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Stress of Not Being “Man Enough”: The Role of Masculine Discrepancy Stress and Emotion Dysregulation in the Link Between Cumulative Childhood Trauma and Perpetrated Intimate Partner Violence in a Clinical Sample of Men

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Cumulative childhood trauma (CCT; e.g., sexual abuse, neglect) has been consistently associated with intimate partner violence (IPV) perpetration. However, we know little about the processes involved in this association. Although emotion dysregulation has been identified as a mechanism explaining the CCT–IPV association in men survivors, it is also critical to investigate whether masculine-relevant processes might explain the specific experience of men. Evidence suggests that male CCT survivors are particularly prone to experience masculine discrepancy stress (i.e., stress arising from perceived failure to conform to masculinity norms), which could contribute to higher emotion dysregulation and, consequently, higher IPV perpetration. Using a large clinical sample of 1883 Canadian men seeking services for IPV perpetration, this study examined the role of masculine discrepancy stress and emotion dysregulation in the relationships between CCT and four types of perpetrated IPV (psychological, physical, and sexual IPV, and coercive control). Path analysis indicated that (a) emotion dysregulation was a consistent intermediary mechanism of the CCT–IPV link, (b) CCT was indirectly associated with higher perpetrated psychological IPV and coercive control through masculine discrepancy stress, and (c) CCT was associated with higher perpetrated IPV sequentially through masculine discrepancy stress and emotion dysregulation. Findings support the importance of trauma-sensitive interventions targeting emotion dysregulation and masculine discrepancy stress in men seeking help for IPV perpetration.

Public Significance Statement

Although it is recognized that men who perpetrate intimate partner violence (IPV) have often experienced an accumulation of childhood interpersonal trauma, little is known about the processes involved in the association between childhood trauma and IPV. Findings of this study suggest that an accumulation of childhood trauma contributes to increased masculine discrepancy stress (i.e., stress arising from the perception of not aligning with traditional norms of masculinity) and increased emotion dysregulation, which are, in turn, linked to more perpetrated IPV. These results support the need for implementing trauma- and gender-sensitive interventions to help men develop nonviolent intimate relationships.

Keywords: masculine discrepancy stress, cumulative childhood trauma, male survivors, emotion dysregulation, intimate partner violence

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Intimate partner violence (IPV) perpetration is a pervasive public health problem that occurs with high prevalence. In North America, 22%–42% of adults have perpetrated at least one form of IPV (e.g., psychological, physical, or sexual; Abrahams et al., 2006; Desmarais et al., 2012; Godbout et al., 2019). IPV refers to any behavior from one intimate partner (e.g., romantic, sexual, or ex-partner) to another that causes psychological, physical, or sexual harm (World Health Organization, 2021a). IPV includes psychological violence (e.g., humiliating, denigrating, insulting), physical violence (e.g., pushing, hitting, slapping), sexual coercion (i.e., tactics to pressure or force someone into sexual acts), and coercive control behaviors (i.e., verbal and nonverbal tactics to control and dominate the partner, such as the use of threats or punishments; Breiding et al., 2014; Johnson et al., 2014; World Health Organization, 2021b). IPV affects people of all backgrounds regardless of gender, race, or socioeconomic status (Badenes-Ribera et al., 2019; Renner et al., 2015). Indeed, according to the Canadian General Social Survey, rates of IPV perpetration and victimization by men and women are approximately equal (Lysova et al., 2019). However, studies show that men are more likely than women to inflict an injury to their female partners (Archer, 2000). IPV perpetration can even result in death, with 38% of female homicides in 2021 having been committed by an intimate partner (World Health Organization, 2021a). Moreover, intimate partner homicide is mainly perpetrated by men, which raises the question of the impact of patriarchy and masculinity norms on the perpetration of violence against women (Lysova et al., 2019; World Health Organization, 2021b). These figures are especially troubling, considering that IPV has several short- and long-term interpersonal, psychological, and emotional consequences for victims (Spencer et al., 2019). Considering the seriousness of the consequences associated with IPV, identifying risk factors for its perpetration is a crucial task for researchers in the field as it supports the targets of intervention and of IPV prevention programs that aim to reduce rates of IPV (for a literature review, see Clare et al., 2021). Past research has identified childhood interpersonal trauma as one of the most stable and well-documented risk factors for IPV perpetration (Eriksson & Mazerolle, 2015; Fonseka et al., 2015; Gilbar et al., 2021; Smith-Marek et al., 2015). However, according to recent meta-analyses (Godbout et al., 2019; Li et al., 2020), more research is needed to extend and deepen our understanding of childhood interpersonal trauma's role in IPV perpetration.

Cumulative Childhood Trauma

Childhood interpersonal trauma refers to adverse experiences that occur within an interpersonal context before the age of 18 (e.g., psychological and physical child abuse, neglect, sexual abuse, witnessing interparental violence, bullying). While childhood interpersonal trauma has often been studied in association with IPV (Brassard et al., 2020; Davis et al., 2018; Fatehi et al., 2022), most of these studies have not considered the accumulation of different forms of interpersonal trauma in childhood (Finkelhor et al., 2007a). Yet, individuals who experience one type of trauma tend to experience many others, which can complicate interventions aimed at reducing violence (Finkelhor et al., 2007b). It is therefore important for researchers to consider cumulative childhood trauma (CCT), which refers to the total number of different forms of interpersonal trauma experienced by a given individual before

the age of 18 (Bigras et al., 2017; Briere et al., 2010). In the scientific literature, this phenomenon has also been referred to as “polyvictimization” (Finkelhor et al., 2007b) and “adverse childhood experiences” (Edwards et al., 2003; Felitti et al., 1998). The literature on adverse childhood experiences has significantly contributed to the field of trauma research by highlighting the profound impact of the accumulation of childhood adversity (i.e., CCT) on survivors' physical, behavioral, and mental health across the lifespan (Zarse et al., 2019). Indeed, research has shown that CCT is associated with a wide range of severe, complex repercussions in adulthood (e.g., emotion dysregulation, substance use) that may influence and heighten the likelihood of subsequent IPV perpetration (Liu et al., 2015). Additionally, most individuals from clinical samples (83%–85%) report CCT (Berthelot et al., 2014; Dugal et al., 2018; Lafrenaye-Dugas et al., 2018). Yet, although most perpetrators of IPV have experienced childhood interpersonal trauma, not all victims of CCT will perpetrate IPV. Indeed, while a positive association between childhood interpersonal trauma and IPV has often been documented in previous research (Eriksson & Mazerolle, 2015; Fonseka et al., 2015; Maneta et al., 2015), recent meta-analyses (Godbout et al., 2019; Li et al., 2020) have shown that the strength of this association varies from weak to moderate (with an overall effect size of .19 across 66 studies; Godbout et al., 2019). Such findings suggest that intermediate mechanisms might be at play in the CCT–IPV association. Given that emotion dysregulation is commonly related to CCT (Dvir et al., 2014) and has often been identified as an important risk factor for IPV perpetration (Maloney et al., 2023), it is relevant to investigate whether it could be an explanatory mechanism of the CCT–IPV link.

