Male survivors of sexual violence and abuse (SVA):

Barriers and facilitators to reporting and accessing services

Authored by:

Louise Dixon[1], Gareth Treharne[2], Michaela Pettie[1], Chris Bowden[1], Tess Patterson[2], Melanie Beres[2], Brigit Mirfin-Veitch[2,3], Rachel Shaw[2], Angela Eketone-Kelly[2], Jacob Ashdown[2]

[1] Te Herenga Waka - Victoria University of Wellington; [2] University of Otago; [3] Donald Beasley Institute

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Disclaimer

The views and interpretations in this report are those of the researchers and are not the official position of the Ministry of Social Development.

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Executive summary

"He kai o te rangatira, he kōrero; The food of chiefs is to talk" (participant #35)

Purpose of the research

Sexual violence and abuse (SVA) is most typically presented as a gender-based problem due to the higher prevalence and incidence rates recorded for women. This has led to male victimisation being overlooked in research, practice and policy, despite international statistics demonstrating that a significant number of men experience SVA across their lifespan. In this research project we move past the question of "how many men have experienced SVA?" and instead we aimed to understand the barriers and facilitators to reporting and accessing support services for adult male survivors of SVA. The lack of knowledge about the experience of marginalised groups, who are over-represented in the victimisation statistics, led us to investigate the problem across a diverse range of male survivors across the broad helpseeking process (including disclosure to anybody through to reporting and accessing a range of services). Therefore, the findings can inform the design of services for male survivors broadly and lay the foundations for further nuanced explorations of subgroups with specific demographic characteristics.

Research questions

Three questions were addressed in this report:

1. What are the demographic characteristics of the male survivors who took part in the study and how had they sought help?
2. How had the male survivors experienced barriers and facilitators to helpseeking?
3. How do service workers' views on barriers and facilitators to helpseeking compare to the male survivors' experiences?

Methodology

Fifty-two male survivors completed a participant interest form and an interview with one of a team of interviewers. Thirteen service workers completed an anonymous online questionnaire.

We employed a novel, trauma-informed research methodology to engage a hard-to-reach and diverse range of male survivors and to prevent re-traumatisation. Specifically, we recruited survivors who differed in their gender identity, sexual orientation, age, ethnicity, learning and physical abilities, geographical location (rural and/or urban residence at the time of SVA) and with those who had, and had not, reported or accessed support services. To achieve this, we collaborated with a range of specialist and non-specialist services working with male survivors and advertised the project using inclusive male-friendly language across a range of mediums.

Using the information that male survivors shared on the participant interest forms and interviews, content analysis was undertaken to answer Research Question 1. We analysed the interview data using an inductive approach to thematic analysis to answer Research Question 2 by identifying themes from the participants' narratives. We used this bottom-up approach to empower the male survivors, ensuring their words and points of importance were captured by the key themes and thus, their voices heard. In line with this bottom-up approach we did not assume there would be differences in the barriers and facilitators associated with reporting and accessing services. We allowed the men to raise differences and similarities between reporting and accessing and reflected these in the titles of the specific sub-themes. To answer Research Question 3, we employed a deductive thematic analysis approach by testing whether existing themes were also present in service workers' questionnaire responses to see if they agreed with the themes identified in the male survivors' narratives. We undertook a sense-making workshop with stakeholders to provide quality assurance of the findings and recommendations. From the overall findings we developed composite case studies to showcase typical examples of the male survivors' experiences.

Findings

Research Question 1: What are the demographic characteristics of the male survivors who took part in the study and how had they sought help?

The novel trauma-informed methodology engaged a diverse sample of male survivors, including survivors who differed across age, gender, sexual orientation, ethnicity, disability, and rural and urban residence at the time of the SVA. This included four (7.7%) men who had never reported or accessed support services prior to engaging in this study. Perspectives of marginalised groups were included within the sample, with 21 (40.4%) of the male survivors identifying with between two and four demographic groups commonly over-represented in the male survivor statistics.

The majority of the male survivors reported the SVA (34; 65.4%) and/or accessed a service for support (48; 92%). Of the 34 who reported, 32 (61.5%) provided an estimation of the time taken to report. The average time taken to first report was 18 years, with the majority (22; 68.8%) reporting between 10-50 years post-SVA. Most reported to ACC (26/32; 81.3%) followed by police and doctors (14/32; 43.8%). The most common reasons for reporting were to access financial aid (18; 56.3%) and to prevent harm to others (8; 25%). Most survivors (40; 83.3%) took between 5-60 years to first access a service. The majority accessed a specialist SVA support service (40; 83.3%). The most common reason for accessing was to address problem behaviours that had arisen from the SVA. With regards to crisis support, only four men reported within 48 hours of experiencing a first incident of SVA from a perpetrator. However, even crisis reporting did not lead to accessing support services quickly, rather the survivors had to feel ready to access support services.

The majority of male survivors had disclosed their victimisation before taking part in the research (47; 90.4%). Disclosure played an important role in the helpseeking journey and was most commonly the first helpseeking action for the majority of male survivors (38; 73.1%). Therefore, disclosure, reporting and accessing support services are interconnected helpseeking behaviours, with 31 (59.6%) survivors carrying out all three actions. Increasing disclosure could, therefore, serve to increase reporting and accessing of support services. However, not all men disclosed or wanted to disclose, and some of the survivors stressed the importance of not placing pressure on survivors to disclose or report before they feel ready to do so.

Research Question 2: How had the male survivors experienced barriers and facilitators to helpseeking?

The male survivors' experiences helped us develop five themes:

1. Gendered social norms and myths are a barrier for helpseeking.
2. The presence and quality of formal and informal social support impacts helpseeking.
3. The complex nature of trauma hinders timely helpseeking.
4. Service provision, visibility and design need to be tailored to male survivors to facilitate access.
5. Quality support from service workers can build agency and maintain male survivors' helpseeking.

Research Question 3: How do the service workers' views on barriers and facilitators to helpseeking compare to the male survivors' experiences?

The five themes identified by the male survivors were endorsed by the service workers. Additional points raised were:

- Optimism over a perceived recent increase in public awareness about men's sexual victimisation.
- Service workers should sensitively phrase direct questions to invite disclosure from male survivors and to promote early intervention.
- Funding is required to increase bespoke and appropriate services for male survivors.
- All-gender services, and workers who are trained to work with diverse populations, provide good opportunities to increase provision for male survivors.
- There is a need for quick and easy access to services via a range of modalities (Zoom, telephone, face-to-face).

Conclusions and recommendations for practice and policy

This research confirms that SVA is a gender-inclusive problem, highlighting that a diverse group of male survivors' needs have to be understood in order to develop targeted and effective prevention and early intervention initiatives. The findings also strengthen the argument that there is a need to understand and respond to SVA as a public health issue, which includes delivering far reaching education initiatives. Indeed, results show that gender-inclusive societal and service worker education is essential to encourage early intervention. Furthermore, as positive social support is shown to be a key factor in encouraging disclosure, both social support and disclosure should be viewed as an important part of the helpseeking process.

Increasing these factors will increase reporting and the access of support services. However, services also need to be bespoke, accessible and trauma-informed to enable men to access them effectively. The findings therefore support the need to move past the question of "how many men?" and put in place effective societal education campaigns, training for specialist and non-specialist service workers and a range of services and resources which, together, can serve to increase reporting and promote helpseeking and early intervention.

Glossary of terms and acronyms

Terms	Description
Critical realist/essentialist epistemological paradigm	A critical realist/essentialist epistemological paradigm is one way that researchers can think about making sense of people's descriptions of their experiences. Within this paradigm, researchers apply the idea that what people say provides direct insight into their experiences that can be used to develop themes about those experiences.
Deductive qualitative analysis	Verifying pre-determined theories, or themes, in the participants' narratives.
Disclosure	We consider that disclosure occurs when a survivor talks about their experiences of SVA to a person or service worker who is not able to initiate a formal process that can result in an investigation, funding, or provision of services, or provide redress. Whilst the individual or worker may be able to refer the survivor onto a support service or assist them in reporting the incident(s) of SVA, this is not the same as being able to initiate a formal process.
Gender-inclusive initiatives	Initiatives that are tailored to meet the needs of all genders, including female, male, and all other gender identities.
Hegemonic masculinity	The dominant position of what it means to be a man in society.
Helpseeking	Is *"any* action of energetically seeking help from the health care services or from trusted people in the community" (Umubeyi, Morgen, Ntaganira, & Krantz, 2016, p.83). We consider it to include elements of disclosure (telling people about the sexual victimisation), reporting (informing services who can help men to formally address the SVA and/or its impacts) and accessing services for support with the impact of SVA.
Inductive qualitative analysis	Identifying themes from the participants' narratives. This approach develops theory through listening to the participants' voices.
Intersectionality	Understanding how aspects of a person's identity overlap to create different models of discrimination, disadvantage, or privilege. In this study we were concerned with the overlap that male survivors presented with across the demographic groups that are over-represented in the male survivor statistics.
Male survivors	People who identify as, or have experience of, living or being perceived as male, and who have experienced SVA at some point in their lives.
Reporting	We consider that reporting occurs when a survivor presents to a service with the goal of receiving some sort of formal action to address the SVA and/or its impact.
Service workers	We use this generic term to refer to any person who is performing tasks that require training gained through formal education and/or experience. It includes professionals, but we prefer the broader term of service worker so as not to limit the definition those just those people who have gained higher education qualifications, which is sometimes understood to define a professional.
Sexual violence and abuse (SVA)	This broad term refers to different non-consensual sexual acts that may involve elements of force, coercion and/or power by one person over another for the purpose of sexual gratification and/or control. This can include both contact and non-contact behaviour, including 'online' computer-assisted sexual harm (Ministry of Social Development, 2018). The terms violence and abuse are used to acknowledge that men's experiences of victimisation can range from one isolated incident to many incidents over time.
Specialist support service	A service where the staff are trained to provide support to specifically address the issue of SVA and its effects.

