QUEEN'S UNIVERSITY BELFAST

SCHOOL OF PSYCHOLOGY

COMMISSIONER FOR VICTIMS OF CRIME

Male Experiences of Intimate Partner Violence:

The ME-IPV Study

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November 2024

Foreword

I am pleased to present this important report which examines the experiences of male victims of intimate partner violence (IPV) in Northern Ireland. This report builds on prior research commissioned by my office, which highlighted a significant gap in our understanding of IPV as it affects men and boys. Despite the progress made and work still needed in addressing violence against women and girls, it is crucial to recognise that men and boys also suffer intimate partner violence and that their experiences also warrant attention and support.

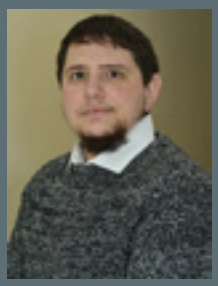
The findings in this report are both enlightening and deeply concerning. They reveal the traumatic impact of IPV on male victims, emphasising significant public health issues that affect their physical health, mental health and overall well-being. The data underscores the need for policies and processes that address the unique needs of male victims and highlights potential gaps in service provision, particularly in rural areas.

This research is a critical step towards informing future policy and service development aimed at meeting the needs of male victims of IPV and will shape future work priorities for my office. It is my hope that the insights gained from this report will help inform government planning, drive meaningful change and ensure that support systems are inclusive, accessible, and effective for all victims, regardless of gender.

I extend my deepest gratitude to the researchers at STARC for their diligent work, the support agencies who helped facilitate this research and in particular to individual victims who courageously shared their experiences through the online survey and interviews. This report would not have been possible without their engagement and willingness to contribute to this vital area of study.

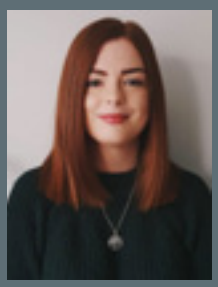
Geraldine Hanna
Commissioner Designate for Victims of Crime

The authors



Dr. Eric Spikol

Dr. Eric Spikol is a Research Fellow at Queen's University Belfast and member of the Stress, Trauma, and Related Conditions (STARC) research centre. He completed his Bsc and PhD at Ulster University before taking up a position at Queen's as part of multiple research projects. His research focuses on trauma/PTSD, resilience, pregnancy loss, and intimate partner violence, and his research interests include the use of administrative data to serve vulnerable populations. He was the lead researcher on the ME-IPV study.



Dr. Emily McGlinchey

Emily is a Lecturer in Psychology (Applied) at Ulster University (UU), and a British Psychological Society (BPS) accredited Psychological Wellbeing Practitioner, with clinical experience working across a range of both statutory and non-statutory mental health services. Emily completed her undergraduate, MSc in Applied Psychology and PhD studies at Ulster University. She then held research fellow and senior research fellow positions at the Stress, Trauma & Related Conditions Research Centre based in Queen's University Belfast. Emily returned to Ulster as a lecturer in early 2024. Emily's research focus is in the area of applied mental health, particularly in the areas of trauma, internalising disorders, emotional regulation and resilience.

Professor Chérie Armour

Chérie Armour is a Professor of Psychological Trauma and Mental Health in the School of Psychology at Queens University Belfast. Professor Armour is the Director of the Research Centre for Stress Trauma and Related Conditions (STARC). Chérie has published extensively in the field of Psychotraumatology and Mental Health. Chérie has a particular interest in understanding risk and resilience factors for adverse psychological outcomes after the experience of trauma. To date, Professor Armour has delivered hundreds of conference presentations and is regularly invited to speak about her research at universities, conferences and events across the world. Chérie has several research awards for her contributions to the field of traumatic stress. Chérie leads a multi-million-pound programme of research delivered in NI, the UK, and internationally in countries such as South Africa and Colombia. Professor Armour has also held several leadership positions external to the University. She is a past member of the board of directors for the International Society of Traumatic Stress Studies (ISTSS), a past President of the UK Psychological Trauma Society (UKPTS) and is currently an Associate Editor of the European Journal of Psychotraumatology. Chérie has published specifically in the area of male interpersonal violence and supervised a PhD thesis to completion related to male interpersonal violence and mental health. She is also interested in mechanisms that promote posttrauma resilience across a variety of trauma populations.

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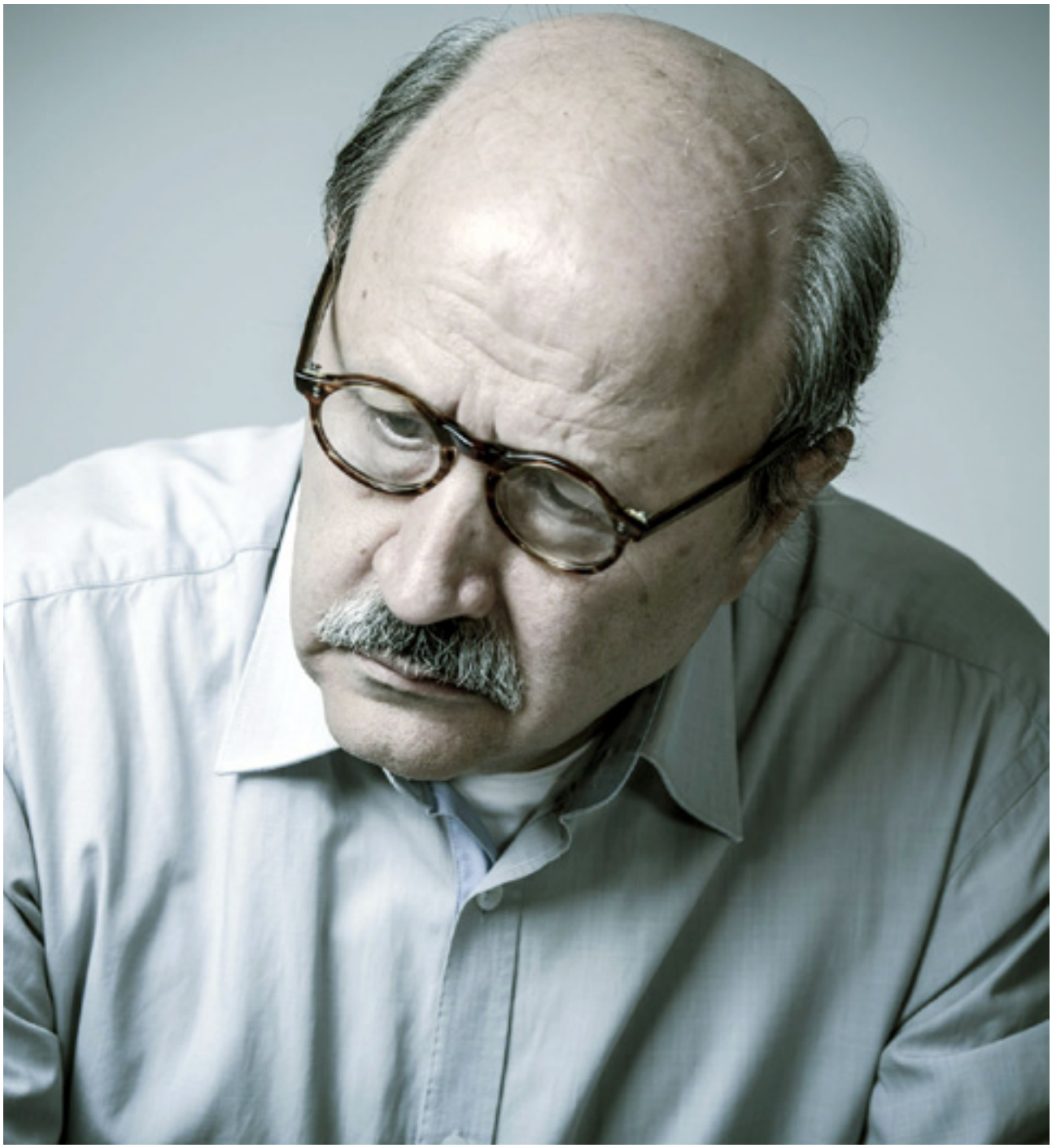
CVOCNI	Commissioner for Victims of Crime Northern Ireland
DV	Domestic Violence
FREC	Faculty Research Ethics Committee
GDPR	General Data Protection Regulation
IPA	Interpretative Phenomenological Analysis
IPV	Intimate Partner Violence
LGBTQ+	Lesbian Gay Bisexual Transgender Queer (+ other identities)
MAP	Men's Advisory Project
MANI	Men's Alliance Northern Ireland
ME-IPV Study	Male Experiences of Intimate Partner Violence Study
MSM	Men who Sleep with Men
NI	Northern Ireland
ONS	Office for National Statistics
PIS	Participant Information Sheet
PPS	Public Prosecution Service
PSNI	Police Service Northern Ireland
PTSD	Post-traumatic Stress Disorder
QUB	Queen's University Belfast
SA	Sexual Assault
SPSS	Statistical Package for Social Sciences
STARC	Stress Trauma & Related Conditions
UK	United Kingdom



EXECUTIVE SUMMARY

Background

There is a critical **lack of research** into the prevalence rates of IPV against men/boys and the impact these experiences can have on them.

The sparse research available indicates that IPV has a significant, **negative impact on men's mental and physical health**, including anxiety, depression, posttraumatic stress disorder (PTSD), alcohol/substance misuse, and suicidal ideation.

Self-stigma often prevents men from reporting or disclosing abuse, and societal stigma leads to them not being believed when they do report or disclose, or the abuse being ignored or downplayed.

The ME-IPV Study was commissioned with an overall objective to explore the experiences of IPV in men in NI, including the physical/psychological impact, barriers to reporting, and experiences of disclosure.

Study

The research team set up an **online survey** and conducted **in-depth interviews** with men in NI who have experienced IPV.

Findings

Participants in the study had an **average age of 45 years** and were more likely to be:

- **93%** white
- **87.8%** heterosexual
- **73.2%** not currently in a relationship
- **64.4%** having at least a Diploma qualification or higher
- **68.7%** economically active
- **69.5%** in the top half of socioeconomic status by job role

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A majority of participants were either '**getting by**' **(46.1%)** or '**struggling**' **(39.1%)** financially, as opposed to '**doing well**' **(14.8%)**

Psychological aggression (78%), **coercive control (68.5%)**, and **physical assault (49.8%)** were the most common IPV experiences, and most experiences took place over several years.

Psychological aggression and **coercive control** were associated with **increased symptoms** of **depression, PTSD distress**, and **overall poorer mental health**.

The **greater the IPV exposure**, the **worse the associated distress** was likely to be.

Alcohol consumption:
39.4% of participants engaged in **hazardous consumption**.

Mental illness:
58.8% of participants met caseness criteria for **anxiety**, **71.7%** for **depression**, and **67%** for **PTSD**.

Suicidal ideation:
71.4% had thoughts of **ending their life** and of these, **91.7%** had **formulated a plan** to take their life, and **46.7%** had made **at least one attempt**.

Disclosure: 51.2% did not disclose their abuse (**65.1%** of these said they had no plans to do so in the future).

Barriers to help-seeking: barriers associated with stigma and trust were most likely to prevent participants from disclosing or seeking help.

Interview participants discussed initial **red flags in the relationship** and **multiple types of abuse** including:

- False allegations
- Psychological/emotional abuse
- Physical abuse
- Manipulation of others against them
- Being monitored or controlled
- Forced social isolation
- Manipulation of their children against them
- Institutional abuse (use of the police, courts, and/or civil systems)
- Financial abuse
- Sexual abuse/reproductive coercion

Interview participants described **the toll their experiences of IPV have taken** on their physical and mental health & wellbeing, including stress-related illnesses, anxiety, depression, and suicidal ideation.

Interview participants discussed **disclosure and not being believed** by friends/family, being disregarded by police/court system, and not receiving justice for the abuse they experienced.

Conclusions

Male experiences of IPV in NI are **a significant public health issue** which warrants immediate attention.

The academic, statutory, and third sectors of NI should act to **support men who have experienced IPV**.

The research team has made **the following recommendations** based on these findings:

Recommendations

Research

1. Future research concerning men in NI who have had the experience of IPV perpetrated against them should prioritise specific sub-populations with targeted studies:
   - **a.** to LGBTQ+ individuals, specifically transgender/transmasculine men and men in same-sex relationships
   - **b.** Ethnic/cultural minorities
   - **c.** IPV experiences of boys (13-17)
   - **d.** IPV experiences of older men (+65)
2. Studies exploring mental health and wellbeing in this population should focus on institutional abuse and its impact on the individual, including future participants' quality of life, belief in a just world, and locus of control.
3. While no participant espoused these views, it is evident in online spaces that this population may be vulnerable to radicalisation based on experiences of stigma and gender bias/discrimination after disclosure, and due to institutional abuse. Future research should explore if this underlying issue is present in NI.
4. Further studies utilising the ME-IPV Study interview data should focus on comparative synthesis research using similar data from other studies in other countries to explore male experiences of IPV from a global perspective.
5. Cumulative IPV exposure, coercive control, psychological and sexual abuse were all associated with adverse mental health outcomes; future broad-scale survey studies with this population should concentrate on the psychological mechanisms underlying these associations.

Practice

1. Charities/support organisations should explore expanding their remit for additional types of support, particularly legal support/advice. Additionally, third sector organisations should signpost clear eligibility requirements for service users (if the organisation uses such criteria).
2. All charities/support organisations who service individuals who have had the experience of IPV should consider forming a task force or executive advisory group to foster collaboration and contribution to a united front against abuse. This could be facilitated via public awareness campaigns with a goal of reducing stigma and polarisation, as well as challenging stereotypical thinking about IPV.
3. Charities/support organisations should investigate the creation of educational and training materials for use with multiple target audiences:
   a. Boys (13-17), on identifying the types of IPV, understanding abuse in adolescent relationships, and reducing stigma
   b. GPs/healthcare professionals, on identifying potential indicators of IPV in service users and on appropriate responses to disclosure, including signposting support
   c. Police officers, to foster an understanding of the multiple types of IPV, believing victims of abuse regardless of gender, reacting appropriately to disclosure, and reducing stigma/belief in harmful stereotypes
   d. Social services workers, to foster an understanding of the multiple types of IPV and that fathers can be victims, and to challenge a culture of stigma and harmful stereotypes within the workplace
   e. General public, featuring a broad-spectrum line of materials available online or in-print, with an aim towards awareness and stigma reduction

Policy

1. As the experience of IPV constitutes a significant public health concern, the creation of a task force or expert advisory group at the NI governmental level for all matters of NI law/policy involving IPV would be invaluable.
2. As the Department of Justice is currently undertaking a consultation and review of civil legal aid in NI, it may be beneficial to also consider partnering with NI third sector charities/organisations to release the results of this consultation in an educational/lay-language format. It is evident that the general public has a great deal of misperception and misinformation surrounding this issue, especially when the family court is involved.
3. The continued support of the NI government for IPV awareness and stigma reduction campaigns, especially those which are gender/age/minority inclusive, will be invaluable in effecting lasting change in attitudes towards IPV victims in NI.

1.0 Introduction

1.1 Background

In February 2022, the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021[1] came into force under law. This legislation marked the first time in Northern Ireland (NI) that protections were extended to include non-physical abuse, including sexual, psychological, financial, emotional abuse, and abuse conducted through digital means (social media, phone/text, email, etc.). Additionally, the law as read covers coercive control, a pattern of abusive behaviour by an individual with a goal of forcing their target into a dependent/subordinate role, working to isolate them from their support network (friends, family, coworkers, community), stalking and/or monitoring, and seeking to control their target's life through a campaign of fear, intimidation, humiliation, and shame (Stark & Hester, 2019).

Legislation clearly outlining these abusive behaviours is vital, as it works to bring relief to those who have been abused by creating a pathway for their abusers to be brought to justice. The context of the abuse is also significant for resultant legal action, in recording/categorising instances, and in exploring the effects that this violence has on those who experience it. For example, an oft-cited definition of intimate partner violence (IPV) describes it as any act of "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner" (Breiding et al., 2015, p. 11). It is important to note its definition differs from that of domestic violence (DV), "threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member" (PSNI, 2023).

It is helpful to think of DV as an overall category of abuse perpetrated by any individual in the same household, with IPV specific to an intimate partner. This difference matters when it comes to local, national, and global statistics examining the prevalence of IPV, as some agencies report only DV, which can also include child/parent and sibling abuse and can further 'muddy the waters' on the true rates of IPV in a given population. This is problematic as IPV is a global issue which impacts all genders, with significant effects on the physical/mental health, wellbeing, and life circumstances of those who have had this experience (McNeill et al., 2022). A large body of research exists investigating the prevalence, experiences, and impacts of IPV in cisgender women but there remains lack of research into these experiences in men/boys (Taylor et al., 2021; Scott-Storey et al., 2023).

A recent review of global prevalence rates and mental health impacts of IPV in men/boys (McGlinchey et al., 2023) found that results varied widely based on location, study methodology, definition of IPV, and other factors. The profound lack of research leaves massive gaps in the knowledge base of IPV prevalence in men/boys, the types of abuse experienced, the impacts of this abuse, and support needs/support use (Bates, 2020a). Men/boys who experience IPV perpetrated against them constitute a hidden population within a hidden population; often underserved by research, overlooked in policy, and stigmatised by society.

It is estimated that the global prevalence of IPV in men ranges from approximately 17% (Gubi & Wandera, 2022) to 20% (Lanre et al., 2014). However a range of factors such as, underreporting, a lack of empirical research, and differences in the definition of abuse, must be considered. Additionally, many men who have experienced IPV are not aware that their experiences meet the definition of abuse

[1] *https://www.legislation.gov.uk/nia/2021/2/enacted*

(Bates, 2020b; Taylor et al., 2021), or fail to report due to self/societal stigma, concerns of retaliation by their abuser, and fear of not being believed (Walker et al., 2019; Bates 2020a; Taylor et al., 2021). In the UK, prevalence rates of DV (including IPV) were estimated at 13.8% - or approximately 2.9 million individuals – in England and Wales in 2019 (ONS, 2020), concordant with the UK-wide findings of 13.8% of men having experienced any form of DV during their adult life (The Mankind Initiative, 2021). As these figures are for the wider definition of DV, and considering the above issues in determining prevalence, it is again likely that these approximations underrepresent the true rates of IPV in UK men.

Exploring the commonality of IPV experiences in men in NI is difficult. The Police Service of Northern Ireland (PSNI) openly publishes yearly statistics describing DV in NI[2], these are instances of abuse perpetrated by any family member, which includes intimate partners but is not specific to intimate partners. It should also be noted that these statistics only cover crimes which are reported/known to the PSNI, and as men are significantly less likely to report (Dutton & White, 2013; Walker et al., 2019), the true prevalence of IPV in men in NI remains unknown.

Within the context of IPV, certain beliefs or stereotypes can be commonplace, such as the popular (inaccurate) perception of IPV is a female victim and a male perpetrator, the similarly inaccurate popular perception of male victimisation focuses on a heteronormative couple, i.e. with the female as the perpetrator (Baker et al., 2013; Cannon & Buttell, 2015). However, this ignores the men who experience IPV in same-sex and/or gender variant relationships. A recent meta-analysis of 52 studies, covering approximately 32,000 participants, estimated a pooled prevalence rate of 33% regarding IPV victimisation in relationships among men who sleep with men (MSM) (Liu et al., 2021). While the physiological and psychological impacts of IPV on men from the LGBTQ+ community do not differ from those of heterosexual men (Nowinski & Bowen, 2011), and men in these relationships experience the same types of IPV, indeed, the additional level of psychological abuse present in the threat of 'outing' by the perpetrator, i.e., disclosure of one's LGBTQ+ status to deliberately cause harm (Callan et al., 2021). This results in lower levels of reporting and is a threat which is particularly dire in places where being LGBTQ+ is illegal (Hall et al., 2018; Okanlawon, 2018; Ogunbajo, 2022).

1.2 Impacts of IPV on Men

The impact of IPV on an individual's physical and mental health can be profound. In addition to any physical injuries sustained, the relationship between trauma, especially cumulative trauma such as a sustained pattern of IPV, and adverse health outcomes is well-established (Coker et al., 2002; Lagdon et al., 2014; Hines & Douglas, 2015; Brooks et al., 2020). IPV victimisation in men has been associated with anxiety and depression (Próspero, 2007; Scott-Storey et al., 2022; Macassa et al., 2023), suicidal ideation (Randle & Graham, 2011), post-traumatic stress disorder (PTSD) (Hines, 2007; Lagdon et al., 2014; 2023; McManus et al., 2022), and alcohol/substance misuse (Coker et al., 2002). Evidence of long-term effects of IPV on men is lacking, as most longitudinal studies focus on women, only include men who are 'victim-perpetrators', are taken from census-style datasets not focused on DV/IPV, or follow a teenage cohort. One such study which focused on IPV experience in adolescents (Exner-Cortens et al., 2013), found an increase in antisocial behaviours, cannabis use, and suicidal ideation in boys over a 6-year period.

