IPV data source. The association between CM and IPV varied as a function of who reported IPV, $Q_B(3) = 14.70$, $p = .002$, with official records related to a lower effect size ($k = 1$; $r = .07$, 95% CI [.02, .13], $p = .014$) as compared with self-reported data ($k = 64$; $r = .20$, 95% CI [.17, .22], $p < .001$). Associations did not differ according to whether the data were self-reported, reported by the partner ($k = 2$; $r = .28$, 95% CI [−.05, .55], $p = .096$), or by both the respondent and his partner ($k = 3$; $r = .22$, 95% CI [.07, .35], $p = .004$).

Sample source. No significant difference was observed in the association between CM and IPV in function of the source of the sample, that is, clinical versus nonclinical samples, $Q_B(1) = 1.23$, $p = .267$.

Publication date. Finally, a meta-regression examining the relationship between publication date and the strength of the reported effect sizes of CM on IPV revealed a nonsignificant coefficient ($b = -.007$, standard error = .005, $p = .110$).

Meta-Analytic Results: Global Effect Size

Effects of CM on IPV. Results for the global effect size are presented in Table 1. Using each study as the unit of analysis, there was a small but significant positive association between having experienced CM and both subsequent perpetration of, or victimization by, IPV as an adult ($k = 66$; $r = .19$, 95% CI [.17, .22], $p < .001$). Significant heterogeneity of results across studies was noted, $Q(65) = 200.24$, $p < .001$, $I^2 = 67.54$, supporting the analysis of potential moderating variables.

Moderation Results: Simple Moderator Effects

To determine whether the variability in the global relation between CM and IPV could be explained by specific moderators, homogeneity analyses across subgroups were conducted. Specifically, we investigated whether the form of CM, type of IPV, or form of IPV moderated the overall relationship between CM and IPV. Effect sizes were grouped according to each moderator, and tests of homogeneity between categories of the moderator were conducted to determine whether the mean effect size on the relationship between CM and IPV differed across categories of the moderator. Results for simple moderation effects are presented in Table 1.

Form of CM. In all included studies, 55 studies reported information on the form of maltreatment experienced in childhood; the 11 studies that evaluated CM in general, without providing the information on forms of CM, could not be used in this moderation analysis. This yielded 125 effect sizes: 43 for physical abuse, 11 for psychological abuse, 11 for neglect, 25 for sexual abuse, and 35 for witnessing interparental violence. All mean effect sizes across moderators indicated a small positive association between CM and IPV. Results of the homogeneity test demonstrated that the association between CM and IPV varied significantly according to the form of CM experienced, $Q_B(4) = 16.67$, $p = .002$. Post hoc pairwise comparisons were

Table 2. Association Between CM and IPV in Men as a Function of Interaction Between Moderators.