Survivor	People who have experienced SVA. We opt to use this term over victim or victim-survivor as the majority of men in the study who indicated a preference, chose the term survivor.
Thematic analysis	An approach to analysing qualitative data often used in psychology and the social sciences, described by Braun and Clarke (2006). Patterns of meaning are identified across a dataset to answer questions about people's experiences, views and perceptions of a given phenomenon.
Trauma-informed	An approach that recognises the role that trauma may play in an individual's life. A set of principles guide how systems and service providers work to reduce the likelihood of re-traumatising individuals.
Whānau	Family, including extended family.

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1. Introduction

1.1 Purpose and requirements of the research

The Ministry of Social Development (MSD) commissioned the research team to conduct an exploratory study into the barriers and facilitators to reporting and accessing support services for male survivors of sexual violence and abuse (SVA). It is intended that the findings will inform the design of services for male survivors and ongoing research into male SVA. MSD (2020) requested that the study focus on:

- The barriers and facilitators to reporting and accessing support services for male survivors.
- The extent to which male survivors know how to report and access support services.
- Factors that influence male survivors' decisions to report and access support services.
- How easy it is for male survivors to report and access support services.
- Which agencies/support services men prefer, and tend, to report to and access support from.
- The experiences of men from diverse identity groups.
- Men's experiences of specialist services.
- Variation over time in the survivors' experiences.

To inform the design of the study and the rationale for the research project, we also reviewed the research literature.

1.2 The study rationale

1.2.1 Defining SVA

We adopt the term SVA in this study to acknowledge that men's experiences of victimisation can range from one isolated incident to many incidents over time (HM Gov 2018; World Health Organization [WHO] 2014; 2021). We also adopt a broad definition of SVA to recognise the range of acts that constitute victimisation:

> *"Sexual abuse is a descriptor for a number of sexual behaviours that are engaged in without consent and involve elements of force, coercion and/or power by one person over another for the purpose of sexual gratification and/or control. This can include both contact and non-contact behaviour, including 'online' computer-assisted sexual harm. [...] it is acknowledged that many male survivors experience sexual harm that may not be perceived as violent or abusive"* (Ministry of Social Development (MSD), 2018, p. 6).

1.2.2 Male sexual violence and abuse is an under-researched area

SVA has most typically been presented as a gender-based problem (Foster, Boyd, & O'Leary, 2012) where, unlike women, men are understood as perpetrators rather than victims or survivors (Depraetere, Vandeviver, Vander Beken, & Keygnaert, 2020). This has led to male sexual victimisation being overlooked in research, practice, and policy (Foster et al., 2012; Mejía, 2005; Porta, Johnson, & Finn, 2018; Quadara et al., 2017).

However, a growing body of international statistics and research has demonstrated that a significant number of men experience SVA across their lifespan and that it creates many difficulties for men, their families, and communities (Fergusson, McLeod, & Horwood 2013; Petersson & Plantin, 2019; Quadara et al., 2017). International prevalence rates of child sexual abuse of males under age 16 have been estimated at between one -in-six to one-in-10 (Carswell, Donovan & Kaiwai, 2019). With regards to adult male SVA, victimisation rates are estimated at 3.7% in the USA (Smith et al., 2017), 3.8% in England and Wales (or one in 27 males; Office for National Statistics, 2018) and 4.7% (or one in 20) in Australia (Australian Bureau of Statistics, 2016).

In Aotearoa New Zealand, Cycle Two of the New Zealand Crime and Victims Survey (Ministry of Justice [MOJ], 2020) reported that 12% of men surveyed had experienced one or more incidents of SVA during their lifetime. Whilst survey methodology differs, making it difficult to compare rates across countries (e.g., Esquivel-Sanotveña & Dixon, 2012), this is a significant number of men, especially considering the under-reported nature of SVA. This international and national evidence has led some practitioners and academics to call for a public health conceptualisation and response to male sexual victimisation (e.g., Foster et al., 2012).

Despite statistics and research showing that adult men also experience SVA and therefore need support (Mejía, 2005; Petersson & Plantin, 2019; Stemple & Meyer, 2014) most attention has been placed on understanding sexual abuse in childhood. Therefore, little is known about adult male victimisation or how adult men cope with the effects of childhood sexual abuse. Stemple and Meyer (2014) argue that this area has received little attention because of a stereotypical sexual victimisation paradigm that perpetuates myths such as female-perpetrated abuse is rare or non-existent, male victims experience less harm, and that sex is welcomed by all men. The authors argue that objective research findings concerning male victimisation that conflict with dominant feminist theory (i.e., that men use sexual aggression to keep women subordinate) are politically unpalatable and are, therefore, not used to improve outcomes for all genders.

Furthermore, certain groups of men have not typically featured in research on SVA, including younger and older men, homeless men, those who belong to rainbow communities (Kiss et al., 2020), and disabled men (Foster et al., 2012). Despite high rates of SVA on university campuses (e.g., Fedina, Holmes, & Backes, 2016) little is known about the victimisation experiences of male university students. Therefore, a range of men's perspectives, experiences and views is needed to inform practice and policy, so that responses can meet the needs of all male survivors.

1.2.3 Intersectionality

Marginalised groups of men are disproportionally over-represented in the male survivor statistics (Foster et al., 2012) and therefore require understanding. For example, the 2014 New Zealand Crime and Safety Survey found that Māori men were more likely to have experienced SVA in their lifetime (6.1%) compared to the New Zealand average for men (5.6%; MOJ, 2015). Cycle Two of the New Zealand Crime and Victims Survey (MOJ, 2020) shows that adults who are bisexual, gay or lesbian were more than twice as likely to experience SVA in their lifetime compared to the New Zealand population average. Cook-Daniels and Munson's (2016) survey of

256 transgender and non-binary participants found 50% of transgender people were survivors of sexual abuse, most of whom had experienced 'repeated sexual violence'. Considering persons with a disability, the Australian Royal Commission into Institutional Responses to SVA reported 4.3% of survivors were disabled at the time of their abuse and that the majority of these people were male (61.4%; Australian Royal Commission, 2017).

Given the interconnected nature of social or identity categorisations it is unsurprising that there is overlap (intersectionality) amongst the different groupings. This level of intersectionality should be taken into account when designing research, practice, and policy initiatives.

1.2.4 Low levels of helpseeking

The lack of knowledge about men's experiences of SVA victimisation is impacted by the low levels of helpseeking by male survivors. Helpseeking has been defined as "*any* action of energetically seeking help from the health care services or from trusted people in the community and includes understanding, guidance, treatment and general support when feeling in trouble or encountering stressful circumstances" (Umubeyi, Morgen, Ntaganira, & Krantz, 2016, p.83). It has been described as a dynamic process, including elements of disclosure (telling people about the sexual victimisation), reporting (informing services who can help men to formally address the SVA and/or its impacts) and accessing services for support with the impact of SVA.

Research shows that men do not seek help for a range of social issues as often as women, and this is especially true for those issues that are deemed non-typical by society, such as male SVA victimisation (Dixon, Treharne, Celi, Hines, Lysova & Douglas, 2020). Indeed, men are more likely to under-report compared to women and therefore the rate of victimisation is likely to be much higher than official reports show (Reitsema & Grietens, 2016). Furthermore, other factors, such as living in rural locations may increase barriers to reporting and accessing support due to limited access (Hossain et al., 2014; Kiss et al., 2020; Lewis, 2016).

Poor understanding of the problem reduces opportunities to develop practice and policy for male survivors (Foster et al., 2012; Porta et al., 2018; Quadara et al., 2017). Indeed, limited practice and policy has been aimed at men, and men remain a largely invisible and under-researched group (Van Gough, 2018). It is, therefore, important we enable male survivors to seek help.

1.2.5 Overcoming barriers to helpseeking

Experiencing SVA results in many negative and lifelong effects for male survivors (Petersson & Plantin, 2019). For example, research has associated SVA with experiences of traumatic stress and trauma-related symptoms (Alaggia, 2005), higher risk of re-victimisation, further perpetration, intergenerational trauma (McElvany, Greene & Hogan, 2012; Quadara et al., 2017), impoverished cognitive, behavioural, and social functioning, and physical and mental health difficulties (Quadara et al., 2017). Indeed, the traumatic impact of SVA has led to the school of thought that service workers need to adopt a trauma-informed response to SVA (Campbell, 2016; Mejía, 2005; Quadara et al., 2017). Considering the traumatic impact of SVA, it is concerning that men do not readily report or seek help for SVA victimisation.