Additionally, the experience of IPV can take a significant toll on men's wellbeing. Bates (2020a)

[2] *https://www.psni.police.uk/about-us/our-publications-and-reports/official-statistics/domestic-abuse-statistics*

described the negative impact of IPV on men's physical health and the damaging effect that it had on their relationships (both with intimate partners and others) after those experiences. Participants in a qualitative study on the life impacts of IPV (Sita & Dear, 2021) described decreased self-worth, self-efficacy, and concentration, and increased social isolation and sleep disturbance.

There is also variation in impact/adverse outcomes depending on the type of IPV experienced. Sexual violence/aggression has been found to be highly associated with depression, PTSD, and poor physical health (Hines & Douglas, 2016a), physical violence was associated with chronic illness/mental illness, with worse physical health outcomes when psychological violence was also present (Coker et al., 2002), and psychological violence (including coercive control) has been associated with PTSD, depression, suicidal ideation, poor physical health, and decreased wellbeing (Shorey et al., 2012; Hines & Douglas, 2016b; Machado et al., 2021; Scott-Storey et al., 2023). A study with Italian men focused on their experiences of IPV, reported that though participants described quite severe physical violence, many found that the psychological violence had a more detrimental impact (Entilli & Cipoletta, 2017).

The experience of IPV victimisation therefore has drastic and potentially long-term effects on the mental health, physical health, and wellbeing of men (Coker et al., 2002; Walker et al., 2019; Taylor et al., 2021), which constitutes a significant public health issue.

1.3 Disclosure, Barriers to Help-Seeking, & Policy

One of the primary challenges in addressing male experiences of IPV in research, practice, and policy is the problem of disclosure. For an instance (or pattern of instances) to be recorded and further actioned upon, it must be reported, and as stated above, men are more likely to either not report due to psychosocial and cultural influences, or to not recognise their experiences as IPV and thus not report (Bates, 2020b; Taylor et al., 2021). This lack of disclosure masks the actual scope of the problem, with institutional financial stakeholders unwilling to commit funds to organisations or statutory initiatives for what they may perceive to be a 'minor issue'. In terms of research, relying on official disclosure/prevalence rates can be problematic, as researchers are aware of the significant under-reporting in men. Additionally, studies are often limited to small sample sizes taken from clinical or help-seeking populations as few broad-spectrum population-level datasets exist which explore experiences of IPV in men (Ali et al., 2021; McGlinchey et al., 2023).

Societal perception of gendered violence has a substantial impact on reactions to IPV, as Bates et al. (2019) found that individuals were less likely to identify behaviour as IPV when the victim was male and were more likely to find the behaviour acceptable when compared against an identical scenario where the victim was female. Thus, one of the main contributory factors in lack of disclosure in men is fear that their experiences would be minimised or ignored, they would not be believed, or they themselves would be accused of abuse when they sought support (Walker et al., 2019; Bates 2020a; Taylor et al., 2021).

Bates' (2020a) in-depth qualitative exploration of IPV in men described participants' experiences of being mocked by police and medical/mental health professionals, being told to "just man up" by family and friends, and being told they must have "deserved it" by DV/IPV support staff. Men may be met with suspicion when they disclose (Dutton & White, 2013) and forced into a network of interconnecting institutions of the state which have been predisposed to stereotype men as aggressive perpetrators and women as fragile victims incapable of perpetration

(Barber, 2008). Reluctance to disclose can also be affected by the family situation, as courts/legal systems in many countries favour women in custody disputes (Brown, 2004; Tsui, 2014), with many men remaining in abusive relationships out of fear they will be kept from their children (Berger et al., 2016; Bates, 2020a; Moore, 2021).

Gender stereotypes also play a significant role in the lack of both disclosure and help-seeking among men. The pervasive notion that to be male means to conform to a set of behaviours espousing concepts such as 'strength', 'stoicism', and 'self-reliance' is present in many cultures, with any deviation seen as being 'weak', 'unmanly', or outright 'feminine' (Tsui et al., 2012). A survey amongst support agencies in the United States which served male victims of IPV (Tsui et al., 2010) described a perception of services as female oriented, shame and embarrassment, denial over the abuse, stigmatic beliefs, and fear as the main explanations for the low rates of disclosure and help-seeking among men. Given that help-seeking is associated with better outcomes after experiencing IPV (Douglas & Hines, 2011), more must be done to ease this process for male victims.

Even when men in NI make the decision to disclose and/or seek support, they face a lack of dedicated support services compared to those available for women. At present, there is no domestic abuse refuge in NI for male use, meaning there are no specialist places for men who wish to leave an unsafe environment. Several IPV/DV charities operate in NI to provide what support they can, including Men's Alliance[3], Men's Action Network[4], and the Men's Advisory Project[5], but these have suffered in terms of funding due to years without a sitting Executive. Additionally, while some stigmatic beliefs around help-seeking have declined in NI since 2015 (O'Neill et al., 2022), potentially because of awareness campaigns, stigma remains an enduring barrier to support (Betts & Thompson, 2017; Spikol et al., 2024a).

Lack of disclosure, barriers to help-seeking, and similar societal challenges have a direct impact on service provision, governmental strategies, criminal justice policies, and implementation of new/additional support initiatives. On a national level, the UK has adopted a specific framework to guide policy on IPV focusing on women and girls (the Violence Against Women and Girls strategy[6]; Crown Prosecution Service, 2019), which mentions male victims of IPV once, "Male specific services will see a 60% funding increase following a significant increase for demand for support from men and boys." (pg. 55), and links to a separate government statement[7] on male DV and sexual assault (SA) victimisation which is not specific to IPV and includes SA by strangers. Locally, the NI Executive has proposed two strategies, 'Tackling Violence Against Woman and Girls Action Plan', which only applies to females and the 'Domestic & Sexual Violence & Abuse Strategy'[8], which covers both males and females. Both documents have completed the public consultation phase and are now pending response from the Executive.

1.4 Study Rationale & Aims

It is now quite evident that the prevalence rates, experiences, and impacts of IPV among men in NI "remain understudied and poorly understood" (McGlinchey et al., 2023). In the 'Strategy 2022-2025' initiative[9], the Commissioner for the Victims of Crime in Northern Ireland (CVOCNI) committed to focusing on domestic abuse and crimes where the victim faces specific challenges due to their immutable characteristics, for example, gender, race, or sexuality. This dedication led to the funding of a systematic review in 2023, 'Experiences and Mental Health Impacts of Intimate Partner Violence against Men and Boys: A Rapid Review'[10], which

[3] *https://mensallianceni.co.uk/*
[4] *https://www.man-ni.org/*
[5] *https://mapni.co.uk/*
[6] *https://tinyurl.com/37fvb3xv*
[7] *https://tinyurl.com/4wketrp9*
[8] *https://www.justice-ni.gov.uk/sites/default/files/consultations/justice/dsa-strategy.PDF*
[9] *https://www.cvocni.org/files/cvocni/2023-02/CVOC-Strategy-22-25.pdf*
[10] *https://tinyurl.com/4artdt2r*

noted significant gaps in the literature and urgently recommended a research programme exploring these experiences in men in NI. The Commissioner stated, "If we want to support male victims, who have too often not sought the help they need because of the stigma around IPV, then we need to know the best way to provide that support. We all have a role in combatting the stigma that men who experience this crime face and this research will help inform how we best do that." (Queen's University Belfast, 2024).

As IPV constitutes a significant public health issue, a campaign of targeted local research is urgently needed to form a better understanding of IPV in men, specifically exploring the experiences of sub-groups (ethnic or gender/sexual minority men, urban and rural communities, and by age) and short versus long-term health impacts of IPV. Along with adding to the literature describing the physical, mental, and wellbeing impacts of IPV, such findings can be used to improve the reporting/disclosure process, reduce self, institutional, and societal stigma around male IPV, and potentially form the basis of new initiatives/programmes to assist male victims and provide support and refuge. This study, the Male Experiences of Intimate Partner Violence (ME-IPV) is a response to this call to action.

The ME-IPV Study was commissioned with an overall objective to explore the experiences of IPV in men in NI, with four main research goals:

1) Examine the physical & psychological impact of intimate partner violence on male victims in Northern Ireland.
2) Identify any perceived barriers to reporting of the crime to friends, family, or authorities.
3) Examine the responses the participant received to disclosure & any impact on them.
4) Identify if any differences in impact, barriers or response depending on geographical location, including mandatory requirements.

A quantitative online survey was designed to gather the appropriate data to meet these four goals and additional questions for ongoing research, specifically:

i. What is the current reported rate of IPV and nature of these experiences among males within NI?
ii. An examination of rates and nature of IPV experiences by specific demographics e.g., age, sexual orientation, urbanicity.
iii. What are the rates of a range of mental and physical health outcomes among men who have experienced IPV?
iv. Does the experience of IPV predict poorer mental and/or physical health? Do any specific types of IPV incur a greater risk?
v. Are there any specific subgroups (e.g. age, living location, sexual orientation) of IPV victims that are at great risk for specific mental health outcomes such as suicidality, depression, PTSD etc?
vi. Explore what the potential barriers to help seeking are among this population. Does stigma play a significant role or certain socio-demographic factors e.g., urbanicity?
vii. What type of help was sought (if any)? And was this helpful?

The qualitative interview schedule was also planned to explore participants' experiences in-line with the study's main goals, including more specifically:

i. Individual demographic characteristics of the participant, the context/background of the relationship where the IPV took place, and the type and frequency of IPV events experienced.
ii. Participants' experiences of coping during the period of violence, including which coping strategies were helpful and/or harmful.

iii. If participants disclosed their experiences of IPV to authorities and/or friends, family, and others, and any barriers which prevented them from disclosing (including stigma).
iv. Any experiences of formal or informal support received, how helpful and/or harmful this support (or lack of support) was, and any barriers which prevented the participant from seeking support (including stigma).
v. What were the short-term and long-term impacts of their experience of IPV, including physical health, mental health, and wellbeing.
vi. Understanding support needs and what (if anything) needs to change from a service perspective, society perspective and policy perspective within an NI context.

2.0 Methodology

2.1 Study Design

The ME-IPV Study was designed as a 2-phase mixed methods study. Phase 1 involved a large-scale cross-sectional quantitative survey investigating the experiences and impacts of male victims of IPV in NI through a variety of sociodemographic, mental health, and wellbeing variables. Phase 2 involved a series of one-on-one qualitative interviews conducted with male victims of IPV in NI, conducted to explore the lived experience and nuances of male victims of IPV in their own words.

2.1.1 Definition of Intimate Partner Violence

In concordance with previous research, IPV is defined in this study as any act of *"physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner"* (Breiding et al., 2015, p. 11). It must be noted that this definition differs from other wider definitions of domestic violence but is inclusive for the purposes of defining specific categories of experiences, particularly those associated with coercive control.

2.1.2 Survey Design

The survey was designed to be pseudonymous, meaning that participants were not asked to provide any identifiable information, other than very broad key socio-demographic variables. Additionally, the survey did not contain any text box-based questions which would allow participants to provide written responses. The survey questions were pre-coded, thus participants could only provide an answer from a selection of pre-determined responses, including validated psychometric scales used in psychological research (see Table 1), and the survey did not contain any free text reply fields where participants would provide written responses. This was done to protect participants and avoid self-disclosure, and is a method preferred by governing ethical bodies. The survey content was comprehensive, capturing a range of sociodemographic characteristics, nature and frequency of IPV experiences, other trauma exposure, mental health (anxiety, depression, PTSD, loneliness, suicidality) and physical health (e.g., alcohol use), attitudes and experiences of help seeking for IPV, and a range of wellbeing factors (e.g. resilience).

2.1.3 Interview Design

The interview schedule (Appendix B) was developed based on the findings of the available IPV related empirical literature, as well as the recent rapid review published by the STARC team (McGlinchey et al., 2023), which examined the experiences and mental health impacts of IPV experienced by males. The interview contained a series of open-ended questions which include:

- Demographic characteristics of the participant
- Understanding the context and background of the relationship(s)
- The circumstances surrounding the IPV experience(s) including type, duration, frequency etc.
- Participants' experiences of coping during the period of violence
- Short-term and long-term impacts of IPV – mental, physical, social etc.
- Disclosure, help seeking and associated impacts of this
- Barriers to help seeking and stigma and associated impacts of this
- Moving forward – understanding support needs and what (if anything) needs to change from a service perspective, society perspective and policy perspective within a NI context

Table 1. Measures included in the ME-IPV Study

Area Under study	Assessment Tool	# of Items
Demographics	Common use single items to assess: gender, age, relationship status, sexuality, household population, urbanicity, ethnicity, education, employment status, socioeconomic status by job role, financial situation	11
Intimate partner violence	Replication of Hines & Douglas 2016: Revised Conflict Tactics Scale (CTS2, Straus et al., 1996; victimization items only, 28 items) + 9 items adapted for use with men from the Psychological Maltreatment of Women Inventory (PMWI, Tolman, 1995)	37
IPV relationship context & duration	Single items to assess: relationship context and duration	2
Lifetime trauma	Stressful Life Events Screening Questionnaire (SLESQ, Elhai et al., 2012) +4 items from the Life Events Checklist for DSM-5 (LEC-5, Weathers et al., 2013a)	19
Childhood trauma	Adverse Childhood Events Scale (ACE-10, Felitti et al., 2019)	10
Post-traumatic stress	PTSD Checklist for DSM-5 (PCL-5, Weathers et al., 2013b) +2 dissociation items adapted from the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5, Weathers et al., 2013c)	22
Cognitive processing of trauma	Cognitive Processing of Trauma Scale (CPOTS, Williams, Davis, & Millsap, 2002)	17
Depression	Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001)	9
Anxiety	Generalised Anxiety Disorder Assessment (GAD-7, Spitzer et al., 2006)	7
Loneliness	De Jong Gierveld Loneliness Scale (De Jong Gierveld, 2006)	6
Suicidality	Items adapted from the Ulster University Student Wellbeing Survey	6
Self-rated mental health	Single item for self-assessment of mental health	1
Barriers to help-seeking	Adapted for IPV (from Hoge et al. (2004), Britt et al. (2008) and Brown et al. (2011))	16
Social support	Multidimensional Scale of Perceived Social Support (MSPSS, Zimet et al., 1988)	13
IPV support & disclosure	Single items to assess: support received for IPV, any formal/informal disclosure	4
Physical health	Short Form Health Survey (SF-12, Ware et al., 1996)	12
Diagnosed health conditions	Single item checklist of any diagnosed health conditions	1
Alcohol Consumption	Alcohol Use Disorders Identification Test (AUDIT-10, Babor et al., 2001)	10
General Wellbeing	Psychological Wellbeing Questionnaire (PWS-18, Ryff et al., 1995)	18
Anger	Dimensions of Anger Reactions (DAR-5, Forbes et al., 2004)	5
Guilt & shame	Guilt and Shame Questionnaire (GSQ-8, Hoppen et al., 2022)	8
Emotion expression & flexibility	Flexible Regulation of Emotional Expression (FREE, Burton & Bonanno, 2016)	16
Coping	Coping Flexibility Scale (CFS-R, Kato, 2012)	12
Context sensitivity	Context Sensitivity Index (CSI, Bonanno et al., 2020)	6
Resilience	Connor-Davidson Resilience Scale (CDRS-10, Campbell-Sills & Stein, 2007)	10

Each section included follow-up 'probes' that the researcher could use to seek clarification or to ensure understanding. These were questions such as, "Can you tell me about the relationship you were in when you experienced intimate partner violence? (Probe) How long ago was this?", or "What kind(s) of support did you receive? (Probe) Are there any type(s) of support you now wish that you'd had?". These questions were written to mirror the quantitative information from the online survey, with an eye towards adding depth and nuance in the exploration of the physical/mental health & wellbeing impacts of these experiences.

2.1.4 Ethical Approval & Duty of Care

Ethical approval for the ME-IPV study was sought from and granted by the Faculty Research Ethics Committee (FREC) at Queen's University Belfast under approval #EPS 23_455. The mental health, wellbeing, and safety of participants was a priority for the research team. The online survey was set up so that a participant could 'pause' completion and return where they left off any time within 10 days and should they become distressed while completing, a link to support resources was signposted throughout. These support resources were also included in the survey debrief. A distress protocol

(Appendix C) was also in place should a participant become distressed during an interview and support resources were given at the completion of each interview. Participants had the option to withdraw from the study at any time and for any reason and could request that their data be removed from the study if they wished.

Both in the field and in wider popular culture there exists the belief that discussing trauma/traumatic events, PTSD, and/or conducting research with trauma-exposed or traumatised participants will result in distress and worsening mental health for those participants. However, decades of research have established that not only is this not the case (Rojas & Kinder., 2007; Savell, Kinder & Young., 2006; Shorey, Cornelius & Bell., 2010), individuals have reported that participating in trauma-centric research has had beneficial effects (Owen, Heyman & Slep., 2006; Shorey et al., 2011). A meta-analysis conducted by Jaffe et al. (2015) covering 73,959 participants across 70 studies found overwhelmingly that while trauma research can result in immediate distress, this distress is not severe nor enduring. While the perceived distress was worse in those with a history of trauma or PTSD (especially when data collection was conducted via interview), participants were largely positive about participation, finding value in the process (Jaffe et al., 2015).

2.2 Study Participants

Eligibility criteria for participation in the ME-IPV study included four qualifiers, which were assessed as screener items before a potential participant could access the online survey and were assessed by the researcher prior to scheduling a participant interview. These criteria were:

- Male/identify as male (including transgender male)
- Currently living in Northern Ireland
- Having had the experience of intimate partner violence perpetrated against them
- Currently 18 years of age or older

2.2.1 Survey Sample Characteristics

A total of 115 participants provided their data via the online survey exploring their experiences, including their sociodemographic characteristics (see Table 2 below). While the survey was open to transgender men, all survey participants identified as cisgender men. The mean age of this sample was 45.77 years, with a range of 22-72 years. Participants were more likely to be white (93%), heterosexual (87.8%), not in a relationship (73.2%), living with others (60.8%), have at least a Diploma qualification or higher (64.4%), be economically active (68.7%), and in the top half of socioeconomic status by job role (69.5%). Considering urbanicity, the sample was marginally split between those living in a city (32.2%), a town (37.4%), or a rural setting (30.4%). When asked their financial status compared with how they perceive others to be in NI, a majority were either 'getting by' (46.1%) or 'struggling' (39.1%), with only a small percentage 'doing well' (14.8%).

2.2.2 Interview Sample Characteristics

A total of 10 individuals consented to be interviewed about their experiences. At the beginning of the interview, they were asked their age and if they considered themselves to live in a city, town, or rural setting. The mean age was 44.3 years (range 36-62, SD=6.36), 40% lived in a city, 40% lived in a town, and 20% lived in a rural setting. Full sociodemographics were not asked of interview participants due to the risk of potential identification. All 10 participants identified as cisgender men who had been in heteronormative relationships with their abusive partners, and all specified that they were no longer in these relationships.

Table 2. Demographic characteristics of the ME-IPV survey participants

	N=(115)	%
Relationship Status		
Single or never married	25	21.7%
Married/civil partnership or living w/partner	28	24.3%
Separated or divorced	53	46.1%
Previous separation; living w/current partner	4	3.5%
Widowed	1	0.9%
Other	3	2.6%
Prefer not to say	1	1.9%
Household Composition		
Nuclear family household	13	11.3%
Blended family household	12	10.4%
Single parent household	20	17.4%
Couple w/no children	13	11.3%
Living alone	45	39.1%
Other	12	10.4%
Sexuality		
Heterosexual	101	87.8%
Homosexual	6	5.2%
Bisexual	4	3.5%
Pansexual	1	0.9%
Prefer not to say	3	2.6%
Urbanicity		
City	37	32.2%
Town	43	37.4%
Rural	35	30.4%
Ethnicity		
White	107	93.0%
Black/African/Caribbean	3	2.6%
Asian	2	1.7%
Mixed	2	1.7%
Other	1	0.9%

Table 2 (continued)

	N=(115)	%
Education		
No qualifications	10	8.7%
O-level/GCSE or similar	15	13.0%
A-level or similar	11	9.6%
Diploma	25	21.7%
Undergraduate degree	20	17.4%
Postgraduate degree	18	15.7%
Technical qualification(s)	11	9.6%
Other	5	4.3%
Employment Status*		
Unemployed	16	13.9%
Self-employed	19	16.5%
Employed full-time	56	48.7%
Employed part-time	4	3.5%
Student	5	4.3%
Unable to work	10	8.7%
Retired	11	9.6%
Medically retired	5	4.3%
Other	3	2.6%
Socioeconomic Status		
Higher managerial	15	13.0%
Lower managerial/administrative/professional	44	38.3%
Intermediate occupations	9	7.8%
Small employers/own account workers	12	10.4%
Lower supervisory/technical occupations	17	14.8%
Semi-routine occupations	7	14.8%
Routine occupations	9	7.8%
Never worked/long-term unemployed	2	1.7%
Financial Status		
Struggling	45	39.1%
Getting by	53	46.1%
Doing well	17	14.8%

** Participants were advised to select all options which applied to their situation*

2.3 Recruitment

Due to the sensitive nature of this research, recruitment was managed primarily through the study's stakeholder partners. While the research team had initially planned a social media campaign to assist in recruitment, several factors complicated these efforts:

- Ongoing deterioration of the Twitter/X platform
- Algorithmic suppression of posts on Meta-associated platforms due to 'advertiser unfriendly' terms including "violence"
- Risk to the research team via doxing or other actions due to political views around male experiences of IPV
- Risk to the study's data integrity by bad actors
  - Potential 'ballot-stuffing' of the online survey by individuals misrepresenting themselves as the target population demographic (male, resident in NI, ≥18, experienced IPV) to push an agenda through skewed findings

Ultimately, the research team used a variety of contacts, networks, and assistance from the stakeholder partners to reach potential participants. Digital versions of the recruitment flyers (Appendix D) were used for online dissemination through the above contacts and networks, with copies of the flyers given to organisations with physical office presence. A formal press release was issued on 27 March 2024 by Queen's University Belfast (QUB) explaining the background, rationale, and need for the study, while detailing how an individual could participate if they fit the inclusion criteria.

