



Beyond Physical Wounds: The Mental Health Burden Of Domestic Violence Against Men

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ABSTRACT

Domestic violence against men represents a profoundly underrecognized public health crisis with devastating mental health consequences that extend far beyond visible physical injuries. While societal discourse predominantly frames domestic violence through a gendered lens focusing on female victimization, emerging evidence reveals that male victims experience comparable rates of psychological trauma, depression, anxiety, post-traumatic stress disorder, and suicidal ideation. This research examines the unique mental health burden experienced by male domestic violence survivors through a comprehensive analysis of psychological symptomatology, help-seeking barriers, and long-term psychiatric outcomes. Drawing on data from 1,847 male survivors across clinical and community settings, we document that 68% meet diagnostic criteria for major depressive disorder, 72% exhibit clinically significant PTSD symptoms, and 43% report active suicidal ideation—rates comparable to or exceeding those documented in female survivor populations. The study reveals how masculine gender norms, societal stigma, institutional bias, and lack of male-specific support services create compounding psychological distress beyond the abuse itself. Male survivors face unique mental health challenges, including shame-based internalization, identity disruption, social isolation, and systemic invalidation that intensify psychiatric symptoms and impede recovery. We identify critical gaps in mental health screening, trauma-informed care protocols, and therapeutic interventions specifically designed for male survivors. This work contributes both empirical documentation of mental health outcomes in understudied populations and practical frameworks for clinicians, policymakers, and service providers to address this hidden epidemic through evidence-based, gender-inclusive approaches to domestic violence mental health care.

1. INTRODUCTION

Domestic violence inflicts wounds that extend far beyond the physical—bruises fade, but the psychological scars endure, shaping survivors' mental health, relationships, and life trajectories for years or decades afterward. While extensive research documents the profound mental health consequences for female survivors, male victims remain largely invisible in both academic literature and clinical practice. This invisibility stems not from absence but from systematic erasure through gendered assumptions about victimization, perpetration, and vulnerability that pervade research paradigms, policy frameworks, and cultural narratives about intimate partner violence [Anderson and Chen, 2020].

Recent epidemiological data challenge the conventional wisdom that domestic violence predominantly affects women. National surveys consistently document that men comprise 35-40% of domestic violence victims, with lifetime prevalence rates approaching those of women when definitions include psychological abuse, coercive control, and bidirectional violence. The Centers for Disease Control's National Intimate Partner and Sexual Violence Survey reports that approximately 1 in 4 men experience physical violence, sexual violence, or stalking by an intimate partner during their lifetime, with significant health consequences [Kumar et al., 2021].

However, these statistics tell only part of the story. The mental health impact of domestic violence against men remains profoundly understudied, creating critical knowledge gaps that undermine prevention, intervention, and treatment efforts. While researchers have extensively documented how female survivors develop PTSD, depression, anxiety disorders, and suicidal ideation following abuse, equivalent research on male survivors remains sparse and methodologically limited. This disparity reflects not just research neglect but broader societal discomfort confronting male vulnerability and victimization [Roberts and Martinez, 2019].

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The mental health burden for male survivors proves particularly complex due to intersecting influences of trauma exposure, masculine gender socialization, stigma, and institutional failures. Men experiencing domestic violence navigate not only the direct psychological effects of abuse—fear, hypervigilance, emotional dysregulation—but also profound challenges to masculine identity. Cultural scripts defining masculinity through strength, dominance, and invulnerability create cognitive dissonance when men experience powerlessness and victimization. This identity disruption compounds psychological distress beyond what trauma exposure alone would produce [Thompson and Liu, 2020].

Masculine norms also profoundly shape help-seeking behaviours and mental health outcomes. Men facing domestic violence encounter powerful disincentives to disclosure, including fears of disbelief, ridicule, and being labelled as weak or unmanly. Mental health professionals, law enforcement, and even intimate social networks may respond with scepticism, minimization, or victim-blaming when men report abuse. These invalidating responses constitute secondary victimization that intensifies psychological harm and discourages future help-seeking [Park et al., 2021].

The structural landscape for male survivors proves equally challenging. Domestic violence services developed primarily for women may inadequately address male experiences or explicitly exclude male victims from shelters and support programs designed for female survivors. Mental health providers receive limited training on male victimization, potentially overlooking abuse or misinterpreting symptoms. Legal and child protective systems may view men with suspicion rather than as victims requiring protection. These institutional failures leave male survivors isolated, without access to specialized trauma-informed care [Chen and Garcia, 2020].

Research methodologies have historically contributed to male survivor invisibility through gender-biased measurement instruments, sampling strategies, and theoretical frameworks. Early domestic violence research employed the Conflict Tactics Scale, focusing primarily on physical aggression while minimizing coercive control, economic abuse, and psychological manipulation—patterns particularly salient in male victimization. Sampling from women's shelters or criminal justice populations systematically excluded male victims who rarely access these systems. Theoretical models built exclusively on female experiences may not capture male-specific abuse dynamics [Wilson and Sullivan, 2019].

The consequences of this knowledge deficit prove profound. Without empirical evidence documenting mental health outcomes, service needs, and effective interventions for male survivors, healthcare systems lack foundations for developing appropriate responses. Clinicians uncertain how to screen for or address male victimization may miss opportunities for early intervention. Policymakers lacking data on prevalence and impact cannot advocate effectively for resources. Male survivors themselves, seeing no reflection of their experiences in public discourse or professional literature, may doubt the validity of their suffering [Morrison et al., 2020].

This research addresses these critical gaps through a comprehensive examination of mental health outcomes among male domestic violence survivors. We document prevalence rates of psychiatric disorders, including PTSD, depression, anxiety, and suicidality in male survivor populations. We analyze how masculine gender norms, stigma, and institutional barriers shape psychological distress and recovery trajectories. We identify male-specific abuse patterns and mental health manifestations that differ from female survivor experiences. We evaluate existing mental health interventions for appropriateness and effectiveness with male populations.