To enable men to more easily report and access services, some research has sought to understand the barriers to helpseeking and how they can be overcome. Quadara et al.'s (2017) survey of survivors of childhood sexual abuse identified key factors that made disclosing sexual abuse and accessing support services more or less difficult. These factors included the availability of support services, personal readiness, approachability/supportiveness of service staff, service coordination, referral processes, systems design and welcoming spaces that reflect a trauma-informed approach. Further research is required to fully understand the barriers and facilitators for all male survivors of SVA.

1.3 The study aim and research questions

MSD allocated Budget-19 funding to initiatives focused on male survivors of sexual abuse. Services dedicated to male survivors in Aotearoa New Zealand are relatively new and therefore research is required to inform their ongoing development and address gaps in service provision (MSD, 2020). This research project aimed to understand the barriers and facilitators to reporting and accessing support services with a view to informing the design of services so that male survivors can be better supported.

Specifically, three research questions were addressed:

1. What are the demographic characteristics of the male survivors who took part in the study and how had they sought help?
2. How had the male survivors experienced barriers and facilitators to helpseeking?
3. How do service workers' views on barriers and facilitators to helpseeking compare to the male survivors' experiences?

1.4 A note about the study design

The literature review identified some key considerations that guided the study design.

The lack of knowledge about adult male survivors coupled with the intersectionality of marginalised groups, confirmed the need to investigate the problem across a diverse range of male survivors. It was not our intention to compare specific subgroups of male survivors in this report, rather, we aimed to understand the issue across all male survivors so that we could broadly inform knowledge and the design of services. This research will lay the foundations for further nuanced explorations of specific subgroups of male survivors. We also explored the intersectionality of men so as not to create false expectations that subgroups of men are homogenous (Carswell et al., 2019).

The research methodology was designed to engage a hard-to-reach and diverse range of male survivors who identified with different demographic groups. To achieve this, we employed a novel, trauma-informed design to ensure the safety of participants, prevent potential re-victimisation and encourage engagement. Indeed, it has been noted that when conducting research that addresses traumatic events, it is important to implement such a research methodology (Fraga, 2016; Jewkes, Dartnall & Sikweyiya, 2012; Seedat, Pienaar, Williams & Stein, 2004) to ensure the safety of participants and researchers, minimise harm and avoid re-traumatisation (Becker-Blease & Freyd, 2006; Coles Astbury, Dartnall & Limjerwala, 2014; Ellsberg & Heise, 2002). We were guided by the trauma-informed practice literature to achieve this (Campbell, 2016; Fallot & Harris, 2009; SAMHSA, 2014a). Specifically, we were mindful that our methodology should provide men with:

- Safety (physical, psychological, and cultural)
- Trust and transparency (ensuring the setting is safe and rules and boundaries are explicit)
- Peer support (provide participants with access to peer support and other services)
- Collaboration and mutuality (sharing power and decision-making, preventing coercion)
- Empowerment, voice, and choice (e.g., enabling survivors to tell their story safely, choose how much they tell, and to whom)
- Recognition of cultural, historical and gender issues (e.g., ensuring cultural processes, following tikanga, being gender-responsive and mindful of the experiences and needs of marginalised groups; Koetting, 2016; SAMHSA, 2014b).

Finally, the inductive (bottom-up) methodological approach used in this study allowed the men to raise the issues that they deemed relevant to the helpseeking process. In doing so, our conclusions were led by the survivors. For example, although MSD commissioned this study to specifically examine men's reporting and accessing of support services over and above disclosure, this inductive approach afforded male survivors the opportunity to discuss the role of disclosure as a barrier or facilitator in reporting and accessing services. Any barriers and facilitators relevant to reporting or accessing services are reflected in the titles of the sub-themes. In keeping with this bottom-up approach, reporting, and accessing services are defined using the data in Section 3 of this report. A detailed description of the methodology undertaken is provided in Section 2.

1.5 Introducing the research team

To effectively conduct research with a diverse range of male survivors we engaged a diverse team of researchers with academic expertise in applied research and who identified with a range of social and identity groups. This allowed us to meet the potential cultural needs of individual interviewees and provide them with a choice of interviewer. The investigators and research assistants were:

- **Professor Louise Dixon**, Te Herenga Waka Victoria University of Wellington
- **Professor Gareth Treharne**, University of Otago
- **Dr Michaela Pettie**, Te Herenga Waka Victoria University of Wellington
- **Dr Chris Bowden**, Te Herenga Waka Victoria University of Wellington
- **Dr Tess Patterson**, University of Otago
- **Associate Professor Melanie Beres**, University of Otago
- **Associate Professor Brigit Mirfin-Veitch**, University of Otago and Donald Beasley Institute
- **Rachel Shaw**, University of Otago
- **Angela Eketone-Kelly**, University of Otago
- **Jacob Ashdown**, University of Otago.

The team has specific experience of working with people from a range of identity groups, including Māori (Eketone-Kelly, Pettie, Ashdown), Pākehā (all investigators), rainbow communities (Treharne, Beres, Dixon), cisgender heterosexual men (all investigators), people with learning disabilities[1] (Mirfin-Veitch, Patterson, Dixon) and university students (all investigators). Dixon and Patterson are also registered psychologists.

We also recruited a group of advisors with experience of working with a diverse range of male survivors in the community. Their expertise informed the design, recruitment, and interpretation of findings. The advisors were:

- **Philip Chapman**, Chair of Male Survivors Aotearoa and experienced peer support worker with male survivors of sexual abuse.
- **Ken Clearwater**, National Advocate for Male Survivors of Sexual Abuse (at the time of data collection): Survivor and experienced peer support worker with male survivors of sexual abuse.
- **Richard Jeffrey,** Chief Executive of MOSAIC and MOSAIC Takatāpui (at the time of data collection): Experienced peer support worker and survivor.
- **Kevin Rowlatt,** Associate Director Mauri Ora (Student Health and Counselling), Victoria University of Wellington: Experienced manager of health and wellbeing service provision in primary care with experience of implementing new models of care and service delivery redesign in primary care.
- **Dr Julia Ioane,** Clinical Psychologist and Senior Lecturer, Massey University: Experience of working with Pasifika youth and families and research frameworks grounded in indigenous world views.
- **Dr Cathy Stephenson,** General Practitioner Student Health, Student Service, Victoria University of Wellington: Expertise in medical and sexual health practice with young people who identify as Māori, Pasifika, international and gender diverse students.

1.6 Report outline

The report is structured into seven sections:

- **Section 1** provides the context for the research
- **Section 2** describes the research methodology
- **Section 3** presents a content analysis of the interviews with male survivors to answer Research Question 1
- **Section 4** presents an inductive thematic analysis of the interviews with the male survivors to answer Research Question 2
- **Section 5** presents a deductive thematic analysis of the service workers' responses to the online questionnaire to answer Research Question 3
- **Section 6** presents composite case studies to bring to life the reality of the survivors' experiences of helpseeking over time

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[1] We use the term learning disability in this report to reflect the position of People First New Zealand, a self-advocacy group, [who] promote use of the term 'learning disability' instead of 'intellectual disability'. They feel the term is more reflective of the difficulties they experience, respectful to them as people, and easier to say. (Mirfin-Veitch & Conder, 2017, p.2).

- **Section 7** concludes the report and provides implications for practice, policy, and future research.

2. The research methodology

2.1 Introduction

The research was conducted between August 2020 and May 2021. We adopted a trauma-informed approach to engage with a diverse and hard-to-reach sample of male survivors. We describe this novel methodology below and comment on its ability to engage a diverse sample of male survivors in the Discussion (Section 7).

The project centred on interviewing male survivors who resided in the Greater Wellington and Dunedin regions of Aotearoa New Zealand about their experiences of the barriers and facilitators to reporting and accessing support services. The male survivors' experiences were compared to the perspectives of a range of service workers from the same regions using an anonymous online questionnaire. Sampling participants from the Greater Wellington and Dunedin regions allowed us to capture experiences from both urban and rural locations across the North and South Island, whilst ensuring immediate support could be provided to survivors who took part, if required.

Ethical approval was granted by Te Herenga Waka Victoria University Human Ethics Committee on 13 October 2020 (#28954).