The Role of Emotion Dysregulation in the Link Between CCT and IPV

Emotion dysregulation refers to an individual's difficulties to control, tolerate, and cope with strong and difficult emotions without resorting to strategies that divert attention from or momentarily ease emotional distress, including maladaptive externalization such as mood swings and explosive expressions of anger (Briere & Runtz, 2002; Gratz et al., 2009). Emotion dysregulation is commonly theorized as a repercussion of CCT, as the latter exposes the child to extreme emotional demands that they do not have the capacity to manage or understand. CCT's underlying context is typically characterized by a lack of positive role models and by attachment figures who struggle to regulate their own mental states (e.g., failure to respect the child's boundaries, child abuse, and dysregulation of their own emotions; Briere & Runtz, 2002; Calkins & Hill, 2007; Cole et al., 1994; Dugal et al., 2016). Consistent with this theoretical literature, empirical studies have documented a link between CCT and higher levels of emotion dysregulation (Dvir et al., 2014; Ehrling & Quack, 2010; Lavi et al., 2019; Messman-Moore & Bhuptani, 2017; Warmingham et al., 2023). Yet, few studies examined this association in clinical samples of men seeking help for IPV perpetration (i.e., entering therapy in community organizations that offer support to men dealing with violent behaviors in the context of intimate relationships). Moreover, a recent meta-analysis found an association between emotion dysregulation and IPV perpetration with an overall effect size of 0.09 across 62 studies (Maloney et al., 2023). Interestingly, this meta-analysis indicated that the magnitude of the association was stronger when a measure of emotion

dysregulation was used instead of a measure of emotion regulation (Maloney et al., 2023). This finding suggests that understanding the disruptions in emotion regulation processes is as critical, if not more so, than merely examining the presence of emotion regulation skills. This nuanced distinction underscores the importance to examine emotion dysregulation in a model examining the links between CCT and IPV perpetration.

There is also a lack of studies investigating the path from CCT to IPV perpetration through the emotion dysregulation of men seeking help for IPV. Yet, theoretically, there is a probability that this path exists. Experiencing indifference, violence, or hostility from caregivers or peers during childhood tends to hinder an individual's capacity to develop adaptive coping mechanisms to manage negative feelings. In turn, this may predispose the individual to resort to violence in their own intimate relationships (Berthelot et al., 2014). Violent behaviors might also be an inappropriate and impulsive externalization of intense emotions (i.e., emotion dysregulation) that enables one to avoid and/or escape the contact with difficult or vulnerable emotions such as shame, sadness, or helplessness (Jakupcak et al., 2005). Empirical research has provided some support for the path between CCT and IPV perpetration through emotion dysregulation. For instance, Dugal et al. (2018)'s findings support the existence of the intermediary role of emotion dysregulation in the relationship between CCT and the perpetration of psychological IPV in a clinical sample (65 men and 97 women) consulting for sexual or relational problems. Furthermore, Dugal et al. (2021) found in a community sample (62 men and 179 women) that CCT was indirectly related to the perpetration of psychological IPV and coercive control through emotion dysregulation, maladaptive personality traits, and negative urgency. Moreover, in a sample of undergraduate students (96 men and 245 women), Gratz et al. (2009) found evidence supporting the role of emotion dysregulation in the relationship between childhood maltreatment (emotional neglect, physical, and sexual abuse) and the perpetration of physical and sexual IPV in men but not in women. Such findings highlight the differential role of gender in the emotion dysregulation of CCT survivors (for a review, see Nolen-Hoeksema, 2012).

However, past studies have failed to consider the specific realities of men when exploring these links. First, these studies have not considered gender differences in the emotion dysregulation, even though there are noticeable differences in the ways men and women regulate their emotions. For instance, men are more prone to avoid their emotions by suppressing or numbing them (Nolen-Hoeksema, 2012). Additionally, findings from previous studies may not represent the realities of most men who perpetrate IPV because most of these studies have relied on nonclinical samples (e.g., community or undergraduate samples; Gratz et al., 2009), clinical samples of individuals consulting for psychological, sexual, or relational problems (e.g., Dugal et al., 2018), or small male subsamples (Dugal et al., 2021). In a meta-analysis of studies examining emotion dysregulation and IPV perpetration, Maloney et al. (2023) also highlighted the use of small male subsamples, the paucity of studies using clinical samples (16% of the studies included), as well as the scarcity of studies using clinical samples of men seeking help for perpetrated IPV, more specifically (Audet et al., 2022, Tager et al., 2010). While this lack of empirical knowledge of the specific experiences of men seeking treatment for perpetrated IPV is understandable due to the difficulties involved in recruiting these

men, gaining a better understanding of their experiences could improve intervention programs aimed at reducing male violence. Last, although emotion dysregulation is an important risk factor for IPV perpetration, it is insufficient to explain why men perpetrate IPV. Yet, previous studies have not considered the sociocultural variables known to facilitate or hinder the use of violence. Hence, these gaps in the literature highlight the importance of investigating additional mechanisms that may be involved in the path between CCT and IPV perpetration through the emotion dysregulation of men seeking help for perpetrated IPV. To this end, an examination of the constructs related to masculinity is particularly relevant.

Masculine Gender Socialization and Masculine Discrepancy Stress

Masculine gender socialization is a process that boys go through in childhood and from which they learn the tenets and the norms of masculinity (Green & Addis, 2012). Masculinity is defined as a dynamic set of social roles, attitudes, norms, and behaviors that a given society or culture associates with the biological aspects of being a man (Berke et al., 2018). Available research and theories suggest that masculine-relevant processes emerging from gender socialization may exacerbate negative emotional consequences of CCT in men, which could lead, in turn, to higher emotion dysregulation and higher perpetration of IPV in adulthood (Moore & Stuart, 2005).

