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Men's Experiences of Psychological and Other Forms of Abuse in Intimate Relationships: A Qualitative Study

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Abstract: Intimate partner violence (IPV) is a public health and social problem worldwide. However, most studies have concentrated on violence against women and not also against men. Interventions for victimized men will only be successful if there is a better understanding of the real experiences, as narrated by the victims themselves, and how these impact their health and wellbeing. This study aimed to investigate the experiences of intimate partner violence, health, and wellbeing among men in east-central Sweden. Data were gathered using eleven in-depth, semi-structured interviews with men who were victims of IPV. Four categories emerged from the analyses: experiences of abuse in the relationship; feelings of isolation, loneliness, and shame; perceived deterioration of health and wellbeing; and negative experiences with public services. The findings indicate that interviewees experienced psychological (rather than physical) violence at the hands of their intimate partner. The abuse had consequences for their health and wellbeing, as they experienced stress, anxiety, depression, and suicidal thoughts. In some instances, it affected their health behavior, as they reverted to alcohol and drug use to cope with the abuse. Moreover, the interviewees felt lonely and unwilling to disclose their suffering because of fear of what family, friends, society, and professionals across different services would think of them. Also, they experienced negative responses from the health and social care services and police when seeking help, which made them even more entrenched in their fear of disclosing the suffering caused by the abuse.

Keywords: intimate partner violence; men; east-central Sweden; health and wellbeing; qualitative methods

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1. Introduction

Intimate partner violence (IPV) is a public health and social problem worldwide [1,2]. It is defined as violence by a former or current spouse or partner, occurring in an intimate relationship against the abused spouse or partner in the context of marriage, cohabitation, or any other formal or informal union [3–6]. Intimate partner violence is a public health

problem affecting both women and men [6–8]. It can take on different forms, from physical, verbal, emotional, sexual, financial, and digital violence to coercive control [9], and is associated with adverse physical health (e.g., physical injuries, impaired physical health) and mental health (e.g., stress, anxiety, depression, post-traumatic stress disorder (PTSD), suicide ideation and behavioral outcomes (e.g., alcohol and drug use, as well as weight problems) among women and men alike [9–20]. However, although IPV affects all genders, the majority of available evidence relates to IPV committed against women and not so much against men [21,22].

Global estimates suggest a prevalence of IPV against men of 17% [23] with variations according to context, the selected sample, and the measurement scales used [23–25]. For instance, a UK-based survey found that 32% of all domestic abuse between 2021 and 2022 was committed against males [23], and results of another study in the same context showed that 29% of men experience IPV in their lifetime [24]. In New Zealand, Mellar et al. [19], investigating a sample of 1355 ever-partnered men, reported that almost half of the sample (49.9%) experienced lifetime IPV, with unemployed men reporting the highest prevalence [19].

Globally, various studies have gathered experiences of IPV among men and found that they endure various forms of abuse [26–29]. For instance, a qualitative study that investigated how men coped with experiences of violence towards them in heterosexual relationships found that there was an internalization of socially constructed structural gender expectations in the study participants' self-perception as men, spouses, and parents [28]. Moreover, the participants' narratives depicted various dichotomist gender perceptions regarding the unacceptability of emotional vulnerability, as well as traditional male roles as responsible spouses and parents. This intensified the frustration and emotional repression of their experience, conducing to engendered helplessness and hopelessness [28].

In Sweden, quantitative studies based on different population samples have reported a prevalence of IPV against men of 4–11% [30–32]. In east-central Sweden and, particularly, the Gävleborg region, which is the setting for the current study, there are no reliable estimates of IPV among men. However, a recent study using data from the 2018 Survey of Health on Equal Terms found that of the 124 men who reported exposure to interpersonal violence in the previous 12 months, the majority (n = 93) had experienced psychological violence. The remaining 31 men had suffered incidents of physical violence, 7 of which had occurred at home, 15 in places of entertainment, 8 in unspecified places, 5 in other people's residences, and 2 in public transport areas [32]. There was no information on where the reported psychological violence had taken place [32]. In addition, the study showed that interpersonal violence had an association with stress, anxiety, and depression, which was largely explained by demographic, health/behavior, and socioeconomic-related factors [32]. Given the need to better understand the issue of IPV among men in the region, as narrated by them, this study sought to investigate experiences of IPV, health, and wellbeing among men residing in east-central Sweden. It is hoped that this knowledge can be used to aid prevention strategies in the region.