2.2 Interviews with male survivors

2.2.1 Procedure

2.2.1.1 Recruiting a diverse sample of male survivors

We set out to recruit male survivors who identified with a range of diverse demographic groups. Recruiting a diverse and hard-to-reach sample required an innovative approach. We considered Robinson's (2014) comprehensive approach to planning the sampling for a qualitative interview study to guide our approach:

- We first considered how to define the diverse study population and what language to use when advertising the study. After consultation with stakeholders, we specifically advertised for people with experience of living, or being perceived, as men who had experienced SVA, from any demographic grouping. This broad and inclusive language was used to engage a diverse sample of male survivors including transgender survivors.
- Our sample size was determined by the diversity of participants and the depth of the data they provided, as sufficiently detailed interviews were required to enable robust thematic analysis.
- We sought diversity in helpseeking in terms of having reported the SVA and having accessed specialist support services. Further details on how we defined reporting and accessing support are provided in Section 3.
- We also sought diversity in terms of the following demographic factors:
  - Gender identity
  - Sexual orientation
  - Age
  - Ethnicity
  - Learning and physical abilities

  - Rural and urban residence at the time of the SVA
- To recruit diverse survivors in each helpseeking group we collaborated with specialist SVA support services (e.g., peer support for male survivors) and non-specialist support services (e.g., services for the treatment of addictions or mental health difficulties). Considering the high rates of overlap between SVA and related trauma symptoms, we predicted that survivors who had not accessed support for the SVA could be recruited through non-specialist services. In addition, given that transgender people and other members of rainbow communities are likely to access distinct support services, we purposefully recruited from services related to gender identity and sexual orientation to engage male survivors who identify with these demographic groups.
- To achieve diversity in age we purposefully recruited from services who were likely to work with younger (university and community service workers) and older men (specialised peer support groups).
- To achieve diversity in ethnicity, rather than adopt a specific cultural approach to the study, we tailored our interviews to meet the potential cultural needs of the male survivors and provided them with choice of interviewer. Interviewers with different demographic characteristics were selected and their details/bios and relevant experience were shared with the men via the study information sheets.
- To promote diversity, we also provided male survivors with a range of ways in which they could show their interest in the study, including completing an interest survey online or in person with a researcher, emailing or telephoning the researcher, or asking a nominated person to email or telephone the research team on their behalf. Male survivors also had the option to receive Easy Read versions of information, consent and debrief sheets. This allowed men with a range of learning and physical abilities, differing access to technology, and from urban or rural geographical locations to take part.

2.2.1.2 Advertising the study

Male survivors and minority groups of men under-report SVA. We therefore conveyed clear, inclusive, and male-friendly messaging. To achieve this, we employed digital artists to co-develop a project logo and adverts that could be disseminated via email, social media, or posters (see Figure 2.1).

The logo represents the diversity of Aotearoa New Zealand men that we wanted to engage with the study and showed a group of men diverse in age and ethnicity, a resilient native tree (tī kōuka; cabbage tree) and trans-pride colours. In addition, posters detailed the researchers' university and organisation logos to indicate that the project was being conducted by institutions independent of the government. The poster also featured inclusive language to signal that we sought to work with and learn from a diverse range of men (e.g., any sexual orientation, gender, ethnicity), empowering language (e.g., use of the word survivor, not victim) and language that promoted agency and action (e.g., "Help create change").

HELP CREATE CHANGE

For Male Survivors of sexual abuse

We are researching what helps and hinders male survivors when reporting and accessing services for sexual violence and abuse.

We want to interview people over 16 with experience of living or being perceived as men, with any sexual orientation, gender, ethnicity, physical and learning abilities.

To register your interest, complete our online questionnaire:
https://tinyurl.com/mssaproject
Or call us and we can complete it together:
04 886 4560 | 021 0908 1913 | MSSA@vuw.ac.nz

Victoria University of Wellington's Human Ethics Committee has approved this project (project number 28954). Any concerns about the ethical conduct of this research, contact VUW-HEC Convener: Dr Judith Loveridge (email: [illegible]@vuw.ac.nz or telephone: 04 463 6028).

Figure 2.1: Poster used to advertise the study, co-developed with digital artists Bo Moore and Georgie Kirton.

2.2.1.3 Steps taken to engage and interview the male survivors

Senior managers of support services were invited to recruit male survivors for interviews and provide them with an information and consent sheet for their consideration. This meant that male survivors who considered taking part were in contact with a service from which they could access support, ensuring their safety. Managers who agreed to recruit male survivors used the approved materials to advertise the study via the service website, email distribution list, social media sites and/or on the service premises using physical or digital posters. They agreed that service workers would be available should participants ask for support and to enact their organisation's safeguarding procedures in the event any survivor disclosed serious risk of harm to themselves or others. Two services requested that the researchers also be present to answer any questions that potential participants may have had about the study.

Male survivors who were interested in taking part were asked to fill in an online expression of interest form, where they learned more about the study and provided demographics, information about their safety and their preferred methods of contact. The advertising materials provided a link or a Quick Response (QR) code to the online form. Alternatively, male survivors could choose to complete the form over the phone or in person with a research team member, or they could nominate a support person to do this on their behalf. The participant information/consent sheets and expression of interest forms were also adapted into an Easy

Read version for those with lower literacy or a learning disability. This version presented the information in plain language and had supporting pictures or symbols to communicate the messages.

One member of the research team monitored the information provided in the expression of interest forms to select a diverse range of men for interviews and to ensure the safety of the male survivors. Discussions with other team members were held to make decisions on those survivors who were not selected for interviews. In the study information it was made clear to potential interviewees that, depending on demand, we might not be able to interview everyone who volunteered to take part, but all eligible survivors were invited to participate.

Male survivors who were invited to be interviewed were contacted by the research team via their chosen method and provided with a full information and consent sheet that they could return in advance or bring with them on the day of the interview. Survivors could choose which local interviewer they worked with. Interviews could be completed in person, by telephone or using secure online video.

A summary of the interview questions is in Appendix A. The interviews began with a reminder about the details of the project and confirmation of informed consent to participate. Culturally appropriate introductions and closures were undertaken, guided by each interviewee's requests. The survivors were asked to map out their journey using a physical timeline and in response to prompts from the interviewer. This provided broad information to help the interviewer gauge whether the men had disclosed, reported, and accessed services and therefore what questions to ask in the main body of the interview. The interview concluded with a scenario mapping exercise where male survivors were asked to describe what ideal pathways and outcomes would look like when reporting and accessing support services.

All potential interviewees were provided with a resource sheet that detailed free helplines and services that could provide them with support. Male survivors who took part in an interview were also offered a warm handover to a local peer support service which specialised in working with male survivors and which could facilitate their access to a wide range of services. All interviewees were offered a supermarket voucher to reimburse them for any expenses related to their participation. Participants were given the option of being provided with a copy of their transcript and the opportunity to be selected to comment on the composite case studies after the analysis phases of the project.

Interviews were transcribed verbatim by a professional service working under a confidentiality agreement, or the research team. Transcriptions were checked for accuracy and de-identified by the research team and stored securely.

2.2.1.4 A note on the trauma-informed methodology

We were mindful that the methodology used should be cognisant of the role that trauma may have played in the male survivor's lives. It was therefore designed to reduce the likelihood of re-traumatising the survivors and to meet a range of needs that are particularly important for people who have experienced a traumatic event. Below, we briefly outline those needs and note examples of how they were addressed in this study:

- **Safety.** Recruiting male survivors via support services ensured they had access to a service where they could debrief or seek help from if they chose to. In addition, everyone who expressed an interest in the study was provided with a resource that detailed free helplines and support services. Interviewees were also offered warm handovers to peer support services. A sense of safety was also provided by placing a table as a physical barrier between the interviewer and articulating what would happen in the interview very clearly beforehand in both written and verbal format. Interviewees were reminded of their rights as research participants including their right to stop the interview or withdraw without any disadvantage.
- **Trustworthiness and transparency.** We engaged male survivors for the study by working closely with support services. The aim was to promote trust in the project. We also clearly articulated: the purpose of the study, that the men did not have to disclose detail about the nature of the SVA, what would happen at each stage, who the funders were, and who the independent research team was in all advertisements and study information. This clarity provided structure and avoided male survivors feeling that they may have to repeat their story at each stage of contact with researchers. In addition, in the first part of the interview, we used a physical road map that survivors could write on to help them provide an overview of key markers in their journey of SVA and recovery. Men reported that this was helpful and provided a sense of safety and clarity for them by “helping to make a messy story logical”, or that it provided space from the interviewer whilst they grounded themselves “this makes me feel safe because you are not looking at me doing the interview”.
- **Peer support.** The adverts were designed to develop a sense of collective spirit and let male survivors know that they were not alone and that this happens to a diverse group of men. The adverts also promoted the idea that the men could help and support other male survivors through their participation in the research, creating a sense of agency. Access to peer support and other support services was also provided to all who expressed interest in taking part.
- **Collaboration and mutuality**. We adopted a qualitative approach to this research project that positioned the male survivors as the experts. The interview used open questions so that the male survivors could discuss their experiences in their own words. Hence, the study was designed to generate a collaborative approach between the researcher and male survivors to understand their perspectives and experiences. Men participated of their own free will, and they received reimbursement for expenses, so they were not out of pocket for participating.
- **Empowerment, voice, and choice**. An inductive, or bottom-up, approach to thematic analysis of the male survivors’ interviews was taken. This ensured that we recognised what the male survivors had to say in relation to their helpseeking experiences. Furthermore, male survivors were afforded choice in where to conduct the interview and what modality to use (face-to-face, telephone, or Zoom). They also had choice over which interviewer they talked to, where they sat in the interview room, whether they wanted to take breaks or stop and withdraw from the interview. After completion of the

analysis, the male survivors who requested it were contacted and asked to comment on how well the composite case studies represented their experiences as a form of 'member checking' (Treharne & Riggs, 2015), an action which also increases agency.