2.4 Data Collection & Analysis

All quantitative data collection was managed through the online survey platform Qualtrics[11]. The survey was posted to Qualtrics and piloted by members of the research team and lay individuals before being opened on 26 Feb. 2024, and it remained 'live' for 20 weeks before closing on 30 June 2024. Participants could access the survey through the direct link and/or QR code in the recruitment materials, and those who accessed the study were shown the study landing page on Qualtrics, featuring the Participant Information Sheet (PIS). Those who decided to participate continued to the next page, the consent form, and on providing consent, were shown the screener items to assess eligibility. Individuals who did not meet eligibility were redirected to an end-of-survey page.

Participants who met the inclusion criteria continued to the full survey. On completion, they were shown a debrief with the reasons the study was being conducted and what the research team hoped to learn from the study. This debrief also included a list of support resources including mental health services and telephone/text helplines. Support, help, and advice are freely available from these resources and did not require the participant to register/join/subscribe to any services. In total, N=115 participants at least partially completed the survey, with N=69 participants fully completing it, as Qualtrics allows for survey responses to remain 'open' for up to 10 days if paused, meaning a participant may leave and return later to complete the survey.

Potential participants with interest in the study interviews contacted the research team by email to express their interest. The researcher ensured that they met the inclusion criteria (identify as male, at least 18 years of age, currently living in NI, experienced at least one instance of IPV perpetrated against them) before sending the PIS and consent form. Once the participant had returned a signed consent form, they were scheduled for a one-on-one interview via telephone or through Microsoft Teams or Zoom. Participants were instructed that, if meeting online, they did not have to turn on their

[11] *https://www.qualtrics.com/*

camera if they did not feel comfortable doing so and could proceed through the interview using only their microphone. Prior to the interview, participants were provided with a copy of the confidentiality agreement and the researcher read the introductory statement aloud before beginning the recording. Each interview lasted approximately 60-150 minutes, with the researcher asking participants the questions listed in the interview schedule and using the follow up probes to seek clarification where necessary. A total of N=10 participants completed interviews. On completion, participants were given the study debrief and list of support resources. All audio recordings of interviews were transcribed by the research team and the recordings were deleted after transcription.

All data was managed in accordance with Queen's University Belfast policies and procedures for data protection and in compliance with the General Data Protection Regulation (GDPR), Data Protection Act, and all other relevant legislation.

2.4.1 Quantitative Analysis

After the survey closed, data was downloaded from Qualtrics to the statistical analysis software Statistical Package for Social Sciences (SPSS; IBM, 2020) for data cleaning and refinement. General analyses included sociodemographics, descriptive statistics for variables of interest, derivation of psychometric scores, and determining caseness for use with diagnostic psychometric scales. Some variables were used in multiple and linear regression models to explore the relationships between variables of interest (IPV exposure, IPV type) and the outcome (mental health and distress).

2.4.2 Qualitative Analysis

Interpretative Phenomenological Analysis (IPA; Smith et al., 1999) was used to analyse the interview transcripts. IPA is a qualitative approach that provides detailed examinations of personal lived experience (Gill, 2014) by utilizing an idiographic focus which offers insights into how a given person, in a given context, makes sense of a given phenomenon (Larkin et al., 2006; Smith, 2011). The goal of IPA is to explore how individuals perceive themselves and the world around them and is commonly utilized within qualitative research on sensitive topics in relation to trauma or mental ill health (Larkin & Thompson, 2011; Hefferon & Gil-Rodriguez, 2011), including IPV (Reynolds & Shepherd, 2011; Shah et al., 2016). The researcher accomplishes this by abandoning any preconceived notions while analysing the data from a 'bottom-up' perspective employing thematic coding and generating emergent themes rather than exploring pre-existing hypotheses (Pietkiewicz & Smith, 2012).

Researchers use a 6-step process (Smith et al., 2009) for exploring experiential data using the IPA framework:

1. Read and re-read transcripts to get to know the data.
2. Make initial notes to systematically capture observations.
3. Develop emerging (prototype) themes for each case.
4. Search for connections across emergent themes for each case.
5. Move to the next case.
6. Look for patterns across cases.

Using this process, the research team was able to identify emergent themes both within each interview and across interviews. Data was analysed using NVivo 14 (Lumivero, 2023).

3.0 Findings

Why does the number of participants change from start to end?

Missing data is very common in online surveys due to attrition: participants who decide that they would no longer like to continue filling out the survey and exit before completing. This leads to a higher number of participants completing sections earlier in the survey and a lower number of participants completing later sections. In reporting the findings below, tables will indicate the number of participants who completed the section being analysed. Thus, N=(85) would indicate that 85 of the 115 participants completed the section, question, or group of questions and are included in the analysis.

3.1 IPV Experiences

Results are presented below for participants' experiences of IPV. Findings from the survey are presented through tables and figures describing how participants responded to survey items and questions. Findings from the interviews are presented by theme, with each theme introduced by a brief, relevant quote which summarises that theme.

In following the framework for interpretive Phenomenological Analysis, the research team read through each interview transcript and identified or 'coded' themes which described participants' experiences. For example, where a participant spoke about being hit or punched, that quote would be coded as 'IPV type: physical'. 'Meta-codes' were then generated by exploring these codes across all participants, thus all instances of 'IPV type: physical' could be analysed together as the theme 'physical'. Table 3 below shows these meta-codes as the main themes discussed in this report and a full table including the original codes can be found in Appendix E.

Table 3. Framework and meta-codes

Report Themes
IPV Experiences
• Early indications of IPV behaviour
• Sudden change in behaviour
• IPV experiences by type
- Psychological/emotional abuse
- Physical abuse
- Sexual abuse
- Coercive control
- Institutional abuse
Coping
• IPV Impact
- Physical impacts
- Psychological impacts
- Suicidality
- Social impacts
Experiences of Disclosure
Barriers to Help-Seeking
Experiences of Support
Post-IPV Recovery & Meaning Making
Future Recommendations

3.1.1 Early Indications of IPV behaviour

'I look back now and I see the red flags.'

Most interview participants described early indications or initial 'red flags' early on in the relationship which, when they reflected back on that time, were warnings of the more abusive behaviour to come. These manifested as small arguments, minor instances of psychological abuse, irrational jealousy, off-hand comments, reproductive coercion (became abusive when the participant wanted to use a condom), or other behaviour which participants ascribed to a variety of causes including 'pre-wedding nerves', stress, being pregnant, and the strain of physical and/

or mental illness. All stated that these were small and easily ignored warning signs and some stressed that in the context of a new or blossoming relationship, there is a period of adjustment for both partners as they become more comfortable with each other. Only two participants stated they had experienced IPV in relationships prior to the ones they spoke about during the interview.

> "That was like, sure, they're in a bad mood or it was only the one time. And I kind of brushed it off, but a lot of smaller things happened over a long period of time. It wasn't as if it was a massive, crazy insane incident where you would kind of know straight away that that's abuse. It's the small things." (P002)

> "Again at the beginning I was thinking to myself, "What did I do wrong? Did I cause it?" For her to turn like that, I just couldn't work it out in my own head. Was it me or was it just her?" (P008)

> "The courtship, I suppose, was stable enough with the odd instance that probably in hindsight, caused me a little concern but I suppose at that point I was young and naive and thought to myself, 'I'm only imagining things.'." (P010)

3.1.2 Sudden Change in Behaviour

'All of the sudden, it was like a different person.'

Most of the participants described a sudden change in their partner's behaviour as the 'red flag' incidents became worse and/or became a pattern of abusive behaviour. This change coincided with major life events, namely moving in together, getting married, and directly after the birth of children. Some participants theorised that stress or pre-existing mental health problems caused this sudden change, while others speculated that their ex-partners had been hiding or minimising their abusive tendencies to reach certain relationship or life milestones.

> "I really noticed a big change actually, the week we came home from our honeymoon. And I again sent a text message from work saying like, 'We really need to talk.' So I very quickly found that the marriage was quite controlling." (P001)

> "There was never a bad word between the two of us. We never had an argument. We never fought, I don't think, until we got married and once we got married then the violence started." (P008)

> "And then after both of our children were born, the abuse seemed to intensify." (P010)

For several, this led to a period of 'keeping up appearances' as they tried to downplay or hide the abuse from friends, family, and coworkers and others tried to engage their partner in counselling (individual therapy and/or marriage counselling) or take other measures to fix or improve the relationship. Participants spoke about being hopeful that the relationship could be salvaged by both parties making an effort and putting in the work to ultimately make the relationships successful. Unfortunately, these attempts seemed to be fairly one-sided.

> "Purely because I hoped that the marriage would work at some point, that it could be saved, so I never wanted anyone to have a negative view of her." (P001)

> "I felt that, like, right, we'll just keep working on it. We'll keep chipping away and we'll get there and we'll get the relationship in a good place in the end. But obviously it took me a long time to work this out, but I realised, you know, if it's one person working on it properly, then it's not really gonna work." (P005)

During this period, participants said the home environment was quite unstable and some tried to avoid being at home as much as possible or hiding in personal spaces while at home to avoid touching off abusive events. They described a pervasive, anxious state of anticipation during relatively peaceful intervals as they waited for the next 'blow-up', a cycle of violence which rendered their home environment unstable. This stress was compounded by uncertainty around what, if any concrete thing, was responsible for triggering these episodes from their ex-partners. In this way, participants were unable to enjoy any quiet/uneventful time as they were preoccupied with trying to avoid anything which might incite their ex-partners.

> "So yeah, I just had an overwhelming feeling of paralysis in the marriage and just constantly felt on edge, constantly walking on eggshells kind of thing. And almost waiting for the next event to come that would be toxic and harmful and those sorts of things." (P001)

> "So in the end, you know, I felt like I couldn't do anything around the house for fear that she was just going to make comment or go off on one, as it were, so I did feel I had to walk on eggshells about the house." (P004)

> "There was just violence. Her behaviour just became so unpredictable that I didn't know what I was getting up to in the mornings. Was she going to kick off?" (P008)

Several participants highlighted that at the time, they were unaware of the multimodal nature of IPV and conceptualised 'domestic abuse' as purely physical violence. Many expressed that they learned about coercive control, psychological, institutional, and financial abuse only after leaving the relationship. This lack of awareness left many to blame themselves for the actions of their ex-partner as they had no other readily available explanation for the violence they were experiencing in their relationships.

> "I didn't even consider it to be domestic violence or a domestic abuse. You know, I had no idea. There were, there were no, at that time there were no posters up all around the city saying here's what domestic abuse is like." (P005)

> "It was a marriage, and so I didn't know what I was being subject to until the marriage finished. As far as I was concerned it was a normal, normal life." (P006)

Even when physical violence was present, some participants downplayed its severity and others explained that they expected a certain extent of this type of abuse from women and didn't consider it a serious matter (see below).

3.1.3 IPV Experiences by Type

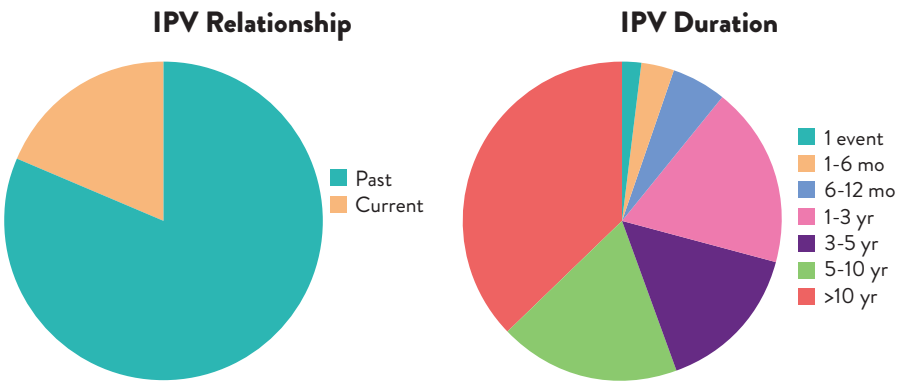
Survey participants were shown a list of events covering different types of psychological aggression (4 items), physical assault (12 items), injury (6 items), sexual assault (6 items), and coercive control (9 items), and asked to endorse all that they had experienced (Table 4). Participants indicated if they had experienced each item, thus their 'score' on this list was equal to their number of experiences for each IPV type and overall. Higher scores for overall IPV and by type indicated higher cumulative IPV experiences. Out of 37 items, the average number of experiences in this sample was 19.74, or 53.35% of 37, with psychological aggression (78%) and coercive control (68.55%) showing higher average endorsements than physical assault (49.75%), occasion of injury (39.5%), and sexual assault (30.33%; lowest average endorsement).

Participants were asked to indicate the context of these experiences, with a majority occurring during a past relationship (81.5%), and in examining the duration of events, 10.9% indicated the duration of events lasted under 1 year, 18.5% over 1-3 years, 15.2% over 3-5 years, 18.5% over 5-10 years, and 37% occurring over the course of >10 years (Figure 1).

Table 4. Descriptive statistics showing IPV experience by type (survey)

	Average number of experiences	Endorsement
Intimate partner violence (total – 37 items)	19.74 out of 37	53.35%
Psychological aggression (4 items)	3.12 out of 4	78.00%
Physical assault (12 items)	5.97 out of 12	49.75%
Injury (6 items)	2.37 out of 6	39.50%
Sexual assault (6 items)	1.82 out of 6	30.33%
Coercive control (9 items)	6.17 out of 9	68.55%

Figure 1. IPV relationship & duration details (survey)



'Everything. All of that and more.'

Interview participants described the types of IPV events they were exposed to, which fell into 17 overall categories (Table 5). While most of these categories could be further collapsed into the main domains of psychological, physical, sexual, and coercive control, the breadth and severity of these experiences are best described by the categories below. For example, a partner manipulating others against the victim and making threats of self-harm/suicide would both be considered psychological abuse but are semantically very different. Additionally, institutional abuse (weaponizing systems/institutions, i.e., the police, the courts, social services) was not captured by the survey scale as it has only recently been considered as an independent category of IPV. As per Table 5 above, these original themes were then coded into the larger meta-themes of Psychological, Physical, Sexual, Coercive Control, and Institutional.

All participants described having false allegations made against them and various forms of general psychological/emotional abuse, which included gaslighting behaviour. A majority of the sample experienced physical abuse and specific aspects of psychological abuse and coercive control; manipulation, monitoring/controlling, social isolation, and the involvement of children (excluding parental alienation).

Table 5. IPV experiences by type (interview)

IPV Type	Domain	N=(10)
False allegations	Institutional	10
Psychological or emotional abuse (general)	Psychological	10
Physical abuse	Physical	8
Manipulation of others against the victim	Psychological	7
Monitoring or controlling behaviour	Coercive control	7
Social isolation	Coercive control	7
Involving children	Psychological/coercive control	6
Institutional abuse	Institutional	5
Financial abuse	Coercive control	4
Parental alienation	Psychological/coercive control	3
Punished for positive events	Psychological	3
Harassment	Psychological	2
Self-harm & suicide threats	Psychological	2
Sexual abuse	Sexual	2
Sleep deprivation	Physical	2
Career sabotage	Psychological	1
Reproductive coercion	Sexual	1

What does 'parental alienation' mean?

This phrase is commonly used in popular discourse when discussing any behaviour by one parent which seeks to undermine, damage, or destroy the relationship between their child(ren) and the other parent. However, there is no single agreed-upon definition for 'parental alienation' in either a research, academic, or legal context, with some criticising and disputing its origins and use. Johnston & Sullivan (2020) provide a review of the issues involved and propose multiple models of codifying this complex phenomena. Participants in the ME-IPV Study have used the term in its popular meaning and so it is used here with that general context in mind.

3.1.3.1 Psychological/emotional abuse: 'Causing great hysteria and confusion.'

General experiences of psychological and/or emotional abuse covered shouting, swearing, abusive language, gaslighting/manipulation of the participant, 'mind games', and blaming the participant for a variety of situations/events (many of which were beyond the participants' control). Specific experiences included manipulation of others against the participant, weaponizing children (or the participants' relationship with their children), 'punishing' participants when something positive occurred in their life, harassment by phone/Internet/social media, threats of self-harm and/or suicide, and an instance of repeated career sabotage. Participants expressed that their interactions with their abusers often left them confused, frightened, or doubting what they knew to be true.

> "And very quickly I got that cold sense in our marriage that actually anything good in my life, whether it was my family or a new car or a pay rise, I was punished for them, so to speak, you know, so that really took the tone for the rest of our marriage." (P001)

> "I would call it narcissistic abuse, which is something I didn't really recognise until after the fact when I started to try and go through counselling and educate myself. And realised a lot of what I've experienced was extreme, emotional and psychological torture." (P002)

> "Or she would shout and scream, or throw things in the house again, if I did something random that upset her, it could even be a simple thing as, I'd get home from work and see the house was untidy and I would just start tidying up." (P004)

> "My family had a family group chat on WhatsApp. And she started putting messages on it, all about me that I was having an affair, I was cheating on her. I was doing this and that. One of my sisters lives in Scotland. She was ringing me going, 'What's going on? What are you doing?' And I went, 'This is all crap.'." (P008)

Participants described engaging adaptive strategies to try and minimise the damage of psychological abuse or to manage the situation once it got out of hand. One participant described secretly giving up drinking alcohol but pretending to drink at gatherings, knowing that their ex-partner would later claim they had said/done inappropriate things while 'drunk' which they knew did not occur. Another participant adopted a mitigation strategy of immediately acknowledging their ex-partner's anger concerning conflicts with others and encouraging action against these individuals to avoid that anger being redirected onto him once the primary conflict was resolved.

Psychological abuse had a detrimental effect on the mental health and wellbeing of all participants.

While direct impacts are addressed in the next section, participants spoke about feeling helpless and/or confused, blaming themselves, being uncertain of their own words and actions or who they could reliably reality-check against. Notably, one participant (below) stated he'd have preferred physical violence over psychological abuse as he felt he could better deal with and heal from physical injuries over the complex process of healing from psychological abuse.

> "I honestly feel I would have preferred if my partner would have beat me every day because I could physically recover from those kind of things and have left my scars, but I have been completely destroyed and my mental health has suffered so much." (P002)

> "You know, the relationship didn't break down, the relationship was toxic for years, and I left. I left that dynamic. I didn't want to be part of [it] anymore because it was killing me. It was genuinely killing me." (P003)

3.1.3.2 Physical abuse: 'Clawing at my neck with her hands.'

General physical abuse covered a range of actions, including being hit, slapped, punched, kicked, shoulder-checked, shoved (into walls, traffic, etc.), threatened with knives, hammers, and other improvised weapons, cut, scratched with nails, and having objects thrown at them.

> "And yet I always seemed to be the one that had money. She always came to me looking more, and she also on occasion, uh, hit me when I didn't do what I was told. So things continued like that and I'll be honest, she would have been violent to me." (P004)

> "She grabs my neck with her hands, long, relatively long nails, and just starts clawing at my neck with her hands. She drew some blood on my face as well, and then just starts whacking me, just slapping me as hard as she possibly could across the face." (P005)

> "Threw bottles at me, threw tins of beer at me, full tins of beer. She cut my nose. She caught me, she hit me in the ears, split me ear." (P008)

> "So the first instance of domestic assault was three days before our wedding in [date redacted], where [she] kicked me in the privates without any provocation. And I was sitting speaking to a couple of friends and she kicked me in the privates." (P010)

Several participants spoke about trying to protect themselves from this abuse without taking retaliatory action against their ex-partners, backing themselves into corners to avoid having to shove their way past their abuser, rushing to get behind a closed/locked door, and pulling away as their clothing was ripped from them. Importantly, participants described the physical size/weight/strength disparities between themselves and their ex-partners, and explained that while 'no one would believe' that their (relatively) diminutive ex-partner had physically abused them, it had happened. This illustrates the internalisation of the popular stereotype that men are tall, strong physical abusers and women are small, weak victims.