2. Materials and Methods

2.1. Study Design

The current study was carried out using a descriptive and exploratory qualitative design [33–35]. According to Colorafi and Evans [33], this type of study requires much less abstraction when conducting data analysis, thus allowing for the inclusion of more intimate details. Furthermore, it is suggested that descriptive qualitative studies are based on the principles of naturalistic research, which allows researchers to describe phenomena by focusing on how interviewees see, interpret, and experience a particular phenomenon in

its natural state [34]. Exploratory qualitative studies have been suggested to be appropriate when the topic under investigation has received little previous attention, which is the case with IPV against men.

2.2. Study Sample, Data Collection, and Procedure

This study was conducted in Gävleborg County, east-central Sweden, from October 2023 to June 2024. It is based on a convenience sample of 11 men exposed to IPV in a heterosexual relationship who had sought help at a crisis center for men. Inclusion criteria were (a) being a resident of the Gävleborg region, (b) being 18 years and over, and (c) being a victim of IPV. Perpetrators, or men who were both perpetrators and victims, were excluded. Contact with the study participants was facilitated by the crisis center, and a total of eleven (out of sixteen invited) were interviewed in the study (after saturation was achieved). The mean age of the participants was 45 years. Four participants were married, two cohabitated with their partners, and five were separated. Regarding education attainment, five had a university degree, two had completed secondary, and four had completed primary education. The majority of participants earned > 250,000 SEK; two earned < 150,000 SEK (see Table 1).

Table 1. Sociodemographic characteristics of the interviewed sample.

Respondent	Age (Years)	Marital Status	Educational Attainment	Income (in-Thousand SEK/Year)
A	56	Separated	University	>250
B	73	Separated	Secondary	150–250
C	35	Separated	University	>250
D	38	Cohabitating	Primary	>250
E	38	Separated	Secondary	>250
F	47	Separated	University	>250
G	28	Married	University	>250
H	52	Married	Primary	<150
I	39	Cohabitating	University	>250
J	47	Married	Primary	<150
K	47	Married	Primary	<250

A total of eleven in-depth semi-structured interviews were conducted based on saturation. A thematic interview guide was used to collect the data. Originally designed in English, the interview guide was translated into Swedish and thereafter back-translated into English to ensure accuracy. Questions included participants' sociodemographic information, experiences of victimization by an intimate partner, consequences of victimization for participants' daily life and for their health and wellbeing, and participants' perceived treatment in encounters with social work and healthcare professionals as well as with the police (see Table 2). The interview guide was piloted with two participants whose responses were subsequently included in the final study.

The interviews were conducted in a secluded place and at a time and place chosen by the participants to ensure maximum privacy and were recorded after consent. The interviews lasted 50 min on average (range 30–73 min). Data collection was carried out by the author, F.S. Interview texts were transcribed verbatim.

Table 2. Example of topics of discussion for the interview.

1. When we talk about violence/abuse, it can mean many things. What experiences of violence and abuse have you had?
2. When did the violence/abuse start? And how did it develop?
3. If you ever tried to confide in someone, what happened?
4. How have your experiences affected your life? At home, at work, your friendships?
5. How have your experiences affected your health and wellbeing?
6. What is your experience with different services such as primary care, social services, and the police when you told them that you were exposed to violence/abuse in your relationship?

2.3. Data Analysis

Analyses were carried out using content analysis [36–38]. According to Preiser et al. [38], content analysis seeks to find and examine patterns of sense-making and meaning creation in the communicative characteristics of language by focusing on the content, underlying themes, and meanings that emerge in a text (in either written or spoken form). The analysis used the three steps suggested by Elo and Kyngås [37]. In the first step, interviews were read several times to reach an understanding of the essential meanings of the text. Thereafter, the text related to the study's aims was marked and divided into meaning units. These were condensed, coded, and analyzed by comparing similarities and differences and then merged into categories that described the manifest content. This was an iterative process guided by the first author (G.M.) in discussion with the second author (F.S.) to ensure accuracy. The procedures described above were used to achieve the best categories reflecting the study's aims and the obtained data [37]. Finally, the categories were reviewed by the remaining authors, M.R., J.P., D.W., A.-S.H., and J.S.