The theoretical framework of the gender role strain paradigm (GRSP; Pleck, 1981) provides a basis from which to generate hypotheses about the masculine-relevant processes involved in the CCT-IPV relationship. The GRSP's first assumption (Pleck, 1981) postulates that throughout male socialization, men experience various social pressures to live up to what they perceive, or what is perceived to be the social ideals or norms of masculinity. One issue is that because masculinity norms are inherently constraining, contradictory, and inconsistent (Berke et al., 2022; Levant & Richmond, 2016), all men will inevitably fall short of these norms at one time or another in their life. For example, boys learn to inhibit vulnerable emotions (e.g., shame, sadness, fear; Berke et al., 2018) and to rather display behaviors, beliefs, and feelings associated with masculine norms such as aggressiveness, emotional control, and dominance (Mahalik, Locke, et al., 2003). However, not only is maintaining sustained control over one's emotions impossible, but research also indicates that inhibiting or restricting emotions increases the risk of emotion dysregulation and physiological arousal (Green & Addis, 2012). Restrictive emotionality has also been shown to be indirectly related to aggression through emotion dysregulation, and this relationship appears to be driven by a lack of acceptance and an inability to tolerate emotional experiences (Cohn et al., 2010). The second assumption of the GRSP is that perceived violations of masculine norms generate stress and anxiety in men. Pleck (1995) described masculine discrepancy stress (Berke et al., 2022; Reidy et al., 2016) as a form of stress that occurs when one perceives he is failing to live up to the social ideals of masculinity. This stress arises when a man believes that he is perceived as insufficiently masculine. Through a process of fear-based learning, men have learned that negative consequences may follow the violation of gender norms (e.g., physical threat, social condemnation, loss of status; Addis et al., 2010; Franchina et al., 2001; Moss-Racusin et al., 2010). According to Pleck (1981), this process concerns all men but could be especially harsh for specific

marginalized groups of men, including male survivors of childhood abuse (Lisak, 2005; Slegel et al., 2021). Given that experiences of childhood victimization run counters to masculine norms of strength, stoicism, and dominance, male survivors of CCT could be more prone to feel inadequate in their masculinity, to experience more masculine discrepancy stress and, in turn, more emotion dysregulation. Those difficulties regulating vulnerable emotions (e.g., shame, inadequacy, fear) could lead them to perpetrate IPV in a paradoxical and dysfunctional attempt to reestablish their masculinity (Berke et al., 2017; Conzemius et al., 2021; Weaver et al., 2010).

In the last decade, a growing body of studies has provided some empirical support for the postulated links between masculine discrepancy stress, emotion dysregulation, and/or perpetrated IPV. For instance, Reidy et al. (2014) found in an online sample of 600 men that masculine discrepancy stress was related to men's perpetration of psychological, physical, and sexual IPV. Sileo et al. (2022) found, in a community-dwelling sample of 711 men, that masculine discrepancy stress was indirectly associated with perpetrating sexual and physical IPV through feelings of anger (i.e., inadequate expression of anger such as losing your temper or yelling). Finally, Berke et al. (2016) found that the association between masculine discrepancy stress and physical and sexual IPV was explained by men's emotion dysregulation.

Need for an Integrative Model

Although previous studies provide support for the relationships between most of the studied variables, they have important limitations that need to be addressed. First, no study has examined those variables within an integrative model. Yet, an integrative model would provide a richer and more comprehensive overview of the specific links between CCT, masculine discrepancy stress, emotion dysregulation, and the different forms of perpetrated IPV. Indeed, most studies adopt narrow conceptualizations of IPV that fail to assess the variety of violent behaviors that could result from CCT, masculine discrepancy stress, and emotion dysregulation. Furthermore, most studies generally failed to consider the accumulation of more than two or three types of interpersonal traumas. Yet, the inclusion of the major types of childhood interpersonal traumas (i.e., psychological and physical child abuse, neglect, sexual abuse, exposure to interparental violence, and bullying; Bigras et al., 2017) is likely to be more representative of the realities of men seeking help for IPV perpetration. This is because the average number of childhood interpersonal trauma in clinical populations is documented to be high, reaching four different types of interpersonal trauma (Lafrenaye-Dugas et al., 2018). Moreover, researchers increasingly highlight the need to study the accumulation of different interpersonal trauma because, compared to the experience of a single traumatic event, CCT is linked to greater emotion dysregulation (Ehring & Quack, 2010). Other gaps also highlight the need to examine the role of masculine discrepancy stress and emotion dysregulation in the link between CCT and IPV using larger representative samples of male perpetrators of IPV. Finally, no study has empirically tested the theoretical links between CCT and masculine discrepancy stress. Furthermore, the potential role of masculine discrepancy stress in the relationship between CCT and emotion dysregulation leading to IPV perpetration needs empirical support because its inclusion in IPV prevention and treatment programs could increase their efficacy.

The Present Study

The aim of this study was to examine, in an integrative model, whether increased masculine discrepancy stress and emotion dysregulation played a sequential explanatory role in the relationship between CCT and IPV perpetration (i.e., psychological, physical, and sexual IPV and coercive control). In line with the existing literature, we hypothesized that (1) CCT would be indirectly related to higher IPV perpetration through higher emotion dysregulation. We also expected that (2) CCT would be indirectly related to higher IPV perpetration through higher masculine discrepancy stress. Finally, we expected that (3) CCT would be indirectly related to higher IPV perpetration through the sequential role of masculine discrepancy stress and then emotion dysregulation. Since perceptions of masculinity are intrinsically linked with the cultural/social contexts in which individuals are socialized, studies should control for characteristics that might impact levels of masculine discrepancy stress. Because Yang et al. (2018) found that younger and single men (vs. older and married/cohabitating ones) reported higher levels of masculine discrepancy stress, participants' age and marital status were considered as control variables. According to these researchers, these findings may be explained by the fact that younger and single men may be more likely to find themselves in situations that generate this type of stress (e.g., situations involving competition or social comparison).

Method

Participants

The sample included 1883 Canadian men aged between 18 and 89 years ($M = 38.2$, $SD = 11.7$) and seeking services in the context of their IPV perpetration. Participants were recruited as part of a larger ongoing partnership project involving 20 community organizations that are part of a national association in Canada offering specialized services in IPV perpetration in the province of Quebec. These services target men engaged in situational couple violence (i.e., occurring during conflict, often escalating from arguments to verbal and sometimes physical aggression) or in intimate terrorism (i.e., a pattern of violence and control tactics to dominate one's partner; Johnson et al., 2014). In the current sample, 76.7% of men sought help voluntarily, and 23.3% were mandated by court order. All men identified with their sex assigned at birth, and most defined their sexual orientation as heterosexual (see Table 1). Most participants were born in Canada, spoke French, were currently working full or part time, and did not have postsecondary education. In the current sample, 61.9% of participants ($n = 1,166$) were currently in a relationship, but all of them had been in a relationship in the past 12 months. Moreover, 74.7% of participants were fathers ($M = 1.7$ children; $SD = 1.5$). The sample's median annual personal income was between CAN\$40,000 and CAN\$44,999. See Table 1 for more detailed sociodemographic characteristics.