> "She was quite a petite lady and quite short, quite slim. I'm almost 6 foot, you know, I work out. Quite physically fit, I look quite imposing, big beard and so on. So, I think for me it was, it was quite difficult to try and rationalise that's what that was, given sort of the physical disparities between us." (P003)

Quite notably, some participants stated that they expected a certain amount of gendered violence. This seemed to imply that either these participants did

not consider specific types of physical violence to be 'actual' physical violence (slapped but not punched, pushed but not knocked down, etc.) or that they were acknowledging that society is more accepting of physical violence from women as they are perceived to be weaker and thus the physical violence is inherently less threatening or less serious and thus to be expected.

> "My ex partner at one point physically kicked me in the back. I've been slapped in the face before, but these are things that are kind of shrugged off like." (P002)

> "Like she used to slap me and push me and but, you kind of expect that from women to an extent." (P003)

> "I didn't go to my GP to report it because it's expected, if your girlfriend's angry at you, she might push you or slap you. Gendered violence is normalised whenever it's women directing against men, you know, it's almost seen as righteous." (P005)

3.1.3.3 Sexual abuse: 'I kept telling her, 'No, don't do this!'

Sexual abuse in the interview sample included sexual contact/activities without consent and instances of reproductive coercion. UK law specifies that as rape can only be perpetrated by an individual with a penis (Sexual Offences Act 2003[12]), women cannot be charged with/prosecuted for rape, only lesser charges of sexual assault or causing sexual activity without consent. However, at least one participant described his experiences as rape, and it must be noted that the legal systems of multiple countries consider that women can commit rape. Reproductive coercion here concerned repeated instances of psychological abuse when the participant asked to use a condom and repeated unprotected sex during a period of time when the ex-partner alleged to have been using contraceptive methods in order to conceive a child against the participant's wishes.

> "She came back early, drunk, and I was asleep in bed. And like basically raped me, like I know you can't really say rape because you know, [...] but at the same time, I kept telling her, 'No, don't do this!'." (P005)

3.1.3.4 Coercive control: 'Like being kidnapped in your own body'

General instances of coercive control included monitoring or controlling behaviour while more specific aspects included socially isolating the participant from friends and family, financial abuse, weaponizing the participant's relationship with their children, and direct parental alienation. A significant portion of monitoring behaviour was described as the ex-partner having/taking control of participants' phones to monitor their social media and communications with others, usually under the justification of the suspicion of infidelity (where there was none). Additionally, participants stated that they were often made to account for their whereabouts at all times but especially during the workday when their job role might not afford them time/opportunity to communicate with their ex-partner.

> "At times, she accessed my phone. At the start of the marriage, she insisted that we knew each other's pin numbers for our phones. So, I mean, she admitted then on several occasions, you know, looking through my mobile phone, when I was in the shower or something like that." (P001)

> "She would call me when I was in the middle of work and demand that I come home. And 'no' would not be taken for an answer and it didn't matter where it was and the job I had at the time I could have been anywhere in the county." (004)

[12] *https://www.legislation.gov.uk/ukpga/2003/42/contents*

Controlling behaviour was a very prevalent experience for the interview sample. Participants described their lives as being controlled both directly (being explicitly told) and indirectly (use of manipulation to force an outcome), frequently being told where they were permitted to go, with whom they could communicate, and when they were permitted to do so. Often participants spoke of 'staying in line' and complying with the controlling behaviour as they would face further abuse if they resisted. As with psychological abuse above, this type of IPV took a heavy toll on participants' mental health & wellbeing, particularly their sense of self and adult agency. For some, this control continued after the relationship ended through various methods of harassment and institutional abuse.

> "And before you know it, you're so low down and so controlled and so craving that person's approval and attention at all times that they have you exactly where they want you. They just control every aspect of your life. It's like being kidnapped in your own body, it's like your soul is being taken from you because physically you're there but emotionally you're completely destroyed and broken." (P002)

> "I felt and I still feel that even after I've left the relationship, I have no power. I have no control over my own life. You know, the abuse is continued. It's in a different fashion." (P003)

> "She then took our keys off me, she says, 'You're not allowed anywhere. You're staying here.'." (P010)

A majority of participants described their ex-partner socially isolating them from their pre-existing relationships and support networks. This was done through psychological abuse and manipulation of participants when they tried to participate in these relationships, control of participants' contact with others, and seeking to 'poison' relationships by turning participants against family/friends, manipulating others against participants, and harassment/abuse of others so that they would avoid associating with participants. These behaviours succeeded in cutting participants off from their support networks, depriving them of any individuals who might have helped them escape the abuse, and generally reinforcing the idea that ex-partner was the only person the participant could trust/rely on.

> "She would have told me that people we knew were talking about me and that really isolated me from those people and gave me a deep sense of insecurity that, who did I have that I could go to, or who did I have that I could confide in?" (P001)

> "I was very isolated from my family. You know my, my relationship with my family was significantly impacted, to the extent that I remember, whenever I left, she told my mum, like basically told them all that I'd been cheating on her for months, which wasn't the case. Told my friends and family that I was having a mental breakdown." (P003)

> "It sounds really stupid because my dad asked me so many questions and says, 'Why did she keep the children from us? Why did you not speak to us? Why?' and I had no answers for him." (P006)

> "People that I've known for years that like, on a Sunday evening we used to go down to the bar and we'd sit and put the world to rights and have a laugh. […] She had actually accused one of the girls of trying to chat me up. Which is absolute rubbish. So that sort of then isolated me from them because if I walked into the bar with her, they wouldn't come anywhere near me. They wouldn't even sit with me." (P008)

Several participants reported experiencing financial control during the relationship with their ex-partners. This was usually done indirectly by either not being in employment or not engaging in realistic spending behaviours, resulting in participants having to put a majority of their funds towards household/child expenses. However, some participants described direct financial control as ex-partners demanded their funds for personal use. Participants spoke about wanting to leave the relationship but being 'trapped' by their financial obligations to the household and having no funds to use on an exit strategy. This aspect of control often continued after the end of the relationship through court costs, fees associated with child custody, and other aspects of institutional abuse explored fully in the next section.

> "She had refused to work and refused to do any steps to get work and I think when people think of financial control, at least, certainly whenever I used to think of financial control, I would think of giving your money over to somebody else and spending it and doing what they want with it. But in this case it was just because we lived together and we had [a child], that all my income was tied up. [...] That left me feeling very trapped and very isolated." (P003)

> "She also, so not directly controlled money, but she would get herself into a situation and I would feel obliged to get her out." (P004)

> "It then started to become a bit of a joke between me and my friend. I said, 'It's coming up the 25th of every month.' If I didn't give her my pension to pay her mortgage on [details redacted], that was her started. And it was just non-stop until she got the money to pay her bills." (P008)

One of the most affecting aspects of coercive control was the involvement of children by the ex-partner, either using them/their relationship against the participant or through direct parental alienation. This included psychological and verbal abuse of children if they agreed with or seemed to sympathise with participants, withholding access to the children (sometimes in violation of court orders), alleged physical abuse/neglect of children by the ex-partner after the end of the relationship, and in one case, illegally removing the children from the UK. Parental alienation included the above but also sustained campaigns to 'poison' the children's relationship with participants and in one case, false allegations by a child against a participant which have since resulted in a perjury charge.

> "They know like. They know the only thing that hurts me. And the only way they can hurt me now is through my children. [...] They manipulate every part of my ability to be able to see them, to have a relationship with them, my rights as a father even to have information about their school and how they're doing." (P002)

> "After we separated, my ex-partner used my daughter quite badly, I think to get back at me, my daughter ended up self harming. You know she has bruises and stuff in her arms from self-inflicted [injuries] and whatnot. I had ended up in family court. I'm still in family court." (P003)

> "That's when she started getting the daughter in fold by getting the daughter to ask me to leave because her and her mum would have a better relationship." (P007)

> "She started on the child, 'How dare you! You treat me like dirt!' And then she turned around and says, 'It's your daddy, it's his fault!'." (P010)

3.1.3.5 Institutional abuse: 'The system has left her still in control of my life.'

Institutional abuse covers the weaponisation of the institutions of the state (and lesser authorities) against the participant, which here included more general forms of abuse including harassment through solicitors, manipulation of institutions to control the participant, retaliatory and punitive use of the courts, family courts, police, and social services, and perjury in court and on court documents. Importantly, institutional abuse dovetailed with financial abuse, as participants did not have access to public legal funds and have had to pay out-of-pocket for every aspect of legal involvement. Many described constant and/or repeated delay tactics, seemingly to make 'fighting back' prohibitively expensive for participants. All participants described significant issues with the courts/legal system when engaging with male victims of IPV and this is explored fully in the section on disclosure.

> "It was very calculated to be as destructive as possible. And the expectation was that you just get on with it and you forget about it. You know, there was no signposting the support. There was no real acknowledgement that she was an abusive partner and she was using the court processes to be abusive." (P003)

> "She withdrew them all every time that she went, usually after it cost me £2000 in representation fees at various hearings that have been adjourned by her legal counsel that were getting legal aid and could adjourn all day long and just play with government money to do it. It's on and on this has gone. No ending in sight." (P004)

> "The services were weaponized, she weaponized them against me every step." (P009)

All interview participants reported that their ex-partners had made false allegations against them. While these allegations were, in some cases, made to friends/family/others in an attempt to manipulate, control, or isolate the participant, they were also made to police, courts, social services, and support/charity organisations. Allegations centred on accusing the participant themselves of IPV, physical/sexual abuse of children, child neglect, stalking/harassment, criminal behaviour (drug dealing, public indecency, paramilitary involvement), alcohol/substance misuse, and being unfit due to mental health issues.

> "I've had my daughter taken away from me twice. I've been accused of sexual assault. I've been accused of domestic violence. I've been accused of stalking. Like I had everything thrown at me [...] anything that she thought could stick." (P003)

> "On being told about the allegations in an interview with the police, I said no, 'These allegations are false. They're designed to pervert the course of justice, and she's making them maliciously because I have phoned the police for help.'." (P004)

> "I've not done nothing and that's exactly what it was. He [police officer] said, 'I've got no times. I've got no date,' he said, 'These are just random allegations,' I said, 'Well, why are you even listening to it then?'." (P006)

> "Days after she got the child taken off me, the whole family got, in the same few weeks, my house and my family's house were raided for illegal firearms. Tactical support group, armed response, CID. Loads of stuff, loads of cars, all looking for these [alleged] illegal firearms, stolen equipment." (P009)

Participants spoke about their experiences of IPV being compounded by the stress of being accused of things they did not do and having to spend considerable amounts of time and money attempting to fight false allegations to clear their names. Some

participants were (legally) successful in this and others were not. While this will be explored in more depth in later sections, participants expressed that their experiences and identities as victims were 'overwritten' as perpetrators by a system they described as designed to believe their ex-partners while dismissing their own claims and evidence, simply on the basis of gender.

> "I've had so many false allegations thrown against me and I've had to prove that they're not true. It's not a case of they've had, they've not given any shred of evidence. They've treated it as though what she's saying is true until we prove otherwise." (P002)

> "The social worker basically said, "[Child's] mum told me you were abusive. And I believe her. So you need to stop what you're doing and basically get your act together." And to me, that kind of felt like, what the h***, you know? I had left an abusive relationship." (P003)

> "Since I have moved into the flat here, I've had 79 police visits. I have been arrested here twice. [...] She had said that I was making false allegations to police, and was harassing her. And turns out that when police did their investigation, that her brother was making them on her behalf and then projecting that back on me." (P010)

In explaining about the false allegations they were dealing with, participants stated that once allegations were in place, they were subsequently used by ex-partners as justification for further allegations and further institutional abuse, both within the original institution and with additional institutions/authorities. For example, counter-allegations of IPV which were investigated by the police but for which the PPS did not bring a case could then be used with social services to further 'smear' the participant as an unfit parent, and those allegations made to social services could then be used in family court in petitions to deny visitation/custody, etc. These examples are described here in the abstract and without quotations to avoid potentially endangering any active court cases.

3.2 Coping

Survey participants completed a measure asking them several questions about their coping strategies and ability to change coping strategies when one was found to be ineffective (Table 6). This ability is reflected as 'coping flexibility', which plays an important role in posttraumatic resilience. Higher scores are indicative of better coping flexibility and the average score in this sample was 17.63, meaning that most scores fell into a moderate-to-high range of ability. The Coping Flexibility Scale – Revised (Kato, 2020) has 3 subscales; Abandonment (the ability to abandon unsuccessful coping strategies), Re-coping, (the ability to switch to a different strategy), and Meta-coping, (the ability to monitor/provide feedback on the coping process). In this sample, average scores were lowest for Abandonment, higher for Meta-coping, and highest for Re-coping. The average score for resilience in this population fell into the moderate range (Table 5)

Table 6. Coping flexibility & resilience scores (survey)

	Range	Average score
Coping flexibility	0-35	17.63
Abandonment	0-12	5.39
Re-coping	0-12	6.16
Meta-coping	0-12	6.09
Resilience	0-40	20.45

'I needed to feel some kind of comfort.'

Interview participants were asked about their strategies for coping with their experiences of IPV, specifically: what strategies they used, what strategies were particularly helpful, and if any were particularly unhelpful/harmful. Some described adaptive protective strategies in their interactions with their abuser (immediately retreating from conflict/confrontation, deflecting blame onto an external party, etc.), spending more time in the workplace, escaping the situation, room, or house, and exercise (especially walking).

> "My coping mechanism was, 'Get out, just escape. Go for a drive. Go to a different room,' and she followed me to that room, which happened a lot. Then I would leave the house." (P001)

> "I find exercise helped me so much because it relieved a lot of that stress. It got me out of the house meeting other people. You know, it was almost like the only positive thing that I felt could help me at all." (P002)

> "So then I had to quickly realise, I had to quickly go back in my box, stay quiet and let it ride out." (P009)

Others spoke about either having no coping strategies, or strategies which were unhealthy or harmful. These included shouting or 'raging' while alone, isolation, maladaptive eating habits, self-harm (hair-pulling), alcohol misuse, and internalising, ignoring, blocking, and 'pushing down' negative emotions. Many participants who shared about their unhealthy coping strategies stated they understood that these methods were potentially harmful but that they did provide some measure of coping in the context of the abusive situation.

> "I drank a lot more than I should have in the immediate short term. So it was almost a kind of coping mechanism and not a very good one. [...] I can really see how they, someone could spiral into alcoholism with that because it's just, it numbs that, the sadness, the depression and helped me kind of nod off and stuff." (P002)

> "So in terms of like coping mechanisms, I guess ignore it, is the big one. You know bottle it up, push it down, forget about it." (P003)

> "I don't know if I did cope, if I'm honest. I didn't have work to fall back on because I was suspended from work. [...] I basically just sat on my dad's sofa." (P004)

3.3 IPV Impact

3.3.1 Physical Impacts

Survey respondents were asked about their general physical health and the extent to which health problems affect their daily life, including if they experienced/had been diagnosed with any physical health conditions (Table 7). A majority of the sample indicated that they were suffering from mood disorders/emotional conditions (61.1%), nearly half were experiencing stress-related disorders (43.5%), and over a third were troubled by musculoskeletal problems/injuries (37.6%).

Table 7. Physical health conditions (survey)

	N=(85)	%
Musculoskeletal problems or injury	32	37.6%
Mood disorder or other emotional conditions	52	61.1%
Stress-related disorder	37	43.5%
Eye/sight problems	11	12.9%
Ear/hearing problem	15	17.6%
Nervous system problem	5	5.8%
Gastro/Digestive problem	17	20.0%
Skin or subcutaneous tissue problem	20	23.5%
Respiratory problem	17	20.0%
Circulatory problem	12	14.1%
Hormone, nutritional, or metabolic problem	4	4.7%
AIDS or HIV infection	1	1.1%
Alcohol or drug problems	13	15.2%
Cancer (any type)	5	5.8%
Other	11	12.9%
None	7	8.2%

In exploring the impact of these conditions on daily life (Table 8), the average physical health score in this sample was 44.65 and the average mental/emotional health score was 32.72. A physical health score <50 is indicative of a significant impact of a physical condition and a mental/emotional health score <42 can be interpreted as clinically relevant distress (Ware et al., 1995), indicating that the survey sample showed profound physical and mental/emotional impact from their conditions.

Table 8. Physical & mental/emotional health score (survey)

	Range	Average score
Physical health	25.40–58.20	44.65
Mental/emotional health	17.83–49.11	32.72

Survey participants were asked about their alcohol use. Those who answered that they did not drink (never drank or used to drink but no longer do) continued to the next survey section while (N=62) answered questions about their use and consumption (Table 9). When using the Alcohol Use Disorder Identification Test (AUDIT; Babor et al., 2001) scores between 1-7 suggest 'low risk consumption', scores ranging from 8-14 suggest 'hazardous/harmful' consumption, and scores >15 are indicative of 'likely alcohol dependence'. The average score in this sample is 9.13, falling into the 'hazardous' range, with 10.4% (N=12) of this group scoring in the 'likely alcohol dependence' range.

'Sitting there and dying on a sofa'

Interview participants described a range of physical impacts including cognitive impairment or 'brain fog', nightmares and sleep disturbances, and a range of medical conditions which had been brought on or exacerbated by the stress of their experiences (vision issues, fatigue, high blood pressure, tinnitus, obesity, arthritis, weight loss, memory issues). A few participants spoke about no longer being able to take exercise, either due to a stress-related decrease in motivation or financial concerns, and several reported an associated decline in hygiene motivation and healthy eating habits. These outcomes were often described as part of an overall pattern of the effects of their experiences on their physical health and not as independent/unrelated health concerns.

> "A lot of confusion too, I think is something that I experience a lot just because of the brain fog, it generally feels like there's just, there's a cloud in the brain at all times and I can't kind of think properly, remember things properly or just string a sentence together at times. It genuinely feels as though my brain has just been broken." (P002)

> "Probably for the first six months or so, I struggled with nightmares. [...] I would have quite a lot of waking in the night and the first thing that I had to do was turn on my bedroom light to make sure she wasn't in the room. [...] And then it took a few minutes to calm down again and be like, yeah." (P001)

> "I just don't have the energy or the income or the time to manage it anymore. I'm constantly fatigued, like constantly fatigued." (P003)

Table 9. Alcohol use & consumption (survey)

	Range	Average score	N=(62)	%
Alcohol use score	1-36	9.13		
Low risk consumption			32	51.6%
Hazardous consumption			18	29.0%
Likely alcohol dependence			12	10.4%
None			7	8.2%

Importantly, several of these physical impacts have known associations, i.e., sleep disturbances/deprivation are well-established contributors to overall poorer physical health and can exacerbate other health conditions, including cognitive impairment, and adverse changes in diet/exercise can lead to a range of cardiovascular outcomes.

3.3.2 Psychological Impacts

Survey participants were asked what traumatic/stressful childhood and lifetime events they had been exposed to, including their experiences of IPV. The mean number of childhood traumatic events was 3.56 (SD=2.83) and the mean number of lifetime traumatic events was 5.70 (SD=3.49). It is important to note that on a population level, NI has a higher rate of cumulative trauma exposure when compared to similar countries (Ferry et al., 2013; Redican et al., 2022) and that while cumulative trauma exposure is associated with an increased risk of posttraumatic distress/PTSD, trauma-exposed does not necessarily mean an individual is traumatised because of the exposure (Robinson et al., 2022; Spikol et al., 2024b).

Participants' cognitive processing of their trauma (CPOTS; Table 10) was explored using 5 subscales. In this sample, average scores were lower for the positive aspects of processing (Positive Cognitive Restructuring and Resolution/Acceptance) and higher for the negative aspects (Denial, Regret, and Downward Comparison). This indicates that in this sample, participants were more likely to be in denial, have regret, and make downwards comparisons about themselves than positively processing their trauma or experiencing feelings of resolution/acceptance.

Table 10. Cumulative childhood & lifetime trauma, cognitive processing of trauma (survey)

	Range	Average score
Childhood traumatic events	0-9	3.56
Lifetime traumatic events	0-14	5.70
Cognitive processing of trauma		
Denial	0-24	10.28
Positive cognitive restructuring	0-18	6.96
Resolution/acceptance	0-24	9.95
Regret	0-18	12.01
Downward comparison	0-18	12.60

Survey participants were shown 3 measures used to assess distress/symptomology associated with anxiety, depression, and PTSD (Table 11). These measures are often used by clinicians to assist in diagnostic assessments and have a built-in 'clinical threshold', meaning a score above which an individual would likely be diagnosed with a mental illness. For the GAD-7 (anxiety) and the PHQ-9 (depression), this clinical cut-off is ≥10, meaning that a score at/above 10 is a likely indicator of anxiety or depression. In the absence of a formal assessment, this is referred to as 'probable caseness', as the individual would likely be diagnosed with the disorder if they were assessed by a clinician. The clinical threshold for the PCL-5 (PTSD) is ≥33. As is evident from Table 11, the average score for all 3 measures exceeds the clinical threshold for each, resulting in a very high prevalence of anxiety (58.8%), depression, (71.7%), and PTSD (67%) in this sample.