2.4. Ethical Considerations

The study was approved by the Swedish Ethical Review Authority [Dnr 2023-03493-01]. In the transcribed data, to ensure the participants' anonymity, the participants' names were coded using letters. Furthermore, before each interview, the participants were informed of the voluntary nature of their participation and that they were free to withdraw from the interview at any time if they so desired. The participants provided oral informed consent. Moreover, given the sensitivity of the research topic and following the ethical board's guidelines, the study and interview information and the invitation letter to the participants included details of the head psychotherapist at the crisis center for further guidance and support where needed.

3. Results

Four categories emerged capturing participants' experiences of victimization in their relationships: (a) experiences of abuse in the relationship; (b) feelings of isolation, loneliness, and shame; (c) perceived deterioration of health and wellbeing; and (d) negative experiences with public services.

3.1. Experiences of Abuse in the Relationship

Participants experienced verbal abuse from their partners. For example, an interviewee stated:

> *It was many verbal assaults. She also threatened me with a rivet, to hit my head with the rivet, and [has] threatened to cut my throat. But otherwise, it's verbal abuse that she has exposed me to. With infidelity, and humiliation; and smearing my children, my friends,*

even work colleagues. A narcissistic behaviour that I had a hard time coming to terms with and I didn't think in any way that I deserved to be exposed to that. Not blows, but then the screaming, infidelity and betrayal. Well, I don't even know how to describe it all.

(Participant B)

Another participant said,

Yes, I sat and thought about it earlier today and it's hard just to kind of feel that you're a member of that group of people—men—who've been exposed to violence. It was nothing physical, but rather it has been an incredible number of stressful situations, psychological abuse through games and manipulations and things like that which have caused me to basically burn out, and not be able to sleep. I take anti-depressants; I've gone to psychologists.

(Participant C)

In addition, another participant indicated that,

It's difficult to judge when the violence began. But afterward, I came to understand that it is violence and that it started a little earlier than I thought. Early on, I even thought that my partner maybe had a mental illness; she criticized me in front of others constantly, and her own problems became mine. Also at first, I thought she suffered some kind of depression. And anything that was not done her way was somehow wrong. So, I didn't get to be myself. I had to adapt to her mood and kept finding excuses for her behaviour. Yes, I felt controlled through SMSs [short message services], long e-mails, verbal assault, and criticism even in front of my child.

(Participant F)

Some participants felt terrorized in their abusive relationships. One said,

"My partner called me constantly, but as I said, she called at work all the time, so I lost that job. And then I lost another job because of this. I ended up losing two jobs."

(Participant A)

Another participant said,

Five years of physical, psychological, and economic abuse. We actually met at a pub. It was good at first, but then it got worse and worse. I saw this tendency quite early, but it escalated as time passed. It was like where are you?, Where are you going? (My partner needed constant FaceTime and my exact location.) [. . .] My freedom of movement and my freedom of speech were limited; and also, I was not allowed to express myself in the way I wanted.

(Participant G)

There were also instances of physical abuse. One interviewee related,

I have been beaten, often. I have tried to talk to friends about it. I've said that I think maybe, it's so much to repress, but maybe it's. It's not once every 6 months and it's not once a week, but maybe once a month or once every 2 months.

(Participant K)

One participant described the abuse experienced in his relationship as follows:

". . . it was mostly psychological abuse. She tormented both me and the children and everyone else around. She's been like that for 12 years."

(Participant J)

3.2. Feelings of Isolation, Loneliness, and Shame

Some participants preferred to stay in their abusive relationships for fear of being isolated as well as for fear of having to disclose the violence in their relationship. One said,

> *No, I'm not afraid for my life. I am mostly afraid of being alone. Because if I lose her, then I will be alone for the rest of my life. Two previous relationships and one with an addict who was completely crazy, threatening me with serious violence at one point and scamming me out of money at another.*
>
> (Participant I)

Another participant described feelings of isolation:

> *During the relationship, I felt isolated from my sister and my parents because they wanted nothing to do with her. They haven't, they haven't come here to visit almost. I mean in other contexts, well, what should I do [. . .]. I don't know. It's probably all that has been affecting everyone.*
>
> (Participant H)

Talking about finding help, one participant said that there was no point in disclosing the violence he experienced:

> *I can't bear it; it doesn't matter, because I won't be believed anyway. And the women explain it away and the men think "Well, blame yourself, you idiot. Who runs after chicks?" Because if you're functional then you are a man. If you're a woman and functional, you're still that other. But if you are a man and not well, then you are nothing else, you will be alone.*
>
> (Participant I)