Variables in the Interactions		*k*	*n*	*r*	95% CI	*z*	*Q* Value	I^2
Form of CM and type IPV								
Physical abuse	Perpetration	38	39,196	.21	[.17, .25]	9.45***	230.56***	83.95
	Victimization	15	18,045	.22	[.14, .30]	5.36***	106.60***	86.87
Psychological abuse	Perpetration	10	17,648	.18	[.12, .24]	5.87***	18.26*	50.72
	Victimization	4	920	.26	[.15, .35]	4.70***	7.36	59.21
Neglect	Perpetration	11	33,018	.09	[.04, .14]	3.42**	37.31***	73.20
	Victimization	2	5,241	.05	[−.04, .14]	1.01	1.92	47.89
Sexual abuse	Perpetration	18	35,324	.18	[.09, .26]	3.95***	244.89***	93.06
	Victimization	12	23,462	.17	[.09, .24]	4.21***	56.03***	80.37
Witnessing IPV	Perpetration	33	28,474	.19	[.15, .23]	9.02***	132.35***	75.82
	Victimization	11	4,697	.16	[.10, .22]	5.38***	19.05*	47.51
Form of CM and form of IPV								
Physical abuse	Physical	36	44,110	.23	[.19, .27]	10.34***	161.87***	78.38
	Psychological	13	11,388	.15	[.11, .19]	7.39**	16.94	29.14
	Sexual	8	7,887	.15	[.04, .25]	2.65**	41.21***	83.02
Psychological abuse	Physical	10	17,154	.24	[.15, .32]	5.39***	33.97***	73.51
	Psychological	6	2,347	.21	[.15, .26]	7.33***	6.23	19.70
	Sexual	5	2,032	.20	[.07, .32]	2.99**	17.57**	77.23
Neglect	Physical	10	27,369	.09	[.02, .16]	2.53*	36.13***	75.09
	Psychological	4	1,780	.17	[.08, .26]	3.58***	6.24	51.90
	Sexual	3	7,192	.08	[.06, .10]	6.29***	0.80	0.00
Sexual abuse	Physical	18	42,292	.19	[.12, .27]	4.96***	96.93***	82.46
	Psychological	7	11,564	.17	[.09, .24]	4.36***	14.56*	58.80
	Sexual	9	11,474	.20	[.07, .33]	2.86**	215.38***	96.29
Witnessing IPV	Physical	28	11,853	.19	[.15, .24]	8.09***	93.58***	71.15
	Psychological	13	4,694	.12	[.08, .16]	6.25***	14.54	17.49
	Sexual	5	2,986	.11	[.03, .19]	2.69**	6.39	37.44
Type of IPV and form of IPV								
Perpetration	Physical	46	41,914	.19	[.16, .23]	10.22***	152.13***	70.42
	Psychological	17	6,664	.14	[.11, .17]	9.64***	8.89	0.00
	Sexual	12	9,758	.13	[.08, .18]	4.98***	20.47*	46.27
Victimization	Physical	20	25,466	.20	[.14, .25]	6.68***	62.71***	69.70
	Psychological	11	9,628	.13	[.05, .20]	3.21**	30.16**	66.85
	Sexual	8	3,223	.21	[.10, .31]	3.72***	37.20***	81.19

Note. CM = child maltreatment; IPV = intimate partner violence; CI = confidence interval.
*$p < .05$. **$p < .01$. ***$p < .001$.

used to examine which forms of CM significantly differed from the others. Results indicated that the association between IPV and neglect ($r = .09$) was significantly lower than the association between IPV and psychological abuse, $r = .21$, $Q_B(1) = 7.41$, $p = .006$; physical abuse, $r = .22$, $Q_B(1) = 15.27$, $p < .001$; sexual abuse, $r = .19$, $Q_B(1) = 5.30$, $p = .021$; and witnessing interparental violence, $r = .19$, $Q_B(1) = 9.92$, $p = .002$. Other pairwise comparisons were nonsignificant.

Type of IPV. All 66 studies provided information on the type of IPV and yielded 85 effect sizes: 58 included perpetration of IPV and 27 included IPV victimization. Results of the homogeneity test revealed no significant differences between the effect of CM on IPV perpetration versus victimization, $Q_B(1) = 0.69$, $p = .406$.

Form of IPV. In all included studies, 57 contained data on the form of IPV and yielded 88 effect sizes: 52 for physical IPV, 21 for psychological IPV, and 15 for sexual IPV. Results of the homogeneity test revealed no significant differences in the effect sizes of CM on IPV as a function of the form of IPV, $Q_B(2) = 5.74$, $p = .057$.

Moderation Results: Interaction Between Moderators

Since there was still some heterogeneity within some subgroups of moderators, and because the pool of studies included in this meta-analysis was sufficiently large, we investigated whether there were any interaction effects between specific moderator subgroups. Three types of interactions were examined as potential moderators: form of CM by type of IPV, form of CM by form of IPV, and type of IPV by form of IPV. These analyses required some supplementary interaction coding, and then tests of homogeneity were conducted between the new subdivided categories. Results for the interaction moderation effects are presented in Table 2.