- **Recognition of cultural, historical and gender issues.** We actively applied a bicultural framework to engage appropriately with Māori and people of other cultures, drawing on models of collaboration we have applied in our previous research (Ashdown, Treharne, Neha, Dixon & Aitken, 2019; Ratima et al., 2019). Researchers Eketone-Kelly, Pettie and Ashdown have knowledge of Te Ao Māori, and our advisor Dr Ioane has knowledge of Pasifika communities, which supported the design of the interviews. We followed established protocols for consulting Māori at the research sites, including a formal submission to the Ngāi Tahu Research Consultation Committee as well as consulting with Māori advisors and services within the rohe of Wellington and Dunedin. We applied the principle of whakapapa by allowing participants to give their pepeha (oration of whakapapa) within a general rapport-building question at the start of the interview. We applied the principle of tika by seeking validation of findings from interviewees and service workers. We applied the principles of manaakitanga and mana by addressing cultural and social responsibility through consulting relevant parties during recruitment, validation, and dissemination. The research team was comprised of people with a mix of gender identities which provided additional choice to interviewees.

2.2.2 Sample

- The senior managers of 20 support services who were likely to come into contact with male survivors through their work, were approached to advertise the study and recruit survivors to take part in the interviews. Of those services, 13 agreed to recruit male survivors to take part in an interview, and men came forward from 10 of these services. The types of service and the number of men recruited through each is listed in Table 2.1.
- Male survivors who were 16 years or older, living in Aotearoa New Zealand at the time of the study and who had experienced SVA as a child and/or as an adult were invited to take part in an interview. Sixty-one men completed an online form expressing an interest to be interviewed. Of those 61 expressions of interest, eight were excluded due to: 1) a lack of contact details; 2) no response after initial attempts to contact them; or, 3) not meeting the safety screening requirements. Fifty-three of the men went on to complete an interview between 26 November 2020 and 9 February 2021. One interview was excluded as it eventuated that the person had not experienced SVA as defined by this study. The demographic details of the 52 male survivors interviewed are detailed in Table 3.1 of this report.
- On average the interviews lasted for one hour and 28 minutes, with the shortest being 27 minutes and longest two hours and 41 minutes. One interview was completed via telephone, six were completed on a secure online audio-visual link, and 45 were completed in person.

Table 2.1: The number and type of services who recruited male survivors for interview

Organisation type	Number of organisations	Number of interviewees
Male peer support services	3	23
Student health and counselling	2	8
Family and sexual violence services	3	2
Residential rehabilitation and community based social support organisations	3	11
Rainbow community support organisations	2	8

2.2.3 Analysis

2.2.3.1 Content analysis

Content analysis (Stemler, 2000) of the free-text data in the participant expression of interest forms and interviews with 52 male survivors was undertaken to identify a series of categorical variables on which descriptive statistics and bivariate statistical analysis could be performed. This analysis was conducted to answer Research Question 1 (What are the demographic characteristics of the male survivors who took part in the study and how had they sought help?). The findings are presented in Section 3.

Appendix B provides the coding dictionary that was developed by one researcher to extract the information. Both emergent and a priori coding (codes developed prior to the coding exercise) principles were used to capture the depth and complexity of the data. Intra-rater reliability (a test of the rater's ability to code the same data over time with accuracy) was assessed by re-coding 11.5% (n = 6) of the participant data. Agreement between first and second extraction was 95%. Variables that showed discrepancy were re-visited and amended for accuracy. Data was analysed in SPSS (IBM, version 26).

2.2.3.2 Thematic analysis

Thematic analysis was conducted to answer Research Question 2 (How had the male survivors experienced barriers and facilitators to helpseeking?). The guidance for conducting thematic analysis outlined by Braun and Clarke (2006) was employed, which encompasses six phases of analysis:

- **Phase One**: Familiarisation with the data via repeated readings of the transcript, annotating the transcript, and compiling the annotations.
- **Phase Two**: Develop codes from the transcripts. A code is a specific pattern of meaning across the dataset.
- **Phase Three**: Combine the codes into overarching themes.
- **Phase Four:** Review the themes to ensure they are distinct from each other and have a defensible core characteristic that relates to the research question and reflects the data.
- **Phase Five:** Define and name the themes through a consensus process.
- **Phase Six:** Draft and check that the narrative description of the findings retains the ethos of the data.

An inductive (bottom-up) approach was taken to analysis to ensure that themes were derived from the participants' perspectives (Braun & Clarke, 2006). A critical realist/essentialist epistemological paradigm was used to identify semantic themes that directly reflected the participants' interpretation of their experiences, as they described them (Braun & Clarke, 2006). Please note, whilst an inductive approach allows the participant voice to be heard and for the survivors to raise issues that are salient to them, areas not discussed during this study may still have been pertinent to them. That is, the themes identified will not represent an exhaustive list of areas of importance to the male survivors.

The interview transcripts were collaboratively analysed primarily by five members of the research team (Dixon, Treharne, Bowden, Pettie, and Shaw) using a series of meetings to discuss preliminary development of codes and ongoing discussions of the core message of each code. The finalised codes were then organised into themes, checked, and drafted by two researchers (Dixon & Treharne) before being checked by, and then discussed with other researchers. Findings of the thematic analysis are presented in Section 4.

2.2.3.3 Composite case studies

We developed a set of composite case studies to bring to life the key barriers and facilitators described by men at different stages of the helpseeking process. The case studies use Ellis's (1999) approach to managing the ethical consideration of anonymity. That is, they draw on details from a range of interviewees and therefore no single interviewee is identifiable. They include aspects of quotes from relevant interviewees and sufficient detail to provide rich insights into the core outcomes of the qualitative research (Braun & Clarke, 2006). Some of the interviewees and service workers who had consented to do so were randomly invited to review the composite cases to ensure they resonated with their experience and expertise. This is an appropriate form of 'member checking' in qualitative research (Treharne & Riggs, 2015).

2.3 Comparison of the service workers' views and the male survivors' experiences

2.3.1 Procedure

The senior managers of support services were invited to take part in the anonymous online questionnaire via email. The email contained a study information and consent sheet for their consideration. Managers who provided informed consent for workers in their service to take part were asked to disseminate an approved invitation via an email to their workforce. The invitation briefly described the study and contained a link to the online questionnaire. The questionnaire asked about the participant's work experience and their perspectives of the barriers and facilitators to male survivors reporting and accessing support for SVA.

2.3.2 Sample

Twenty-three managers of support services which were likely to come into contact with male survivors were approached and asked if they would consent to the workers at their service completing an anonymous online questionnaire. Of these, 15 consented. The types of services who agreed to take part are depicted in Figure 2.2. Thirty service workers began the online questionnaire (key questions are described in Appendix C). Three asked for their data to be deleted and 14 did not provide any rich qualitative data in their responses, with most only answering fixed choice questions about their level of experience working for a service. Thus, only the responses of 13 service workers who provided rich qualitative data were used in the comparison with the male survivors' responses.

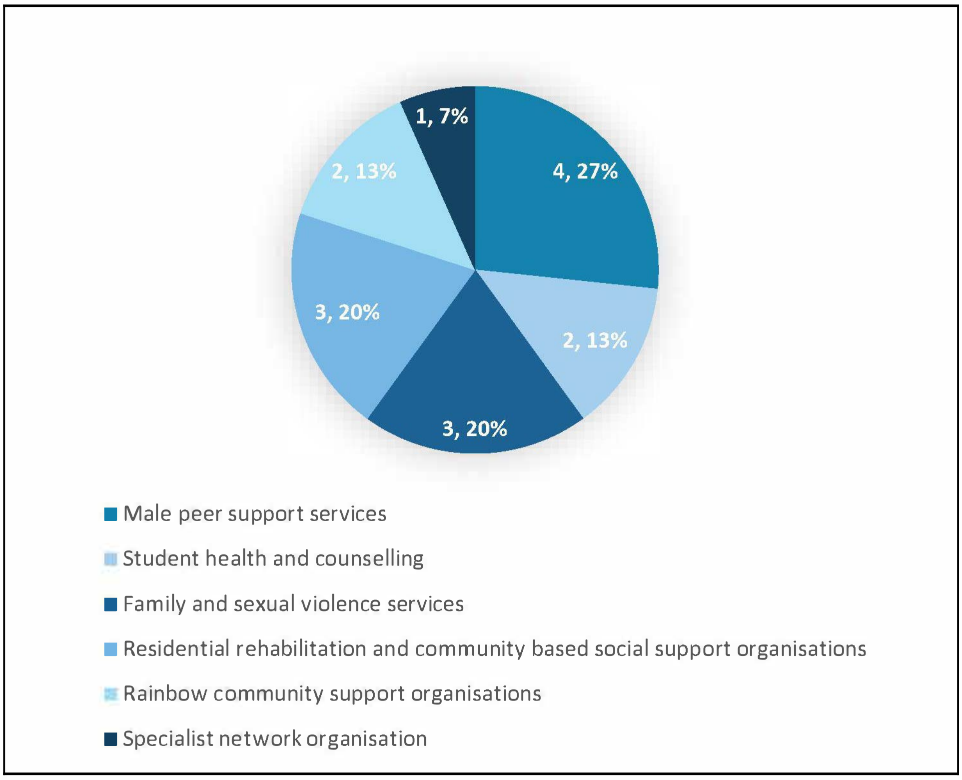

Figure 2.2: The type of services who agreed to take part in an anonymous online questionnaire (n = 15).