Reflecting on his situation, a participant explained,

> *I decided to tell no one what I was going through—the physical and verbal abuse probably because I felt shame, I think. You don't want to tell that your wife is going "bananas". You try to quiet her down at parties when she may have a little too much to drink. Stuff like that all the damn time. And instead of just being able to be proud of your wife.*
>
> (Participant K)

On the question of leaving the relationship, one participant reflected,

> *"I stayed; I didn't leave [. . .]. I have no idea. I kind of just wanted to keep it together . . . Then, there was that thing that you had, you didn't think you deserved anything better; you don't want to be alone."*
>
> (Participant J)

Another participant said

> *I'm probably "old school", you keep the family together at any cost, obviously. Oddly enough, I have cried like hell. There is so much stuff that we have, so much financial stuff together that it becomes difficult. I have built a whole life, a summer cottage by the water, boats, jet skis, scooters, and more [. . .]. I'm afraid to be in debt, afraid that I won't be able to afford to keep certain things. For example, the summer cottage which has gone up by two million SEK.*
>
> (Participant K)

3.3. Perceived Deterioration of Health and Wellbeing

Respondents talked about the deterioration of their health and wellbeing, which they perceived was directly linked to the abuse they were experiencing. One participant related,

Yes, it's been difficult, very, very difficult. I have gained 25 kg in weight. As I said, I can't sleep without psychiatric medication. I've never taken a tablet for something like that before. There is also the shame. In my world, it's shameful to have to do that kind of crap to be able to sleep.

(Participant K)

Another said,

Yes, still it's like a kind of after-violence as well. She never gives up. She has even begun to go after my new relationship. What she wants to get out of it, I don't understand. It went so far that I tried to kill myself before meeting my current partner. I was going crazy. And it's been a hell of a story in itself. I drank alcohol and took sleeping pills. Then it started to hit home.

(Participant J)

Talking about his experiences of lack of wellbeing in the abusive relationship, a participant commented,

When my partner would say, I'm going to the police, I became scared, I can honestly say. Because then it was like, yes, even if I am the victim of the abuse if I'm convicted of something, then I'm in trouble. Then I might as well kill myself.

(Participant I)

Regarding his wellbeing, one participant said,

If you think in terms of everyday life, I have been and am still very, very tired. Constantly exhausted. It's hard to do a lot of things. I have a hard time getting through a workday, it's like it's a struggle even though I don't even work full-time now. Otherwise, you're just really tired. It has driven me into depression and anxiety that is still ongoing. I really have a hard time, and I have very little motivation for things in general and I'm just like this, I have no desire to do anything so it's very much like that. I've had a hard time sleeping. Still today is pretty hard to sleep, but it's gotten better.

(Participant C)

Another type of abuse leading to deterioration of wellbeing was described as follows:

My partner ghosted me from time to time . . . one day she's gone, then she returns and starts being cute, but then you confront her and say something; and then all of a sudden she disappears again for a couple of days, and you know this could happen, could it be a week before my birthday or something. I felt really bad and asked my sister to take me to a psychiatrist because I had suicidal thoughts.

(Participant E)

Another participant who had had treatment for addiction to narcotics said,

Because of the abuse, my addiction escalated; it was even worse because of the things that were happening. I tried to have my treatment in place and put right the pieces to understand the whole. But I really had a hard time, for a year I was clean. I didn't feel well, felt emotionally closed, depressed, and thought I was worth nothing . . . and I believed that I wouldn't be able to have a life without her.

(Participant D)

3.4. Negative Experiences with Public Services

Interviewees often expressed that the public services (healthcare, social services, and the police) did not help. However, one participant had the opposite experience:

I don't know, I contacted the health services, and they sent me to a good private psychologist. And he raised a lot of thoughts in me. So that helped a little bit and then some

things he explained that, yes. He told me that I needed to start thinking about myself and not just think about everyone else. That yes, I'm not the one who is selfish or egotistical. "It's not about being selfish", he said. "This is about respecting yourself". And it is actually so.

(Participant A)

By contrast, a participant who sought help from social services because his son was also exposed to violence, related,

She [his partner] has been physically aggressive towards him [his son]. I have to always be awake in case something happens. I know I should apply for sole custody. They changed personnel, and I didn't feel that they always handled the investigation in a serious way. And I'm thinking, they take the child's perspective. It's about the child, but it can also make it difficult because they are different services; because I am an adult, this is on another level. The social services listened to her narrative, especially based on her way of criticizing me as a father.