Form of CM and Type of IPV. A total of 154 effect sizes (55 studies) were used to analyze the subdivisions of form of CM by type of IPV. All mean effect sizes across subgroups indicated a significant positive association, except for the effect of neglect on IPV victimization, which was nonsignificant. Result of the homogeneity test revealed that the effect sizes were significantly different from each other, $Q_B(9) = 25.05$, $p = .003$, indicating that the associations between CM and IPV varied as a function of the form of CM and the type of IPV. Post hoc pairwise comparisons indicated that the association between neglect and IPV perpetration ($r = .09$) was significantly lower than the associations between physical abuse and IPV perpetration, $r = .21$, $Q_B(1) = 12.07$, $p = .001$, and victimization, $r = .22$; $Q_B(1) = 7.17$, $p = .007$; psychological abuse and IPV perpetration, $r = .18$; $Q_B(1) = 5.15$, $p = .023$, and victimization, $r = .26$; $Q_B(1) = 7.49$, $p = .006$; and witnessing interparental violence and IPV perpetration, $r = .19$; $Q_B(1) = 8.36$, $p = .004$. The association between neglect and IPV victimization ($r = .05$) was also significantly lower than the associations between physical abuse and IPV perpetration, $r = .21$; $Q_B(1) = 10.69$, $p = .001$, and victimization, $r = .22$; $Q_B(1) = 8.26$, $p = .004$; psychological abuse and IPV perpetration, $r = .18$; $Q_B(1) = 6.27$, $p = .012$, and victimization, $r = .26$; $Q_B(1) = 8.83$, $p = .003$; sexual abuse and IPV perpetration, $r = .18$; $Q_B(1) = 4.24$, $p = .039$, and victimization, $r = .17$; $Q_B(1) = 3.98$, $p = .046$; and witnessing interparental violence and IPV perpetration, $r = .19$; $Q_B(1) = 8.14$, $p = .004$, and victimization, $r = .16$; $Q_B(1) = 4.46$, $p = .035$.

Form of CM and Form of IPV. A total of 175 effect sizes (49 studies) were used to analyze the subdivisions of form of CM by form of IPV. All effect sizes indicated a positive and significant association between CM and IPV. The homogeneity test revealed that the effect sizes were significantly different from each other, $Q_B(14) = 65.32$, $p < .001$, indicating that the associations between CM and IPV differed as a function of form of CM by form of IPV. Post hoc pairwise comparisons indicated that the association between neglect and sexual IPV ($r = .08$) was significantly lower than the associations between physical abuse and physical IPV, $r = .23$; $Q_B(1) = 12.09$, $p = .001$; physical abuse and psychological IPV, $r = .15$; $Q_B(1) = 17.51$, $p < .001$; psychological abuse and physical IPV, $r = .24$; $Q_B(1) = 35.91$, $p < .001$; psychological abuse and psychological IPV, $r = .21$; $Q_B(1) = 9.00$, $p = .003$; sexual abuse and physical IPV, $r = .19$; $Q_B(1) = 7.95$, $p = .005$; sexual abuse and psychological IPV, $r = .17$; $Q_B(1) = 4.80$, $p = .028$; and witnessing interparental violence and physical IPV, $r = .19$; $Q_B(1) = 17.87$, $p < .001$. The association between neglect and physical IPV ($r = .09$) was also significantly lower than the associations between physical abuse and physical IPV, $r = .23$; $Q_B(1) = 12.14$, $p < .001$; psychological abuse and physical IPV, $r = .24$; $Q_B(1) = 7.09$, $p = .008$; psychological abuse and psychological IPV, $r = .21$; $Q_B(1) = 7.16$, $p = .007$; sexual abuse and physical IPV, $r = .19$; $Q_B(1) = 4.11$, $p = .043$; and witnessing interparental violence and physical IPV, $r = .19$; $Q_B(1) = 6.03$, $p = .014$. The associations between witnessing interparental IPV and psychological IPV ($r = .12$) or sexual IPV ($r = .11$) were significantly lower than the association between physical abuse and physical IPV, $r = .23$; $Q_B(1) = 14.34$, $p < .001$; $Q_B(1) = 7.59$, $p = .006$; psychological abuse and physical IPV, $r = .24$; $Q_B(1) = 5.95$, $p = .015$; $Q_B(1) = 4.86$, $p = .027$; and psychological abuse and psychological IPV, $r = .21$; $Q_B(1) = 6.56$, $p = .010$; $Q_B(1) = 4.32$, $p = .038$. Finally, the relationship between witnessing IPV and psychological IPV ($r = .12$) was also significantly lower than that between witnessing IPV and physical IPV, $r = .19$; $Q_B(1) = 5.43$, $p = .020$, whereas the association between physical abuse and physical IPV ($r = .23$) was significantly higher than the relationship between physical abuse and psychological IPV, $r = .15$; $Q_B(1) = 7.45$, $p = .006$.

