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How Trauma, Depression, and Gender Roles Lead to Intimate Partner Violence Perpetration Among a Sample of Predominately Low-Income Black, Indigenous, Men of Color: A Mixed Methods Study

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Abstract

Despite decades of research and significant efforts by practitioners and advocates, intimate partner violence (IPV) in the United States remains a public health issue that disproportionately affects racial/ethnic minorities. The lack of mixed methods and qualitative studies, particularly with Black, Indigenous, Men of Color (BIMOC), limits the field's ability to tease apart the complex, multifaceted aspects of IPV perpetration and minimizes diverse perspectives of how childhood trauma and key proximal factors culminate in IPV perpetration. An explanatory design, follow-up explanations model, was used with a sample of predominately low-income BIMOC in a batterer intervention program (BIP). Associations between IPV and theoretically supported factors (e.g., trauma symptoms, depression, gender roles) were examined using a cross-sectional survey ($N = 67$) with ordinary least squares

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regression. Following up, processes explaining how these factors might lead to IPV perpetration were explored using semistructured interviews ($N = 11$) with narrative analysis. Results indicate that depressive and posttraumatic stress disorder (PTSD) symptoms together predict men's IPV perpetration. Participants' collective narrative explains how key factors—such as adverse childhood experiences, PTSD, depression, social isolation, anger, and restricted emotionality—work together to culminate in IPV perpetration. Findings shed light on potential trajectories and antecedents that manifest in IPV perpetration, providing implications for practice techniques and program development with low-income BIMOC in BIPs.

Keywords
intimate partner violence, mixed methods, trauma, depression, social isolation, batterer intervention program, Black; Indigenous; Men of Color

In their lifetime, nearly 49% of men and 48% of women will experience psychological aggression, and 10% of men and 25% of women in the United States will experience some form of stalking, physical violence, and/or sexual violence in an intimate relationship (Breiding et al., 2014). Victims of intimate partner violence (IPV) experience a multitude of bio-psycho-social health consequences, including physical injuries, depression, posttraumatic stress disorder (PTSD), substance abuse, sexually transmitted infections, and suicidality (Dillon et al., 2012). Though victimization rates are similar across men and women, the severity and injury rates from male-perpetrated IPV are significantly higher than female-perpetrated IPV (Breiding et al., 2014). Disparities in IPV victimization are also evident across racial groups with multiracial (53.8%), Black (43.7%), and Native American or Alaskan Native (46%) women experience disproportionally higher rates of IPV victimization compared to Hispanic (37.1%), White (34.6%), and Asian or Pacific Islander (19.6%) women (Black et al., 2011).

Given that factors causing IPV are likely to interact with gender, class, and race (hooks, 2004), attention to the study of IPV perpetration from the perspective of men of different races and socioeconomic standings is warranted. Though researchers have examined factors associated with men's IPV perpetration, such as exposure to IPV in childhood (e.g., Narayan et al., 2017), mental health issues in adulthood (e.g., Machisa et al., 2016), and rigid gender roles in adulthood (e.g., Fleming et al., 2015), few studies have explored how these experiences precipitate the use of violence (e.g., Webermann & Murphy, 2019) and rarely with low-income Black, Indigenous, Men of Color (BIMOC). In order to effectively intervene with violence against women, a clearer

understanding of how key IPV-related factors resonate in the lived experiences of low-income BIMOC and culminate in their perpetration of IPV is critical.

Literature Review

Childhood trauma and IPV perpetration. A seminal quantitative study using a retrospective, cross-sectional survey design with 8,629 mostly White, middle-class adults known as the Adverse Childhood Experiences (ACEs) study found that men who experienced either sexual abuse or physical abuse or witnessed interparental IPV in childhood were two times more likely to perpetrate IPV and 3.8 times more likely if exposed to all three (Whitfield et al., 2003). Despite this robust area of research (Godbout et al., 2019), few quantitative studies have explored this phenomenon with BIMOC (e.g., Webermann et al., 2019). A qualitative study using grounded theory found that low-income African American men's exposure to ACEs and traumatic experiences in childhood diminished their sense of trust and safety, which was carried forward into later developmental stages and influenced their perpetration of IPV in adulthood (Voith et al., 2020). However, qualitative studies exploring how childhood trauma leads to IPV perpetration among men in general are scant (e.g., Machisa et al., 2016).

Mental Health and IPV Perpetration

A considerable body of quantitative research in the United States has illuminated a positive association between men with a PTSD diagnosis and a higher likelihood and greater frequency of IPV perpetration compared with men without a PTSD diagnosis (e.g., Hahn et al., 2015; Smith et al., 2015), though most study samples are predominately White and middle class. Few studies explain how trauma symptoms precipitate men's IPV perpetration, limiting clinical implications for IPV cessation programs. Some qualitative studies have attempted to tease apart this phenomenon. Drawing from a sample of 23 heterosexual couples in the military who were recruited from a PTSD treatment program, researchers used modified grounded theory to compare interviews of couples with IPV histories to those without IPV histories (Gerlock et al., 2014). Findings showed that PTSD symptoms interacted with other issues such as alcohol and drug abuse, stress due to physical impairment, and military cultural norms, which impaired relationship functioning and ultimately culminated in IPV (Gerlock et al., 2014). This phenomenon needs to be explored further with subpopulations of civilians (e.g., BIMOC) given that some themes (e.g., military cultural norms) are likely not transferrable to other populations.