Procedure

Upon arriving at the organizations, men were invited to complete an online questionnaire (40–45 min) hosted on the secure web platform Qualtrics as part of the organizations' systematic assessment protocol. Men were free to consent to the use of their

Table 1
Sample's Sociodemographic Characteristics (N = 1883)

Sociodemographic characteristic	%	n
Sexual orientation		
Heterosexual	95.8	1804
Homosexual	0.8	15
Bisexual	1.6	30
Pansexual	0.3	5
Questioning	0.3	5
Prefer not to answer	1.0	19
Other	0.3	5
Did not provide this information	0.3	2
Relationship status		
Single (not in a relationship)	26.8	326
Dating (start of a relationship)	2.6	49
In a relationship, without cohabitation	11.0	207
In a relationship, with cohabitation	37.2	700
Married	11.0	207
Separated or divorced	5.3	101
Currently breaking up	14.0	263
Other (e.g., sexual partner, polyamorous)	1.7	30
Fatherhood		
No children	25.3	472
One	23.1	431
Two	27.6	515
Three	13.9	259
Four	5.5	103
Five	2.4	45
Six	1.2	23
Seven	0.5	10
Eight or more	0.5	8
Country of birth		
Canada	94	1,767
Other	6.0	113
Did not provide this information	0.2	3
Primary language		
French	94.8	1,786
English	4.1	78
Spanish	0.6	11
Other	0.4	8
Education level		
Primary elementary school	17.5	279
High school (general or professional)	59	1,110
College (College of General and Vocational Education)	16.7	313
University (baccalaureate, master, etc.)	9.3	176
Did not provide this information	0.3	5
Employment status		
Worker	63.8	1,238
Student	2.5	48
Without paid occupation	8.8	166
Welfare, sick leave, etc.	12.6	256
Retired	4.2	79
Other	5.0	95
Did not provide this information	0.1	1
Personal yearly income (CAN\$)		
\$00,000–\$19,999	18.4	341
\$20,000–\$39,999	27.4	508
\$40,000–\$59,999	25.4	471
\$60,000–\$79,999	13.8	256
\$80,000–\$99,999	7.4	137
\$100,000 and more	5.6	103
Prefer not to answer	1.9	35
Did not provide this information	2.2	32

data for research purposes without this affecting the services received (90.9% acceptance rate). Data were collected from April 2022 to March 2023. Out of the 3,126 participants who completed the questionnaire, individuals who were minors ($n = 30$), did not identify as men ($n = 206$), did not report their age or gender ($n = 20$), were not in a relationship in the last year ($n = 444$), had missing data on the total score of CCT ($n = 262$), or on all variables except for CCT ($n = 33$), were excluded from analyses. Participants who had missing data on the questionnaires measuring other main study variables, namely psychological, physical, and sexual IPV, as well as coercive control or masculine discrepancy stress ($n = 248$), were also excluded from the analyses. Thus, the final sample included 1883 men. This study was approved by the ethics committee of the researchers' institution.

Measures

Participants were first asked a series of sociodemographic questions about their age, biological sex at birth, gender identity, relationship status, sexual orientation, employment status, level of education, country of birth, fatherhood, and annual personal income.

CCT

CCT was assessed using the 15-item Childhood Cumulative Trauma Questionnaire (Bigras & Godbout, 2020). This measure assesses eight types of interpersonal trauma experienced (i.e., psychological and physical child abuse, psychological and physical child neglect, childhood sexual abuse, exposure to psychological and physical interparental violence, and peer bullying). Childhood sexual abuse was operationalized in accordance with Canadian law, which states that childhood sexual abuse occurs when there is any sexual contact before the age of 18 with (a) a person in a position of authority, (b) a person who is at least 5 years older, or (c) when there is unwanted sexual contact with a person of similar age. For other forms of trauma, participants were asked to indicate the frequency of each traumatic experience on a Likert scale ranging from 0 (*never*) to 6 (*every day*) in a typical year before the age of 18. Scores were dichotomized to indicate the presence or absence of each trauma. The CCT variable was calculated by summing all dichotomous scores (ranging from 0 to 8). This measure demonstrated satisfactory internal consistency in previous studies ($\alpha = .90$; Bigras et al., 2017), as well as in the current sample ($\alpha = .84$).

IPV

IPV was assessed using three subscales from the Revised Conflict Tactics Scales–Short Form (CTS2-S; Straus & Douglas, 2004) and four items from the Coercive Control Scale (Johnson et al., 2014).

Psychological, Physical, and Sexual IPV. The CTS2-S measures the perpetration of psychological (e.g., *insulted, swore, shouted, or yelled at my partner*), physical (e.g., *pushed, shoved, or slapped my partner*), and sexual IPV (e.g., *insisted on sex when my partner did not want to*). Each type of IPV was assessed using two

items: one measuring a minor form, and the other, a severe form. For each item, participants indicated the perpetrated IPV's frequency on a scale ranging from 0 (*this never happened*) to 6 (*more than 20 times in the past year*), with 7 as an alternative option (*not in the past year, but it did happen before*). As recommended by Straus and Douglas (2004), scores were transformed into midpoints of the range mentioned (e.g., "3 to 5 times in the past year" was coded as 4) and were summed to create total scores for each subscale (psychological, physical, and sexual IPV). Higher scores represented a greater annual frequency of perpetrated IPV. Adequate internal consistency for this questionnaire was demonstrated in previous studies ($\alpha = .77-.89$; Straus & Douglas, 2004; Straus et al., 1996). However, Cronbach's α coefficients cannot be computed due to the low number of items per subscale (i.e., two items).

Coercive Control. Behaviors of coercive control were assessed using four items from the Coercive Control Scale (e.g., *I tried to limit my partner's contact with family and friends*; Johnson et al., 2014). To facilitate the interpretability of the data (Audet et al., 2022; St-Pierre Bouchard et al., 2023), the response options and midpoints used for the CTS2-S were also used to create participants' coercive control scores. In the current sample, the ω reliability coefficient for the coercive control items was .50, which, although low, is nonetheless similar to those of previous studies (e.g., .66 in St-Pierre Bouchard et al., 2023). This lower homogeneity was expected, as the purpose of the four items was to document different coercive control behaviors rather than a single one.