Type of IPV and form of IPV. The available samples allowed 114 effect sizes (57 studies) to be included as a function of the interaction between type of IPV and form of IPV. These results revealed no significant differences in effect size, $Q_B(5) = 9.54$, $p = .089$, indicating no difference in the association between CM and IPV as a function of type of IPV by form of IPV.

Discussion

This meta-analysis examined how men's experience of different forms of CM is related to both IPV victimization and perpetration, whether sexual, psychological, or physical. We identified and recorded 66 adequate studies of males that were conducted over the last 10 years and examined the association between CM and IPV. Notably, however, only 27 of these studies included an association with IPV victimization, indicating that most research in this area examines men solely as perpetrators of IPV. This bias likely reflects the fact that women are more severely impacted by IPV (Dobash & Dobash, 2004; Tjaden & Thoennes, 2000), thereby supporting the need for continued research on IPV in women. In addition, increased understanding of the social/patriarchal contributions to violence, and the growing prevalence of feminist societal attitudes, may influence research on IPV (Dutton & White, 2013; George & Stith, 2014). Nevertheless, in order to further clarify the link between CM and IPV in men and women, both partners' IPV victimization and perpetration should be examined in future studies as well as the social and personal contexts underlying IPV in both men and women. The first finding in the present meta-analysis is the significant but relatively low-level, association ($r = .19$) between CM and later IPV in men. The magnitude of this relationship is similar to those obtained in other meta-analyses that examined only the association between witnessing interparental violence or experiencing childhood physical abuse and IPV (Smith-Marek et al., 2015; Stith et al., 2000). As also found in other meta-analyses, the current findings indicate that certain study characteristics influence the strength of this association, with studies using either longitudinal design or official records to assess CM or IPV leading to smaller effect sizes. These results emphasize the need to consider methodological and sampling issues when forming

conclusions about the associations between CM and IPV. For example, official records may substantially underestimate victimization and perpetration rates, since many experiences of CM and IPV remain unreported to the authorities.

The relatively small association observed between CM and IPV in men suggests that the majority of CM survivors will not experience or perpetrate IPV. Thus, a combination of individual, relational, and societal factors likely contributes to the risk of being a victim or a perpetrator of IPV in male CM survivors. Future meta-analyses should examine the mechanisms underlying the link between CM and IPV to determine protective and risk factors. For example, internalized attachment representations (Godbout, Dutton, Lussier, & Sabourin, 2009) and level of affect dysregulation (Berzenski & Yates, 2010) have been identified as mediators of the relationship between CM and IPV.

The current study found that all forms of CM are related to IPV victimization and perpetration, albeit with small effect sizes. These results indicate that sexual, physical, and psychological abuses, neglect, and witnessing IPV in childhood are significantly associated with both perpetration and victimization involving physical, sexual, and psychological IPV—suggesting not only a revictimization process (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Lalor & McElvaney, 2010) but also the intergenerational transmission of violence perpetration (Fang & Corso, 2007; Widom & Wilson, 2015) in male survivors of CM. Consistent with trauma-focused theories, these links between all forms of CM and IPV may reflect a behavioral reenactment of the trauma (van der Kolk, 1989) or the detrimental effect of CM on the development of the relational and affect regulation skills required to deal with conflicts or issues related to intimacy in close relationships (Briere & Rickards, 2007; Godbout, Briere, Sabourin, & Lussier, 2014).

Our second major finding is that although all forms of CM are related to IPV, with effect sizes ranging from .09 to .22, some forms of CM relate to IPV in different ways than others. As predicted by social learning theory, witnessing interparental IPV or having directly experienced childhood physical abuse were most strongly associated with physical IPV. In this regard, it appears that acts of physical violence tend to precipitate similar violence in the context of close relationships, such that physical abuse was more strongly related to physical IPV as compared to other forms of IPV. Yet, each form of CM was not fully restricted to a similar form of IPV; psychological and sexual abuse, in particular, were related to all forms of IPV. Results also indicate that the relationship between having experienced neglect during childhood and IPV was significantly lower than the effect of other forms of CM on IPV. This may reflect the distinct nature of neglect as compared to other forms of CM. Neglect is an act of omission in which caregivers fail to provide the needed care and opportunities for promoting safe and normal development, whereas other forms of CM involve acts of commission that include actual abusive behaviors directed toward the child (Briere, 2002). It is these direct acts of aggression toward the child that seem to be more closely related to later IPV. Examination of the interaction effects between forms of CM and forms or types of IPV indicated that the smaller association between neglect and IPV was only observed for sexual and physical IPV. This suggests that neglect may be specifically related to subsequent psychological IPV, although the associations between neglect and all forms of IPV were small.