Eleven of the 13 service workers were specialists in supporting survivors of SVA who had worked in the field for between three and 20 years (median 13 years). Most respondents reported working with men of all ages, although five worked mainly with younger people. Most reported working with men of all ethnicities, although two noted they work mainly with New Zealand European men. Six of the 13 service workers reported working with transgender and non-binary people. Most reported working with men of all sexual orientations, although one reported working only with straight men and one reported only having worked with LGBTQ people. Eight reported working with men with learning and/or physical disabilities. The demographic details of the 13 service workers are captured in Table 5.1. The workers' job descriptions are described as specialist or non-specialist service worker only (rather than peer support worker etc.) to protect their anonymity.

2.3.3 Analysis

Braun and Clarke's (2006) approach to thematic analysis was used to understand the perspectives of service workers to the barriers and facilitators to reporting and accessing support services. This thematic analysis was undertaken to compare the views of the service workers with the results identified from the male survivors' narratives. We centred our analysis on the male survivors and sought information from the service workers to support or expand on the perspectives of the male survivors. As such, we employed a deductive, or top-down, approach to thematic analysis whereby the service workers' responses were investigated to see how they compared to the male survivors' responses. The findings of this analysis are presented in Section 5.

2.4 Sense-making workshop

The research team shared the results of the study with 38 stakeholders in an interactive sense-making workshop designed to provide quality assurance of the results and recommendations. Participants included the research team, workers from MSD, specialist, and non-specialist services for SVA, and male survivors. Participants were provided with a summary of key results and then allocated to one of five groups. Each group was asked to sense check one of the five themes and then feed back a summary and their conclusions to the whole group. Participants were asked to comment on whether the findings resonated with their experiences, or if anything surprised them or was missing. Participants were placed into groups which consisted of a mix of people from different agencies. They were also asked to workshop whether the implications of each barrier and facilitator resonated with them, before considering how these implications would best be implemented in practice. The participant responses were used to shape the implications and recommendations provided in Section 7 of this report.

3. Demographics of the male survivors and how they had sought help

3.1 Introduction

This section of the report answers Research Question 1: *What are the demographic characteristics of the male survivors who took part in the study and how had they sought help?* A content analysis of the 52 participant interest forms and interviews was conducted to identify demographic information. Frequency data detailing the nature of the SVA and helpseeking experiences is provided. Content analysis is described in Section 2 of this report and Appendix B contains the content dictionary used to code and extract the data.

3.2 Demographic characteristics

The demographic characteristics of the male survivors are summarised in Table 3.1. Their ages ranged from 19 to 74 years old, with a mean of 42.2 years. The majority of male survivors were classified in the 40-64 (22; 42.3%) age category, with a smaller number of survivors aged ≤24 (7; 13.5%) or ≥65 (4; 7.7%).

Male survivors could identify with more than one gender. The majority (51; 98.1%) identified as male, with two of those men also identifying as agender or a non-binary gender. One (1.9%) male survivor identified as non-binary only. Four male survivors (7.7%) described a history of gender transition, two of whom identified as male only and two as male and non-binary. One of the survivors (1.9%) who identified as transgendered, male and non-binary, also described having an intersex variation. In total, six (11.5%) male survivors identified with a minority gender and 46 (88.5%) as cisgender male.

In terms of sexual orientation, just over half of the male survivors described themselves as heterosexual, including two who identified as both heterosexual and bisexual or gay (31; 59.6%). Several male survivors identified with sexual orientations that did not include heterosexual (20; 38.5%), namely asexual and/or aromantic, bisexual, gay, queer (as a reclaimed identity term), and/or pansexual. Within our results we use the term minority sexual orientation as an inclusive way of describing men with these identities. Three survivors (5.8%) did not provide their sexual orientation.

Most of the male survivors identified as New Zealand European/Pākehā or European (39; 75%). Four of these survivors identified as a specific European nationality. Thirteen (25%) identified as Māori, five of whom also identified as New Zealand European/Pākehā. No participants identified as Pasifika or any other identities.

In the 12 months prior to the interview, just under half of the male survivors were primarily employed in a waged job (15; 28.8%) or self-employed (7; 13.5%). A quarter were students (13; 25%), six of whom were also working. Around a third were primarily unemployed (18; 34%), and two were retired (3.8%).

In total, 33 (63.5%) of the male survivors reported having lived experience of a disability. Specifically, almost half of the male survivors reported a mood disorder or were experiencing mental distress (22; 42.3%); seven (13.5%) reported a physical disability; seven (13.5%) were neurodiverse; three (5.8%) reported having a learning disability; and two reported sensory impairments (3.8%).

Table 3.1: Demographic characteristic of the male survivors (n = 52)

Demographic variable*		**Summary statistics**
		Mean (SD)
Age (years)		42.2 years (15.4)
		N (%)
Age category	≤24	7 (13.5%)
	25-39	19 (36.5%)
	40-64	22 (42.3%)
	≥65	4 (7.7%)
Gender*	Male	51 (98.1%)
	Non-binary	3 (5.8%)
	Agender	1 (1.9%)
	Female	0 (0.0%)
Transgender status	No history of gender transition	48 (92.3%)
	History of gender transition	4 (7.7%)
Intersex status	No intersex variation stated	51 (98.1%)
	Intersex variation	1 (1.9%)
Gender minority (agender, non-binary, or had transitioned gender)	Cisgender male	46 (88.5%)
	Gender minority	6 (11.5%)
Sexual orientation*	Heterosexual	31 (59.6%)
	Gay	10 (19.2%)
	Bisexual	7 (13.5%)
	Asexual and/or aromantic	4 (7.7%)
	Queer	2 (3.8%)
	Pansexual	2 (3.8%)
	Did not provide sexual orientation	3 (5.8%)
Heterosexual	Heterosexual identity (only)	29 (55.8%)
	Other sexual identity (not including those who did not provide an answer)	20 (38.5%)
Ethnicity	Non-Māori (New Zealand European/Pākehā or European only)	39 (75.0%)
	Māori	13 (25.0%)
Main activity or job in the previous 12 months*	Unemployed	18 (34.6%)
	Waged job	15 (28.8%)
	Student	13 (25.0%)
	Self-employed	7 (13.5%)
	Retired	2 (3.8%)
	Other	5 (9.6%)
Disability*	Mood disorder/mental distress	22 (42.3%)
	Physical disability	7 (13.5%)
	Neurodiverse	7 (13.5%)
	Learning disability	3 (5.8%)
	Sensory impairment	2 (3.8%)
	None	19 (36.5%)

* Participants could select more than one option.

3.3 The nature of the SVA

Table 3.2 summarises the nature of the SVA experienced by the male survivors. The majority experienced SVA whilst living in an urban or suburban region in Aotearoa New Zealand (38; 73.1%); seven (13.5%) lived in a rural setting and eight (15.4%) lived overseas at the time of the SVA.

Most of the male survivors had experienced SVA during childhood (37; 71.2%) and/or adolescence (24; 46.2%). A total of 10 (19.2%) survivors had experienced SVA during adulthood, of whom five had experienced the abuse only during adulthood, representing 9.6% of the overall sample.

The majority of the male survivors experienced more than one incident of SVA by the same perpetrator (repeat victimisation) in their lifetime (24; 46.2%). Twenty-two (42.3%) experienced more than one incident by different perpetrators (re-victimisation). Five (9.6%) experienced one incident by one perpetrator in their lifetime (single victimisation) and one (1.9%) a single incident with more than one perpetrator (multiple victimisation). The majority (32; 61.5%) also experienced SVA from someone outside of the immediate family (stranger, acquaintance, friend, authority figure), whilst 21 (40.4%) experienced SVA from a family member. A minority of men lived in state care, a transition home or foster home at the time of the abuse (11; 21.2%).

Table 3.2: The nature of the sexual victimisation experienced by the male survivors (n = 52)

Nature of sexual victimisation*		**N (%)**
Residential location at the time of SVA*	Urban Aotearoa New Zealand	38 (73.1%)
	Overseas	8 (15.4%)
	Rural Aotearoa New Zealand	7 (13.5%)
Life stage of male survivor at the time of SVA*	Childhood	37 (71.2%)
	Adolescence	24 (46.2%)
	Adulthood	10 (19.2%)
Degree of victimisation	Repeat victimisation (more than one incident by the same perpetrator)	24 (46.2%)
	Re-victimisation (more than one incident by different perpetrators)	22 (42.3%)
	Single victimisation (single incident with one perpetrator)	5 (9.6%)
	Multiple victimisation (single incident with more than one perpetrator)	5 (9.6%)
Number of perpetrator(s)	1	28 (53.8%)
	2	10 (19.2%)
	3	9 (17.3%)
	4+	5 (9.6%)
Gender of perpetrator(s)	Male perpetrator(s) only	36 (69.2%)
	Female perpetrator(s) only	8 (15.4%)
	Both male and female perpetrator(s)	7 (13.5%)
	Not reported	1 (1.9%)
Relationship to perpetrator(s)*	Extrafamilial relationship (e.g., stranger, acquaintance, friend, authority figure)	32 (61.5%)

Nature of sexual victimisation*		N (%)
	Intrafamilial relationship (e.g., family member or relative)	21 (40.4%)
	Intimate partner	6 (11.5%)
Living arrangement at time of abuse	Not living in state care or a religious congregation	41 (78.8%)
	Living in state care, transition, or foster home	7 (13.5%)
	Living in a religious congregation	4 (7.7%)

* Participants could select or describe more than one option.