What is a Regression Analysis?

A regression analysis takes a set of factors and explores the extent to which they contribute to or 'predict' the outcome. Here, the analysis was used to determine if exposure to each IPV type: Psychological, Physical, Injury, Sexual, and Coercive Control, 'predicted' higher scores associated with anxiety, depression, PTSD distress, loneliness, and overall mental/emotional health. A regression model also shows the contribution of these factors to outcome scores, meaning how much each type of IPV contributes to increases in the mental health outcomes. Using regression models made it possible to determine which IPV types had the greatest effect on mental health.

Table 11. Mental health scores and caseness prevalence

	Range	Average score	N=(85)	%
GAD-7 score	0-21	11.79		
Anxiety caseness			50	58.8%
PHQ-9 score	0-27	15.27		
Depression caseness			61	71.7%
PCL-5 score	0-77	41.07		
PTSD caseness			57	67.0%

Several multiple regression analyses were run to explore the relationship between IPV type and mental health in survey participants (see Appendix F for the full statistical output). Regression models run for anxiety and loneliness were non-significant, meaning that there was no statistically significant relationship in this sample between IPV type and likelihood of higher anxiety or loneliness scores. Further regression models showed that participants who experienced Psychological and Coercive Control were more likely to report symptoms of depression, PTSD distress, and overall poorer mental health. There was a direct, linear relationship between overall IPV exposure and anxiety, depression, and PTSD distress, meaning the more IPV exposure a participant experienced, the worse their distress was likely to be.

'Paralysed in my own body'

Interview participants described a wide range of psychological and emotional impacts due to their experiences of IPV. Many discussed the emotional impact in terms of feelings of enduring fear of their ex-partner, grief from the inability to see their children, a sense of hopelessness, and strong feelings of injustice which have changed how they perceive the world.

> "When I talked to my therapist about it, the therapist was like, 'Yeah, that's very f****** obvious, you're scared of this woman. You're scared of what she can do to you.'." (P003)

> "The way they [counsellor] described it is, 'You have to deal with the idea, the grief over your perspective of fairness, because what's happened to you,' [...] they're saying, 'What's happened to you is so unfair that your entire world has changed.'." (P004)

Some participants spoke about how their sense of personal security and trust in others has been radically damaged, describing elements of hypervigilant behaviour consistent with posttraumatic symptomology. While they expressed levels of paranoia which in any other situation might be taken as a potential sign of mental illness, these participants acknowledged that their behaviour would seem extreme outside of the context of their experiences of abuse.

> "I can't still get over the fact that, who am I physically dating? And this has messed up relationships. Full stop. So massive issues around trust and I question everything and everybody all the time. I can't just take people on face value." (P006)

> "There's nights I'm coming up the road, and I'm thinking, I need to watch them alleyways in case she's standing in an alleyway with a knife because I wouldn't put it past her. Or she'd maybe pay somebody to come and attack me." (P008)

> "I have a ritual going to bed and [the] chain has to be in the door, check the door's locked, check that the windows are closed. I'm in a third floor apartment. So I know that she can't get in. [after waking from a nightmare] I check the very wardrobe to make sure she's not hiding in the wardrobe. And that's quite disturbing and distressing, but I just, I feel that kind of, I've checked that she's not there, you know, you have to actually bring yourself back into consciousness again and know that she's not there." (P010)

Others stated that the impacts of their experiences influenced how they saw themselves and understood themselves in terms of others and their place in the world. They described not living 'just surviving', feeling like they weren't themselves, that they'd lost everything about their life which was previously meaningful, and a significant loss of agency and self-worth.

"You get rid of the kings so you can have a say over your own life, you know, have a democracy so that you have agency. I don't have agency, you know, at the minute, my life is dictated by somebody I left six years ago. The impact that has on, I think one's self-esteem and confidence and just capacity to be, I think it's profound." (P003)

"So the answer to your question is, on a daily basis I'm surviving and I'm doing no more. I'm making no progress. I'm ticking over and then I go home to an empty home." (P006)

Most of the interview participants discussed symptoms of distress and mental illness which they had been managing under the care of their GP, various types of counselling, and formal mental health care. Participants shared that these diagnoses were mostly anxiety (including panic attacks), depression, and PTSD, but others spoke about a more general sense of poor mental health and wellbeing. In a few cases, participants described pre-existing mental health issues (PTSD) which had been exacerbated by the stress of their IPV experiences.

"I mentioned anxiety and depression that I have now, that's because of what's happened to me, that's not, I wasn't born with it." (P002)

"I was diagnosed with PTSD as a result of the relationship. I haven't had a panic attack in a good while, which is good, but I did have panic attacks for a while. I'm on fluoxetine currently to help manage depression and anxiety. I got agoraphobic. You know, at the minute, my mental health is quite poor." (P003)

"In the long term, I have experienced mental health problems, depression and anxiety. These all have been down to, looking back on it now, with time and space to reflect on it, I honestly think that it is solely down to the domestic abuse." (P010)

One participant shared a very illuminating insight on the nature of depression and the stigmatic beliefs he had held about it prior to his experiences. Once he began to experience symptomology, he reached a more complete understanding of what depression is and the impact it can have on life.

"I was a strong believer that depression didn't exist years ago. I'm like, 'You're not depressed. You're just being weak. You need to find a way out of it. OK, someone died. They're not going to come back. You need to continue with your life.' I was taken for a reality check. I had to go on antidepressants, beta blockers, had to give me some of the stronger sleeping tablets." (P009)

Several participants spoke about the experience of mental and emotional 'paralysis', a feeling of not being able to make decisions, start/finish tasks, meet deadlines, make personal or social plans, or engage in leisure activities. It is clear that the stress of their experiences has caused problems with their executive functioning, though none have undergone any formal medical investigation into this outcome and many linked it directly to their poor mental health. This paralysis has complicated their professional lives, with a few participants sharing that they have taken a health leave of absence from employment.

"I suppose I can be very overwhelmed at the smallest of tasks now, which is difficult and I think it's just that sort of paralysis, crippled sensation that this all leaves you with. And yeah, I mean, even something as simple as, you know, fulfilling an Amazon return. [...] Something so simple, just seemed overwhelming, and there's actually things that I've bought on Amazon and I've missed the return mark of like 30 days because I just can't bring myself to do it." (P001)

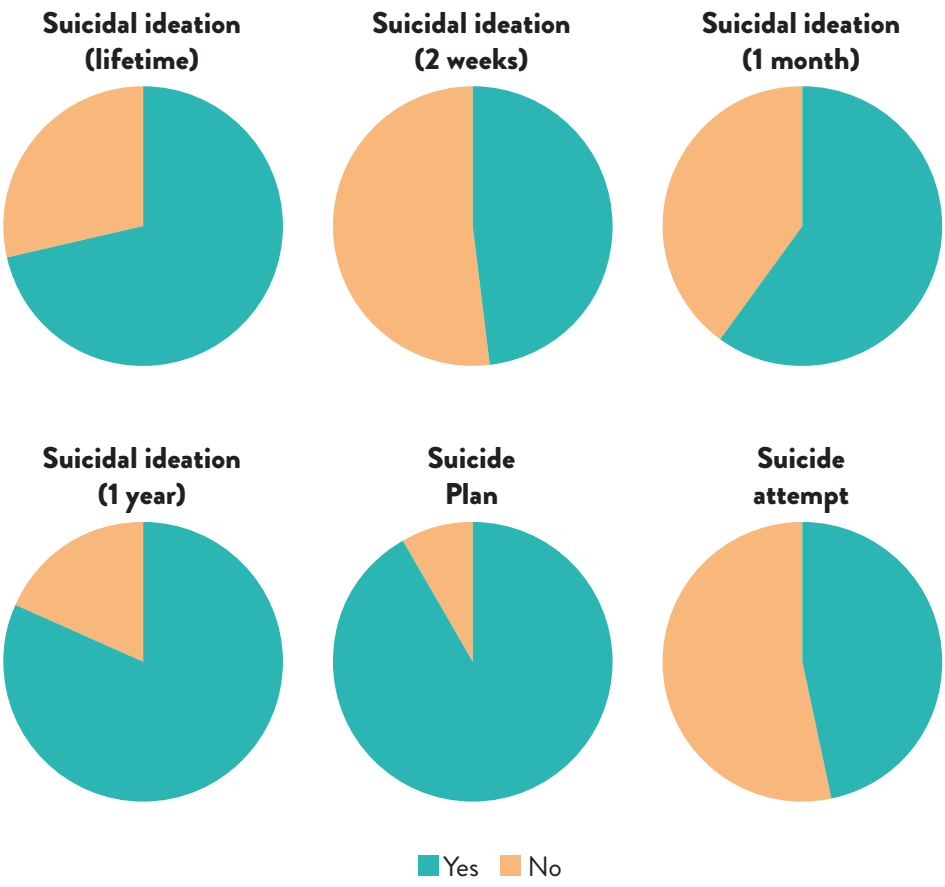
"I can't walk into a pub or anything. I can go out for a meal with someone, but walk into the pub, even arranging something, I just seem to have lost the ability to do everything, which is pathetic because I'm a grown adult. All you gotta do is just arrange it, right? I just can't be bothered to make that effort to get it moving." (P006)

"I'm suspended from work so if I didn't have my daughter, I would literally do nothing. I wouldn't know why I didn't." (P009)

3.3.3 Suicidality

Survey participants were asked if they had ever in their lifetime had thoughts of ending their life and N=60 (71.4%) indicated that they had (Figure 2). These 60 participants were then asked if they'd had these thoughts in the past 2 weeks (yes; N=29 (48.3%), 1 month (yes; N=36 (60.0%), and 1 year (yes; N=49 (81.7%). Further, they were asked if they had ever formulated a plan to take their life (yes; N=55 (91.7%) and if they had ever made a suicide attempt (yes; N=28 (46.7%) per Figure 2 below. As with trauma exposure, it is vital to mention that NI

Figure 2. Suicidal ideation, plan & attempt (survey)



has a historically high rate of suicide/suicidality when compared with other similar countries (O'Neill & O'Connor, 2020).

'I could just not be here.'

Multiple interview participants discussed feeling suicidal, formulating a plan, and/or making one or more attempts to take their own life. For them, suicide was described as an escape from the pain of past IPV experiences but also from the certainty of continuing abuse from their ex-partner and weaponized institutions. These experiences were described alongside feelings of hopelessness, loss of agency, and depression. In the interest of participant safety, all participants discussing suicidality were asked if they were currently experiencing thoughts of self-harm and/or suicide and fortunately, all stated that they had been able to seek help through a variety of support measures. If any participants had expressed current suicidal ideation, the interviewer would have ended the interview and engaged the safety protocol.

> "From having my life sort of on track and I knew how to cope and knew what I was doing and everything else, to have it then sort of all ripped away from you and you're back in that dark hole again, not knowing what to do. And I did get a point where I did tell him [GP], I said, 'Look, I feel like just putting a rope up and that's it.'." (P008)

> "I was like, I could just not be here. I have to continue to suffer not only from [ex-partner], from the social services, from the police and family courts, from everything. Anyway, I realise, 'You need to be here for [child].'." (P009)

> "The abuse had got so, so bad that I actually had a rope tied to hang myself that day. And I knew at that point, my eldest girl was [age redacted] and I knew that she would be the one coming home from school to find that and that's the thing that pulled me back. [...] I don't want her living with that for the rest of her life." (P010)

As with depression above, two participants said that their experiences have brought about an understanding of what suicidality is and how someone might experience it, whereas before they'd had stigmatic beliefs about the issue.

> "I do have an understanding now why people do it. I can see, but it's not justified, but I can see the line that people take and [...] justify in their own mind why they do it. Before, I used to think, 'You inconsiderate bastard. What the f*** is wrong with you?' But with everything that's going on, had I have been a weaker mental person, who knows?" (P006)

> "My whole life, as I said about depression, I've always believed suicide is a very selfish act. Very selfish act. I've had people try to explain how, 'You don't understand, it's the chemical reactions or imbalances that make people do it,' and I'd think no, they're not, it's selfish. And then there was a day I walked into the kitchen and I seen the Stanley knife." (P009)

3.3.4 Social Impacts

'Now they stare at me.'

Some of the significant impacts of IPV experiences manifested in the way interview participants interacted with others and how they perceived themselves on a social level, with the most frequently mentioned outcome being social isolation. For some, this was the aftermath of social isolation being used by their ex-partner against them, but many disclosed they had self-isolated due to poor mental health and feelings of paralysis/lack of motivation. For some, this included having trouble dating, starting a new relationship, and in one instance, the loss of a

relationship due to the ex-partner's harassment and abuse of their new partner.

> "I love the colleagues that I work with. And I was almost afraid to lose that routine because it was almost like the one steady thing that I had." (P001)

> "I've always been like a very outgoing person and I've always liked to be with friends and joking, but it's, I found myself shrinking so much away from who I always was." (P002)

> "I'm in a situation where I work alone and I live alone and yeah, I'm still quite isolated. So and I can't seem to get back into socializing and doing stuff. I'll go out for a drive by myself. I'll go out and, you know, visit people, but actually going out and socialising, it's just, I can't do it. I can't get back into it." (P006)

In discussing the social impacts of their IPV experiences, some participants described the damage to their reputations and their employment prospects alongside feeling 'criminalised' due to their ex-partners' false allegations and manipulation of others. The fact that they had been victims of abuse was not considered by others and left them feeling twice victimised. As NI is not a large country in terms of geography and population, there was concern that the damage to their reputations would be lasting, if not permanent.

> "I used to have relationships with some of the other parents [at school] and now they stare at me, you know, because it's much, much easier for a petite woman to make the case that she was domestically abused than it is for someone like me to make that case." (P003)

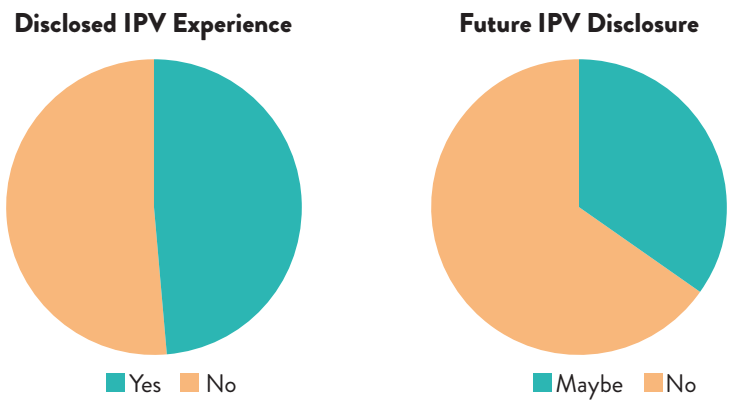
> "I'm a law abiding citizen though, I've never been on the wrong side of the law in my life, and now I feel like I'm living a life like a criminal." (P006)

> "As I say, when this all first came out, I'd been branded a paedophile and everything. [...] Just didn't feel easy even though I was proved innocent, but still didn't feel easy walking about in my own home town. So just basically had to move from, away from my family and all." (P007)

3.4 Experiences of Disclosure

Survey participants were asked about their experiences of disclosing their IPV experiences to the police or other authorities (Figure 3), with 48.8% answering that they had and 51.2% answering they

Figure 3. IPV experience disclosure and future disclosure (survey)



had not (N=(84)). Those who did not disclose were asked if they intended to do so in the future, with 34.9% selecting 'Maybe' and 65.1% selecting 'No'. In exploring disclosure rates by urbanicity (Figure 4), participants living in cities and towns were less likely to disclose, while participants living in rural settings were more likely to disclose.

'Things...things aren't good.'

Interview participants were asked if they had disclosed their experiences of IPV to people in their lives, including family, friends, coworkers, etc. Experiences of disclosure to family members were mixed, with some reporting family who did not believe that they had been being abused or who sided with their abuser, while others embraced and supported participants through the dissolution of the relationship.

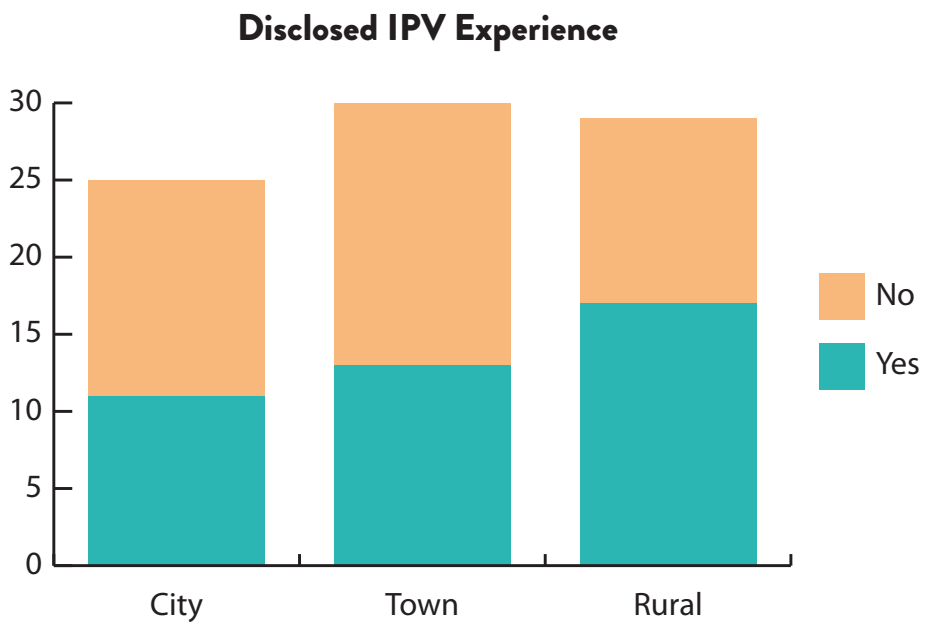
Participants' experiences of disclosure to friends were roughly the same, ranging from disbelief to wholehearted support. One participant, returning to work after being physically assaulted by his ex-partner during his lunchbreak, disclosed to a coworker who had partial knowledge of the situation.

> "So I think the first time I disclosed anything would have been after the death of my parent. The first person would have been a sibling that I disclosed to. They were in complete shock because I tried my best to hide everything." (P001)

> "I even had my own friends questioning me saying, 'Well, there's no smoke without fire, mate. You must have done something.'." (P006)

> "One of my friends, she kept coming up to me and saying, 'What's happening with you?' She'd

Figure 4. Disclosure rates by urbanicity (survey)



seen the cut across my nose. She'd seen the one on me ear and she was like, 'What is going on?' And then when I finally told her, she said, 'I knew that was happening.'." (P008)

"My mom was extremely shocked, almost 78, and that's not something that she would have been ok with. She was basically like, 'Why? Why didn't you leave sooner?' I told her I stayed as long as I could to protect the children." (P010)

Most participants discussed the process of disclosing their experiences of IPV to the police, and for some, this resulted in positive outcomes (non-molestation orders, ex-partner removed from shared accommodation, arrest and investigation, case brought against the ex-partner by PPS, etc.). Two participants spoke highly of individual police officers who took the time to signpost support, give advice, and were generally supportive throughout the process. For these participants, initial contact was made with the police to establish a 'paper trail' of evidence and instances of IPV or as they were being physically threatened and/or attacked by their ex-partner.

"I then decided to make a formal statement, but it was actually the police officer who had spoken to me a couple of times who said, 'You know, you really should consider this.' And she mentioned this new [coercive control] law to me." (P001)

"She had phoned the police but what she didn't know was I had been on the phone to the police to get advice the night before and they had given me a reference number. And when the police called, I give him the reference number and he was able to check that, yes, I had been in contact about her behaviour looking for advice." (P008)

"I was told that if I disclosed that she would make things, that things would get worse. But after coming out of the relationship, everything was reported to police. Police have investigated and there's now a criminal case." (P010)

However, many participants found the police either initially quite dismissive of their experiences, or dismissive/unbelieving throughout the entire process. They described reporting IPV incidents to the police only to later find those incidents were not recorded, being made to feel that they were just 'being dramatic' or being told to 'man up', accused of being misogynists, or accused of lying. Participants stated that their belief was that even when police evidence existed detailing their ex-partner violating the law, they were told by either police or the PPS, without explanation, that no investigation would take place. This was a very detrimental experience for participants, who explained how they overcame significant fear and distress to disclose, only to be met with apathy or outright hostility.