In fact, our results revealed relatively small effect sizes for all CM–IPV relationships. There are many potential causes of IPV (Capaldi et al., 2012), and CM is not only a distal risk factor but also is relatively difficult to accurately assess by retrospective report (Hardt & Rutter, 2004). Given these constraints, any significant relationship found between these two classes of variables is of interest and supports the value of further research on the role of child abuse and neglect in IPV perpetration and victimization.

Limitations and Future Studies

There are several potential limitations of this meta-analysis. First, almost all of the studies included in this review employed retrospective reports. As a result, causal relations cannot be confirmed. Even though the association between CM and IPV was found to be significant, we cannot conclude that it is the earlier traumatic experience that directly led the participant to experience or perpetrate IPV: CM may set into motion more proximal risk factors that have a stronger association with IPV, such as substance use and emotion dysregulation. Errors due to retrospective recall in the data are not confined only to distal versus proximal risk factors for IPV caused by CM. They may also positively bias the association between specific forms of CM and IPV, with IPV victims being more likely to recall, at whatever level of accuracy, childhood victimization. This potential limit is tempered by findings indicating similar effects based on self-reports versus partner reports, although official records indicated lower effects.

Second, socially mediated nondisclosure of experiences of violence and victimization (i.e., CM and IPV) in men may have diminished the strength of associations found between CM and IPV (Hébert, Van Camp, Lavoie, Blais, & Guerrier, 2014; Yeager & Fogel, 2006), just as official records may underreport male victims of IPV. Specifically, male underreporting may mean that some CM- and IPV-affected men are placed in comparison groups, thereby reducing effect sizes.

Measurement method also might affect the results of CM–IPV research. For example, neglect measurement is less developed psychometrically and less anchored in commonly accepted definitions (Briere, Godbout, & Runtz, 2012), and even well-examined variables, such as sexual or physical abuse, are often defined differently in various studies (Chiu et al., 2013). As well, different studies often ascertain CM and IPV status based on different sources of information (self-report, partner report, parent report, etc.). Although modern meta-analyses attempt to quantify these sources of variance, some (e.g., differences in definition) are not easily taken into account.

Although efforts were made to identify studies meeting our inclusion criteria, we only included studies that reported specific data for men, precluding the inclusion of studies that pooled data on men and women. Similarly, we computed effect sizes comparing CM victims to nonvictims, eliminating a number of potentially important studies focusing on CM victims alone. Although difficult to correct for, these excluded studies may have differed in significant ways from the sampled studies. Finally, although several tests to verify publication bias were performed in the current study (i.e., funnel plot, fail safe *N*, and trim and fill) and all indicated the absence of a significant publication bias, future research would benefit from authors routinely reporting bivariate effect sizes when publishing their findings.

Finally, given the paucity of research on the relationship between various forms of CM and IPV in gay, lesbian, and transgender individuals, the current results are limited to heterosexual (or heterosexually reporting) individuals. Yet, the 2010 National Intimate Partner and Sexual Violence Survey (Walters, Chen, & Breiding, 2013) indicated that sexual minority respondents report similar or higher levels of IPV than heterosexuals respondents, with 26% of gay men, 37% of bisexual men, and 29% of heterosexual men having experienced rape, physical violence, or stalking by an intimate partner in their lifetime. Rates of lifetime sexual victimization were higher among gay (40%) and bisexual (47%) men as compared to heterosexual men (21%). Those different rates likely reflect social, demographic, and personal contexts that specifically affect individuals from sexual minorities. Similarly, high rates of IPV occur among transgendered individuals (National Coalition of Anti-Violence Programs, 2013). Further study is clearly indicated in this area, so that future meta-analytic reviews can include the full range of sexual orientations and identities.