Other studies have focused on depression as a risk factor for IPV perpetration (Caetano et al., 2020; Capaldi et al., 2012). Racial differences were found in a longitudinal study employing growth curve modeling: Researchers found that men's depression was a risk factor for an increase in sexual IPV over time among Black women, but not Hispanic women (Preiser & Assari, 2018). One study aiming to explore the underlying nature of this relationship found an indirect effect between men's ACEs and their IPV perpetration via depression using cross-sectional data from over 1,800 couples (Mair et al., 2012). However, the underlying nature of this relation remains unclear due to the small number of studies examining this phenomenon (especially with racial/ethnic minority groups) and limited study designs.

Gender Roles and IPV Perpetration

Research shows a positive association between traditional gender roles and IPV perpetration, with some attention to racial/ethnic differences. In a nationally representative sample of heterosexual adults, Golden et al. (2013) found that traditional gender beliefs in concert with economic hardship and economic dependency on a romantic partner increased women's risk for exposure to IPV, explaining most of the racial/ethnic disparities. Researchers have also explored more nuanced aspects of gender roles, finding "restrictive emotionality," or the difficulty of expressing one's emotions, had a consistent impact on IPV perpetration (O'Neil, 2008). In a mixed methods study using grounded theory with predominately Black men, Peralta and Tuttle (2013) found that economic instability threatened men's masculine image and contributed to their IPV perpetration. Despite gender being an underlying theoretical foundation to the study of gender roles and IPV, few qualitative or mixed methods studies explore how elements of traditional gender roles (e.g., restrictive emotionality) culminate in IPV perpetration from the perspective of men, especially BIMOC.

Theoretical Framework

The ACEs framework highlights the long-term harmful effects of ACEs on physical, mental, and behavioral health, including future violence victimization and perpetration. Specifically, exposure to child maltreatment and other traumas at sensitive periods of development can alter structural and functional interconnections in the brain through biochemical changes (Kelleher et al., 2008) that regulate emotion regulation (Hébert et al., 2018), stress response (De Bellis & Zisk, 2014), and attachment (Alexander, 2009), which are critical to healthy interpersonal development. Throughout development, these biological changes interact with environmental conditions that either

exacerbate or ameliorate the bio-psycho-social interplay, setting children on a trajectory for success or continued challenges. If gone unaddressed, violence-exposed children become more vulnerable to environmental triggers (e.g., interpersonal conflict), unhealthy coping mechanisms (e.g., alcohol and drug use), and mental illness (e.g., depression, PTSD) in adolescence and adulthood, which can then affect the conditions of romantic relationships in adulthood, ultimately contributing to IPV perpetration (Voith et al., 2018).

Current Study

The lack of mixed methods and qualitative studies, particularly with low-income BIMOC, limits the field's ability to tease apart the complex, multifaceted aspects of IPV perpetration and minimizes diverse perspectives of how childhood trauma and key proximal factors (e.g., trauma symptoms, depression, gender roles) culminate in IPV perpetration. These gaps hinder the field's understanding of critical nuances necessary for the effective application of research to practice and policy. Therefore, the current study examined the associations between theoretically supported factors and processes, explaining how these factors might lead to IPV perpetration with a sample of predominately low-income BIMOC in a batterer intervention program (BIP) using mixed methods. The following research questions guided our study: (a) Do depressive symptoms in the past month, PTSD symptoms in the past month, and restricted emotionality predict increased rates of IPV perpetration? (b) How do depressive symptoms, trauma symptoms, and restricted emotions interact to affect IPV perpetration?

Method

Design

This study utilized an explanatory design: follow-up explanations model (Creswell & Plano Clark, 2007) to determine which life experiences (e.g., adversity and trauma) were important to IPV perpetration, and to gauge how these underlying mechanisms function to precipitate IPV perpetration based on the lived experience of men in a BIP. In Phase I, a cross-sectional survey was administered to assess an array of life experiences, including ACEs, behavioral health (e.g., substance use), mental health (e.g., PTSD, depression), physical health (e.g., wellness), attitudes (e.g., gender roles), incarceration history, and violent perpetration and victimization. The current study focuses on survey questions related to ACEs, depression, PTSD, and restricted emotionality. In Phase II, semistructured interviews were developed and

conducted using findings from Phase I to better understand how key factors (e.g., depressive symptoms) led to IPV.

Procedure

In Phase I, men were recruited and screened for eligibility at the point of referral to the largest BIP in a Midwest city between November 2017 and December 2018. Recruitment was conducted in a private room at the probation office using IRB-approved materials. Eligible men were 18 years or older, could speak and/or read English fluently, and were referred to a court-mandated BIP. Eligible participants were consented and given the option to complete the survey at that time or to schedule an alternative time. Surveys were completed using an iPad or paper/pencil, taking approximately 60 min. Participants were provided $25 cash, a snack, and a beverage for their time.

In Phase II, a subsample of men was recruited from the Phase I sample via phone and email to complete a semistructured interview between January 2019 and May 2019. A stratified design was used to guide recruitment for a purposive sample. Specifically, men who endorsed depressive symptoms, trauma symptoms, and/or restricted emotionality, as well as men who did not endorse these symptoms, were targeted for recruitment to allow for comparisons across these experiences. Interviews took place in a private room at the probation office. Participants were provided $25 cash, a snack, and a beverage for their time.

Sample

Phase I: Quantitative sample.

Out of 360 men who were referred to the BIP as part of probation between November 2017 and December 2018, 67 men participated in the survey. The men in the sample were 35 years old on average. The majority of the men were employed (86.6%), Black (76.1%), high school graduates (49.3%), and reported an annual income less than $20,000 (71.6%; see Table 1 for complete demographic information).

Table 1. Quantitative Study Sample Demographics, ACEs, IPV Perpetration Past Year Frequency, and Clinical Variables (*N* = 67).