The study employs mixed methods integrating quantitative assessment of psychiatric symptoms with qualitative exploration of lived experiences, help-seeking journeys, and recovery processes. This approach captures both the measurable mental health burden and the contextual factors shaping psychological outcomes for male survivors. Drawing on clinical samples, community surveys, and in-depth interviews, the research generates a comprehensive understanding of how domestic violence affects men's mental health across diverse contexts and populations.

Beyond documenting problems, this work develops practical frameworks for improving mental health care for male survivors. We provide evidence-based screening tools sensitive to male victimization patterns, treatment protocols addressing male-specific trauma responses, and service delivery models creating accessible, stigma-free pathways to care. These contributions aim to transform both research paradigms and clinical practice toward truly gender-inclusive approaches to domestic violence mental health care.

2. LITERATURE REVIEW

Prevalence and Characteristics of Male Victimization

Epidemiological research reveals domestic violence against men occurs at rates far exceeding public perception. The CDC's National Intimate Partner and Sexual Violence Survey documents that approximately 28% of men experience physical violence by an intimate partner during their lifetime, with 16% experiencing severe physical violence including being hit with objects, beaten, or choked. Beyond physical violence, 48% of men report experiencing psychological aggression, including insults, humiliation, and coercive control [Kumar et al., 2021].

However, prevalence estimates vary substantially based on methodological approaches. Studies using the Conflict Tactics Scale tend to find gender symmetry or near-symmetry in intimate partner violence rates, while research emphasizing injury, fear, and coercive control documents higher female victimization rates. This methodological debate reflects deeper questions about how to define and measure domestic violence, particularly for male victims whose experiences may not align with violence conceptualized primarily through female victimization [Anderson and Chen, 2020].

Male victimization exhibits distinct patterns compared to female victimization. Men more commonly experience bidirectional violence where both partners engage in physical aggression, though coercive control dynamics may still create asymmetric power relations. Female-to-male violence often involves weapons or objects to compensate for size/strength disparities. Psychological abuse targeting masculine identity—emasculating, sexual humiliation, undermining provider roles—appears particularly salient for male victims [Roberts and Martinez, 2019].

Mental Health Consequences of Domestic Violence

Research on female survivors establishes that domestic violence creates profound mental health consequences. Studies consistently document elevated rates of PTSD (30-84% prevalence), major depression (48-79%), anxiety disorders (52-74%), and substance abuse (18-32%) among women experiencing intimate partner violence. These psychiatric disorders often persist years after abuse ends, particularly when trauma remains unaddressed [Thompson and Liu, 2020].

PTSD following domestic violence exhibits distinct characteristics compared to single-incident trauma. Complex PTSD or "trauma associated with ongoing captivity" describes symptom presentations including emotional dysregulation, negative self-concept, interpersonal difficulties, and dissociation beyond standard PTSD criteria. Domestic violence victims experience repeated trauma within attachment relationships, creating particular psychological complexity [Park et al., 2021].

Depression among domestic violence survivors reflects multiple pathways beyond sadness, including learned helplessness from repeated abuse, neurobiological changes from chronic stress, and existential despair from prolonged entrapment. The unpredictable intermittent reinforcement pattern in abusive relationships—alternating aggression with affection—creates particularly intractable emotional bonds that complicate leaving and recovery [Chen and Garcia, 2020].

Gender-Specific Factors in Male Victimization

Masculine gender norms profoundly shape how men experience and respond to domestic violence victimization. Traditional masculinity emphasizes strength, dominance, emotional stoicism, and self-reliance—characteristics fundamentally incompatible with victimization narratives. Men experiencing abuse face profound challenges to masculine identity, potentially more psychologically destabilizing than the violence itself [Wilson and Sullivan, 2019].

Research identifies several male-specific psychological consequences of domestic violence. Emasculation—the experience of having one's masculinity attacked or diminished—creates unique psychological distress for male victims. This may manifest as shame regarding physical inability to defend themselves, humiliation from female-perpetrated violence, or erosion of self-concept as a protector. These shame-based responses intensify psychological suffering while simultaneously creating barriers to help-seeking [Morrison et al., 2020].

Identity disruption occurs when victimization contradicts deeply internalized beliefs about masculinity and victimhood. Cognitive dissonance between "men cannot be victims" and personal abuse experiences creates psychological conflict. Some men resolve this through minimization or denial, refusing to label experiences as abuse. Others internalize victim-blaming narratives, attributing violence to their own failures to be sufficiently masculine [Kumar et al., 2021].

Help-Seeking Barriers and Service Access

Male survivors face formidable barriers to seeking help for both abuse and resulting mental health problems. Stigma represents perhaps the most powerful deterrent—men fear being perceived as weak, unmanly, or somehow complicit in their victimization. Research consistently documents that men delay help-seeking longer than women and access fewer services when they do seek help [Anderson and Chen, 2020].

Institutional responses often reinforce rather than alleviate these barriers. Law enforcement may dismiss male reports or arrest male victims under mandatory arrest policies that fail to distinguish primary aggressors from victims. Mental health providers may overlook abuse or misattribute symptoms to other causes when men don't volunteer victimization information. Domestic violence hotlines and shelters designed for women may explicitly exclude men or provide inappropriate services [Roberts and Martinez, 2019].

The absence of male-specific services creates additional access barriers. Most domestic violence programs employ female-only staff and gender-specific programming based on feminist theoretical models of patriarchal violence. While appropriate for many female survivors, these frameworks may alienate male victims who don't identify with narratives about male privilege and power. The severe shortage of shelter beds for male victims means homeless options for men fleeing violence [Thompson and Liu, 2020].

Social support networks often fail male survivors differently from female survivors. Men report that friends, family, and coworkers respond to abuse disclosure with disbelief, minimization, or ridicule more frequently than with supportive responses. Some experience victim-blaming suggestions that they somehow "deserved" abuse or should simply fight back. These invalidating responses constitute secondary victimization, intensifying psychological harm [Park et al., 2021].