3.4 Intersectionality

Categorising survivors into single demographic groups can shape expectations that each group is homogenous and that the needs of all group members can, therefore, be met via a generalised response from service workers (Carswell et al., 2018). To avoid this expectation, we explored the intersectionality of the male survivors by examining the overlap across marginalised groups that are over-represented in the male survivor statistics. Specifically, we explored the overlap between:

- Minority sexual orientation groups
- Minority gender identity groups including those with history of gender transition
- People with Māori whakapapa
- People with disabilities.

Figure 3.1 depicts the number of male survivors categorised by the different marginalised groups that are over-represented in the victimisation statistics. It shows that:

- None of the survivors identified with all four groups.
- Five (9.6%) survivors identified with three of the groups, four of whom had a disability, were transgender, and had a minority sexual orientation identity; and one of whom had a disability, had a minority sexual orientation identity, and was Māori.
- Sixteen (30.8%) of the survivors identified with two of the groups, nine of whom had a disability and a minority sexual orientation identity; five of whom had a disability and were Māori; one of whom had a disability and was transgender; one of whom had a minority sexual orientation identity and were Māori.
- Twenty-three (44.2%) survivors identified with one group.
- Eight survivors (15.4%) did not identify with any of the marginalised groups.

The sample of 52 male survivors had good spread across the different groups over-represented in SVA statistics. For example, the sample included some takatāpui among Māori male survivors, as well as some gay and bisexual people among New Zealand European participants.

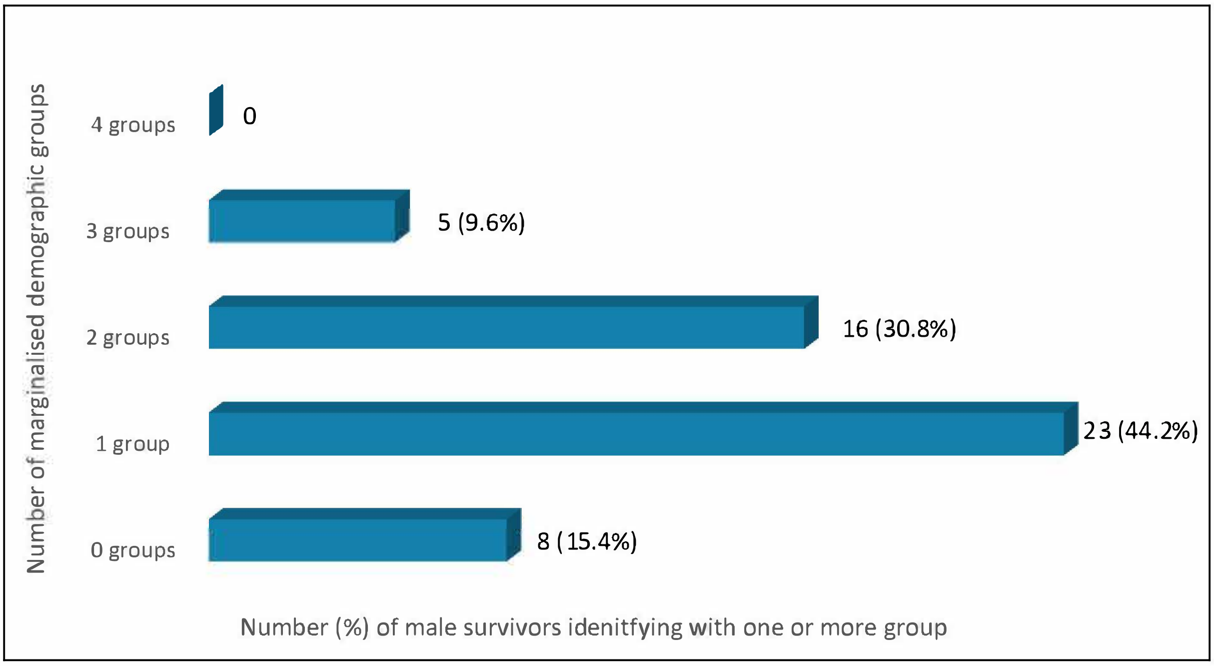

Figure 3.1: The intersectionality of marginalised demographic groups amongst the male survivors

3.5 To whom, when and why male survivors reported SVA

3.5.1 Who the male survivors reported to

The male survivors described having talked to a range of people and services about the SVA. As discussed in Section 1, we consider disclosure to be an important part of the helpseeking process and thought it useful to investigate this issue. MSD wanted to understand reporting separately to disclosure, we therefore aimed to understand the differences between these two aspects for the male survivors who took part in this study.

We considered that **Disclosure** occurred when a survivor talked about their experiences of sexual victimisation to a person or service worker who was not able to initiate a formal process that could result in an investigation, funding, or provision of services, or provide redress. Whilst the individual or worker may have been able to refer the survivor onto a support service or assist them in reporting the incident(s) of SVA, this is not the same as being able to initiate a formal process. We considered that **Reporting** occurred when a survivor presented to a service worker with the goal of receiving some sort of formal action to address the SVA and/or its impact.

To determine what disclosure and reporting meant for the sample of male survivors, we identified which men spoke about the SVA and what action was taken. Table 3.3 summarises the various support services or other people that male survivors disclosed to and the ability of those people or groups to take formal action. Table 3.4 summarises the actions or processes that were initiated by those services.

Table 3.3: Organisations, services, or agencies that participants disclosed to about their experiences of SVA

Who the male survivors disclosed to	Number of male survivors	Can the service/person take formal action?
Friends, family, intimate partners, colleagues, strangers	45	No
Non-specialist therapists	29	No
Accident Compensation Corporation (ACC) or ACC-funded specialist therapist	28	Yes
Specialist sexual abuse organisations	24	No
Medical doctors	17	Yes
Police	14	Yes
Faith-based organisations	5	Yes
Non-specialist helplines	4	No
Royal Commission of Inquiry into Abuse in State Care	4	Yes
Employer or University	3	Yes
Teachers	1	Yes

Table 3.4: The formal actions or processes that were initiated by services taking male survivors' reports of sexual victimisation

Service	Actions that were undertaken
Police	Receive statements and initiate criminal investigations; arrest; press charges against the perpetrator
Accident Compensation Corporation (ACC)	Process sensitive claims; facilitate access to therapy to address the victimisation
Medical doctors	Initiate an ACC sensitive claim; facilitate access to therapy to address the victimisation
Teachers	Convene family conferences; notify Oranga Tamariki (formerly known as Child Youth & Family Services) and/or the Police
Employer/university	Investigate and remove employees who have perpetrated SVA; change the work environment to prevent future exposure to the perpetrator in the workplace; facilitate access to therapy through Employee Assistance Programmes (EAP). For any survivors who accessed EAP, it was not necessary to disclose their experiences of SVA to their employer
Faith-based organisations	Investigate complaints made against members within the faith-based organisation
Royal Commission of Inquiry into Abuse in State Care	Receive complaints and investigate them; provide an avenue for survivors to speak about their experiences, afford redress, and for the inquiry to make legal/policy recommendations

Based on this information we adopted the following definitions of reporting and disclosure in this research project:

Disclosure occurred when survivors told friends, family or whānau, strangers, counsellors, non-specialist helplines (like Lifeline or Victim Support), social workers, and other social supports (e.g., learning disability services, home help, Plunket nurses) who could not initiate a formal process.

Reporting occurred when a survivor presented to police; ACC; medical doctors; teachers, employers/universities; faith-based organisations; or the Royal Commission of Inquiry into Abuse in State Care, with the goal of receiving some sort of formal action from that service.

Based on the above definitions, 47 of the 52 (90.4%) disclosed to someone and 34 of the 52 (65.4 %) survivors reported the SVA.

3.5.2 When male survivors reported

Of the 34 survivors who reported the sexual victimisation, 32 estimated the time it took them to first report to services in the interview. Table 3.5 shows the time it took the 32 men to report. The mean time taken to report was 18 years. Ten (31.25%) male survivors reported within the first three years, followed by a steady flow of reports over the following decades. Six men (19.4%) reported between 40-50 years post-SVA.