Characteristic/Variable	*n* (%)	*M (SD)*	Clinical Threshold (%)	Min	Max
Age (*N* = 67)		35.42 (11.61)		18	67
Race (*N* = 67)					
White	4 (6.0)				

(*continued*)

Table 1. continued

Characteristic/Variable	*n* (%)	*M (SD)*	Clinical Threshold (%)	Min	Max
African-American or Black	51 (76.1)				
Hispanic or Latino	7 (10.4)				
Native-American or Alaska Native	1 (1.5)				
Other	4 (6.0)				
Annual income (*N* = 66)					
Less than $10,000	21 (31.3)				
$10,001– $20,000	27 (40.3)				
$20,001– $30,000	10 (14.9)				
$30,001–$40,000	3 (4.5)				
$40,001–$50,000	3 (4.5)				
$50,001–$60,000	1 (1.5)				
$60,001 or higher	1 (1.5)				
Education level completed (*N* = 66)					
Less than high school	3 (4.5)				
Some high school	18 (26.9)				
High school diploma or GED	33 (49.2)				
Some college or college	12 (17.9)				
Intimate partner violence perpetration					
Psychological aggression (*N* = 58)		31.91 (30.47)		0	116
Physical assault (*N* = 57)		6.25 (12.96)		0	84
Injury (*N* = 61)		3.80 (7.63)		0	31
10 traditional ACEs (*N* = 66)		3.50 (2.66)	51.5a	0	9
21 extended ACEs (*N* = 66)		8.58 (4.96)		0	20
Depression (*N* = 63)		5.76 (6.09)	22.2b	0	22
PTSD (*N* = 64)		26.26 (19.06)	29.7c	0	68
Restrictive emotionality (*N* = 61)		29.95 (13.22)		10	60

Note. [a]Four or more ACEs were used as a threshold above which there is a higher risk of negative developmental outcomes (Felitti et al., 1998).

[b]PHQ-9 scores equal to or greater than 10 were considered to be indicative of clinical depression (Manea et al., 2012).

[c]PCL-5 scores equal to or greater than 33 were considered to be indicative of clinical PTSD (Blevins et al., 2015).

Phase II: Qualitative sample.

Of the 67 men who participated in the survey, 8 men consented to participate in a semistructured interview. Three of the 8 men consented to a follow-up interview for a total of 11 interviews, each lasting approximately 45 min. Sample demographics of men in Phase II mirror the Phase I sample. Men were 35 years old on average, with the majority being employed ($n = 6$), Black ($n = 7$), high school graduates ($n = 5$), and having an annual income less than $20,000 ($n = 8$; see Table 2 for complete demographic information).

Measures

Phase I: Survey.

The measures detailed below are reflective of a subset of variables measured during Phase I with men in the BIP.

Demographics. Race/ethnicity was measured using six categories: African-American or Black, Hispanic or Latino, Asian, Native-American or Alaska Native, White, and other. Men were allowed to select more than one category. Income in the past 12 months was measured using one item, with response options in $10,000 increments ranging from 1 = less than $10,000 to 11 = above $100,001. One item measured the highest level of education completed with five response options: less than high school, some high school, high school diploma or GED, some college or college, and graduate school.

Adverse childhood experiences. This study measured ACEs using the 10 "traditional" ACE items (e.g., abuse, neglect, witnessing IPV, and household dysfunction; Felitti et al., 1998) and two "expanded" ACEs checklists. The expanded checklists included 11 ACE items focusing on adversities in settings outside of the home (e.g., witnessing community violence, experiencing identity-based discrimination, bullying victimization; Cronholm et al., 2015; Mersky et al., 2017). Scores from the 10 traditional ACEs and the 21 combined traditional and expanded ACEs are reported. The response option for each item in the checklist was dichotomous, 0 = *no* and 1 = *yes*, making a total score ranging from 0 to 10 for the traditional ACEs and 0 to 21 for the combined traditional and expanded ACEs checklist.

Intimate partner violence perpetration. Thirty-three items from the Revised Conflict Tactics Scale (CTS2) were used to measure men's IPV perpetration of psychological aggression, physical assault, injury, and sexual coercion (Straus et al., 1996). Frequencies of each type of behavior in the past year was ascertained using a 7-point Likert scale with response options ranging from 0 = *this has never happened* to 6 = *more than 20 times*, and 7 = *not in the past year, but it did happen before*. Based on Straus et al. (1996),

Table 2. Qualitative Study Sample Demographics, ACEs, IPV Perpetration Severity, and Clinical Variables (*N* = 8).

	Demographics				ACEs		IPV Perpetration Severity (Past Year)a				Mental and Emotional Health		
Name	Age	Race	Annual Income	Education	10	21	Psych	Phys	Sexual	Injury	Depressionb	PTSDc	REd
Jamar	34	Black	$10,001–20,000	College	4	7	Severe	Mild	Mild	None	Minimal	C	24
Cameron	28	Black	$10,001–20,000	HS/GED	1	7	Severe	Mild	Mild	Mild	Minimal	NC	14
James	40	NA/AN	<$10,000	HS/GED	6	15	Severe	Mild	Mild	None	Minimal	NC	22
Tyler	31	Black	$10,001–20,000	HS/GED	7	16	Severe	Severe	Severe	None	Mild	C	18
Anthony	29	Black	$10,001–20,000	HS/GED	6	11	Mild	None	None	None	Moderate	NC	34
Chris	49	Black	$10,001–20,000	College	4	6	Severe	Severe	Severe	None	Mild	NC	16
Michael	18	Black	None	Some HS	4	12	Severe	Mild	Mild	Mild	Minimal	C	31
Isiah	50	Black	$10,001–20,000	HS/GED	0	4	Severe	None	None	None	Minimal	NC	20

Note. C = clinical; NC = nonclinical; RE = restrictive emotionality; NA/AN = Native-American or Alaska Native; HS/GED = high school diploma or GED; some HS = some high school.