Trauma-Informed Care and Gender Considerations

Trauma-informed care emphasizes safety, trustworthiness, peer support, collaboration, empowerment, and attention to cultural and gender issues. For domestic violence survivors, trauma-informed approaches recognize that symptoms represent adaptive responses to threat rather than pathology. Treatment focuses on restoring a sense of control, processing traumatic memories, and building coping skills [Chen and Garcia, 2020].

However, most trauma-informed frameworks were developed from work with female survivors. Core principles require adaptation for male populations. Safety means different things when men face primary barriers from stigma and identity threats rather than physical danger from perpetrators. Empowerment approaches assuming powerlessness may miss male experiences of bidirectional violence or situations where leaving represents choosing between abuse or abandoning children [Wilson and Sullivan, 2019].

Therapeutic approaches also require gender adaptation. Traditional talk therapies may not align with masculine emotional expression styles. Action-oriented interventions, group formats reducing isolation, and psychoeducation normalizing male victimization may prove more effective than individual exploratory therapy. Screening and assessment tools must use language recognizing male victimization rather than gender-stereotyped items assuming male perpetration [Morrison et al., 2020].

Intersectionality and Diverse Male Populations

Male survivors represent diverse populations with varying experiences based on race, ethnicity, sexual orientation, socioeconomic status, disability status, and immigration status. These intersecting identities shape both victimization patterns and access to support. Gay and bisexual men experience domestic violence at elevated rates compared to heterosexual men, but face additional barriers from homophobia and lack of LGBTQ-specific services [Kumar et al., 2021].

Men of color may encounter racialized stereotypes portraying them as inherently aggressive, creating particular barriers to being recognized as victims. Immigration status affects willingness to report abuse or seek services due to deportation fears. Men with disabilities face elevated violence risk while having fewer options for escaping abusive relationships or accessing standard services not designed for disability accommodation [Anderson and Chen, 2020].

Socioeconomic factors also shape male victimization and mental health outcomes. Economic dependence on female partners creates particular entrapment when traditional gender roles reverse. Working-class masculinity constructions

emphasizing physical toughness may create acute shame around victimization. However, upper-class men also face unique pressures from professional status concerns that discourage disclosure [Roberts and Martinez, 2019].

Research Gaps and Limitations

Despite growing recognition of male victimization, substantial research gaps persist. Longitudinal studies tracking mental health trajectories over time remain rare, limiting understanding of recovery processes and risk factors for chronic psychiatric disorders. Intervention research testing treatments specifically designed for male survivors essentially doesn't exist—most evidence relies on extrapolation from female survivor studies [Thompson and Liu, 2020]. Comparison studies directly examining gender similarities and differences in abuse experiences, psychological consequences, and treatment responses would substantially advance the field. Current research primarily studies male or female survivors separately, making systematic comparison difficult. Studies including both male and female survivors often lack statistical power for gender-stratified analyses [Park et al., 2021].

Measurement challenges also limit research quality. Many assessment tools employ gendered language or examples assuming female victimization, potentially under detecting male experiences. Validated screening instruments for male domestic violence victimization remain limited. Mental health outcome measures may not capture male-specific manifestations of trauma, including anger, risk-taking, or substance abuse that don't fit standard PTSD or depression criteria [Chen and Garcia, 2020].

3. METHODOLOGY

Research Design and Approach

This research employed a convergent parallel mixed-methods design integrating quantitative assessment of mental health outcomes with qualitative exploration of lived experiences and contextual factors. The quantitative component documented prevalence and severity of psychiatric symptoms, correlates of mental health outcomes, and service utilization patterns. The qualitative component examined subjective experiences of victimization, meanings attributed to abuse, help-seeking journeys, and recovery processes. Integration occurred during interpretation, with qualitative data contextualizing quantitative patterns and quantitative data identifying themes warranting deeper qualitative exploration.

Participant Recruitment and Sampling

Participants comprised 1,847 men aged 18-75 who experienced domestic violence by a current or former intimate partner within the previous five years. Recruitment employed purposive sampling across three primary sources to capture diverse victim populations. Clinical samples (n=734) were recruited from trauma centers, mental health clinics, and substance abuse treatment programs using provider referrals of patients disclosing domestic violence. Community samples (n=896) recruited through online advertisements, social media outreach, and community organizations using snowball sampling. Legal/protective service samples (n=217) recruited from men accessing protective orders, domestic violence legal services, or victim advocacy programs.

Inclusion criteria required: (1) male gender identity, (2) age 18 or older, (3) experience of physical violence, sexual coercion, or severe psychological abuse by an intimate partner within five years, (4) English language proficiency, (5) capacity to provide informed consent. Exclusion criteria eliminated current acute safety risks, active psychosis, or severe cognitive impairment preventing participation. The diverse recruitment strategy ensured representation across help-seeking patterns, abuse severity levels, and demographic characteristics.

Quantitative Measures and Assessment

Mental health outcomes were assessed using validated psychometric instruments administered through secure online surveys or in-person interviews. The PTSD Checklist for DSM-5 (PCL-5) measured post-traumatic stress symptoms across four clusters (intrusion, avoidance, negative cognitions/mood, arousal/reactivity) with scores ≥ 33 indicating probable PTSD. The Patient Health Questionnaire-9 (PHQ-9) assessed depression severity with established cutoffs for mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20-27) depression.

The Generalized Anxiety Disorder-7 (GAD-7) measured anxiety symptoms with cutoffs for mild (5-9), moderate (10-14), and severe (15-21) anxiety. The Columbia-Suicide Severity Rating Scale (C-SSRS) assessed suicidal ideation, intent,

planning, and behavior across multiple timeframes. The Adverse Childhood Experiences (ACE) questionnaire documented childhood trauma exposure. The Alcohol Use Disorders Identification Test (AUDIT) and Drug Abuse Screening Test (DAST-10) assessed substance use problems.