Emotion Dysregulation

Participants' emotion dysregulation was assessed using the nine-item Affect Dysregulation scale of the Inventory of Altered Self-Capacities (Bigras & Godbout, 2020; Briere & Runtz, 2002). Items assessed mood swings, difficulty tolerating anger and other strong emotions, and a relative inability to move out of dysphoric states without using deleterious externalizing or avoidance behaviors (no example provided due to copyright restrictions). A *T* score of 70 or greater was used as a clinical cutoff score indicating clinically significant levels of emotion dysregulation (Briere & Runtz, 2002). Participants indicated the frequency of these emotional experiences on a 5-point Likert scale ranging from 1 (*never*) to 5 (*really often*). The total score is calculated by averaging the items, and higher scores indicate greater levels of emotion dysregulation. This measure demonstrated satisfactory internal consistency in previous studies ($\alpha = .89$; Briere & Runtz, 2002), as well as in the current sample ($\alpha = .92$).

Masculine Discrepancy Stress

Participants' masculine discrepancy stress was assessed using the five-item Discrepancy Stress subscale of the Masculine Gender Role Discrepancy Stress Scale (Reidy et al., 2014, 2016). This subscale measures the distress stemming from the perceived gender role discrepancy or the stress related to one's perception of not aligning with social expectations of masculinity (e.g., "I am afraid that people will judge me because I am not like the typical man," "I am afraid that women will find me less attractive because I am not as macho as other guys"; Reidy et al., 2016). Participants indicated their agreement to each item on a Likert scale ranging from 1 (*strongly agree*) to 7 (*strongly disagree*). Items were summed, with

higher scores indicating higher levels of masculine discrepancy stress. This measure demonstrated satisfactory internal consistency in previous studies ($\alpha = .86$; Berke et al., 2016), as well as in the current sample ($\alpha = .88$).

Data Analyses Strategy

Descriptive analyses and preliminary correlations were first conducted using SPSS 28 (International Business Machines Corporation, 2021). Then, a path analysis was conducted using the eighth version of Mplus (Muthén & Muthén, 2017) to test the hypothesized model of the links between CCT and perpetrated IPV (i.e., psychological, physical, sexual, coercive control) sequentially through masculine discrepancy stress and emotion dysregulation. Missing values were handled using the full information maximum likelihood estimation. The robust maximum likelihood estimator was first used to account for variables that were expected to be nonnormally distributed. The significance of indirect paths was examined by computing 95% confidence intervals (CIs) on 5,000 bootstrapping random samples (Preacher & Hayes, 2008). Indirect effects are deemed significant when the confidence interval does not contain the value of zero (Caron, 2018). Four fit indices assessed whether the model fit the data well: a nonsignificant chi-square, a comparative fit index (CFI) of .95 or higher, a root-mean-square error of approximation (RMSEA) inferior to .06, and a standardized root-mean-square residual inferior to .08 (Kline, 2016).

Results

Preliminary Analyses

Table 2 presents the descriptive results. Significant positive correlations were found between all key study variables except for the link between masculine discrepancy stress and physical IPV. Further, participants' age did not significantly correlate with masculine discrepancy stress ($r = -.01, p = .776$), physical IPV ($r = -.04, p = .063$), or sexual IPV ($r = -.03, p = .173$) but negatively correlated with emotion dysregulation ($r = -.13, p < .001$), psychological IPV ($r = -.09, p < .001$), and coercive control ($r = -.08, p < .001$). Relationship status (0 = *not in a relationship*; 1 = *in a relationship*; 2 = *other*) was positively correlated with emotion dysregulation ($r = .06, p < .001$) and masculine discrepancy stress ($r = .09, p < .001$) but not with psychological IPV ($r = .01, p = .745$), physical IPV ($r = .01, p = .62$), sexual IPV ($r = .02, p = .424$), or coercive control ($r = .03, p = .157$). Variables were normally distributed except for IPV variables, which were highly skewed, as expected.

Table 3 presents the number of men who reported each type of childhood interpersonal trauma, the frequencies of men for each type of perpetrated IPV, and the cumulative number of interpersonal trauma experienced by participants (from 0 to 8). Participants reported an average of three different interpersonal traumas ($M = 3.15, SD = 2.25$). Most participants experienced at least one type of trauma (87.1%, $n = 1,640$), and 70.2% ($n = 1,321$) reported experiencing two or more, with a sample average of three ($M = 3.15, SD = 2.25$). Over half of participants (69.6%, $n = 1,310$) reported emotion dysregulation scores superior to the clinical threshold reflecting problematic (8.6%, $n = 161$) or clinically significant levels (61.0%, $n = 1,149$) of emotion dysregulation (Briere & Runtz, 2002).

Table 2
Descriptive Statistics and Spearman Correlations for CCT, ED, MDS, and IPV

Variable	1	2	3	4	5	6	7
1. CCT	—	.27***	.17***	.12***	.08***	.08***	.14***
2. ED		—	.25***	.43***	.20***	.10***	.35***
3. MDS			—	.06**	.03	.06**	.14***
4. Psycho. IPV				—	.34***	.13***	.42***
5. Phys. IPV					—	.10***	.31***
6. Sexual IPV						—	.17***
7. Coercive control							—
Mean	3.2	23.2	11.2	8.7	0.9	0.7	5.0
SD	2.3	8.9	6.9	10.13	3.12	3.25	9.5
Minimum	0.0	9.0	5.0	0.0	0.0	0.0	0.0
Maximum	8.0	45.0	35.0	50.0	50.0	50.0	79.0
Skewness	0.31	0.38	1.06	1.30	7.29	8.27	3.29
Kurtosis	-0.98	-0.66	0.29	1.14	69.80	85.84	13.91

Note. CCT = cumulative childhood trauma; ED = emotion dysregulation; MDS = masculine discrepancy stress; IPV = intimate partner violence; psycho. IPV = psychological IPV; phys. IPV = physical IPV.
** $p < .01$. *** $p < .001$.

The mean level of masculine discrepancy stress in this sample was 11.22 ($SD = 6.86$), with total scores varying from 5 to 35.