[a]IPV perpetration severity categories were created based on guidelines suggested by Straus et al. (1996).

[b]PHQ-9 scores from 0–4 were categorized as "minimal," 5–9 as "mild," and 10–14 as "moderate" depression (Kroenke et al., 2001).

[c]PCL-5 scores equal to or greater than 33 were considered to be indicative of clinical PTSD (Blevins et al., 2015).

[d]Overall mean score of restrictive emotionality for the larger sample (*N* = 61) was 29.95 (*SD* = 13.22, range = 10–60).

the following steps were taken to create frequency scores in the past year. First, each response option was converted into a score that represents the midpoint of the response option; for example, the response *3–5 times in the past year* was recoded to equal 4. The score for *not in the past year, but it did happen before* was recoded to 0, as this study focuses on IPV frequency in the previous year. Then, the total frequency mid-point scores for each perpetration subscale were summed. Severity categories (i.e., none, mild, and severe) were also created for each eligible subscale (Straus et al., 1996). As internal consistency is not considered a good measure of reliability with behavioral experiences (Hulme, 2007), we do not report Cronbach's α. However, previous studies report good validity (Jones et al., 2002) and reliability (Straus et al., 1996) for this measure.

Restrictive emotionality. Assessing the degree of men's difficulty expressing their own feelings was measured using the 10-item restrictive emotionality subscale of the Gender Role Conflict Scale-I (O'Neil et al., 1986; e.g., "I have difficulty expressing my emotional needs to my partner"). Participants responded to each item using a Likert scale, 1 = *strongly disagree* to 6 = *strongly agree*. Scores were summed to create a total restrictive emotionality score (range 10 to 60), with higher scores indicating more restrictive emotionality. Cronbach's α was .87, indicating high internal consistency for this study.

Depression. The 9-item Patient Health Questionnaire (PHQ-9) was used to measure depression, specifically how often the respondent has been bothered by depressive symptoms (e.g., "Little or no interest or pleasure in doing things") in the past 2 weeks (Löwe et al., 2004) with Likert scale response options ranging from *0 = not at all* to 3 = *nearly every day*. Scores were summed to create a total depressive symptom severity score ranging from 0 to 27, with higher scores indicating greater severity of depressive symptoms. Cronbach's α for this study was .88, indicating high internal consistency.

Posttraumatic stress disorder (PTSD). The 20-item PTSD Checklist for *DSM 5* with Criterion A (PCL-5) measured the four domains of PTSD symptoms: avoidance, arousal or reactivity, re-experiencing, and negative thoughts (Blanchard et al., 1996). Participants were asked to respond to the presence and severity (i.e., extent bothered by each symptom) of symptomatology during the past month on a Likert scale ranging from 0 = *not at all* to 4 = *extremely* as they recall the most stressful event that has happened to them. Scores were summed to create a total symptom severity score ranging from 0 to 80, with higher scores indicating greater severity of symptoms (Blevins et al., 2015). Cronbach's α for this study was .94, indicating high internal consistency.

Phase II: Semistructured interview.

A semistructured interview guide was created to illuminate the nuances among variables of interest and draw out men's narratives describing how developmental experiences (i.e., ACEs) and proximal factors (i.e., depressive and PTSD symptoms, restrictive emotionality) affect their behavior with significant others. For example, we asked questions to elicit men's understanding of the effect of ACEs on their interpersonal relationships, such as, "Do you think that some of the bad things that happened growing up impacted the way you treat or interact with others, like your intimate partner? How so?" We also inquired about depression (e.g., "Thinking back on the things that made you feel depressed, do you think that these feelings [affected you emotionally or how you behaved?] and [impacted how you interacted with your partner?]") and emotional expression (e.g., "In your relationship with your significant other, are you comfortable sharing your emotions and feelings? If not, why do you think it is difficult?" "How would you describe the impact of this on the way [you responded to your partner] and [your partner responded to you] during conflicts or fights?"). After an initial analysis of the data, we conducted second round interviews about responses to trauma (e.g., "Some respondents reported that after experiencing certain negative things in childhood (e.g., abuse), they had a harder time feeling in control of themselves at certain times. Is this true for you? If so, how would you say it has impacted your close relationships?").

Analysis Plan

Phase I: Quantitative analysis.

Univariate analyses were conducted for each variable. Ordinary least squares (OLS) regression was used to answer the first research question. Bivariate correlations between each predictor and outcome variable were examined to rule out any relationships with marginal correlations (i.e., $r < .30$; Cohen, 1988), and to screen for multicollinearity between predictors (i.e., $r > .80$; Allison, 1999). Sexual IPV perpetration was minimally correlated with all predictors, and restrictive emotionality was minimally correlated with all types of IPV perpetration; thus, these variables were excluded from the analysis. No signs of potential multicollinearity were detected. As a result, the final OLS regression model examined the associations between depression and PTSD and three types of IPV perpetration (i.e., psychological, physical, and injury). Following recommendations and precedent, cases with more than 20% missing items on the descriptive variables (ACES, $n = 1$, restricted emotionality $n = 6$) and independent variables (PTSD $n = 3$, depression $n = 5$) were dropped; otherwise, incomplete cases were retained and missing data were recoded as "0" to provide a conservative estimate (Hammer et al., 2018;

Kroenke et al., 2010). Based on measurement guidelines, only cases with full data on the outcome variables were retained (Straus, 2004).