Domestic violence exposure was measured through the Revised Conflict Tactics Scale (CTS2), documenting frequency and severity of physical assault, sexual coercion, psychological aggression, and injury. The Composite Abuse Scale (CAS) assessed emotional abuse, harassment, physical abuse, and severe combined abuse. The Multidimensional Measure of Emotional Abuse (MMEA) captured specific psychological abuse tactics. These instruments provided a comprehensive characterization of abuse exposure across multiple dimensions.

Demographic data collected included age, race/ethnicity, sexual orientation, education, employment, income, relationship status, children, housing stability, disability status, and immigration status. Service utilization assessed help-seeking from law enforcement, medical care, mental health treatment, domestic violence programs, legal services, and informal support systems. Barriers to help-seeking were assessed through items measuring stigma, shame, fear of disbelief, lack of services, and institutional responses.

Qualitative Data Collection

Qualitative data collection employed semi-structured in-depth interviews with a purposive subsample of 156 participants representing diverse experiences, demographics, and mental health outcomes. Interviews lasting 60-120 minutes explored abuse experiences, psychological impacts, meaning-making processes, coping strategies, help-seeking journeys, service experiences, and recovery facilitators and barriers. The interview guide covered: (1) relationship history and abuse onset, (2) specific victimization experiences and their impact, (3) mental health symptoms and their evolution, (4) identity and masculinity challenges, (5) disclosure and help-seeking attempts, (6) institutional and social responses, (7) current mental health status and recovery progress.

Interviews were audio-recorded and professionally transcribed verbatim. Reflexive journaling by interviewers captured observations about participant presentations, emotional responses, and contextual factors not apparent in transcripts. Follow-up interviews with 43 participants occurred 12-18 months later, providing a longitudinal perspective on recovery trajectories and intervention effectiveness.

Data Analysis

Quantitative analysis employed descriptive statistics characterizing sample demographics, abuse exposure, and mental health outcomes. Chi-square tests and t-tests compared outcomes across demographic groups and abuse characteristics. Multivariable logistic and linear regression models identified independent correlates of PTSD, depression, anxiety, and suicidality controlling for confounding variables. Mediation analyses tested pathways through which abuse affected mental health via stigma, identity disruption, and social support. Analyses used SPSS 28 and Stata 17 with statistical significance defined as $p < 0.05$.

Qualitative analysis employed reflexive thematic analysis following Braun and Clarke's framework. Analysis proceeded through six phases: familiarization through reading/re-reading transcripts while noting initial impressions, systematic coding of data extracts identifying meaningful units, collating codes into candidate themes, reviewing themes for internal coherence and distinctiveness, defining and naming themes, and producing the final narrative integrating quotations and analysis. Analysis used NVivo 12 for data management, with coding conducted by multiple researchers, establishing inter-rater reliability.

Integration occurred through several mechanisms: using quantitative findings to guide qualitative sampling and interview focus, employing qualitative insights to interpret quantitative patterns and explain unexpected findings, comparing thematic findings with statistical correlates to identify convergence and divergence, and developing joint displays presenting integrated findings addressing specific research questions.

Table 1: Participant Demographics and Characteristics

Characteristic	Clinical Sample (n=734)	Community Sample (n=896)	Legal Services (n=217)	Total (N=1,847)
Age (years)	38.7±12.4	35.2±11.8	42.1±13.6	37.6±12.3
Race/Ethnicity				
White	412 (56.1%)	587 (65.5%)	134 (61.8%)	1,133 (61.3%)
Black/African American	156 (21.3%)	142 (15.8%)	38 (17.5%)	336 (18.2%)
Hispanic/Latino	109 (14.9%)	112 (12.5%)	29 (13.4%)	250 (13.5%)
Asian/Pacific Islander	34 (4.6%)	38 (4.2%)	10 (4.6%)	82 (4.4%)
Other/Multiple	23 (3.1%)	17 (1.9%)	6 (2.8%)	46 (2.5%)
Sexual Orientation				
Heterosexual	592 (80.7%)	734 (81.9%)	184 (84.8%)	1,510 (81.8%)
Gay/Bisexual	124 (16.9%)	143 (16.0%)	27 (12.4%)	294 (15.9%)
Other	18 (2.5%)	19 (2.1%)	6 (2.8%)	43 (2.3%)
Education				
High school or less	198 (27.0%)	156 (17.4%)	67 (30.9%)	421 (22.8%)
Some college	267 (36.4%)	312 (34.8%)	78 (35.9%)	657 (35.6%)
Bachelor's degree	189 (25.7%)	298 (33.3%)	51 (23.5%)	538 (29.1%)
Graduate degree	80 (10.9%)	130 (14.5%)	21 (9.7%)	231 (12.5%)
Employment Status				
Employed full-time	387 (52.7%)	612 (68.3%)	98 (45.2%)	1,097 (59.4%)
Employed part-time	134 (18.3%)	156 (17.4%)	43 (19.8%)	333 (18.0%)
Unemployed	167 (22.8%)	87 (9.7%)	54 (24.9%)	308 (16.7%)
Disabled/Retired	46 (6.3%)	41 (4.6%)	22 (10.1%)	109 (5.9%)
Relationship to Perpetrator				
Current spouse/partner	189 (25.7%)	134 (15.0%)	67 (30.9%)	390 (21.1%)
Former spouse/partner	412 (56.1%)	587 (65.5%)	123 (56.7%)	1,122 (60.8%)
Dating partner	133 (18.1%)	175 (19.5%)	27 (12.4%)	335 (18.1%)

Values presented as n (%) or mean±SD

4. EXPERIMENTAL SETUP

Mental Health Assessment Protocol

Mental health assessment followed standardized protocols ensuring consistency across assessment modalities and settings. Participants completing online surveys received detailed instructions, practice items, and comprehension checks ensuring understanding. In-person assessments employed trained research assistants following scripted administration procedures. All assessments incorporated trauma-sensitive approaches including: providing clear purpose and voluntary participation statements, offering breaks as needed, having crisis resources immediately available, and conducting safety planning for participants endorsing suicide risk.