"The police officer who was a Sergeant, a Detective Sergeant, turned around in the interview and said, 'Well, I believe her.' And I said, 'Well, what makes you believe her?' 'Oh, I just do.'." (P004)

"The police were hopeless, man. I mean, they literally just looked at me, they saw I'm 6'. She's 5'2 and they were just like, 'You're claiming she's done this? Get over yourself, mate. Like you should be able to handle yourself.'." (P005)

"The police officer that [first] dealt with it was an absolute shambles. He stood in the inquiry office in [location redacted] here, he says, 'Catch yourself on, Mr. [P010]. Do you expect me to believe that a big feller like you was abused by your wife?' And I just, I turned and walked out." (P010)

Throughout their experiences of non-police disclosure, whether to other authorities, organisations, or individuals in their lives, one omnipresent stressor was the experience of not being believed or the fear that they wouldn't be believed. At the beginning of each interview, the interviewer stated to the participant that they believed them, and that the participant didn't need to focus on proving or justifying anything to the interviewer, only on their experiences and the impacts of those experiences. Several participants stated that was the first time anyone had said that to them, or believed them without substantial proof, evidence, or documentation. One participant likened his own situation to a form of gaslighting, whereby he knew what he had experienced but when he asked for help, those he disclosed to had denied his experiences and insisted that he himself was the abuser.

> "At the very start there, you said you believe me, like I think that's the first time I've heard someone ever say that. I think generally, even when I went to the police and I went to social workers, I don't think I've ever heard anyone say, 'I believe what you're saying,' and I've had to prove it." (P002)

> "I'm pretty solid looking, solid guy. And she's like, a 5'2, wee woman. And when you tell people, 'Listen, I've been abused by her.' They sort of look at you like, 'Yeah, right. She's 5'2 and she's abusing you?'." (P008)

In some cases, participants' first disclosure to police was made during an episode of IPV and participants contacted police for their own safety. Unfortunately, several of these incidents resulted in the ex-partner making an immediate false counter-allegation and it was the participant who was arrested after phoning for help. It is possible that as police may have experience with 'common couple violence' (Graham-Kevan & Archer, 2003; Simpson et al., 2007) wherein both parties are perpetrators and victims, they may be more willing to accept allegations that the person who asked for help has perpetrated as well.

> "Police are not interested in anything she done to me. 'No, she didn't lift the knife to hurt you. She was going to kill herself.' Even though that [her statement] was after I got the knife off her. So after that happened, I got arrested." (P009)

'I just don't get justice. It's not there.'

Interview participants spoke at length about their experiences with the courts and legal system following their disclosure of IPV experiences and the ensuing false counter-allegations from ex-partners. This section covers interactions with the courts (criminal and family), the legal system (solicitors and barristers), and other institutions of the state, namely social services. There are instances in this section where specific experiences of participants are paraphrased rather than presented as a quote, and this is to avoid endangering any active court cases and respect any reporting restrictions which might be in place.

With this in mind, it should be mentioned that there are significant differences in the functions, processes, and remit of criminal courts compared to civil courts/family proceedings. 'Respondents' in family court proceedings who are victims of abuse have the ability to access legal assistance without the need for a financial eligibility test (Department of Justice, 2022) via the 'domestic abuse waiver'[13]. This has caused some confusion, as those involved with criminal proceedings would continue to engage with the legal aid system as normal. As this waiver was originally implemented to prevent abusers from utilising the family courts to further perpetrate abuse, the Department of Justice is currently seeking public consultation on changes to the civil legal aid system, including the waiver.[14]

[13] *https://www.justice-ni.gov.uk/publications/guidance-domestic-abuse-waiver-legal-aid-applications*
[14] *https://www.justice-ni.gov.uk/consultations/review-civil-legal-aid-call-evidence*

As above, it is critical to note that if police did not recognise participants as victims, that is, conferring victim status on them, they were not entitled to use the domestic abuse waiver for legal aid in family court proceedings. This was highlighted as a critical failure of the system, whereby participants' reports, evidence, and documentation of IPV were downplayed or ignored while their ex-partners' false counter-allegations were validated, often on the word of the abuser alone. In essence, participants found themselves having to pay out-of-pocket to defend themselves in family court from their ex-partners who had access to legal aid, making the legal system itself a collaborator in their abuse. In some cases, participants' own legal counsel advised them that to continue with legal representation would be very costly and that their chances of 'winning' or achieving a positive outcome were slim.

> "I have to apply to see my children and the mother then is the respondent to that, that was all the accusations, she then gets the whole journey paid for and I have to pay thousands upon thousands apparently go through the system and they know that. The system is set up for that exact reason." (P002)

> "My ex partner will pay nothing, literally nothing. My barrister said to me, 'Nope, she's getting the full award.' That is deeply unfair. You know, I have to pay huge sums and work my ass off to get any semblance of justice, whereas this person gets it for free." (P003)

> "I'm having to pay for these court cases myself, not being entitled to any form of legal aid as not being recognised as a victim by the police. [...] Because she has alleged domestic abuse, she is entitled to legal aid. And she can make these claims for non-molestation orders, and she can make claims to the court and legally, it will pay for it." (P004)

This situation had a 'domino effect'; as participants were forced to live in poverty to fund their own response (including fighting for access to their children), and this poverty was further used by ex-partners as justification to deny them custody/child visitation. Poverty acted as an additional stressor further damaging their physical health, mental health, and wellbeing, which was also then used against them in court and with social services. Participants described the punitive nature of their interactions with the courts, in a system which they perceived to be designed to facilitate their ex-partners' continued financial and coercive control. This extended into retaliatory use of the courts, as several participants spoke about positive events in their lives being 'punished' with additional false allegations, hearings, custody challenges, and massive court costs.

> "Because all my money is pumped into that, I can't pay to support myself in terms of counselling or private stuff. So I have to sit on a waiting list for six months and then my mental health was so poor. And then it was used against me and just over and over and over. It's just like a merry-go-round. You can't get off." (P002)

> "You're paying thousands and thousands for solicitors. You can't leave. You can't support yourself, can't keep a house with a child. Therefore you're made inadequate. Therefore, social services don't like you." (P009)

Participants shared that police and legal counsel had advised them not to bring up their experiences of IPV, despite evidence or documentation, as this would be perceived poorly by the court or taken as evidence that they were 'escalating'. Many described being told that any attempts to seek justice for what had been done to them or to hold

their ex-partner to account for false allegations, lying in court/on court documents, continuing abuse, violation of court orders, and other offences, would be in vain. This created a double standard in the court system whereby participants were held to an impossibly high standard of behaviour but could only watch as their ex-partners were permitted to violate the law with (seeming) impunity. None of the participants who spoke about this issue were given an explanation for why this legal double standard was being reinforced.

> "The policeman, he literally said, "This constitutes harassment, however given the fact that there are allegations of domestic violence and sexual assault against you, we wouldn't be able to pursue it unless you yourself raised a harassment case against them." That's what I was told. [...] My solicitor was like, "You can't report it as harassment because that will be seen by the judges as escalation." (P003)

> "The barrister literally said to me, 'I'd be happy to take your money, [P004]. I'd be happy to take your money, but I'm obliged to give you the correct advice. The correct advice is this: you have a really good case, but that doesn't matter.'." (P004)

> "My solicitor, he didn't even want to actually bring up the fact that there had been this domestic violence stuff, he didn't even want to bring it up in the court case." (P005)

> "A man really has to play the game, bide his time, not react. His ex can react, say she'll commit suicide, lift knives, punch, attack, hit cars, get drunk, take drugs. And [it's], 'Can you sign this declaration that you won't do it again?' Because that's exactly what happens. Whereas the guys, they'll get supervised contact for the next 5 years." (P009)

However, this was not the case for every police officer, institutional official, or officer of the court, as many participants described individuals who did believe them, did help them, and were able to validate their victim status, but it was not a common experience across all participants. The fact that there were (seemingly) little to no consequences for ex-partners' false allegations highlights this issue.

> "There's no recourse. You know, if it's proven an allegation is false, there's absolutely no recourse. The family court doesn't deal with it. The cops don't deal with it." (P003)

> "Throughout all, I felt as I had no voice whatsoever and that it's been very easy for people to lie without any comeback. I don't even know if my ex partner is going to be prosecuted for perjury. They've been reported. [...] My feeling is probably at some point I'll get a letter saying, 'Yeah, she probably did do this but we don't think it's the public interest.'." (P004)

Adjacent to this is the lack of a clear support pathway for men in interactions with the court/legal system, while this does seem to exist for women. Several participants brought up statutory and third sector organisations with specific support roadmaps for women who have had IPV experiences but noted that very little similar support exists for men. The organisations which do provide support to male victims of IPV in NI focus mostly on mental health & wellbeing support and do not currently have the funding or remit to provide legal support or advice to help men through the lengthy processes of court cases/hearings and interactions with social services.

> "I know my ex partner went to Women's Aid and [they] gave her a road map. I'm sure you've probably heard that before as well. And she was given a road map of how to make the court system

work in her favour. How do you access financial support? How do you avoid costs? There's nothing similar at all [for men]." (P004)

"When I've spoken to other fathers as well, I guess our collective frustration is that there almost seems to be a blow-by-blow playbook of what mothers who are going through separations go through in order to get things to pan out the way they like from a legal perspective." (P005)

All participants expressed their frustration while describing multiple instances of gender bias while dealing with the courts and institutions of state. This was ascribed to the common view that men are aggressive perpetrators who should be separated from their children while women are weak victims who should be protected and who are incapable of harming their partner or children. Several participants stated, 'It's not innocent until proven guilty, it's guilty until proven innocent,' nearly verbatim. The core of this frustration and deep-seated feelings of injustice stemmed from the fact that participants were the aggrieved party but the very nature of their identity, their gender, was being used as evidence against them. Many expressed that no amount of proof, evidence, eye-witness accounts, or documentation seemed to balance out or overcome the basic fact that they were male.

"There's almost like it's just this trope that men are abusers. Men are the only people who abuse women. That's what happens. So whenever a man come to a court for whatever reason, he must be an abuser. There must be a reason why he doesn't see his children." (P002)

"A female barrister told me, 'You are the wrong gender to be in the family court. You are fighting a battle every time that she doesn't have to fight.'." (P004)

"There are people in pretty much every position throughout the process who I feel like have let me down. My solicitor, social workers, they don't believe my story. For whatever reason, they're much happier believing [ex-partner]'s story because it's probably a story they hear more often. That's my major frustration." (P005)

3.5 Barriers to Help-Seeking

Survey participants were shown a measure assessing what barriers exist which would (or does) prevent them from seeking help. This measure breaks down into 3 subscales: logistic barriers (no transit to appointments, difficulty scheduling or getting time off work, etc.), stigmatic barriers (would feel 'weak', others would perceive them differently, etc.), and trust barriers (no trust in the care system, uncomfortable disclosing, etc.). The average scores for overall barriers and the subscales (Table 12) are quite high in this sample, meaning that participants experienced more overall barriers to help-seeking and more specific barriers. As an example, this measure has been previously used to assess barriers to help-seeking behaviours in a sample of NI Armed Forces veterans, and all average scores in that cohort were lower than in the sample here (Spikol et al., 2024a).

Barriers to help-seeking are known to be associated with increased psychological distress (Corrigan et al., 2014; Spikol et al., 2024a), meaning that the more perceived barriers, the greater the delay in seeking help and the greater the distress for the individual.

'I've been dropped in the middle of an ocean and I can't see land.'

Interview participants were asked what, if anything, prevented them from seeking help or support or making a disclosure, both in the context of their IPV experiences and the impact those experiences had on them. Their answers fell largely into the 3 main categories of barriers to help-seeking; logistic, stigmatic, and trust barriers.

The main logistic barriers that participants described were the lack of a clear care pathway (both in terms of navigating the courts/legal system and support resources) and a lack of personal awareness that their experiences constituted IPV. Participants described searching online for what they 'should do' in terms of disclosure and support but finding very little information and post-disclosure, they encountered very poor signposting about support resources. This form of logistic barrier had a significant impact, leading to feelings of doubt and reinforcing the stigmatic belief that they had to 'man up' and keep silent simply because there was no one who wanted to, or who could help

Table 12. Barriers to help-seeking (survey)

	Range	Average score
Barriers to help-seeking	16-73	43.48
Logistic barriers	4-18	9.76
Stigmatic barriers	6-30	17.00
Trust barriers	6-30	16.71

them. Several participants stated that they did not disclose or seek support at first because they thought of IPV only as physical abuse and did not realise that coercive control, psychological, sexual, and institutional abuse were IPV.

> "So I was kind of like, I didn't even realise. Yeah, I literally just had no idea what was going on, like I knew it wasn't good. But once again, she was incredibly manipulative and I was so naive about all that." (P005)

> "I didn't even know where to where to turn to. […] I've Googled loads of stuff and people have said, 'You need to speak to this. You need to speak to that,' and you phone them up and you're not suitable or it's not something they deal with and then they pass you on to another number. And you ring the number or you email them and they don't come back to you." (P006)

> "But it wasn't until I came out of the relationship and started to actually unpick things that I realised that this is actually the mental abuse. When I started to unpick it, I knew it to be domestic abuse." (P010)

Mirroring the results from the survey sample, interview participants experienced a significant number of stigmatic barriers to help-seeking. Many participants spoke about fear or anxiety preventing them from disclosing, particularly the fear of not being believed, of social, legal, or reputational consequences, that the abuse would worsen if they disclosed/sought support, and feelings of self-doubt/self-stigma around their experiences.

> "So I actually went to the police station and I was shaking, and every time I had a phone call with the officer, as good as the investigating officer was and very supportive, I still had that underlying fear. […] I remember sitting in my car shaking, just trembling with fear, thinking, 'What's going to happen? It's all going to come back on my head. Am I really better staying silent?'." (P001)

> "I knew I wouldn't be believed and I'm still not believed to this day. […] I almost feel like there's a lot of shame there and yeah, maybe the biggest barrier was my own head and maybe there weren't many physical barriers. I was just thinking that I won't be believed, anyone I tell this to and I won't be given fair treatment." (P002)

> "I did speak to [the GP] about my mental health. But I was so afraid because I was told that if I had disclosed the domestic abuse to anyone that she would make it worse. I just spoke generally about mental health to the doctor. I felt as though I couldn't actually just go, 'This is what's happening to me.'." (P010)

The pervasive gender bias in experiences of IPV and the public perception of IPV victims as being women also substantially contributed to participants hesitance to disclose and seek support. While this barrier is related to not being believed based on being male, participants spoke about how society perceives men who disclose experiences of IPV, particularly that doing so then casts a shadow of suspicion over them. These stigmatic barriers were reinforced by what participants saw on social media, where gender discourse complicates issues of IPV disclosure. One participant explained how he had posted a link to a news article about a high-profile UK IPV case with a male victim on a Facebook group, which was deleted by the moderators, and he was accused of 'misogyny' for the attempt. Several participants brought up the private NI Facebook group 'Are We Dating the Same Guy?' which was ostensibly created for women to share information

about abusive partners but has been co-opted by abusers to spread false allegations. At least one suicide attempt has been linked to the group.[15]

> "You'll see this on social media if something is posted on the news about a woman was convicted for this, that, or the other against a man. Then you'll see people come on and commenting, 'Oh well, this happens to women too,' and I think there's still a very 'them and us'." (P001)

> "People don't believe it actually can be that bad because people will look at me if I'm not getting to see my children and think, 'Well, you must have done something to be able to not see your children. People just don't get to not see their children.'." (P002)

> "When you hear coercive control, like the adverts on a bus for example, or the picture of the woman like this [mimes cowering], and the man standing behind her, there's no mechanism, there's no support there for men in that same position." (P003)

Barriers to help-seeking centring on trust were the least prevalent among interview participants but largely focused on a lack of trust and faith in the court/legal system to protect them and/or their children from their abuser and the belief disclosing to any of the institutions would only make the situation worse for them. Participants felt that, given everything which had happened to them and hearing the experiences of other men, they did not trust the mechanisms of state. When discussing these barriers, several participants shared that their initial misgivings had been correct.

> "I hope you've had a lot of men come to you [the interviewer]. I hope there's a lot of people that are taking this because a lot of voices have gone unheard for a long time. Because the system has made sure that they don't speak up." (P002)

> "Everything's against the man and I'm not a sexist in any way but everything has been piled against me for the last three years and I've been fighting the system that's not interested in men." (P006)

3.6 Experiences of Support

Survey participants were asked about their social support and the satisfaction they found in that social support (Table 13). When assessing social support using the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) a score of 12-35 is considered low, 36-60 is considered moderate, and 61-84 is considered high. The average score in this sample fell into the moderate range for the overall score (47.31) and the subscales: Significant Other (13.22), Family (12.23), and Friends (12.93). In this sample, the highest average levels of support came from participants' significant others, followed by friends, and then family. When these scores are explored by level, a majority experienced moderate-to-high social support. The average level of satisfaction with this support was also moderate.

Alongside social support, participants were also asked about their experience of loneliness, which was assessed using the de Jong Gierveld Loneliness Scale (DJGLS-6; De Jong Gierveld & Van Tilburg, 2006), generating an overall score and subscales exploring social and emotional loneliness (Kenny et al., 2023). Higher scores are indicative of higher levels of loneliness and the average scores in this sample fell into the high range for overall, social, and emotional loneliness.

Participants who indicated that they had disclosed their experiences of IPV to others were asked if those individuals provided support, with 45.2% answering 'no', 38.1% answering 'yes', and the remaining 16.7% did not disclose (Figure 5). In exploring experiences

[15] *https://www.itv.com/news/utv/2024-05-10/are-we-dating-the-same-guy-the-facebook-group-thats-raising-concerns*

of support post-disclosure by urbanicity (Figure 6), participants living in towns were more likely to receive support than those living in cities or rural areas. When asked who provided them support (Table 14), charities/ support organisations and friends were the most frequently endorsed, followed by parents, with Men's Advisory Project, other/unlisted organisations, and the Men's Alliance NI Facebook support group being the most frequently used.

Table 13. Social support, satisfaction, and loneliness (survey)

	Range	Average score	N=(84)	%
Social support	12-84	47.31		
Significant other support	3-23	13.22		
Family support	3-23	12.23		
Friends support	3-23	12.93		
Low support			26	31.0%
Moderate support			34	40.5%
High support			24	28.6%
Support satisfaction	1-7	3.63		
Loneliness	0-6	4.69		
Social loneliness	0-3	2.42		
Emotional loneliness	0-3	2.27		

Figure 5. Support received from others after disclosure

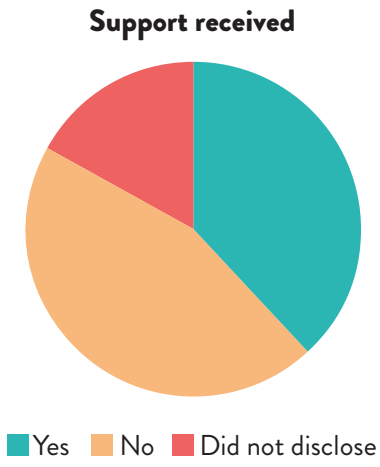


Figure 6. Post-disclosure support rates by urbanicity (survey)

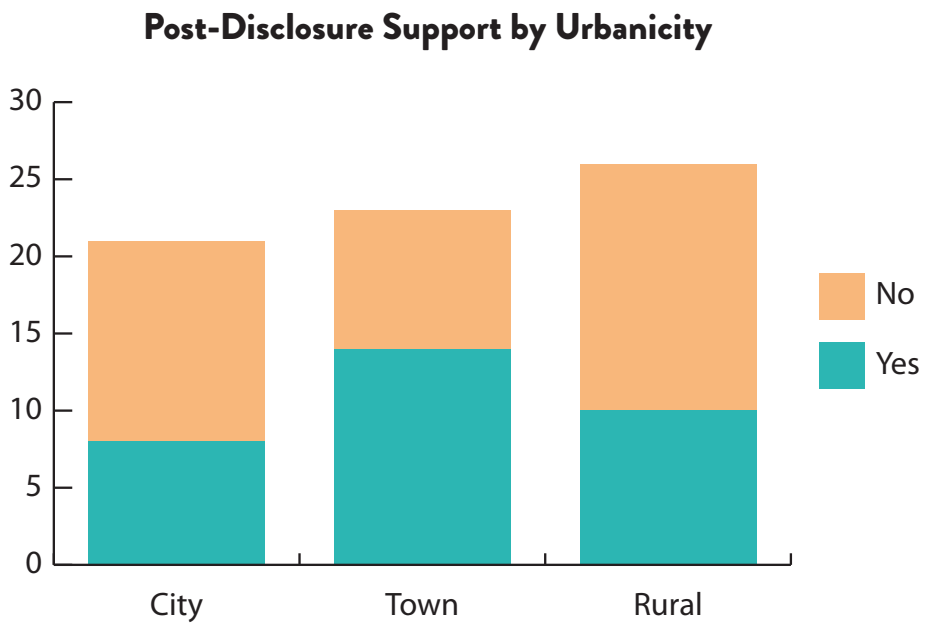


Table 14. Individual and organisational support (survey)

Individual*	N=	Organisation*	N=
Parent(s)	10	Men's Advisory Project	12
Children	5	Men's Action Network	1
Sibling(s)	9	Men's Alliance	4
Other family member(s)	4	MANI support group	7
Friend(s)	20	Victim Support Northern Ireland	3
Current partner	7	Nexus	4
Community member(s)	2	Assist NI	2
Coworker(s)	7	Relate NI	3
Other individual(s)	8	Men's Shed	2
Charity or support organisation	22	The Rainbow Project	1
		Other charity/organisation	10

** Participants were advised to select all options which applied to their situation*

'I genuinely felt that I wasn't alone.'