(Participant F)

The following illustrates a participant's experience with the police:

I reported my partner for fraudulent behaviour and illegal threats. I received a notice from my previous work, then I asked the manager if maybe I could talk to someone; yes, we had an agreement with my previous organization that they would report it. I filed a police report at some point, but they didn't understand anything.

(Participant I)

Another participant said about his contact with social services and the police,

"I have lost trust in everyone. You completely lose trust in everyone. And when I filed a police report on my partner, it led to nothing."

(Participant J)

Another participant who reported being verbally abused and humiliated by his partner described his experience of treatment by the police and health services as follows:

"I received a call from the police saying that I should urgently report to them or contact them, which I did. And at ten o'clock on Tuesday, I was there with a lawyer that I was assigned and then I found out that I am suspected of rape and molestation. She had applied for a restraining order. No, I was not molesting my partner; the authorities believed her story, and I was afraid of what could happen to me. Also, my contact with health services led to nothing"

(Participant B)

4. Discussion

The majority of the participants suffered psychological abuse from their partners, as also reported in other studies carried out in a variety of contexts [9,10,15,39–43]. Not only were the participants verbally abused, but they were also humiliated in front of their children and others. Also, they were terrorized by their partners in their workplaces or when they simply went out alone. Where physical abuse occurred, it was mostly in the form of objects thrown in a participant's face or at his body.

The above findings are in line with the findings of a Canadian study, which showed that participants were controlled, threatened, humiliated, insulted, demeaned, made to feel bad, called derogatory names, and had limited contact with their children [40]. In the same study, physical abuse included assault, broken bones, and bruises; some participants needed hospitalization because of the assaults they had suffered [40]. The findings from

the present study also resonate with those from previous qualitative studies carried out in other Swedish regions. For instance, a qualitative study of 24 men residing in the cities of Stockholm and Gothenburg reported exposure to violence and control [42]. Furthermore, in that study, the victimized men's partners were jealous and did not like their partners' friends, made them pay for things, belittled and humiliated them, called them names, and excluded them from family events. Also, the male victims felt controlled by their partners through emotional abuse [42].

The results of the current study also showed that most of the participants felt lonely and isolated and had difficulties or were unwilling to talk about or disclose their victim status to friends or family. Similar findings have been reported elsewhere [44–54]. According to some, male victimization demonstrates a "forbidden narrative", with some male victims expressing fear of disclosing violence against them as a choice of being "emasculated" and "fac[ing] public ridicule" [48]. Furthermore, it has been maintained that men have more difficulty articulating experiences of abuse as compared with women [45]. Machado and colleagues [46] found that there was a link between men's perception of masculinity and their internal shame, combined with lacking resources for addressing the victimization they experienced. Using a reflexive thematic analysis of 26 men who experienced violence at the hands of their female partners, Hogan et al. [48] found that the men felt shame and were embarrassed for not being able to uphold the dominant cultural expectations on what roles men should have in relationships. The authors of that study found that participants had difficulties accepting their victim status, which they perceived as not being masculine [48]. Similarly, a Swedish qualitative study carried out by Hellgren and colleagues in a smaller sample of abused men reported that participants, to some extent, opposed the view that they were victims and tried to distance themselves from any victim role. Simultaneously and contradictorily, they craved recognition of their experiences of victimization [49]. Moreover, they felt victimized not only by their partners but also by society, which, they believed, saw their victimization experiences as taboo [49].

Some of the participants in the present study preferred to stay in their abusive relationships, among other reasons, because of economic fears, fear of losing the family, and fear of failure. This is in agreement with findings from a recent systematic review investigating why men stay in intimate partner violent heterosexual relationships, which identified reasons such as concern for their children and fear of losing contact, commitment to the relationship, and psychological dependence [50]. The same review found that there were characteristics associated with the role of a man in society that prevented the participants from leaving the relationship, as well as reasons that were not mentioned in the literature, such as family pressure, guilt, threats of suicide by the partner, and fears of not being believed [50]. Wiehe [51] reports that being the victim of domestic violence is destructive to men's self-esteem and self-image and that a man who has been beaten by his wife or partner is most likely to be psychologically broken [51].