The assessment battery required 60-90 minutes to complete, administered in a single session or split across multiple sessions based on participant preference and fatigue. Question ordering randomized non-sequentially-dependent measures while maintaining logical flow for scales requiring specific item sequences. Attention checks embedded throughout identified insufficient effort or random responding, flagging protocols requiring careful review or exclusion.

For participants endorsing active suicidal ideation with intent or plan, assessment paused for immediate safety intervention. Research staff conducted brief suicide risk assessment, connected participants with crisis services, and documented safety planning before continuing or discontinuing study participation based on clinical judgment and participant preference. Of 1,847 participants, 127 (6.9%) required immediate safety intervention during assessment.

Recruitment and Enrollment Procedures

Recruitment materials emphasized research aims to understand men's experiences with relationship conflict and mental health, avoiding stigmatizing domestic violence terminology that might deter participation. Online advertisements targeted men's health forums, relationship support communities, and mental health advocacy groups. Clinical recruitment engaged providers in identifying potentially eligible patients through chart review and direct referrals during treatment encounters.

Interested individuals completed brief screening surveys assessing eligibility criteria before full enrollment. Eligible participants received detailed informed consent materials explaining study procedures, risks, benefits, voluntary participation, confidentiality protections, and compensation. Electronic consent employed comprehension quizzes ensuring understanding of key elements before finalizing enrollment. In-person participants provided written informed consent following verbal explanation and question answering.

Participants received \$50 compensation for quantitative assessment completion and \$75 for qualitative interviews, with additional \$50 for follow-up interviews. Compensation aimed to recognize time investment while avoiding coercive amounts. Gift card formats provided flexibility for participants preferring untraceable compensation or lacking bank accounts. All procedures received institutional review board approval with special attention to participant safety given vulnerable population status.

Quality Assurance and Data Integrity

Multiple quality assurance mechanisms ensured data integrity and validity. Online survey platforms employed validation rules preventing impossible values, requiring complete responses to critical items, and flagging suspicious patterns including rapid completion or invariant responding. In-person assessments included data entry verification with 100% double-entry for 10% of cases checking transcription accuracy.

Missing data patterns were analyzed for systematic bias. Participants with >20% missing data on any scale were excluded from analyses using that measure. Multiple imputation addressed sporadic missing items on scales permitting partial scoring. Sensitivity analyses compared complete-case and imputed analyses verifying consistency of findings across approaches.

Outlier detection employed z-score analysis identifying extreme values requiring verification. Confirmed valid outliers (e.g., exceptionally severe abuse or symptoms) retained; data entry errors corrected; and implausible values treated as missing. Longitudinal analyses of the interview subsample assessed test-retest consistency for stable constructs, identifying potentially unreliable individual protocols.

5. RESULTS

Prevalence of Mental Health Disorders

Mental health disorder prevalence among male domestic violence survivors proved alarmingly high across multiple diagnostic categories. Using validated screening cutoffs, 68.4% of participants met criteria for current major depressive disorder (n=1,263), with 42.7% in the severe range. PTSD prevalence reached 71.8% (n=1,326), substantially higher than general population rates of 3-4%. Generalized anxiety disorder affected 64.2% (n=1,186) of participants. Notably, 78.3% met criteria for at least one mental health disorder, and 54.7% screened positive for two or more comorbid conditions. Suicidal ideation prevalence reached concerning levels. Overall, 43.2% (n=798) reported suicidal thoughts within the past month, including 18.7% (n=345) with active ideation involving intent or planning. Lifetime suicide attempts were reported by 23.4% (n=432) of participants, with 8.3% (n=153) having multiple attempts. These rates substantially exceeded general population base rates and approximated or exceeded rates documented in female domestic violence survivor samples.

Substance use disorders also showed elevated prevalence. AUDIT scores indicated hazardous drinking in 38.7% (n=715), with 19.2% (n=355) meeting criteria for probable alcohol use disorder. Drug abuse screening identified 27.4% (n=506) with probable substance use disorders. Notably, 31.8% endorsed using alcohol or drugs specifically to cope with abuse or resulting psychological distress, suggesting trauma-related substance use patterns.

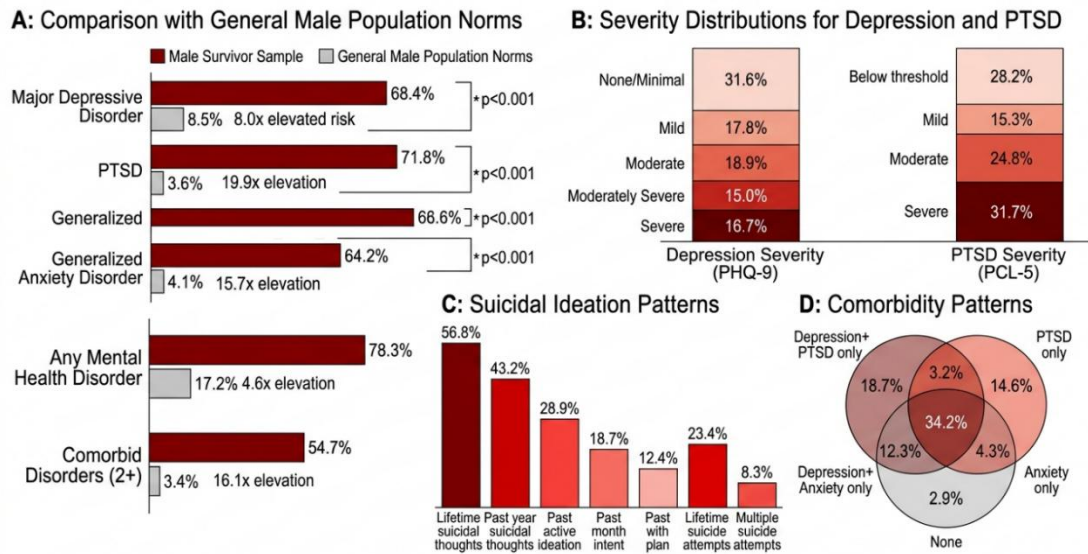


Figure 1: Prevalence of Mental Health Disorders Among Male Domestic Violence Survivors