Interview participants were asked about their experiences of support, either individuals in their lives who provided support, charities/support organisations, or more formal support, including through their GP or counselling.

Many participants discussed the support they received after disclosing their experiences of IPV to family members, though a few clarified that while their family supported them in general, some individuals failed to understand the significant toll the abuse had taken and others eventually 'came around' after initially not believing the participant. Family members were present to support participants in court, provided them with a place to stay, and in one case, talked a participant out of returning to their abusive household. This support was not without a price, however, as several participants described their ex-partner turning abusive towards their family members, including false allegations, manipulation attempts, and harassment. In one case, as above, this led to the dissolution of a participant's new relationship as their new partner sadly opted to leave rather than continue to experience the ex-partner's abuse.

> "I'm really lucky I met my now wife because she's been incredible throughout. She's just, like endured a whole pile of shit that she shouldn't really have had to endured." (P005)

> "The family was in court with me throughout the two days. So they were very supportive. They knew right away that's it's all lies." (P007)

> "My brother literally wanted to go and, I suppose I shouldn't say this, but he wanted to go and confront her. [...] and he actually came to me and apologised for reacting how he did." (P010)

Participants spoke about the support they received from friends, either one or two very close, core individuals, or entire groups of friends. Several expressed how grateful they felt when, after having been socially isolated from their friends (due to either self-isolation or a campaign of isolation by the ex-partner), these friends heard their disclosure and wholeheartedly supported participants. As with family, friends provided much needed 'reality checks', a place to stay when needed, someone to listen, or even the occasional humorous text to brighten a participant's day.

> "I was in a pretty lonely place and I'm lucky I had access to some good friends once I, you know, [had] gone through the separation process, a lot of friends kept in touch with me wanting to hear how things were going. I'm really lucky I had that." (P005)

> "I used to work with him and he's one of the only friends I've maintained all the way through and he's been brilliant. You know, we just take the piss out of each other all day, every day, just to wind each other up. [...] And that sense of humour was, it got me through it." (P006)

> "After I come out of the relationship, I actually had to go to those friends that she'd isolated me from and just go, 'I'm sorry, this is what has happened.' And explained to them. And they were very, very good. They had just rallied around, 'Right. Come on, let's go.'." (P010)

Most of the participants discussed their experiences with formal counselling, accessed through a variety of methods (GP referral, charity/support organisation involvement, self-referral, etc.). Opinions of counselling/therapy were generally positive, with participants citing how counselling had/has been

helping them process their experiences, learn or improve cognitive coping methods, and reduce distress. One participant described the exhaustive nature of the emotional labour he undertook during intensive counselling but acknowledged that overall, it was beneficial. Another criticism of counselling, shared by a few participants, was that though it was helpful in processing immediate, severe distress, there was little that a counsellor/therapist could do about the root cause of that distress for participants in ongoing abusive situations.

> "I don't know where this woman works for that I'm talking to, this counsellor woman, but I know now if I text her shortly and say I'm on a low or I need help, she's there. To have that on hand is the ultimate, because you know there's somewhere you can go to talk. They're not going to fix anything, but they give you the power to fix it yourself." (P006)

> "The ordinary counselling will work for couple of weeks and then you're just back. You're, you just get really low again, if you know what I mean?" (P007)

> "I've done some therapy sessions and in-person sessions. Going into the trauma, different things happening and also then down in the face-to-face where you learn boundaries. What's acceptable, what's not acceptable, how you can express them, how to protect yourself, you meet somebody, what's healthy, what's not." (P009)

Many participants spoke highly of more informal support, namely group counselling or peer support groups accessed through charities/support organisations. Through these groups, participants felt that they were not alone, that their experiences were validated by virtue of seeing that other men had gone through similar experiences. On the surface, this may not seem comparable to the myriad benefits of counselling, but as isolation and stigmatic views were a significant barrier to disclosure, understanding the commonality of IPV experiences could result in higher levels of disclosure and help-seeking. Some of the groups facilitated social events which allowed participants a chance to socialise and engage with their peers without fear of stigma, fostering stronger social support networks.

> "The group work for me was quite good because you were able to stop talking for a while and let somebody else talk and almost listening to them was validating your experience, or my experience? But I got to rest my mind and my voice and let somebody else talk, and then I could chip in." (P001)

> "The vast majority of dads and men in that room were just people who just wanted to see their kids, who had left their relationship that wasn't working and were being heavily punished for it. And so many of them had the exact same story. The false allegations, the abusive dynamic, the financial control, the emotional manipulation, the gas lighting, the pressure, the isolation." (P003)

> "it's peer support, so everybody has been through a different situation, and everybody's kind of, feeding into, you know, 'This helped me. This helped me, try here,' or whatever." (P010)

In discussing support they had accessed; participants did mention NI charity/support organisations and their opinions of these services (Table 15). Participants spoke very positively about the courses of individual therapy/counselling which these organisations either offered or were able to arrange for them, including formal group therapy/support groups. As described, participants found great comfort in the cognitive processing and coping skills they were introduced to

through these services. Others described the sense of community they found in informal support groups, especially sharing of advice, emotional support, and access to a 'grassroots' roadmap for navigating the challenges of life after leaving their abusive relationships. Not every experience was positive, however. Some participants described feeling isolated as men when discussing their experiences with female representatives, long waiting lists to access support, and a general sense of confusion about which services were offered by which organisations and the criteria to qualify for support with each.

Table 15. Use of NI charities/support organisations (interview)

Organisation	N=
Men's Advisory Project	5
Men's Alliance (incl. MANI support group)	5
Victim Support Northern Ireland	2
Nexus	4
Parenting Focus (Dads Talk support group)	1
Relate NI	1
Local hostel	1

3.7 Post-IPV recovery & Meaning Making

'My feeling OK about myself is coming back.'

Many participants spoke about their recovery journey since leaving their abusive relationship and accessing support. These accounts largely focus on regaining lost senses of self-worth and self-confidence, the process of improving their physical health, mental health, and wellbeing, feeling secure enough to enter new relationships, and engaging socially with friends and peers. While nearly all interview participants had children with their ex-partners and thus will have to engage with the ex-partners until the children are 18, some expressed that their relationships with their children were improving as the children aged and gained a better understanding of the new family dynamic.

> "Many of my days I'm still in that paralysis thing. You know, things that I need to do, I just can't do them. I feel like I'm lazy. But I know that I'm not. I know that I am almost in a protective kind of mode where I'm just resting everything. I have to let that happen, I think." (P001)

> "It's obviously been incredibly challenging and draining emotionally, but I can happily say that, yeah, I now feel like I've built a life that I'm actually proud of and I'm remarried. We've just had our first child together." (P005)

> "I do try to keep moving. I do try to keep you know, basically on a on a day-to-day basis, I cook well for myself. I do all of that and I felt when I moved in the flat, it was a long day on my own and that's why I got the dog. [...] I do try to meet up with friends and things like that." (P010)

A handful of participants took the opportunity to share more creative, abstract thoughts about their experiences. This rumination process, meaning making, is common after traumatic or stressful life events and is associated with post-traumatic growth (Park & Ai, 2006; Park, 2010) allowing individuals to reappraise their experiences and change their perspectives (Park, 2022). Participants contextualised their experiences through their world view, a shifting general outlook on society's view of IPV, faith that abusers cannot maintain their control indefinitely, and even through metaphor based on their life experience.

> "The general principle and theme of cricket is as you play cricket, you learn how to be patient. I

feel so lucky that I've played cricket throughout my life and I wonder now was my life lesson of playing cricket, actually learning to be patient. Because throughout this process, through the relationship itself, through the process of being a single father and having to kind of battle through the legal system just to get time with my kids, then rebuild the relationships with each of the kids, it's been all about patience." (P005)

"I'll tell you something weird now, an analogy I used to have. As a child, my mum and dad used to have a shoe box in the bottom of their wardrobe and I used to have nightmares that someone would come out of that shoebox and drag me into it, and I was trying to scream, but I didn't have a voice and that's the only thing I can summarize over the last three years. I've been screaming. I've got no voice. No one can hear it." (P006)

"You know when I'm talking to guys about domestic abuse, they say to me, 'Why? Why does this keep happening? Why don't the authorities see this?' I says, 'Rotten apples fall out all on their own. They can only hold tight to something. They can only hold on to that persona for so long. They'll trip themselves up and they'll drop.' […] So I try to use that analogy with them. 'Just sit back. Sit back, watch the show. Hope that you've 20 seconds to get the popcorn in the microwave before they explode,' and that's how I've been trying to play it out this last year and a half." (P010)

3.8 Future Recommendations

'Abuse isn't gender based, it's victim based.'

Interview participants were asked what they believe needs to change in NI to better support men who have experienced IPV. Many discussed the need for public awareness campaigns to help dispel popular myths about IPV including awareness of the various types of IPV, that the impact of IPV spreads beyond the initial victim to encompass friends, family, and others, and the false belief that men cannot be victims, only perpetrators. Participants referenced recent high-profile cases across the UK in which female perpetrators have been convicted of abuse against their male partners and the stigmatic reactions of the general public to these cases. Some commented that an initiative to separate the concept of gender from IPV would focus support on the victim.

"Yeah, the system's broken. It is completely broken and it's getting worse. It's not getting better. The recent focus on violence against women and girls, you know, we talk about figures, but we don't talk about [how] there was a large campaign that they talked about, about encouraging women to come forward with these things. No such campaign for men." (P004)

"I think it needs to be highlighted more, but you never hear of males. It's always sort of females, you always hear, sort of getting all the attention from being victimised against, but you never hear about the males getting victimised, or being victimised." (P007)

Several participants brought up charities/support organisations, specifically the lack of funding compared to organisations which assist women. As this study was conducted in the immediate months after the reforming of the NI Executive, it was hoped that the government would be able to provide sufficient funding across organisations with the coming budget. Other participants called for collaboration between all NI IPV organisations to present a united front against abuse, highlighting that the current discourse and division over the issue both emboldens abusers and harms victims.

"And I think what would be so beneficial would be a public front where you know the likes of Women's Aid or Men's Alliance actually come together and say, "We're in this programme together," [...] or even a project or something where they're both behind it and their PR, and their labels are both on the poster. I think that would send out a huge message where it's not a gender issue. It's a humanity issue." (P001)

"It feels because men aren't supported, there's not budget there, there's not help there. It's just a wee quiet voice." (P002)

"I think actual support for dads, actual support for men leaving these relationships. Parenting NI, the Men's Advisory Project, Men's Alliance have nowhere near the resources of Women's Aid. [...] So proper funding for those organisations to deal with proper training to actually handle those kind of situations, incentives in the family court arena to encourage compromise, particularly around financial means." (P003)

Pursuant to this, participants described a dedicated care pathway, inclusive of both statutory and third sector organisations, with a 'joined-up' approach to support men across multiple domains. They described support organisations as being invaluable for supporting them with their mental health and wellbeing due to their experiences of IPV but noted that they often needed support in other areas, such as accessing legal counsel, financial advice, and navigating the family courts/social services. The fact that these pathways exist for women who have experienced IPV left participants feeling frustrated, seeing that it is possible but just does not exist for them.

"Just to have a pathway or at least a route. I mean, just a step by step process that I could potentially follow. [...] This feels like I've been dropped in the middle of an ocean and I can't see land. So what way do I swim? Or do I just waste my energy just sort of keeping afloat? And that's how I feel." (P006)

"People need whatever help is out there. Standard way seems to be put you through counselling, but as I said, you always go back down, get back down to square one again, but there's nothing to sort of combat the overwhelming power of it." (P007)

"I suppose a network through the Trust that actually? How could you say? I suppose a joined-up approach where there's some there, there's a support mechanism for the abused person that will then link in to social services, link in to police for you." (P010)

Some participants discussed the need for education and training for police, officers of the court, and workers in social services in the support that men with experiences of IPV need, especially in cases where a victim might interact with multiple institutions of the state. A few participants stressed that training should include a gender-equal or gender-neutral stance, understanding that men can experience IPV perpetrated against them and that instead of dismissing these men, they should record the disclosure, investigate as per policy, and direct them to support resources. Not being believed by police and other statutory individuals caused a great deal of distress for many participants, particularly when their ex-partner's false counter-allegations were believed, and a few suggested that education and/or training initiatives might help the issue.

"Specific training around equality, so there's a lot of it done in the media at the minute about, you know, domestic abuse. The title is being changed from domestic abuse to violence against women and girls." (P004)

"They've [police] just left her to carry on doing it [harassment] and every time they say to me, 'Oh, just block her off your phone.' But I said, 'If I block her off the phone, how do I get the evidence to prove what she's doing to me?' (P008)

"Police need to realise that abuse is abuse. This is my favourite thing to say. Abuse isn't gender based. It's victim based. Police need to know that." (P009)

Most participants discussed legal reform and the lack of accountability when their ex-partners made false allegations, committed perjury, took further abusive actions against them, and violated court orders. As above, participants' sense of a just world was damaged by a system which they perceived as being set up to be punitive towards them while validating their ex-partners' abusive behaviour. This was very evident in participants' experiences of institutional abuse when dealing with social services and in matters of child custody and visitation. Judicial reform in the family court system, a participant stated, would mean outcomes in the best interest of children and prevent them from being weaponized against their own fathers.

"There's no public galleries so people can listen to the judges. There's no accountability for the accusations that people make because if you make an accusation in the family court, even if you're found to be false, it's called privileged. So you can't be prosecuted for perjury." (P002)

"Courts also need mechanisms that deal with bad faith actors. […] There needs to be a recognition there, what's going on. There also needs to be better enforcement powers for the police, certainly in the case of false allegations." (P003)

"Make it accessible and make it viable. So has there been any mistakes? Yes. So do I think we need it? Yes, we need it. We don't replace the system, we make the system work better and that's exactly what they need to do. You know, not that we don't need to change the system, we just need to fix it up. We need non-molestation orders, we need to protect women. But we need to be able to hear dads." (P009)

'One little statistic towards the narrative changing.'

As each interview concluded, participants were asked what motivated them to participate in the ME-IPV study. A few said they wanted to participate to bring about change in the public awareness of male experiences of IPV and potentially, how the institutions of state in NI interact with male victims. One participant described taking part because he was worried that his own children might one day experience IPV, and he wanted to be part of working to change a system which he feared might not protect them.

"I have two sons and one of my biggest fears is they grow up and have to experience what I've been put through. And that terrifies me because it is the most horrific thing I've ever experienced in my life. […] And I don't see any change, so I worry that whenever they grow up, it'll be 10 times worse and they'll be driving the same system as I've been." (P002)

"Because if I didn't [participate], then nothing's ever going to change. If people don't stand up and say, 'Look, this is the way I see it, this is the way it's working,' it absolutely won't." (P006)

Many participants stated that they wanted to be involved with the study out of the desire to help future male victims of IPV. They discussed how their

experiences, as painful and distressing as they were, should be used to help others avoid the same distress. Additionally, they expressed the hope that other men who had experiences of IPV but had not left the abusive relationship or disclosed, might read the study results and understand that they were not alone. They perceived their participation as akin to speaking in a peer support group and wanted their words to help bring about change for their peers.

> "Because if nobody comes forward and does these things then nothing changes. So I commend you guys for your work, but if nobody comes forward to actually give the honest answers and responses, then nothing changes. So today for me doing this, it's about that greater picture that's going on in society and hopefully using my bad experience to help affect change in some way." (P001)

> "Discussing it, I don't know whether it would be a positive thing for other people, but for me, discussing what I had gone through and having someone to listen as opposed to someone hearing but not listening or, do you know what I mean? Like not absorbing? If it's used and this could potentially help one other person, brilliant." (P006)

> "If I can give some little nugget of information to you guys that assists something positive, some other poor guy also doesn't experience the same things as I did, that's a big plus for me." (P010)

4.0 Discussion

4.1 Discussion

The ME-IPV Study used quantitative data taken from an open-recruitment online survey and qualitative data taken from a series of interviews to explore the physical and psychological impact of IPV experiences in men in NI, to identify any perceived barriers to reporting/disclosure, to examine the responses (personal and statutory) that participants received to disclosure and any impacts on them, and to identify any differences in these factors based on geographic location where possible.

4.1.1 IPV Type, Duration, & Impact

Most participants' (survey & interview) experiences took place in a past relationship and a majority of these were over the course of several years.

Survey participants were exposed to multiple forms of IPV with the most prevalent being psychological abuse and coercive control, which were both associated with increased depressive symptoms and PTSD distress, with psychological and sexual abuse associated with poorer overall mental/emotional health. There was a direct linear association between cumulative IPV exposure and increased distress associated with anxiety, depression, and PTSD, and a majority of the sample met probable caseness for anxiety (58.8%), depression (71.7%), and PTSD (67%). Mean physical and mental health was poor in this sample and alcohol use was moderate. A majority (71.4%) had experienced suicidal ideation, and nearly 1/3 of the sample (32.9%) had made at least one attempt to take their own life.

Interview participants also described multiple forms of IPV, with coercive control, psychological and institutional abuse (especially false allegations) being highly prevalent. They spoke at length about the detrimental effect their experiences had on their mental and physical health, which included diagnoses of anxiety, depression, and PTSD, and the advent/exacerbation of multiple health conditions. Some participants had dealt with suicidal ideation and attempts, explaining the reasoning behind their thoughts, what factors prevented them from attempting, and how their experiences changed their understanding of suicidality. Additionally, interview participants shared the social impacts of IPV, especially the 'fallout' of disclosure and false allegations on themselves and their reputations.

4.1.2 Coping Strategies

Coping in the survey sample was moderate-to-high, particularly in the ability to switch to a different coping strategy if the current strategy is ineffective. Some coping strategies can be effective during an event (compartmentalising, 'pushing down' feelings, etc.) but become ineffective later, and some strategies (alcohol/substance misuse) can be quite adverse in the long term. In the interview sample, participants shared their coping strategies which largely focused on adaptive protective behaviours (including retreat/escape) and exercise, especially walking. Maladaptive or unhealthy coping strategies included isolation, unhealthy eating patterns, self-harm, alcohol misuse, and internalising, ignoring, or pushing down emotional responses.

4.1.3 Disclosure & Aftermath

Just over half (51.2%) of survey participants chose not to disclose their experiences of IPV to police or other authorities and of these, 65.1% indicated they did not intend to disclose in the future. Participants living in rural settings were more likely to disclose than those living in cities or towns.

Interview participants described disclosing to people close to them (family members, friends/others) with mixed results; they were met with belief and support from some as well as disbelief, mocking,

and hostility from others. In disclosing to the police, a few participants had positive experiences and were able to go forward with court orders and/or police investigations, but majority of participants reported negative interactions with police during disclosure. These included police not recording the disclosure/inciting incidents, being dismissive, not believing participants or accusing them of lying, and telling participants to 'get over it' or 'man up'.

The aftermath of disclosure was, for all interview participants, involvement with the institutions of state (police, courts/family courts, social services). These interactions were mostly negative and had a profoundly adverse impact on participants' mental health and wellbeing, however some participants did discuss positive outcomes or positive interactions with specific individuals during disclosure. Denied victim status, participants had to pay out-of-pocket for all court hearings, to defend themselves from false allegations, and in family courts for issues of visitation and custody while their ex-partners utilised legal aid. They described within these institutions a pervasive gender bias which cast them as perpetrators and held them to impossible standards while seeming to ignore the continued abusive (and occasionally illegal) behaviour of their ex-partners.

4.1.4 Barriers to Help-Seeking

In the survey sample, overall barriers to help-seeking as well as logistic, stigmatic, and trust-based barriers were high. For interview participants, logistic barriers included lack of a dedicated care pathway and lack of personal awareness of types of IPV, stigmatic barriers included fear/anxiety, self-doubt and self-stigma, concerns they would not be believed, lack of public awareness of IPV in men, and societal stigma, and trust barriers included institutional stigma and fear of consequences for disclosing.

4.1.5 Support

In terms of informal social support, participants had a moderate view of the support they received, with the highest degree of social support coming from current significant others, followed by friends, and then by family members. Satisfaction with this social support was also moderate. Following disclosure, 45.2% responded that they did not receive support from others and those who lived in towns were more likely to receive support that those living in cities or rural areas. Those who did disclose and received support mostly received this from charity/support organisations, friends, and parents, with the Men's Advisory Project, Men's Alliance (including the MANI Facebook group), and Nexus being the most utilised. Survey participants also experienced high levels of overall, social, and emotional loneliness.

Interview participants' experiences of informal support from friends and family were mostly positive and the support provided did alleviate some distress from the process of disclosure and the aftermath. Participants spoke highly of their interactions with group/peer support, whether through formal channels or informal groups, including social media. As for formal support, many engaged with various forms of counselling which was beneficial in relieving distress/symptoms of mental ill health, for processing their experiences, and for learning protective cognitive strategies, but several participants criticised the long-term efficacy of counselling in the face of ongoing abuse by their ex-partner through institutions of the state. Mirroring survey results, Men's Advisory Project, Men's Alliance, and Nexus were the most utilised charity/support organisations.