The Roles of Masculine Discrepancy Stress and Emotion Dysregulation in the Link Between CCT and Perpetrated IPV

All hypotheses were verified through one path analysis model (see Figure 1). The path analysis resulted in a saturated model (no

Table 3
Prevalence of Childhood Interpersonal Traumas and Perpetrated Intimate Partner Violence ($N = 1883$)

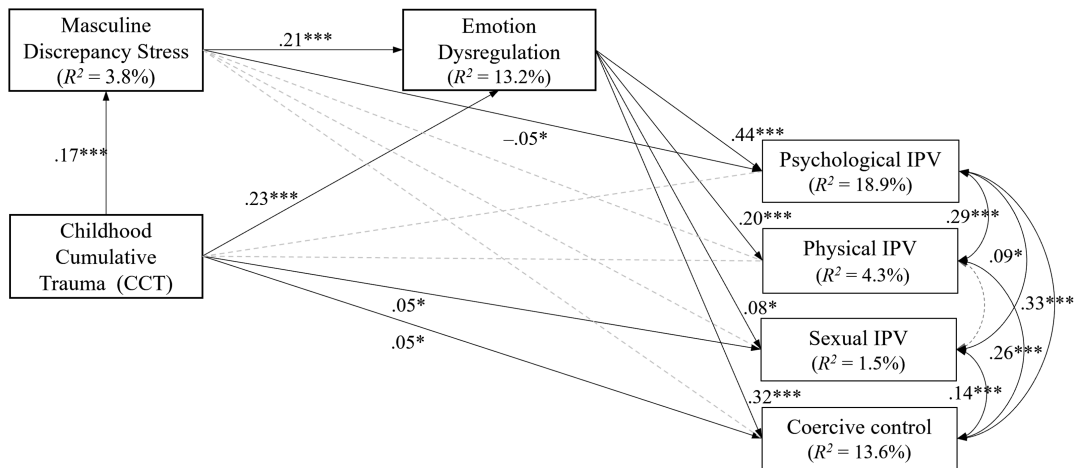
Variable	%	<i>n</i>
Interpersonal childhood traumas		
Bullying	64.5	1,210
Witnessing psychological interparental violence	58.9	1,104
Physical violence from parents	49.0	922
Psychological violence from parents	44.1	831
Psychological neglect	39.1	731
Witnessing physical violence between their parents	24.5	456
Physical neglect	15.0	279
Child sexual abuse.	20.7	390
Number of childhood trauma experienced		
0	12.9	243
1	16.9	319
2	14.8	278
3	13.2	249
4	12.3	232
5	11.2	210
6	9.6	180
7	7.1	133
8	2.1	39
Perpetration of intimate partner violence (IPV; at least one behavior in the last year)		
Psychological IPV	76.7	1,445
Coercive control	60.2	1,133
Physical IPV	28.8	542
Sexual IPV	11.9	225

degrees of freedom left; no adjustment fit). To obtain adjustment fit, a parameter was dropped from the model (i.e., the nonsignificant link between CCT and psychological IPV). Results showed satisfactory fit, which suggests that the proposed model represented the data well: $\chi^2(5) = 3.16$, $p = .675$; CFI/Tucker–Lewis index = 1.00; RMSEA = .00, 90% CI [0.00, 0.05]; standardized root-mean-square residual = .002. Yet, some limitations are to be considered, as the CFI and RMSEA showed no error between the model and the data, which is unlikely. This suggests that the model may be overly constrained or that the fit indices may not adequately capture model–data discrepancies (Civelek, 2018). Analyses yielded 13 indirect effects. In line with the first hypothesis, more CCT was indirectly related to higher perpetrated psychological ($\beta = .10$, $p < .001$, 95% CI [.082, .125]), physical ($\beta = .05$, $p < .001$, 95% CI [.032, .062]), and sexual IPV ($\beta = .02$, $p < .01$, 95% CI [.005, .033]), and coercive control ($\beta = .07$, $p < .001$, 95% CI [.058, .092]) through emotion dysregulation (Hypothesis 1).

Results stemming from the second hypothesis indicated that more CCT was related to less perpetration of psychological IPV ($\beta = -.01$, $p = .034$, 95% CI [-.017, -.001]) and more perpetration of coercive control ($\beta = .008$, $p = .087$, 95% CI [.000, .018]) through masculine discrepancy stress (Hypothesis 2). Results also indicated a direct link between higher masculine discrepancy stress levels and less perpetration of psychological IPV ($\beta = -.05$, $p = .024$; Hypothesis 2).

In support of the third hypothesis, CCT was indirectly related to higher frequencies of perpetrated psychological ($\beta = .015$, $p < .001$, 95% CI [.010, .021]), physical ($\beta = .007$, $p < .001$, 95% CI [.004, .010]), and sexual IPV ($\beta = .003$, $p = .020$, 95% CI [.001, .005]), and coercive control ($\beta = .011$, $p < .001$, 95% CI [.007, .016]) through the sequential roles of masculine discrepancy stress and emotion dysregulation (Hypothesis 3). Results also showed that CCT was indirectly related to higher levels of emotion dysregulation through masculine discrepancy stress ($\beta = .04$, $p < .001$, 95% CI [.024, .048]). Moreover, CCT remained directly related to higher levels of perpetrated coercive control ($\beta = .05$, $p = .028$) and sexual IPV ($\beta = .05$, $p = .024$). The different types of IPV were all intercorrelated except for physical IPV and sexual IPV ($\beta = .08$, $p = .087$). Overall, this model explained 3.8% of the variance in masculine discrepancy

Figure 1
Direct Links Between Cumulative Childhood Trauma and Intimate Partner Violence via Masculine Discrepancy Stress and Emotion Dysregulation



Note. Nonsignificant standardized paths are shown by dotted arrows; IPV = intimate partner violence.

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

stress, 13.2% of the variance in emotion dysregulation, 18.9% of psychological IPV, 13.6% of coercive control, 4.3% of physical IPV, and 1.5% of sexual IPV.

Discussion

This study aimed to examine the role of masculine discrepancy stress and emotion dysregulation in the relationship between CCT and perpetrated IPV using a large sample of men seeking help for IPV perpetration from community organizations. The results yielded three main findings: (1) Emotion dysregulation emerged as a key intermediary mechanism in the relationship between CCT and IPV perpetration, (2) masculine discrepancy stress played an intermediary role in the relationship between CCT and perpetrated psychological IPV and coercive control, and (3) both masculine discrepancy stress and emotion dysregulation sequentially explained the relationship between CCT and IPV perpetration. Overall, these results suggest that men's perception of not being men enough and the lack of emotion regulation skills to cope with their stress are particularly important mechanisms underlying the link between CCT and IPV.