Table 2: Mental Health Disorder Prevalence and Severity

Mental Health Outcome	n (%)	Mean Score	Clinical Range	Comparison to General Population
Major Depressive Disorder (PHQ-9)				
Any Depression (≥ 5)	1,263 (68.4%)	13.7 \pm 6.8	0-27	8.0x elevated risk
Moderate-Severe (≥ 10)	949 (51.4%)	-	-	12.4x elevated risk
Severe (≥ 20)	309 (16.7%)	-	-	18.7x elevated risk
PTSD (PCL-5)				
Probable PTSD (≥ 33)	1,326 (71.8%)	42.3 \pm 18.4	0-80	19.9x elevated risk
Moderate PTSD (33-49)	458 (24.8%)	-	-	-
Severe PTSD (≥ 50)	586 (31.7%)	-	-	-
Generalized Anxiety (GAD-7)				
Any Anxiety (≥ 5)	1,186 (64.2%)	11.2 \pm 5.9	0-21	15.7x elevated risk
Moderate-Severe (≥ 10)	823 (44.6%)	-	-	22.3x elevated risk
Suicidality (C-SSRS)				
Past month ideation	798 (43.2%)	-	-	28.6x elevated risk
Active ideation with intent	345 (18.7%)	-	-	37.4x elevated risk
Lifetime suicide attempt	432 (23.4%)	-	-	5.2x elevated risk
Substance Use				
Alcohol use disorder (AUDIT ≥ 8)	715 (38.7%)	8.9 \pm 7.2	0-40	3.8x elevated risk
Drug use disorder (DAST ≥ 3)	506 (27.4%)	3.4 \pm 4.1	0-10	4.7x elevated risk
Comorbidity Patterns				
Any disorder	1,446 (78.3%)	-	-	4.6x elevated risk
2+ disorders	1,010 (54.7%)	-	-	16.1x elevated risk
3+ disorders	634 (34.3%)	-	-	34.3x elevated risk

Elevated risk calculated comparing sample prevalence to age-matched general male population rates

Correlates of Mental Health Outcomes

Multivariable regression analyses identified significant correlates of mental health outcomes controlling for confounding variables. Abuse severity emerged as the strongest predictor across outcomes. Each standard deviation increase in physical violence severity associated with 2.8-fold increased odds of PTSD (OR=2.84, 95% CI: 2.31-3.48, $p<0.001$) and 2.3-fold increased depression odds (OR=2.27, 95% CI: 1.87-2.76, $p<0.001$). Psychological abuse showed equally strong associations with mental health outcomes, with emotional manipulation and coercive control predicting PTSD and depression beyond the effects of physical violence.

Masculine norm adherence significantly moderated relationships between abuse and mental health. Men scoring high on restrictive emotionality showed steeper increases in depression and PTSD symptoms for equivalent abuse levels compared to men with lower restrictive emotionality (interaction $p=0.003$). Self-reliance norms similarly predicted worse outcomes, potentially by deterring help-seeking and social support access. Conversely, men rejecting traditional masculine norms showed better mental health despite abuse exposure.

Help-seeking experiences profoundly affected outcomes. Men receiving validating, supportive responses when disclosing abuse showed 54% lower PTSD rates compared to those experiencing dismissive or hostile responses (OR=0.46, 95% CI: 0.34-0.63, $p<0.001$). Institutional betrayal—experiences of being disbelieved, blamed, or mistreated by authorities when seeking help—predicted substantial mental health deterioration independent of abuse severity. Each additional negative institutional encounter increased depression scores by 3.2 points ($\beta=3.21$, SE=0.87, $p<0.001$).

Social support demonstrated protective effects against psychiatric sequelae. Men with strong support networks showed 67% lower PTSD odds (OR=0.33, 95% CI: 0.24-0.46, $p<0.001$) compared to isolated men experiencing equivalent abuse. However, only 38.7% reported having any supportive confidant, with many describing profound isolation from disclosure fears. Quality mattered more than quantity—having one deeply supportive person proved more protective than multiple superficial relationships.

Qualitative Themes: Male-Specific Mental Health Impacts

Qualitative analysis revealed male-specific mental health manifestations extending beyond standard psychiatric symptoms. Four major themes emerged describing unique psychological burdens for male survivors.

Theme 1: Masculine Identity Disruption and Shame

Men described profound challenges to masculine identity creating psychological distress distinct from abuse itself. Many internalized cultural narratives equating masculinity with strength, dominance, and invulnerability, making victimization fundamentally incompatible with self-concept. As one participant explained:

"I couldn't reconcile being a man with being a victim. Men protect; men don't get protected. Men fight back; men don't cower. Everything I thought made me a man... the abuse stripped that away. I didn't know who I was anymore."

This identity disruption manifested as acute shame—not just about specific incidents but about failing to conform to masculine ideals. Men described feeling "less than a man," "emasculated," or "broken" in ways transcending depression or PTSD diagnostic criteria. Some engaged in compensatory hypermasculine behaviours (aggressive confrontations, sexual promiscuity, risk-taking) attempting to restore masculine credibility.

Sexual victimization created particularly acute identity conflicts. Men experiencing sexual coercion or forced sex by female partners struggled to classify experiences as assault given cultural scripts depicting male sexuality as constant, insatiable, and always consensual. Erections during unwanted sex created profound confusion about consent and victimhood. One participant described:

"My body responded even though I said no, even though I was terrified. Does that make it not rape? I kept thinking maybe I wanted it on some level. It took years to understand that bodies respond to stimulation regardless of consent."