4.1.6 Future Recommendations

As part of the interview, participants detailed a variety of issues they feel must be addressed to not only support them but to also support future male victims of IPV. These included:

- reducing societal stigma by increasing public awareness of the types of IPV and that men can have perpetrated against them
- separating violence from the concept of gender
- increased funding for charities/support organisations
- collaboration between men's and women's support organisations with a united front against abuse
- dedicated care/support pathways for men which also feature legal assistance
- education and training for the police, agents of the court, and other statutory organisations to help eliminate institutional stigma and gender bias
- judicial reform to combat gender bias/discrimination in the criminal courts/family courts and to increase legal accountability for false allegations and perjury.

4.2 Impact & Implications

The ME-IPV study is the direct descendant of McGlinchey et al.'s (2023) systematic review of literature summarising the global prevalence of IPV perpetrated against men/boys and the mental health impact of these experiences. The recommendations of that report called for direct research within NI to capture the sociodemographic profile, health impact, and support needs of this population. Despite the weight of stigma on members of this 'hidden population within a hidden population', 115 individuals participated in the online survey and 10 individuals agreed to sit for an interview. The research team would like to extend its appreciation and gratitude to those participants who made this research possible and hope that it can lead to lasting change.

The abuse perpetrated against these participants and all the other men in NI with these experiences who were not able to come forward, is staggering. These traumatic events have taken a substantial toll on the physical health, mental health, and overall wellbeing of these men. Additionally, these events have concentrically affected their children, family members, friends, co-workers, and new partners, as well as consuming the time and resources of police, agents of the court, and the institutions of state. Charities/support organisations are underfunded and lack the resources to provide the types of support that men in this situation truly need while society falls back on harmful stereotypes, a lack of awareness of the nature of IPV, and stigmatic beliefs.

This report should be taken as an evidence-based call to action for change in NI, starting with a course of research to continue filling the literature gaps around this population. Assuming a viable budget after the re-forming of the NI executive, charities/support organisations who service men with the experience of IPV should invest in expanding their remit, collaboration, and outward-facing education/training literature with an eye towards awareness and reducing stigma. Policy needs to take male victims of IPV into consideration, especially those who have suffered injustice, through adaptation of existing legal pathways, appointment of a liaison, and through governmental support for IPV awareness and stigma reduction campaigns. The research team has outlined these recommendations in full below.

4.3 Strengths & Limitations

There were several notable strengths associated with the ME-IPV Study. This is, to date, the first exploration into the physical/mental health and experiences of IPV, disclosure, coping, and support of men in NI who have had the experience of IPV perpetrated against them. The mixed-methods

nature of this study, that is, using both survey and interview data, allowed for a more nuanced picture of this population by contextualising statistical results with participants' experiences in their own words. Additionally, the research team worked directly with local stakeholder charities/support organisations to recruit participants from a hard-to-reach population.

The findings presented here must be taken alongside the limitations of the study. The survey data were cross-sectional, meaning they provided a 'snapshot' of participants' thoughts, behaviours, and feelings at the time they completed the survey but cannot be used as an indicator of change over time. The relationships between variables are statistical associations only, as direct causality cannot be assumed. The survey responses were self-report data, which although unlikely, always carry the risk of social desirability bias (van de Mortel, 2008). Due to the stigmatic nature of disclosure and the hidden population status of participants, survey results lacked statistical power for more complex analytical techniques; though the research team and stakeholder partners worked to drive recruitment, this was an anticipated outcome while working with a hard-to-reach population. The experiences of sub-groups, including male/male identifying members of the LGBTQIA+ community and ethnic minorities, could not be explored due to the low sample size and homogeneity of the sample. Finally, as there is no known profile of NI men who have experienced IPV, findings here cannot be taken as representative of this population and cannot be generalised to all NI men who have experienced IPV.

4.4 Recommendations

4.4.1 Research

1. Future research concerning men in NI who have had the experience of IPV perpetrated against them should prioritise specific sub-populations with targeted studies:
   a. LGBTQIA+ individuals, specifically transgender/transmasculine men and men in same-sex relationships
   b. Ethnic/cultural minorities
   c. IPV experiences of boys (13-17)
   d. IPV experiences of older men (+65)

2. Studies exploring mental health and wellbeing in this population should focus on institutional abuse and its impact on the individual, including future participants' quality of life, belief in a just world, and locus of control.

3. While no participant espoused these views, it is evident in online spaces that this population may be vulnerable to radicalisation based on experiences of stigma and gender bias/discrimination after disclosure, and due to institutional abuse. Future research should explore if this underlying issue is present in NI.

4. Further studies utilising the ME-IPV Study interview data should focus on comparative synthesis research using similar data from other studies in other countries to explore male experiences of IPV from a global perspective.

5. Cumulative IPV exposure, coercive control, psychological and sexual abuse were all associated with adverse mental health outcomes; future broad-scale survey studies with this population should concentrate on the psychological mechanisms underlying these associations.

4.4.2 Practice

1. Charities/support organisations should explore expanding their remit for additional types of support, particularly legal support/advice. Additionally, third sector organisations should signpost clear eligibility requirements for service users (if the organisation uses such criteria).

2. All charities/support organisations who service individuals who have had the experience of IPV should consider forming a task force or executive advisory group to foster collaboration and contribution to a united front against abuse. This could be facilitated via public awareness campaigns with a goal of reducing stigma and polarisation, as well as challenging stereotypical thinking about IPV.

3. Charities/support organisations should investigate the creation of educational and training materials for use with multiple target audiences:

   a. Boys (13-17), on identifying the types of IPV, understanding abuse in adolescent relationships, and reducing stigma
   b. GPs/healthcare professionals, on identifying potential indicators of IPV in service users and on appropriate responses to disclosure, including signposting support
   c. Police officers, to foster an understanding of the multiple types of IPV, believing victims of abuse regardless of gender, reacting appropriately to disclosure,

and reducing stigma/belief in harmful stereotypes

d. Social services workers, to foster an understanding of the multiple types of IPV and that fathers can be victims, and to challenge a culture of stigma and harmful stereotypes within the workplace
e. General public, featuring a broad-spectrum line of materials available online or in-print, with an aim towards awareness and stigma reduction

4.4.3 Policy

1. As the experience of IPV constitutes a significant public health concern, the creation of a task force or expert advisory group at the NI governmental level for all matters of NI law/policy involving IPV would be invaluable.

2. As the Department of Justice is currently undertaking a consultation and review of civil legal aid in NI, it may be beneficial to also consider partnering with NI third sector charities/organisations to release the results of this consultation in an educational/lay-language format. It is evident that the general public has a great deal of misperceptions and misinformation surrounding this issue, especially when the family court is involved.

3. The continued support of the NI government for IPV awareness and stigma reduction campaigns, especially those which are gender/age/minority inclusive, will be invaluable in effecting lasting change in attitudes towards IPV victims in NI.

4.5 Conclusion

The findings here clearly point to male experiences of IPV in Northern Ireland being a significant public health issue which warrants immediate attention. In exploring the statistical data from the larger survey sample and the experiences of the interview sample in their own words, it is evident that the impacts of IPV on men's physical health, mental health, and wellbeing are profound. The impetus is on the academic, statutory, and third sectors of NI to act in supporting men with these experiences and to prevent future abusers from causing substantial harm to their victims. Despite the adverse physical and psychological outcomes described in this report, change, awareness, and reform are possible.

> "I've been through a very bad situation and a very toxic situation, but my main focus will be well, I've got the rest of my life to live. How can I have an impact on other people? Now, how can I help other people?" (P001)

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Appendices

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Appendix A – Survey Outline

Construct / items	Measure
Demographics	
• Gender (1 item)	
• Age (1 item)	
• Relationship status (1 item)	
• Sexuality (1 item)	
• Household population (1 item)	
• Urbanicity (1 item)	
• Ethnicity (1 item)	
• Education (1 item)	
• Employment status (1 item)	
• Socioeconomic status by job role (1 item)	
• Financial situation (1 item)	
Trauma	
• Intimate partner violence (37 items)	• Replicate Hines & Douglas 2016: Revised Conflict Tactics Scale (CTS2; victimization items only) + 9 items adapted for use with men from the Psychological Maltreatment of Women Inventory (PMWI)
• IPV relationship context/duration (2 items)	
• Lifetime trauma (19 items)	• Stressful Life Events Screening Questionnaire (SLESQ) (+6 items from LEC-5)
• Childhood trauma (10 items)	• Adverse Childhood Events Scale (ACE-10)
• PTSD (22 items)	• PTSD Checklist for DSM-5 (+2 dissociation items adapted from CAPS-5)
• Cognitive processing of trauma (17 items)	• Cognitive Processing of Trauma Scale (CPOTS)
Mental Health	
• Depression (9 items)	• Patient Health Questionnaire (PHQ-9)
• Anxiety (7 items)	• Generalised Anxiety Disorder Assessment (GAD-7)
• Loneliness (6 items)	• 6-Item De Jong Gierveld Loneliness Scale
• Suicidality (6 items)	• All items from the Ulster University Student Wellbeing Survey
• Self-rated mental health (1 item)	

Support	
• Barriers to help-seeking (16 items)	• Adapted for IPV (from Hoge et al. (2004), Britt et al. (2008) and Brown et al. (2011))
• Social support (13 items)	• Multidimensional Scale of Perceived Social Support (MSPSS)
• IPV support & disclosure (3 items)	
• IPV exposure during childhood and adolescence (2 items)	
Physical Health	
• Physical health (12 items)	• Short Form Health Survey (SF-12)
• Diagnosed health conditions (1 item)	
• Alcohol consumption (10 items)	• Alcohol Use Disorders Identification Test (AUDIT-10)
Wellbeing	
• General wellbeing (18 items)	• Personal Wellbeing Scale (PWS-18)
• Anger (5 items)	• Dimensions of Anger Reactions (DAR-5)
• Guilt and shame (8 items)	• Guilt and Shame Questionnaire (GSQ-8)
• Emotion expression/flexibility (16 items)	• Flexible Regulation of Emotion Expression (FREE)
• Coping (12 items)	• Coping Flexibility Scale (CFS)
• Context sensitivity (6 items)	• Context Sensitivity Index (CSI)
• Resilience (10 items)	• Connor-Davidson Resilience Scale-10 (CDRS-10)

NOTE: Some questions will only be asked if a particular response is given to a previous item. Questions in the table are presented in order in which they will appear in the questionnaire.

Appendix B – Interview Schedule

Qualitative Interview Schedule

Introductory statement: Thank you for agreeing to take part in this interview. As you know, we're conducting this study because we're interested in the experiences of men in Northern Ireland who have had the experience of intimate partner violence perpetrated against them. In particular, the questions I'll be asking you today focus on what it was like for you being in a relationship where you had those experiences, the impact that they had on you, any support that you had, and what you believe needs to change in the future to help support yourself and other men who've had these experiences.

Before we start, I want to let you know that you can stop the interview at any time and for any reason. If you begin to feel stressed or distressed, we can either pause the interview for a few moments or end it entirely if you don't wish to continue. If you change your mind about participating and wish to withdraw from the study, simply inform us and any information that you've provided will be deleted/destroyed. If you choose to withdraw after the interview is completed, you will have 1 month to let us know, otherwise analyses including your data will have begun. At the end of the interview, I'll also be providing you with a list of support resources to have on-hand in case you need them.

This interview is completely confidential. I will be recording the audio, transcribing the recording to a text document, and then deleting the audio. Any information which could potentially identify you will be redacted and your transcript will be associated with an ID number to ensure your confidentiality. Only myself and the research team will have access to the pseudonymized transcript. However, I need to let you know that if you tell me that you're in serious risk of harming yourself or someone else, or if you give me specific details of a crime which has not yet been reported, regardless of perpetrator, I must break confidentiality and give this information to authorities to ensure your safety and the safety of others.

I'll be asking you several questions. Feel free to think before you answer and take as much time as you need. Depending on your answers, I may ask follow-up questions to make sure I have a good understanding. If you're comfortable and ready, we can begin.

Demographics

Questions	Probes
Gender, age, urbanicity	N/A

Context, background, and circumstances of IPV

Questions	Probes
Intimate partner violence can take the form of physical violence, sexual violence, stalking, and psychological aggression, including coercive or controlling tactics. Please keep these examples in mind for the next several questions.	N/A
Can you tell me about the relationship you were in when you experienced intimate partner violence?	• How long ago was this? • How long had the relationship been going on when you first experienced IPV? • Are you still in this relationship?
How would you describe the types of IPV you experienced?	• Did this happen more than once? • How frequently did this happen?
Were these experience always present in the relationship?	• When did they start ? • Did they occur at any particular times?
Was this the first relationship where you had these experiences?	• If not first relationship, then further probing re that relationship in line with the above questions. Max of two prior relationships

Coping

Questions	Probes
How did you find yourself coping with your experiences?	• Was/were your coping method(s) helpful? • Was/were your coping method(s) harmful (alcohol/ substance misuse)? • Was there anything that was especially helpful in your coping process?

Disclosure, support, help-seeking, and barriers

Questions	Probes
Did you disclose your experiences to anyone?	• Did you disclose your experiences to any authorities (PSNI, school, employer, GP/mental health professional)? • Did you disclose your experiences to family, friends, coworkers, or spiritual leaders? [Clarify who] • Why did you tell that person / those people?

Disclosure, support, help-seeking, and barriers *(continued)*

Questions	Probes
(If disclosure) What kind of support did you receive?	• Who provided this support? • Was this support helpful and how did it impact on you? • Are there any type(s) of support you now wish that you'd had?
(If no disclosure) What prevented you from disclosing your experiences?	• Have you sought support for the impact of your experiences without disclosure?
What barriers did you experience which may have hindered you in disclosing your experiences or seeking support?	• Was there anything in particular that prevented you from disclosing? • Was there anything in particular that prevented you from seeking support?

Impacts of IPV and future support needs

Questions	Probes
What would you say have been the short-term impacts of your experiences on your physical health, mental health, and/or wellbeing?	• Have you been able to access support for dealing with these impacts? • Do you feel like you got the support that you needed? • What extra support would have helped you to cope with this experience?
What would you say have been the long-term impacts of your experiences on your physical health, mental health, and/or wellbeing?	• Have you been able to access support for dealing with these impacts? • Do you feel like you got the support that you needed? • What extra support would have helped you to cope with this experience?
Looking at the future, what do you think needs to change, in terms of support services, to better address the support needs of men who've had experiences like yours?	• What needs to change in terms of society? • What do you think the most common misunderstandings are when it comes to men's experiences of IPV? • Do you think the general publics view of IPV is? • What do you think the general public's view of IPV is when it comes to men's experiences? • What needs to change in terms of policy (includes government organisations, PSNI, etc.)
What motivated you to take part in the study? And what was your experience taking part in this study like this for you?	N/A

Finally: Is there anything else that you haven't mentioned that you would like to tell us about?

THANK YOU FOR YOUR TIME

Appendix C – Distress Protocol

Participant Distress protocol

(Adapted from: Draucker, Martsolf and Poole (2009) Developing Distress Protocols for research on Sensitive Topics. *Archives of Psychiatric Nursing, 23(5) pp. 343-350)*

Distress

- A participant indicates that they are experiencing stress or emotional distress OR
- A participant exhibits behaviours suggestive that they are experiencing stress or distress, for example crying, shaking, agitation.

Stage 1 response

- The researcher stops the interview.
- The participant is offered immediate support by the researcher through assessing their mental status, e.g.:
  - "Can you tell me what thoughts you're having?"
  - "Can you tell me what you're feeling at the moment?"
  - "Do you feel safe at the moment?"

Review

- Ask if the participant feels able to carry on:
  - If so, resume the interview.
  - If the participant does not wish to carry on, go to stage 2 response.

Stage 2 response

- Discontinue the interview and cease recording if possible.
- Offer immediate support if appropriate, e.g. advising mental health first aid skills, breathing techniques, etc.
- Encourage the participant to seek support from their usual contact points – their GP, a psychologist, or their mental health team if applicable.
- Offer, with participant consent, for the researcher to contact an agreed professional within their support system.

Follow-up response

- Encourage the participant to seek support if they experience increasing levels of distress in the hours and/or days post interview.
- Ensure the participant has an information sheet with the contact information for having their data removed or any further questions about the study.

Appendix D – Recruitment Flyers


Are you:
Male
18 or older
live in NI
experienced intimate partner violence
Male Experiences of Intimate Partner Violence:
The ME-IPV Study
We want to hear from you.
Intimate partner violence is defined as: any act of "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner".
We want to understand the impact these experiences have had on your physical health, mental health, and wellbeing, what support you received, and how support can be improved.
Can you spare the time to talk with a researcher about your experiences?
If you would like to participate in this study, please contact our team:
meipvni@qub.ac.uk
QUEEN'S UNIVERSITY BELFAST
STARC
COMMISSIONER FOR VICTIMS OF CRIME

Appendix E - Table 16: Framework, meta-codes, and subordinate themes

Table 16. Framework, meta-codes, and subordinate themes

Report Themes	Original Codes
IPV Experiences	
Early indications of IPV behaviour	• Initial red flags
Sudden change in behaviour	• Sudden change in behaviour
IPV experiences by type	
Psychological/emotional abuse	• Psychological or emotional • Manipulation (others) • Involving children • Parental alienation • Punished for positive events • Harassment (all types) • Self-harm & suicide threats • Career sabotage
Physical abuse	• Physical (general) • Sleep deprivation
Sexual abuse	• Sexual assault • Reproductive coercion
Coercive control	• Monitoring or controlling behaviour • Social isolation (of participant) • Involving children • Financial • Parental alienation
Institutional abuse	• Institutional (general) • False allegations
Coping	
	• Adaptive or protective behaviours • Escape • Exercise • Ignore, block, or push down • Unhealthy coping
IPV Impact	
Physical impacts	• Medical condition • Cognitive impairment • Nightmares • Sleep disturbances (all other)

Report Themes	Original Codes
IPV Impact	
Psychological impacts	• Emotional (general) • Fear, grief, or hopelessness • Hypervigilance • Injustice (emotional) • Loss of agency • Mental health (general) • Paralysis • Self-harm • Self worth • Trust issues
Suicidality	• Suicidal ideation • Suicide attempt • Understanding suicidality
Social impacts	• Criminalised • Dating • Employment • Reputation • Social isolation
Experiences of Disclosure	
	• Didn't disclose • Evidence & documentation • Family • Friends • Others • Not believed • Police
Barriers to Help-Seeking	
	• Logistic - Lack of care pathway - Lack of IPV awareness • Stigmatic - Fear or anxiety - Gender bias - Might not be believed - Public IPV awareness - Self-doubt - Social media - Stigma & self-stigma

Report Themes	Original Codes
Barriers to Help-Seeking	
	• Trust - Institutional - Risk of legal consequences
Experiences of Support	
	• Counselling • Family • Friends • Group or peer • Local (NI charities/orgs)
Post-IPV Recovery & Meaning Making	
	• Post-IPV Recovery • Meaning making
Future Recommendations	
	• Awareness • Collaboration • Dedicated care pathway • Education • Judicial reform • Legal accountability • Support funding • ME-IPV experience - Motivation • Change • Help others • Help own children

Appendix F – Multiple Regression Statistical Model Results

Table 17. Regression model for IPV type on depression, PTSD distress, mental health

	t	*p*	β	*F*	*df*	*p*	*Adj. R^2*
Depression							
Model				3.719	5	0.005**	0.141
Psychological	2.280	0.025*	0.284				
Physical	-0.933	0.354	-0.182				
Injury	-0.206	0.837	-0.037				
Sexual	0.329	0.743	0.041				
Coercive Control	2.792	0.007**	0.340				
PTSD distress							
Model				5.264	5	<0.001***	0.197
Psychological	2.290	0.024*	0.267				
Physical	-0.359	0.720	-0.065				
Injury	-0.978	0.331	-0.164				
Sexual	1.313	0.193	0.152				
Coercive Control	2.915	0.005**	0.338				
Mental health							
Model				4.48	5	0.001***	0.174
Psychological	-3.587	<0.001***	-0.438				
Physical	0.527	0.600	0.101				
Injury	-0.689	0.493	-0.121				
Sexual	-2.854	0.006**	-0.345				
Coercive Control	-1.233	0.221	-0.147				

** $p<0.05$, ** $p<0.01$, *** $p<0.001$*

Table 18. Linear relationship models for mental health variables

	t	*p*	β	*F*	*df*	*p*	*Adj. R^2*
Anxiety							
Model				5.804	1	**0.018***	0.055
IPV total	5.292	**<0.001*****	0.257				
Depression							
Model				5.259	1	**0.024***	0.049
IPV total	5.938	**<0.001*****	0.246				
PTSD distress							
Model				9.505	1	**0.003****	0.089
IPV total	5.479	**<0.001*****	0.315				

** p<0.05, ** p<0.01, *** p<0.001*

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