Phase II: Qualitative analysis.
Narrative analysis was used to answer the second research question. Narrative analysis focuses on the process of "re-storying" in which the stories told by a small number of participants are reorganized into a general type of framework based on significant life experiences (i.e., "turning points"; Creswell & Poth, 2015). This framework illuminates the associations between the shared experiences that are commonly found across the stories of individual participants (Creswell & Poth, 2015). As the current study aims were to investigate how men's life experiences of depression, trauma symptoms, and rigid gender roles interact to culminate in their perpetration of IPV using the ACEs framework, narrative analysis was considered optimal for this study. Accordingly, each participant's story was coded to identify turning points that affected their perpetration of IPV. Subsequently, each participant's turning points were reorganized into a chronological order to illuminate potential causal pathways, explaining how the turning points led to IPV perpetration. The reorganized story of each participant was then compared with each of the other participants' narratives to identify shared turning points and pathways leading to IPV perpetration across all stories.

Rigor. Several steps were taken to enhance rigor. After each interview, the interviewer debriefed with the research team to reflect on noteworthy findings and adjustments for future interviews. At each stage of coding, the second and third author independently coded the transcripts, and subsequently met to discuss the codes, resolve any disagreements, and come to consensus. After this was complete, the first author reviewed the codes for accuracy at each stage of analysis, and recoding was conducted based on any discrepancies. The final coding structure represents consensus across all three coders. Each author has doctoral-level training in qualitative methods. Lastly, member-checking was conducted in follow-up interviews with three of the eight participants to ensure the validity of the framework drawn from the reorganized stories and to examine whether the framework aligned with participants' experiences.

Results

Phase I: Survey Results

Descriptive results.
For the Phase I sample (see Table 1), the mean 10-item traditional ACE score for participants in the Phase I was 3.50 (*SD* = 2.66), with 51.5% of men

reporting scores of 4 or more, which is widely considered a "tipping point" that is associated with a number of health risks (Felitti et al., 1998). The mean 21-item expanded ACE score for participants was 8.58 (*SD* = 4.96), with witnessing community violence being the most frequently reported type of expanded ACE (75.8%). The mean PTSD symptom score was 26.26 (*SD* = 19.06), with 29.7% of the sample meeting the clinical threshold for PTSD (i.e., a total score of 33 or above; Blevins et al., 2015). The mean depressive symptom score was 5.76 (*SD* = 6.09), with 22.2% of the sample meeting the clinical threshold for depression (i.e., a total score of 10 or above; Manea et al., 2012). The mean restrictive emotionality score was 29.95 (*SD* = 13.22). Psychological aggression was the most frequently reported IPV perpetration type (*M* = 31.91, *SD* = 30.47). In Phase II (see Table 2), all men reported at least 4 ACEs and half reported more than 10 ACEs. Almost all men reported perpetrating severe psychological IPV, half reported perpetrating at least mild physical and sexual IPV, and two men reported perpetrating mild injury IPV. Most men expressed experiencing minimal depressive symptoms and three men met the clinical threshold for PTSD. Finally, most men had lower restricted emotionality, on average, than the Phase I sample.

OLS regression results.

Table 3 presents the OLS regression results. At the model level, each model significantly predicted psychological, physical, and injury IPV perpetration.

Table 3. Multiple OLS Regression Analysis for Depression and PTSD Predicting IPV Perpetration.

Outcome/Predictor	*B*	SE_b	β	*t*	sr^2	R^2_{adj}
Psychological aggression						.33***
(Intercept)	6.71	5.78		1.16		
PTSD	.82***	.21	.51	3.88	.18	
Depression	.63	.66	.13	.96	.01	
Physical assault						.24***
(Intercept)	–.74	2.64		–.28		
PTSD	.42***	.10	.61	4.32	.26	
Depression	–.69*	.30	–.32	–2.28	.07	
Injury perpetration						.21**
(Intercept)	–1.34	1.53		–.88		
PTSD	.18**	.06	.45	3.20	.14	
Depression	.08	.18	.06	.43	<.01	

Note. SE_b = standard error of coefficient; sr^2 = squared semi-partial correlation; R^2_{adj} = adjusted R^2.

*$p < .05$. **$p < .01$. ***$p < .001$.

At the predictor level, men experiencing greater severity of PTSD symptoms were more likely to report higher frequency of all three types of IPV perpetration, when depression was held constant. Men experiencing greater severity of depressive symptoms were more likely to report *lower* frequency of physical IPV perpetration, when PTSD was held constant.

Phase II: Narrative Analysis

Nearly all participants acknowledged that childhood adversity had an effect on their lives, with five participants explicitly stating that adversity in childhood had a negative impact on their emotional and behavioral health in adulthood, and several men making causal links from past traumatic events (i.e., sexual abuse) to their mental health as adults. All of the men acknowledged that their mental health, namely, depression and unresolved trauma, prompted behavior that limited emotional expression and created conditions leading to IPV perpetration. Key to these stories were men's use of isolation to "cope," and their sense of abandonment and betrayal, which served as a turning point leading to diminished trust and increased restricted emotions with others. Being primed with diminished mental health, unresolved childhood trauma, and affliction from feelings of abandonment or betrayal led men to use manipulative or aggressive and violent behaviors against their significant others.

ACEs.