Practical Implications

The current findings indicate that the magnitude of the relationship between IPV victimization and perpetration in men is similar to what is found in women (Smith-Marek et al., 2015; Stith et al., 2000). Although the relationship between CM and IPV perpetration in women is obviously important, the possibility of intervening on CM to prevent male violence against their intimate partners is especially relevant, since male-initiated IPV is more common and potentially more dangerous. Wells et al. (2013) have identified several promising areas for engaging men and boys in IPV prevention, including (1) engaging fathers as key participants in family strengthening and support, for example, through the development and enhancement of parental leave policies for men and the implementation of fatherhood support and training programs; (2) engaging key role models such as sport coaches and athletes to promote positive male relational behaviors and to influence men as bystanders, peer influencers, and mentors toward ending IPV (Minerson, Carolo, Dinner, & Jones, 2011); (3) providing men and boys with the skills and opportunity to speak up against sexism, inequity, and the maltreatment of women and girls (Flood, 2010); and (4) supporting minority community leaders in their implementation of appropriate responses to violence (Trevethan, Moore, & Allegri, 2005). Although such suggestions also apply to male victims of IPV, they typically have been focused on preventing violence against girls and women perpetrated by boys and males. In fact, despite the increasing awareness that men can both sustain and perpetrate IPV, a recent overview of therapeutic interventions for IPV (Condino, Tanzilli, Speranza, & Lingiardi, 2016) found that most programs focus on male perpetrators and female victims and lack specific interventions for male victims of IPV or bidirectional IPV in which men are both victims and perpetrators (Condino et al., 2016).

To reduce stigma and raise public awareness about the victimization and perpetration of violence in boys and men, it also may be helpful to increase educational media campaigns that address myths surrounding masculinity, victimhood, and violence as they relate to men. Effective prevention programs might include representation of boys and men as potential victims of IPV in order to sensitize the general population and professionals to the importance of supporting men's self-disclosures of victimization (Alaggia, 2010). Moreover, as for women, more resources are needed to improve the quality and quantity of services available to male IPV survivors. For example, greater access to and delivery of support and treatment services for males, across a wider range of settings (e.g., high schools and universities, crisis hotlines, outpatient clinics, and inpatient psychiatric services), might reduce the rate of IPV and would better address the psychological needs of male victims.

Assessment of CM and IPV in men. These results emphasize the importance of assessing different forms of childhood abuse and neglect experiences in men, as well as women, so that the clinician can fully determine the actual violence sustained or perpetrated in a given clinical presentation and offer potential interventions adapted to the needs of each victim. They also support the need to alert health professionals to the possibility of past and current victimization in men, whether they are perpetrators of IPV or not. Health professionals are significantly less likely to assess for victimization in men relative to women (Lab, Feigenbaum, & De Silva, 2000; Yeager & Fogel, 2006), and men are less likely to disclose their victimization histories (Banyard, Moynihan, & Plante, 2007; Hébert, Tourigny, Cyr, McDuff, & Joly, 2009). Universal screening assessments might help identify men who were victims of all forms of CM and both victims and perpetrators of IPV (Vaillancourt-Morel et al., 2016). When men report any form of CM, clinical response is indicated not only for compassionate reasons but also because of the increased potential for current or future IPV victimization and perpetration. Such clinical responses should also respect victims' individual choice by providing them with a range of options and promoting their central role in the decision-making process.

CM-specific interventions. Because our findings indicate that all forms of CM are associated with IPV in males, they suggest the