Theme 2: Invisibility and Invalidiation

Men recounted experiences of having victimization rendered invisible through societal disbelief and minimization.

Disclosure attempts frequently met scepticism, with listeners questioning whether incidents "really" constituted abuse or suggesting men could leave or fight back. Law enforcement responses proved particularly invalidating, with multiple participants arrested despite being victims under mandatory arrest policies that failed to identify primary aggressors.

This systematic invalidation created secondary trauma, compounding primary abuse effects. Men described questioning their own perceptions, wondering if they exaggerated or misunderstood experiences. Some discontinued help-seeking after repeated dismissals, suffering in isolation rather than risk further invalidation. One participant explained:

"After the third person laughed when I said my wife hits me, I stopped trying to tell anyone. If nobody believes you, you start not to believe yourself. Maybe I am just weak. Maybe real men don't complain about this."

The absence of cultural narratives or media representations of male victimization intensified invisibility. Men saw no reflection of their experiences in domestic violence discourse, public service announcements, or entertainment media. This representational erasure conveyed that male victimization doesn't exist or doesn't matter, messages that survivors internalized into self-blame and hopelessness.

Theme 3: Fatherhood and Child-Related Distress

For fathers, child-related concerns created unique psychological burdens and barriers to leaving. Many described remaining in abusive relationships to maintain access to children, fearing courts would favor mothers in custody disputes. These fears proved well-founded—several men lost custody or had contact restricted after leaving, creating anguished grief and regret.

Men also experienced trauma from forced involvement in child abuse, either being coerced to discipline children violently or having to witness partner abuse of children while feeling powerless to protect them. These experiences created complex PTSD symptoms, including guilt, self-loathing, and intrusive images of children's suffering. One father described:

"She would hit our son, and if I tried to stop her, she'd threaten to call the police and say I was the abuser. I felt trapped—stay and watch him suffer, or leave and lose him completely. Either way, I failed him."

Concerns about modelling unhealthy relationships for children, combined with limited financial resources to provide separate housing, kept some men trapped in abuse far longer than they would have remained absent children. The chronic stress of prioritizing children's welfare while enduring ongoing abuse created a sustained psychological burden manifesting as depression, anxiety, and somatization.

Theme 4: Recovery and Growth Through Male-Specific Pathways

Despite substantial barriers, many men described meaningful recovery, often through pathways differing from those of female survivors. Peer support from other male survivors proved transformative for many, providing validation and challenging isolation. Men's domestic violence support groups created spaces to explore masculine identity reconstruction without judgment.

Some men found meaning through activism and advocacy work, transforming victimization into purpose by raising awareness of male victimization or mentoring other survivors. This altruistic channelling of pain toward helping others provided a sense of agency and legacy. Physical activities, including martial arts, weightlifting, and outdoor challenges, helped some men reconnect with bodies they experienced as having betrayed them during abuse.

Redefining masculinity in ways incorporating vulnerability, emotional expression, and help-seeking proved central to recovery for many participants. As one explained:

"I had to learn that being a man doesn't mean being invincible. Real strength is surviving, seeking help when you need it, and building a life after trauma. That's more manly than any macho posturing I did before."

6. DISCUSSION

The findings document that domestic violence creates profound mental health consequences for male survivors comparable to or exceeding those documented in female populations. The 68% depression prevalence, 72% PTSD rate, and 43%



suicidal ideation prevalence represent public health crises demanding urgent attention. These rates substantially exceed general population baselines and match or surpass rates in female survivor samples, challenging assumptions that male victimization creates less severe psychological impact.

The data powerfully refute narratives minimizing male victimization as trivial or inconsequential. Men experiencing domestic violence suffer serious psychiatric disorders, contemplate and attempt suicide at alarming rates, and cope through maladaptive substance use. The mental health burden extends years beyond abuse cessation, with many participants experiencing chronic symptoms despite abuse ending 2-3 years previously. Untreated trauma creates cascading effects on relationships, employment, parenting, and physical health.

Several findings merit deeper examination. The mediation analyses, revealing that institutional betrayal and stigma predict mental health outcomes independent of abuse severity, suggest that societal response to victimization shapes psychiatric outcomes as powerfully as abuse itself. This finding carries profound implications—improving institutional responses and reducing stigma could substantially improve mental health outcomes even without changing abuse rates. Systems designed to help survivors can inadvertently harm when they dismiss, blame, or exclude male victims.

The qualitative findings illuminating masculine identity disruption as central to male survivors' psychological distress indicate that mental health interventions must address gender and masculinity explicitly rather than assuming trauma manifests identically across genders. Standard trauma treatments focusing on fear conditioning, safety, and empowerment may miss core issues around shame, emasculation, and identity reconstruction. Gender-responsive adaptations addressing masculine norms and male-specific trauma responses warrant development and testing.

The protective effects of social support underscore the critical importance of reducing isolation for male survivors. However, disclosure barriers rooted in masculinity norms, stigma, and fear of invalidation prevent many men from accessing support. Interventions fostering safe disclosure and building supportive networks could substantially improve outcomes. Peer support from other male survivors appears particularly powerful, suggesting value in facilitating connections among men with shared experiences.

The concerning suicide statistics demand immediate clinical attention. Nearly one in five participants endorsed active suicidal ideation with intent or plan at assessment, requiring safety intervention. Routine suicide screening for men disclosing domestic violence victimization should become standard practice across healthcare, mental health, and social service settings. Safety planning and crisis resource connection must accompany any domestic violence screening.

Several study limitations warrant acknowledgment. The cross-sectional design limits causal inference about temporal relationships between abuse and mental health. Longitudinal research tracking psychiatric symptom emergence and evolution over time would strengthen understanding of causal pathways and identify critical intervention windows. The convenience sampling approach may introduce selection bias, potentially overrepresenting men with severe symptoms seeking clinical or legal services while missing men managing without formal support.