Interestingly enough, some of our participants mentioned that initially, they were not aware that they were being abused in their relationships. Similar findings were reported in a study by Gueta and Shlichove [52], which found that the reasons why men did not seek help for the abuse they experienced from their female partners were related to internal barriers, which included male roles, excuses for maintaining the relationship, and blindness to the abuse [52]. Specifically, regarding being blind to abuse, the authors argued that the participants of their study were unable to view their partner's behaviors as intimate partner abuse because they could not recognize it as such, either because of a lack of gender-inclusive knowledge about intimate partner abuse or because abusive behavior had been normalized during other parts of their lives [52]. One participant in our study pointed out that he had experienced abuse in childhood, which he perceived to have continued

through the abuse he was experiencing in his relationship. A meta-analysis carried out by Godbout and colleagues regarding IPV among male survivors of child maltreatment found that there was an overall significant association between child maltreatment and IPV. The magnitude of the effect did not vary as a function of type (perpetration vs. victimization) or form (sexual, psychological, or physical) of IPV [53].

Our study findings further indicated that participants experienced poor health and wellbeing, ranging from stress and anxiety to drug use, alcohol, and, in some cases, increased weight and suicidal ideation. Elsewhere, studies have found that male victimization had physical and psychological consequences [33,42,54]. For instance, a study by Bates, which used qualitative methodology among men aged 18 years and over, indicated that participants expressed that the violence they experienced had an impact on their physical and mental health and their subsequent relationships (regarding future intimate partners as well as relationships with others) [54]. In addition, two participants in our study talked about feeling lonely and hopeless to the extent that they had suicidal thoughts. Other studies have found that domestic violence against men is associated with stress, depression, psychosomatic symptoms, and psychological distress; and in some cases, these men have displayed profound depressive symptoms and psychological distress that made them live in misery and stress [9,10,21,40,55]. Furthermore, according to some authors, victimized men can suffer other long-term effects such as guilt, anger, anxiety, shyness, nightmares, disruptiveness, irritability, and problems getting along with others. Long-term effects can also include homelessness and poverty (as a result of an overwhelming lack of resources), which, in turn, can place abused men on a destructive path for their future, as their life is usually shattered [28,46,55–57]. In our study, only two participants were physically abused, and none suffered major injuries that required hospitalization. However, according to other studies conducted elsewhere, men in abusive intimate relationships are physically injured and sometimes even killed as a result of domestic violence [40]. Also, evidence from quantitative studies has found male victimization to be statistically and significantly associated with low self-esteem [58], physical injuries [10], anxiety, depression, suicidal behaviors [10,13,16,58–60], PTSD [60,61], and deterioration of physical health conditions [11,19,22]. Regarding male victims turning to alcohol consumption and drug use, as also reported by our participants, one study argues that alcohol and drug use need to be perceived as a flawed mechanism for coping with the negative emotions arising from the victimization experience [62].

The current study results also reveal that, in general, participants had negative experiences (and perceptions) of their encounters with public services (health and social services and the police), which are expected to help in the first place. Some participants sought help in healthcare facilities or from social services and even contacted the police without success. Those who were attended by healthcare or social services ended up being transferred to private facilities. A common denominator among many participants was that they feared they would not be believed by the personnel working across the public services. Similar findings have been reported elsewhere [52,63]. In addition, the results are in line with the identified external barriers reported in the Gueta and Shlichove study [52], which included fear of seeking help as well as legal self-preservation among male victims of IPV [52]. Furthermore, in the same study, it was found that the male victims avoided seeking help for fear of being arrested and falsely accused by the police or courts [52]. They also believed that professionals working with victimized men had gender biases regarding who should be the victim of intimate partner abuse in heterosexual relationships [52]. Other studies have found similar results [54,63,64]. For instance, one systematic review and qualitative synthesis on help-seeking by male victims of domestic violence and abuse found that barriers to seeking help included fear of disclosure, a challenge to their masculinity,

commitment to the relationship, diminished confidence, or despondency, and a negative perception of services [63]. In our study, one of the participants who contacted the police to report the abuse found no help whatsoever. For instance, another study found that when men called the police during an incident in which the female partner was violent, the police often failed to respond, or worse, the men were ridiculed or incorrectly arrested as the primary aggressor [64]. The same study reports that the abused men who were in contact with the justice system reported experiencing gender-stereotyped treatment, even when there was corroborating evidence that their female partners were violent and that the men were not the perpetrators. Still, they lost custody of or were blocked from seeing their children and were falsely accused by their partners of IPV and abusing their children [64]. In the current study, a participant who had contacted social services perceived that much of the attention was on his partner's narrative.