Emotion Dysregulation as a Key Factor in the Link Between CCT and IPV

In line with our first hypothesis, we found that emotion dysregulation played an intermediary role in the relationship between CCT and all forms of perpetrated IPV. The model accounted for 13.2% of the variance in emotion dysregulation, which is a moderate effect size. This indicates that CCT and masculine discrepancy stress had a moderate impact on emotion dysregulation (Hayashi & Yuan, 2022). This finding corroborates those of previous studies conducted with online population-based samples (e.g., Berke et al., 2018) but goes further by corroborating the role of emotion dysregulation in the link between CCT and IPV in a large sample of men seeking

help for IPV perpetration. The use of such a large clinical sample is a particularly valuable addition to the IPV perpetration literature, as very few studies have examined IPV in this type of sample. While it can be challenging to recruit men who are seeking help for IPV perpetration, it is important to study this population as they have characteristics that will more adequately represent the men for whom IPV reduction programs are designed. For instance, these men tend to be more likely to report an extensive history of childhood interpersonal trauma and severe forms of perpetrated IPV compared to male from community or undergraduate samples (Dugal et al., 2021; Fatehi et al., 2022; St-Pierre Bouchard et al., 2023).

The Role of Masculine Discrepancy Stress in the Link Between CCT and IPV

Our second hypothesis of an indirect association between CCT and IPV through masculine discrepancy stress was partially supported. First, the model revealed a small effect size with only 3.8% of the variance in masculine discrepancy stress that was predicted by CCT. Moreover, masculine discrepancy stress was related with perpetration of sexual IPV in bivariate correlations, but this link was nonsignificant in the integrative model. This finding is inconsistent with those of previous studies having found that greater masculine discrepancy stress was linked to more perpetration of sexual IPV (Berke et al., 2016; Reidy et al., 2014; Sileo et al., 2022). This result introduces a novel perspective suggesting that when CCT, emotion dysregulation, and other forms of IPV are considered within an integrative model, the effect of masculine discrepancy stress alone on perpetration of sexual IPV becomes nonsignificant. This might be explained by the possibility that sexual IPV may be more directly related to aspects of masculinity other than masculine discrepancy stress in male CCT survivors. Indeed, evidence suggests that sexual IPV is associated with hypermasculinity and the performance of a more hegemonic masculinity (Berke et al., 2016; Vechiu, 2019). As such, sexual IPV may be more used as

a calculated strategy to enact masculine norms of power and dominance and might be less related to the perpetrator’s emotions, insecurities, or stress about not being perceived as men enough. Peripherally, a recent study found that higher self-esteem was related with higher perpetration of sexual IPV (Sileo et al., 2022). Since male CCT survivors often have lower self-esteem and masculine discrepancy stress implies experiencing difficulties with one’s masculine self-esteem, it is plausible that men’s CCT would not be associated with higher rates of sexual IPV perpetration through masculine discrepancy stress. However, future studies are required to verify these assumptions and to investigate other potential underlying mechanisms.

In line with our second hypothesis, masculine discrepancy stress was an underlying mechanism explaining the link between CCT and higher perpetration of coercive control. Men with a history of CCT tend to develop a representation of the world as dangerous and might be more hypervigilant to signs of threat to their masculinity when interacting with their partners (St-Pierre Bouchard et al., 2023). Thus, in contexts where male CCT survivors worry about being perceived as not masculine enough, exerting more coercive control over their partners might be a maladaptive way for them to match social expectations dictating that men should always be in control and demonstrate manliness (Berke et al., 2018). Moreover, identity impairment, which has been documented in male CCT survivors (Bigras et al., 2020; Briere & Runtz, 2002), might also explain this finding. Given that masculine discrepancy stress is known to be challenging for men’s self-concept and self-esteem (Cunningham et al., 2020; Sileo et al., 2022). As such, male survivors who experience masculine discrepancy stress are likely to have a weakened sense of their identity as a man. According to preliminary data from Lafleur et al. (2023), men’s weaker identity cohesion was related to increased perpetration of coercive control. In addition, their results suggest that a weaker identity cohesion was often accompanied by difficulties in understanding oneself, lower self-esteem, and feelings of inner emptiness, which could all potentially lead to a perception of lacking control over oneself (Lafleur et al., 2023). This could potentially increase the risk for male CCT survivors’ use of coercive control in their intimate relationships to regain a certain sense of control. This interpretation, however, needs to be empirically verified in future research.

The present study also found CCT to be related to higher levels of masculine discrepancy stress, which, in turn, was related to lower psychological IPV perpetration, thereby contradicting our second hypothesis. This finding was unexpected since bivariate correlations indicated that masculine discrepancy stress was associated with increased psychological IPV perpetration. Yet, when the effect of emotion regulation was taken into account (or controlled for) in our integrative model, a suppressor effect emerged. This effect revealed a residual relationship where higher levels of masculine discrepancy stress were related to less perpetrated psychological IPV *in the absence of emotion dysregulation*. This means that, on one hand, the link between CCT and increased psychological IPV through masculine discrepancy stress seems to be explained by men’s difficulties in regulating their emotions when they experience higher masculine discrepancy stress. Since masculine discrepancy stress refers to the experience of distress associated with the belief of being less masculine than the traditional male, increased psychological IPV perpetration could be understood as a dysfunctional way for male CCT survivors who lack adaptive emotion regulation skills

to reestablish their masculinity. Yet, our results suggest that, without emotion dysregulation, masculine discrepancy stress may not be associated with increased perpetration but rather with decreased perpetration of psychological IPV. Thus, the presence of a suppressor effect complexifies the interpretation of our results and suggests that the relationship between CCT and psychological IPV through masculine discrepancy stress may be more complex than initially thought. Further research is needed to understand the mechanisms underlying this unexpected finding. Additionally, this emphasizes the importance of examining integrative models in research, which better reflect the complex reality of the interconnections between variables that simpler models (e.g., bivariate correlation) would fail to reveal.

Reidy et al. (2014) conducted an integrative model in which several masculinity-related variables were controlled for. Their findings suggest that it is the distress about the perceived nonconformity to masculine norms (i.e., masculine discrepancy stress) that may hinder an individual’s functioning (e.g., increased perpetrated psychological IPV) rather than the mere conformity/nonconformity to masculine norms. A more recent study (Mesler et al., 2022) supported this finding, showing that men who report feeling less masculine but who do not suffer from this perceived nonconformity were not at higher risk for behavioral and mental health problems. Our study corroborates these results but goes a step further, showing that it might be more specifically the experience of “dysregulated” distress that may be maladaptive, leading to perpetrated violence. Yet, as our integrative model shows, the experience of higher levels of masculine discrepancy stress alone may lead to less perpetrated psychological IPV in men who are able to accept, regulate, or tolerate this stress/distress arising from their belief of not conforming to traditional masculine norms.