Seven of the eight participants described experiencing a number of ACEs that were germane to their experiences in adulthood, including sexual abuse, physical abuse from caregivers, caregiver mental health and/or alcohol or drug abuse (AODA) issues, lack of emotional support from caregivers, lack of financial resources, exposure to IPV, community violence, and police violence. Physical abuse and lack of emotional support from caregivers during childhood were most commonly identified as central to men's stories ($n = 4$, 50%). Sexual abuse in childhood and mental health issues or alcohol or drug abuse (AODA) by caregivers were the next most common ACEs that men acknowledged ($n = 3$, 37.5%).

Depression and isolation.

Of the five men who discussed the negative effects of ACEs on their lives in adulthood, each also described experiencing feelings of depression, though none of the participants explicitly made an association between childhood adversity and depression in adulthood. Four of the five men who described depression as central to their narratives screened positive for "minimal" (i.e.,

scores from 0–4) or "mild" depressive symptoms (i.e., scores from 5–9) using the patient health questionnaire (PHQ-9, see Table 2; Kroenke et al., 2001, p. 608). Despite reaching only the level of "mild" depression, these men described multiple negative effects stemming from their depression. The most salient outcome resulting from their depression was social isolation as a coping technique. For example, Jamar said,

> When I'm depressed, I just want to be alone, I want to run away, I don't want to talk about my feelings. I don't want to express myself.

It appeared that the underlying motivation to isolate oneself was common among the men, to avoid further emotional turmoil that might exacerbate their depression. For example, James said that he isolated himself when depressed because he didn't "feel like being bothered." Each of these men also described using drugs or alcohol, with two men explicitly describing their use of substances as an isolating technique to avoid further emotional pain (i.e., when Jamar notes his attempt to "escape" and Michael's attempt to "forget").

> Jamar: [When I'm depressed] I don't want to be around people, don't want to talk to a lot of people. So I would just hide away from family and friends and just drink or do drugs and just escape.

> Michael: I smoke marijuana because it seems like every single moment of the day when I'm sober, I'm thinking about … all the problems I'm going through in life. I'm thinking about stuff … that used to make me happy that I won't feel again. [It's] overwhelming. [I think] … "am I ever going to feel [happy] again?" …. Smoking don't take the pain away, but it helps me forget. I don't care if [it's only] 30 min to an hour … it just helps me forget some [of what I'm] feeling, like, [those feelings] ain't there. I usually just smoke marijuana every day.

The men also explained that their self-prescribed isolation to cope with depressive feelings curtailed their ability to share emotions with significant others, family, and friends, which fueled their rage and anger, prompting impulsive, violent behavior. Jamar illustrates these links:

> You know, I was unable to develop and be in a healthy relationship, because for a long time there, I couldn't even do my part to just communicate with … my girlfriend, or family or friends. When I'm depressed, I just want to be alone, I want to run away, I don't want to talk about my feelings. I don't want to express myself. So, again, all that stuff I will be holding in and then I just burst out of rage or anger or, yell, scream, whatever. Act on impulse, you know? A lot of

> anger. And it had nothing to do with that person. They just happen to be there and I take it [out] on them.

Similarly, James reported that he "lashes out" at his significant other when he is feeling depressed, rather than communicating his feelings.

> Sometimes in communication with my ex I find myself lashing out, you know, [she would say] "Baby, everything going to be okay. Just be patient. Just don't give up." [But], Right now, I'm not feeling good, you know? So I don't want to hear that. [So I] change the conversation. I snap at her sometimes.

Unresolved trauma and anger.

Four participants expressed that anger was central to their narrative of IPV and this connected explicitly to unresolved childhood trauma. Chris described being abused by his mother as a turning point in his childhood that primed intense love-related emotions to serve as triggers for anger and uncontrollable behavior as an adult.

> Who I didn't feel the love from was the one [person] that emotionally, physically and verbally abused me for the greater part of my life, my mother …. You know, everything goes back to our childhood, so, it's been a lot to process.… I'm triggered by people, and [I realize now] that's what [I] need to work on. Knowing your triggers and what sends you off. But I know where it stems from. It stems from my childhood.… But because of my emotions I can see now why certain things have happened, why things have escalated, why, when my emotions were running high, it was easy to push my buttons and send me off and triggering to that place where I'm just angry and can't control [myself and] I'm way too emotional.

Other men described a confluence of adulthood adversities that triggered memories of unresolved childhood trauma, and, thus, primed them to feel emotions as intense and uncontrollable. For example, Jamar described that at a time when he was facing great adversity in adulthood (i.e., AODA issues, divorce, housing instability), his experience of being sexually abused in childhood resurfaced and led to impulsive behavior and violent inclinations.

> I was molested as a child by my cousin, when I was a young boy. It seemed like for years that was swept under the rug. But it came about when I was drinking one day. At this point I just [moved] back home and stayed with my mother after I got a divorce.… Things [were] just all bad, a snowstorm, like, I moved back with Mom, I got kicked out of the house and I had drug problem, alcohol problem, and it's like, that stemmed up in my head, [and] I thought about my

> cousin [who sexually abused me in my childhood]. And so blew up. I wanted to fight him. I was screaming, I was yelling and … I don't know, I think sometimes [that for] years you put this persona on, you try to forget the past, you know, what hurt you or made a bad effect on you.

In the earlier quote, Jamar also describes the ill effects of unresolved trauma; that is, as he grew into a young man, he adopted a type of persona that helped him forget and get by, but ultimately prevented him from healing from being sexually abused. Similarly, Michael also reflected that being sexually abused in childhood and not being able to share his pain with loved ones led to his anger, aggression, and violent behavior against his partner.