4.1. Study Strengths and Limitations

This study has important strengths. It is the first study interviewing victimized men in east-central Sweden to obtain firsthand accounts of their experiences of victimization and perceived consequences to their health and wellbeing. Until now, analyses of male abuse in the region have been carried out quantitatively using population-based surveys that have had low response rates and a high percentage of missing information regarding all forms of abuse (psychological, physical, sexual, and economic) as well as where the abuse took place (especially regarding whether the abuse had occurred at home) [32,65,66]. In addition, because of the collaboration with the crisis center for the purposive recruitment of participants, the research team could interview only men who were victims (i.e., excluding those who were perpetrators or who were both perpetrators and victims). Nevertheless, this study has important limitations. Firstly, it is based on a small sample, and the findings cannot be generalized to other Swedish regions. After eleven participants were interviewed, saturation was achieved, and no added information was obtained from the interviewees. According to Dworkin, several factors can affect the sample size in qualitative studies, including the nature and complexity of the topic and the degree of saturation sought (factors that can be related to the current study) [67]. Secondly, as reported elsewhere, abused men are an exceedingly difficult group to reach, as often, they are not willing to talk about their situation as victims of abuse [49,54,64]. Therefore, the research team was dependent on those who were willing to disclose their experiences.

4.2. Practical Implications

The findings from this study have practical implications for healthcare and social services and the police, as well as for public health promotion in east-central Sweden. Firstly, there is a need for healthcare services (first and foremost, primary healthcare services) as well as social services and the police to be aware that there is a sensitivity that is particular to male victims of IPV. Professionals working in these public services need to consider the possibility that when men contact their services, they may have been exposed to IPV. Moreover, professionals need to bear in mind that when men have been exposed to abuse, it is important to validate their experiences, given that there is a likelihood that they might fear being considered perpetrators when seeking help [48].

Secondly, although the country as a whole, as well as the different regions/counties, do have guidelines for the detection of violence, especially against women, it seems that these services are not well prepared to serve victimized male help-seekers. For instance, a recent mixed-methods study assessing the use of clinical guidelines against domestic violence in southern Sweden found that 73% of first-line managers of healthcare units with patient contact responded that they were aware of the care program; only 27% reported knowledge

of its content [68]. Moreover, the authors also reported that the extent to which the staff of these units knew about and followed the program was relatively low and suggested that it was important to develop collegial and managerial support and training on domestic violence, as well as build care programs [68]. In a study of self-perceived competence and willingness to ask about IPV among Swedish social workers, Lundberg and Bergmark [69] found that a substantial percentage of Swedish social workers considered themselves to be fairly ill-equipped to handle cases of IPV. In the same study, a regression analysis showed that training, high self-perceived competence, and administrative procedures separately increased the likelihood of social workers regularly asking clients about IPV [69]. This illustrates the importance of training social workers in order to enable better identification of cases of IPV.

Thirdly, from a public health (and health promotion) perspective, it is important that primary healthcare facilities (where the majority of prevention and intervention processes take place) engage in the prevention and intervention of IPV among both women and men to mitigate the potential physical and mental consequences of exposure to violence. To this end, it is important that general practitioner doctors and nurses working in health centers are trained to detect male victims of IPV to the same extent they already identify female victims. In the UK, an increase in the identification of male victims of domestic violence was found after an intervention that trained nurses and doctors [70].

5. Conclusions

This study found that the majority of participants experienced psychological (rather than physical) violence at the hands of their intimate partner. The abuse had consequences for their health and wellbeing as they experienced stress, anxiety, depression, and suicidal thoughts. In some instances, it affected their health behavior, as they turned to alcohol and drugs to cope with the abuse. Moreover, the participants felt lonely and were often unwilling to disclose their suffering because of fear of what their family, friends, society, and professionals across different services would think of them. Also, the interviewees reported receiving negative responses from healthcare and social services and the police when seeking help. This made them even more entrenched in their inability to disclose their suffering. Future qualitative studies using larger regional as well as national samples, with different types of abuse against men in various types of relationships, are warranted.

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