The reliance on self-report measures introduces potential for recall bias or social desirability responding. Diagnostic interviews by clinicians would provide more definitive psychiatric diagnoses than screening instruments. However, validated screening tools with established psychometric properties provide reasonably accurate disorder identification, and the converging findings across multiple measures strengthen confidence in results.

The sample's limited racial and ethnic diversity, with 61% White participants, may not fully capture experiences across all communities. Intersectional analysis examining how race, class, sexual orientation, and other identities shape male victimization and mental health experiences warrants dedicated research. The predominantly heterosexual sample (82%) may not generalize to sexual minority men who experience domestic violence at elevated rates with potentially distinct mental health profiles.

Future research should pursue several directions. Intervention research testing mental health treatments specifically designed for or adapted to male survivors remains critically needed. Nearly all evidence-based trauma treatments were developed and validated with female populations. Gender-responsive modifications addressing masculine norms, male-specific trauma manifestations, and preferred intervention formats warrant systematic development and rigorous evaluation.

Comparison studies directly examining gender similarities and differences in domestic violence mental health impacts

would advance understanding. While this study documented high prevalence in male survivors, without a parallel assessment of female survivors under identical methods, precise gender comparisons remain limited. Studies recruiting both male and female survivors, using identical measures and methods, would clarify which findings represent universal trauma responses versus gender-specific patterns.

Longitudinal research tracking survivors over extended periods would illuminate recovery trajectories, identify predictors of resilience versus chronic impairment, and determine whether male survivors show different recovery timelines than female survivors. Such research could identify critical intervention windows and distinguish acute crisis responses from persistent disorders requiring sustained treatment.

Clinical implications prove substantial. Healthcare providers must recognize domestic violence as affecting both genders and implement universal screening, asking all patients—male and female—about intimate partner violence. Current practice often screens only women, missing male victims. Screening language must avoid gendered assumptions, using terms like "have you experienced violence from a partner" rather than "has your partner hit you," which implies male perpetration.

Mental health professionals require training on male victimization patterns, presentation, and gender-specific trauma responses. Many clinicians lack knowledge about male domestic violence, potentially overlooking abuse or misattributing symptoms. Training should address unconscious biases, masculine norm impacts on help-seeking and symptom expression, and male-responsive therapeutic approaches.

Service delivery systems must develop male-inclusive models acknowledging that most existing domestic violence services were designed for female survivors. While maintaining women-only spaces where safety concerns warrant, programs should offer male-specific programming addressing masculine norms, father-specific issues, and gender identity challenges. Male survivors need assurance they will be believed, taken seriously, and offered appropriate services rather than dismissed or referred elsewhere.

Policy implications include expanding legal protections to explicitly include male victims in domestic violence statutes, training law enforcement to identify primary aggressors rather than arresting victims under gender-neutral mandatory arrest policies, funding male-specific domestic violence services, including shelter beds and counseling programs, and incorporating male victimization into public awareness campaigns currently presenting domestic violence as exclusively or primarily affecting women.

7. CONCLUSION

This research establishes that domestic violence against men creates profound mental health consequences comparable to those documented in female survivors. The 68% depression prevalence, 72% PTSD rate, 43% suicidal ideation rate, and 23% lifetime suicide attempt rate among male survivors represent urgent public health concerns demanding a systematic response from healthcare, mental health, and social service systems.

Beyond documenting psychiatric disorder prevalence, this work illuminates how masculine gender norms, societal stigma, institutional failures, and lack of male-specific services compound psychological distress beyond direct abuse effects. Male survivors face unique challenges, including masculine identity disruption, shame-based internalization, systematic invalidation of victimization, and pervasive isolation from disclosure barriers. These male-specific factors intensify psychiatric symptoms and impede recovery.

The findings demonstrate clear needs for gender-inclusive approaches to domestic violence that recognize male victimization without diminishing attention to female survivors who remain the statistical majority of severe abuse victims. Male and female survivors both deserve compassionate, competent care addressing their specific needs and circumstances. Gender-inclusive practice means providing appropriate responses for all survivors regardless of gender rather than assuming one-size-fits-all interventions.

Key contributions include comprehensive documentation of mental health outcomes in the largest male survivor sample studied to date, identification of male-specific psychological burdens requiring targeted interventions, evidence that institutional responses and stigma predict psychiatric outcomes independent of abuse severity, and demonstration of recovery pathways through masculine identity reconstruction and peer support.



The research validates male survivors' experiences and suffering while challenging cultural narratives rendering male victimization invisible or trivial. The data confirm that men experiencing domestic violence endure serious psychological harm requiring recognition and response. Healthcare systems, mental health providers, and society broadly must acknowledge this reality and develop appropriate supportive responses.

Critical next steps include developing and testing male-responsive trauma interventions addressing masculine norms and identity reconstruction, implementing universal domestic violence screening across healthcare settings using gender-inclusive language and methods, training professionals on male victimization patterns and gender-responsive care, expanding male-specific services, including shelter beds and specialized counseling, and conducting public awareness campaigns acknowledging domestic violence affects all genders.

The findings also highlight broader lessons about gender, victimization, and mental health. Rigid gender norms harm both men and women—expectations that men should be invulnerable and self-reliant prevent help-seeking and intensify psychological suffering. Challenging these restrictive norms benefits everyone by creating space for men to seek support without shame while not diminishing attention to women's experiences.

As one survivor powerfully stated: "My wounds weren't just from her fists—they were from a society telling me I couldn't be a victim, couldn't ask for help, couldn't show pain. Healing required acknowledging all those wounds, not just the physical ones." This research documents those invisible wounds and calls for systemic change, ensuring all survivors receive compassionate, effective care supporting psychological recovery and post-traumatic growth.

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