The Role of Masculine Discrepancy Stress and Emotion Dysregulation in the CCT–IPV Link

In support of our third hypothesis, masculine discrepancy stress and emotion dysregulation sequentially explained the relationship between men’s CCT and their higher perpetration of all forms of IPV. The model appeared to have the strongest predictive power for psychological IPV perpetration since the predictors in the model (CCT, masculine discrepancy stress, and emotion dysregulation) explained 18.9% of its variance, which is a moderate to large effect size. The model also accounted for 13.6% of the variance in perpetrated coercive control, which is a moderate effect size. Finally, the model appeared to have relatively weak predictive power (small effect sizes) for physical (4.3%) and sexual (1.5%) IPV perpetration. These findings support the claim that not all male survivors of childhood trauma will perpetrate IPV (Godbout et al., 2019) and add to the IPV literature by highlighting the sequential role of masculine discrepancy stress and emotion dysregulation in the trajectories of CCT survivors who perpetrate IPV. Results also provide preliminary evidence that men with an accumulation of childhood interpersonal trauma might be more sensitive to perceived potential threats to their masculinity. When interacting with their partners, such perceptions may lead some men to interpret ambiguous social cues as invalidations or attacks to their masculinity. In turn, higher masculine discrepancy stress associated with more difficulties regulating emotions could prompt some men to respond with acts of violence (Berke et al., 2018). This interpretation suggests that the use of IPV could be a maladaptive

tentative for emotionally dysregulated men to reaffirm their masculinity while acting in conformity to negative masculine norms (e.g., domination).

Finally, these results, along with positive residual associations between masculine discrepancy stress and less perpetrated psychological IPV, suggest that it might not be the participants' masculine discrepancy stress per se that leads to their perpetrated violence. Rather, it could be their experience of masculine discrepancy stress coupled with their inability to regulate or to cope with their painful and intense emotions, such as those elicited by the stress of not being man enough.

Limitations and Strengths of the Study

This study is not without limitations. First, we used self-reported measures that may be prone to memory biases, lack of self-awareness, or social desirability, especially considering the tendency of men to underreport violence (Emery, 2010). Also, the measures of IPV did not assess patterns of violence nor the context in which it occurred (e.g., intimate terrorism and situational violence; Johnson et al., 2014). To limit these biases, future studies should include multimethod designs (e.g., reports of both partners, daily diaries). Given the cross-sectional design of the study, the directionality was inferred on temporal (e.g., CCT occurred in childhood and IPV in adulthood) and theoretical bases, but causal links may not be drawn and longitudinal design should be adopted in future studies. Although the sample is diversified in terms of age (18–89 years), the generalization of results is limited by the homogeneous sample composed mainly of lower class, heterosexual Caucasian French–Canadian cisgender men consulting in the context of IPV perpetration. Future studies should elaborate personalized recruitments to target individuals from more diverse groups in terms of sexual orientations, genders, and cultural backgrounds. To achieve this, researchers must be deliberate in their choice of recruitment strategies. Bonevski et al. (2014) conducted a systematic review, offering insights into strategies for enhancing research with socially disadvantaged groups. Notably, they recommended the development of a targeted sampling plan to reach the desired group. For example, Voith et al. (2022) employed a stratified design in their recruitment, allowing them to investigate the impact of trauma, depression, and gender roles on IPV perpetration among a sample of predominantly low-income men of color. Finally, the exclusion of participants who did not fully complete the survey may limit the generalizability of our findings and result in a potential bias toward participants who were more motivated to complete the survey. Thus, this omission could negatively impact the external validity of our results. Additionally, the exclusion of incomplete responses may overlook valuable insights and perspectives, potentially limiting the comprehensiveness of our findings. Despite these limitations, by examining the direct and indirect associations between men's history of CCT and the four main forms of IPV in a large clinical sample of men, this study offers additional empirical evidence supporting the importance of targeting emotion dysregulation and masculine discrepancy stress in clinical intervention aiming to end IPV. This study also adds to the understanding of the multifaceted construct of IPV by examining four different subtypes (psychological, physical, sexual, and coercive control). There is also a wide repertoire of interpersonal traumas (eight different forms) that was measured, which provided valuable data regarding men's traumatic experiences.

Implications

The present findings have significant implications for IPV prevention and reduction programs. The focus on identification of modifiable mechanisms such as masculine discrepancy stress and emotion dysregulation is relevant to guide the development of efficient interventions for CCT survivors that follow a trauma-sensitive approach and aim to end perpetrated violence. A trauma-sensitive approach suggests that the focus should be on the experiences of individuals rather than on identifying traumatic symptoms (SAMHSA, 2014). Therefore, this leads to asking questions such as “what happened to you?” rather than “what is the problem with you?” (SAMHSA, 2014). These interventions help to target key mechanisms at the roots of IPV behaviors. This is particularly relevant for men who consult community organizations because health care settings often fail to assess childhood victimization in men (Godbout et al., 2019; Lab et al., 2000). Adopting a universal and standardized screening protocol might also help to identify men who were victims of CCT as well as men who are both victims and perpetrators of IPV (Vaillancourt-Morel et al., 2016).

These findings also underline the need for gender transformative interventions, which involve a conscious effort to deconstruct the gender stereotypes that undermine men's psychological wellbeing (Dworkin et al., 2013). Through the mobilization of community organizations, group discussions about masculinity, and knowledge translation initiatives (e.g., awareness campaigns), these interventions challenge the adherence to norms of masculinity and rigid gender roles. Prevention efforts should target the role of male gender socialization in the emotion dysregulation of men who have experienced interpersonal childhood trauma. A good first step in this direction would be to follow Mahalik, Good, and Englar-Carlson's (2003) recommendations as well as the American Psychological Association guidelines for psychological practice with boys and men (American Psychological Association, Boys & Men Guidelines Group, 2018). More specifically, it would be important to target the reduction of masculine discrepancy stress by deconstructing gender stereotypes (e.g., dominance, self-reliance, emotional control, sexual promiscuity) and reducing the physiological arousal associated with perceived violations of masculine gender norms. This could, in turn, help CCT survivors to better regulate their emotions and resolve their conflicts without resorting to violence.

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