value of therapeutic activities that address the mechanisms whereby CM contributes to IPV victimization and perpetration. Given potential levels of fear and mistrust of others and social role conflicts associated with CM, male survivors may benefit from a safe, supportive therapeutic relationship wherein they can process and resolve the effects of child abuse and neglect and thereby interrupt the cycle of further violent victimization and perpetration. Moreover, adverse consequences of CM such as posttraumatic stress, ineffective coping strategies, and the absence of appropriate conflict management skills may be highly relevant to male victims of CM who experience or perpetrate IPV. However, because abuse-related mechanisms leading to IPV appear to differ according to the form of CM experienced, interventions that target the differential effects of specific abuse types may be more effective than generic treatment approaches. Further, information that similar acts of violence tend to be repeated from childhood to adulthood can assist clinicians and researchers in understanding the specific cycle of reenactment or revictimization relevant to each form of victimization and support specific treatment adaptations accordingly. For example, neglect may lead to impaired psychological and biological regulatory processes, and a relative lack of sense of self, leading to more psychological IPV (De Bellis, 2005; Hildyard & Wolfe, 2002; Straus & Savage, 2005). In such cases, interventions might target self-awareness and mentalization, meaning-making, and the development of a cohesive narrative of the CM and its effects (e.g., Bateman & Fonagy, 2012; Briere & Scott, 2014). Because physical violence may have a specific impact on impulsivity and relational power dynamics associated with physical IPV, treatment might also focus of emotion regulation, relationality, and internalized relational schema (e.g., Cloitre, Cohen, & Koenen, 2006; MacIntosh & Johnson, 2008). At the same time, however, different forms of CM often co-occur and interact with family dysfunction in ways that complicate assessment and treatment.

In some cases, traditional single-trauma Cognitive Behavioral Therapy (CBT) exposure techniques may be insufficient to address the experience of multiple traumatizing events and overall unsafe environments associated with CM (Briere & Scott, 2015). In addition, acts of omission (e.g., neglect) are often at least as harmful as acts of commission (e.g., physical or sexual abuse) and yet are difficult to address with traditional exposure techniques. For these reasons, it may be helpful for CM-focused treatment to focus more on titrated emotional and cognitive processing of implicit and explicit CM memories in the context of a safe and supportive therapeutic relationship (Briere & Scott, 2015; Cloitre et al., 2002; Courtois & Ford, 2012; Herman, 1992). Based on this literature, for example, Hopton and Huta (2013) have developed an empirically validated group treatment for male survivors of CM that takes into account the specific impacts of CM on males in the context of traditional gender socialization. Although this and related approaches represent positive early steps in the treatment and prevention of CM and IPV involving boys and men, there remains a need for considerably more research on male victims of CM and specific interventions for them.

Authors' Note

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Author Biographies

Natacha Godbout, PhD, is professor at the Department of Sexology, Université du Québec à Montréal – UQAM, Canada. She is permanent researcher at the Interdisciplinary Research Centre on Intimate Relationship Problems and Sexual Abuse (CRIPCAS), and the Sexual Violence and Health Research Team. Her research and clinical work center on the impacts of child interpersonal trauma on adults' psychological, sexual and relational functioning. Her website is natachagodbout.com.

Marie-Pier Vaillancourt-Morel, PhD, now a postdoctoral fellow at Université de Montréal and a clinical psychologist specializing in sexual and relational disorders. She has conducted research on the emergence of sexual difficulties in couple relationships as well as on the interdependence between interpersonal and sexual functioning.

Noémie Bigras has a master degree in Sexology and is currently a PhD student in Psychology at UQAM, Canada. Her research interests focus on the repercussions of childhood cumulative trauma on adult marital and sexual adjustment.

John Briere, PhD, is an associate professor of Psychiatry and Psychology at the Keck School of Medicine, University of Southern California, and Director of the USC Adolescent Trauma Training Center of the National Child Traumatic Stress Network. A past president of the International Society for Traumatic Stress Studies, he is recipient of the Award for Outstanding Contributions to the Science of Trauma Psychology from the American Psychological Association. His website is johnbriere.com.

Martine Hébert (PhD in psychology) is the Tier I Canada Research Chair in Interpersonal Traumas and Resilience. She is also director of the Sexual Violence and Health Research Team, and full professor at the department of sexology, UQAM. Her research projects focus on the diversity of profiles in survivors of interpersonal traumas and the evaluation of intervention and prevention programs.

Marsha Runtz is an associate professor and associate dean of Graduate Studies at the University of Victoria, British Columbia. Her research focuses on the long-term effects of interpersonal violence including child sexual, physical, and emotional abuse and neglect and intimate partner violence.

Stéphane Sabourin, PhD, is a full professor in clinical psychology at Laval University, Quebec, Canada, and permanent researcher at the CRIPCAS. He conducts research on the multiple predictors of couple distress including adverse childhood experiences and personality disorder symptoms. He is also Director of the Laval University Couple Therapy Unit.