> I feel like my [adverse childhood experiences] got a lot to do with how I treat people and I approach people. I feel like it [was] a major part of my life while I was growing up. See, I had never really told this to nobody, but when I was eight years old, I got molested and it took me [until I was] eighteen years [old] to finally come out and tell my mother about this whole situation. I felt like if I told anybody they would make fun of me or they'd look bad at me. The only person, the only other person I ever told before my momma was my significant other, the mother of my child.… And she said I was too aggressive or something, like, emotionally [messed] up, like, my head wasn't [on] straight. She said [there] was a lot that was wrong with me. But I was really trying to change myself. I don't want to be violent. I don't want to put my hands on her.… But look where I'm at now. I'm 20 years old, I've got multiple felonies. I got a son that I barely can be in his life right now. I've got emotional problems, abandonment issues, I'm violent, I don't know what to do. I've got a drug problem. There's just so much stuff, like, it's just too much … for real, the only thing I be wanting is just somebody to just be there, like this. And not no significant other, just a friend, like, brother or sister, whoever. I'll talk to whoever [will] listen. I'm just tired of it. Tired of being angry. Tired of being confused. Tired of being upset. Just tired of it.

In the second round interviews, two men indicated that their inability to cope with childhood trauma as adults primed their anger and impulsivity leading to IPV. For example, Chris explains these links when reflecting on his triggers stemming from childhood that contributed to his violent interaction with his partner.

> If I had not gone through what I had gone through as a child… I needed coping skills. Somehow, I had never learned how to cope with those issues growing up and going into manhood. And, yeah, I guess part of that coping skill is learning how to cope with stress and especially when I'm being triggered into anger because of childhood trauma, [I end up] acting on impulse. If you're not thinking clearly, you know? And I guess I wasn't that morning with the partner

> I had last year in March. So, yes, I think if I hadn't had some of the experiences I'd had, I probably wouldn't have been so impulsive that morning and then ended up with the case.

These men's stories illuminate how depression and unresolved trauma contribute to their use of IPV through underlying mechanisms such as isolation, alcohol and drug use, and limited ability and outlets for emotional expression.

Sense of abandonment and betrayal.

Five participants explained feeling abandoned (James, Michael, Chris) or betrayed (Tyler, Anthony) by loved ones as a turning point in their stories. James described his abandonment: "Everybody turned their back on me" and that he was particularly sensitive to this when he and his partner broke up: "My partner's family felt sorry for me when I lost everything, but they treated me like garbage when I left her." Tyler described how his significant other used emotions and secrets he shared with her to shame him for his past behavior and that he felt betrayed when his wife disclosed "dark stuff" about him to the man she was having an affair with.

Men also described how this turning point prompted them to protect themselves from future harm. For example, Anthony said "I'm not about to be betrayed anymore." The other four participants described how their experiences of abandonment or betrayal motivated their behavior in interpersonal relationships, diminishing their sense of trust in others and willingness to share their emotions or vulnerability with others. For example, James said, "Like, trust is a real issue for me. So much has been done to me. Lies, and things like that, so I don't trust too many people." Also, Chris described how a sense of abandonment affected his ability to trust others:

> I'm having trouble wanting to trust anyone right now. You know? Because of the way my father died and the fact that my family has been abandoning me … and now my friends have all disappeared.

Michael described how his sensitivity to betrayal was wrapped up in his "love" for and use of violence against his partner, confounding his understanding of whether or not he truly loved his partner.

> The woman that I was involved with, we were together for a very long time. Since I was twelve years old. She was a couple years older [than me] and so she was more experienced. And I feel like she manipulated me. I feel like all them years we been together and after I gave her a son, then she just turned her back on me, left me high and dry. After I had sacrificed so much, struggled so much

> with her and did all this. And then she just treated me like trash. Like wasn't nothing. And that made me feel some type of way. You treat me like trash and I'm [going to] treat you like trash. But at the same time, I don't want to treat [her] like trash because I really love [her] … do I really love [her]? How can I say I love [her] and keep putting my hands on [her]? And it's hard, because I can do all this: apologize for putting my hands on [her], try to change, but then as soon as something happens, the first thing [I do is] put my hands [on her]. Then it was to the point where every sight or movement of me she'd flinch because she doesn't know if I'm just [going to] lash out and hit her.

Discussion

This mixed methods study adds to and extends the literature linking distal traumatic experiences in childhood (Godbout et al., 2019) and more proximal experiences such as PTSD (e.g., Hahn et al., 2015) to men's IPV perpetration in adulthood. These findings add to the scope of variables under study (i.e., depression, social isolation) and provide a narrative grounded in the lived experience of low-income BIMOC in BIPs. This narrative explains how key factors, namely, ACEs, PTSD, depression, social isolation, anger, and restricted emotionality work together to culminate in IPV, shedding light on potential trajectories and antecedents that manifest in IPV perpetration.

Key Factors

Depression and isolation.

Depressive symptoms significantly predicted higher IPV frequency for all outcomes at the model level. At the predictor level, however, depressive symptoms uniquely contributed to lower physical IPV perpetration when holding PTSD symptoms constant, deviating from previous research. Past studies have found positive links from depressive symptoms to physical and psychological IPV, while others have found no association (Capaldi et al., 2012). Though we cannot be certain of directionality due to design limitations, follow-up qualitative interviews suggest that depressive symptoms were an antecedent to men's IPV perpetration, adding to the few studies that have attempted to identify the directionality and temporal ordering of this relation (e.g., Mair et al., 2012; Preiser & Assari, 2018).

In the narrative analysis, social isolation emerged as a key element of depressed men's maladaptive coping strategies as described by Jamar, James, and Michael. Social isolation then diminished the men's opportunities to develop relationships with romantic partners, family, and friends and receive subsequent support from those relationships. As a result, men held emotions

in until they erupted (as described by Jamar), resulting in IPV as described by James when he would "snap" at his partner. Aligning with the ACEs framework, exposure to trauma at key points during development can impede the development of emotion regulation and make individuals more prone to aggression (Hébert et al., 2018), which appeared to be reinforced in adulthood with men in the study.

Research on social isolation and IPV has focused primarily on women's IPV victimization; however, a handful of studies have examined the effects of social support on men's IPV perpetration in adulthood with military populations (Capaldi et al., 2012). For example, Slep et al. (2010) found that different forms of support (e.g., support from neighbors, spouse deployment support, and formal support from agencies) were protective against men's IPV perpetration among a large sample of active duty airmen. Social isolation emerging from the narrative analysis may explain why depressive symptoms predicted less physical IPV frequency in the current study (i.e., less opportunity), while depressive symptoms at the model level were still positively associated with the occurrence of all types of IPV.

Unresolved trauma and anger.

Increased PTSD symptoms uniquely contributed to all types of IPV perpetration when holding depression constant, which aligns with previous research (e.g., Smith et al., 2015). Though some quantitative studies have examined the links between ACEs, trauma symptoms, and IPV perpetration (e.g., Gilbar et al., 2019), no studies to our knowledge have explored how these experiences culminate in IPV perpetration from the perspective of men's lived experience. In the follow-up interviews, men explained that anger as an expression of unresolved childhood trauma was key to their use of IPV, such as when Chris explained that he was "triggered" to a place where he could not control his anger or behavior. This aligns with previous research reporting a moderate effect size for the association between anger and IPV perpetration, particularly for moderate to severe IPV (Birkley & Eckhardt, 2015).

Considering the ACEs framework, it is possible that the traumatic events in childhood altered the physiology of the brain necessary for the development of emotion regulation and normative stress response (De Bellis & Zisk, 2014; Shonkoff & Garner, 2012), ultimately limiting the span of emotional expression among men and contributing to violent behavior. Feminist scholars have also acknowledged the significant harm done to boys living in a patriarchal society, narrowing their scope of acceptable behaviors and emotional expression to anger, which manifests as violence in adulthood (hooks, 2004).

Sense of abandonment and betrayal.
In the follow-up interviews, five men described that feeling betrayed and abandoned were turning points in their lives that diminished their sense of trust in others and willingness to be vulnerable. Feelings of betrayal and abandonment are shame-inducing, and previous research has tied this to dimensions of PTSD and IPV perpetration using empirical and theoretical literature (Lawrence & Taft, 2013). Shame theory asserts that in situations exposing men's dependency, limitations of power, or eliciting vulnerable emotions (such as feeling abandoned and betrayed), the masculinity of men who are socialized to appear strong and self-reliant will be threatened, causing them to feel shame and subsequently can lead to the use of aggression or violence in order to reassert their sense of strength and self-reliance (Jennings & Murphy, 2000). Similarly, hooks (2004) describes how early childhood experiences of abuse and neglect can sensitize men's experiences of emotional conflict and confound their sense of love in adulthood, which aligns with Michael's description of how a sense of betrayal was wrapped into his understanding of love.

Strengths and Limitations

The findings of this study must be qualified as a result of several limitations. The Phase I quantitative analysis is limited by a small sample size, which simplified the statistical models we were able to analyze, preventing the inclusion of control, mediation, or moderation variables that may have further illuminated important nuances in the relations between IPV and depressive and PTSD symptoms. This limitation ultimately prevented us from fully answering the study's research questions. Additionally, the survey was cross-sectional and limits our ability to infer causation, though the Phase II follow-up interviews do provide insight into the potential causal relations and directionality of the constructs of interest based on low-income BIMOC lived experience. The use of self-report may limit study findings due to recall bias. Of the total possible participants in Phase I, 18.6% chose to participate in the study, which may threaten generalizability due to potential differences of the men who did not participate. However, post hoc analyses of group differences between participants and nonparticipants showed no significant differences on any demographic variable (e.g., race, marital status) except for employment—men who did not participate were more likely to be employed. Finally, the study sample highlights the lived experience of predominantly low-income BIMOC in a BIP, but may not be generalizable or transferrable to other populations.

Practice Implications

Clinicians working with low-income BIMOC in BIPs and other clinical settings should consider adopting a trauma-sensitive or a trauma-informed approach (Voith et al., 2018) to mitigate the effects of unresolved trauma on IPV perpetration. Moreover, interventions targeting IPV behaviors with low-income BIMOC should assess for depressive and PTSD symptoms and refer for specialized care to ensure these mental health diagnoses do not interfere with the effectiveness of IPV interventions. In individual or group sessions, clinicians may want to focus on identifying and addressing anger and shame-inducing emotions (such as feelings of betrayal/abandonment) as key antecedents to IPV perpetration and establish new internal working models (Velotti et al., 2014). Finally, BIPs should teach skills to develop stronger positive social support for men and develop frameworks to implement those skills, such as a recovery group for program completers or involving family members in programming.

Future Research

Future research should explore how the relations between depressive and trauma symptoms affect IPV perpetration, using more sophisticated quantitative analyses (e.g., path models) with larger sample sizes. For example, researchers could examine anger and shame as mediators between trauma symptoms and IPV, or the mediating effect of social isolation on depression and IPV. Additionally, studies employing qualitative methodologies are warranted to better understand how social support could prevent the use of IPV among low-income BIMOC in their communities, as the small body of research in this area focuses primarily on military personnel (e.g., Capaldi et al., 2012). Finally, the mixed research on the relation between depressive symptoms and men's IPV perpetration calls for mixed-methods studies employing longitudinal designs to clarify the directionality and effect on IPV perpetration.

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