Table 3.5: The time taken for male survivors to first report the sexual victimisation (n = 32)

Time taken to report	N (%)	Cumulative (of n = 32)
Less than 1 year	9 (29.0%)	9 (29.0%)
Between 1-2 years	0 (0.0%)	9 (29.0%)
Between 2-3 years	1 (3.2%)	10 (31.3%)
Between 3-5 years	1 (3.2%)	11 (34.4%)
Between 5-10 years	2 (6.4%)	13 (40.6%)
Between 10-20 years	4 (12.9%)	17 (53.1%)
Between 20-30 years	4 (12.9%)	21 (65.6%)
Between 30-40 years	5 (16.1%)	26 (81.3%)
Between 40-50 years	6 (19.4%)	32 (100.0%)

In an attempt to consider factors associated with more timely reports, we tabulate the services accessed by male survivors within or over a three-year timeframe in Table 3.6. This grouping was chosen because it created large enough groups for statistical comparisons to be computed using Fisher's exact statistic.

Fisher's exact statistics did not identify any significant differences at an alpha of 0.01. This means that there were no services that male survivors were more likely to report to in under three years compared to over three years.

Looking at the total number of male survivors who reported to a service, regardless of the timeline, male survivors were most likely to access ACC (26; 81.3%). This was followed by police and doctors (14; 43.8%), employers/university and the Royal Commission (4; 12.5%) and teachers and faith-based organisations (3; 9.4%).

Table 3.6: Number of male survivors reporting within or after 3 years post-SVA (n = 32)

Type of service	Number of male survivors who reported to the type of service		Total number of male survivors reporting to the service	Fisher's exact statistics
	< 3 years (n = 10)	≥ 3 years (n = 22)		
ACC/ACC therapist(s)	9 (90.0%)	17 (77.3%)	26 (81.3%)	p = 0.37
Police	5 (50.0%)	9 (40.9%)	14 (43.8%)	p = 0.56
Doctor(s)	5 (50.0%)	9 (40.9%)	14 (43.8%)	p = 0.46
Employer or university Employee Assistance Programme	1 (10.0%)	3 (13.6%)	4 (12.5%)	p = 0.63
Royal Commission of Inquiry into Abuse in State Care	0 (0.0%)	4 (18.2%)	4 (12.5%)	p = 0.20
Teacher(s)	1 (10.0%)	2 (9.1%)	3 (9.4%)	p = 0.69
Faith-based organisation	0 (0.0%)	3 (13.6%)	3(9.4%)	p = 0.31

3.5.3 Why the male survivors reported SVA

Table 3.7 summarises the reasons male survivors provided as to why they reported their experiences of SVA in a more timely or delayed fashion.

Fisher's exact statistics did not identify any significant differences at an alpha of 0.01. This means that there were no reasons that led male survivors to report in under three years compared to over three years.'

Looking at the total number of male survivors who reported to a service, regardless of the timeline, the most common reason was to access financial aid (18; 56.3%) followed by to prevent harm to others (8; 25%). All survivors who were supported by parents in childhood to report, or who experienced a stranger attack, reported in under three years.

Table 3.7: The reasons the male survivors provided for reporting to services within or after 3 years post-SVA (n = 32)

Reasons for reporting	Number of male survivors giving this reason		Total number of male survivors providing the reason	Fisher's exact statistics
	< 3 years (n = 10)	≥ 3 years (n = 22)		
To access financial aid	4 (40.0%)	14 (63.6%)	18 (56.3%)	p = 0.19
To stop the perpetrator(s) or seek actions against the perpetrator(s)	1 (10.0%)	7 (31.8%)	8 (25%)	p = 0.19
Police contacted the survivor to enquire as part of an ongoing investigation	1 (10.0%)	3 (13.6%)	4 (12.5%)	p = 0.63
Parents/caregivers led them to report	3 (30.0%)	0 (0.0%)	3 (9.4%)	p = 0.02
Someone noticed changes in behaviour, bruising, or marks	1 (10.0%)	2 (9.1%)	3 (9.4%)	p = 0.69
Stranger attack	2 (20.0%)	0 (0.0%)	2 (6.3%)	p = 0.09

3.6 From whom, when and why male survivors accessed support

3.6.1 When the male survivors accessed support services

Table 3.9 describes the time that male survivors took to first access a support service. It shows that eight (16.7%) survivors accessed support within the first five years, three of whom had only accessed non-specialist support (but specific to their experiences of SVA). Forty (83.3%) of the male survivors who accessed services did so between five and 60 years after their experiences of SVA.

Table 3.9: Time for male survivors to first access support services for the victimisation (n = 48)

Time taken to access any support service	**Number of male survivors who took this length of time to access support**			
	Specialist (n = 40)	Non-specialist only (n = 8)	Accessed any support (n = 48)	Cumulative (of n = 48)
Less than 1 year	3 (7.5%)	2 (25.0%)	5 (10.4%)	5 (10.4%)
Between 1-2 years	1 (2.5%)	0 (0.0%)	1 (2.1%)	6 (12.5%)
Between 2-5 years	1 (2.5%)	1 (12.5%)	2 (4.2%)	8 (16.7%)
Between 5-10 years	5 (12.5%)	3 (37.5%)	8 (16.7%)	16 (33.3%)
Between 10-20 years	10 (25.0%)	0 (0.0%)	10 (20.8%)	26 (54.2%)
Between 20-30 years	12 (30.0%)	1 (12.5%)	13 (27.1%)	39 (81.3%)
Between 30-40 years	3 (7.5%)	0 (12.5%)	3 (6.3%)	42 (87.5%)
Between 40-60 years	5 (12.5%)	1 (12.5%)	6 (12.5%)	48 (100.0%)

In an attempt to consider factors associated with more timely accessing, we tabulate the services accessed by male survivors within or over a five-year timeframe in Table 3.10. This grouping is designed to enable statistical group comparisons to be computed using Fisher's exact statistic.

Fisher's exact statistics did not identify any significant differences at an alpha of 0.01. This means that there were no particular types of service that male survivors were more likely to access in under five years compared to over five years.

Looking at the total number of male survivors who accessed a support service, regardless of timeliness, over half of the men (26; 54.2%) accessed ACC registered therapists, with the same number also accessing non-specialist counsellors, psychologists and psychiatrists, and 23 (47.9%) accessed intentional peer support.

Table 3.10: Number of male survivors accessing support services within or after 5 years post-SVA (n = 48)

Type of service	Number of male survivors who accessed the type of service < 5 years (n = 8)	≥ 5 years (n = 40)	Total number of male survivors accessing a service	Fisher's exact statistics
Specialist services or therapists				
ACC referred or ACC registered therapists	3 (37.5%)	23 (57.5%)	26 (54.2%)	p = 0.26
Intentional peer support for survivors of sexual abuse	1 (12.5%)	22 (55.0%)	23 (47.9%)	p = 0.03
SVA specialist services or therapists	0 (0.0%)	6 (15.0%)	6 (12.5%)	p = 0.31
Non-specialist services or therapists				
Non-specialist counsellors, psychologists, psychiatrists	4 (50.0%)	22 (55.0%)	26 (54.2%)	p = 0.55
Emergency crisis support, community mental health	2 (25.0%)	10 (25.0%)	12 (25.0%)	p = 0.67
Drug and alcohol addictions specialists	0 (0.0%)	5 (12.5%)	5 (10.4%)	p = 0.38
Prison or Corrections Department counsellors	0 (0.0%)	5 (12.5%)	5 (10.4%)	p = 0.38
Non-specialist helplines	1 (12.5%)	3 (7.5%)	4 (8.3%)	p = 0.30
Anger management therapy	0 (0.0%)	2 (5.0%)	2 (4.2%)	p = 0.69
Family mediation or therapy	0 (0.0%)	1 (2.5%)	1 (2.1%)	p = 0.83

3.6.2 Why the male survivors accessed support services

Table 3.11 summarises the reasons male survivors provided as to why they accessed support services for their experiences of SVA.

Fisher's exact statistics did not identify any significant differences at an alpha of 0.01. This means that there were no reasons that led male survivors to report in under five years compared to over five years.

Looking at the total number of reasons provided by the male survivors as to why they accessed a support service, regardless of the timeline, almost a third did this to address problem behaviours that had arisen from the SVA (27; 29.2%). Approximately one-fifth of male survivors wanted to talk (10; 20.8%) or to access ongoing support from others who could understand (9; 18.8%).

Table 3.11: The reasons for accessing support services within or after 5 years post-SVA (n = 48)

Reasons for accessing	Number of male survivors who accessed the type of service		Total number of male survivors providing the reason	Fisher's exact statistics
	≤ 5 years (n = 8)	5 years (n = 40)		
To address problems or behaviours that had arisen for them from the SVA	4 (50.0%)	23 (50.7%)	27 (29.2%)	p = 0.05
Wanted to talk or be heard	1 (12.5%)	9 (22.5%)	10 (20.8%)	p = 0.46
Wanted ongoing support, and/or to find others with a similar experience	0 (0.0%)	9 (22.5%)	9 (18.8%)	p = 0.16
Wanted to address interpersonal issues (e.g., marriage breakdown, conflict resolution, employer relationship issues)	3 (37.5%)	3 (7.5%)	6 (12.5%)	p = 0.05
Referred to a support service through interaction with the criminal justice system (e.g., Corrections services)	0 (0.0%)	4 (10.0%)	4 (8.3%)	p = 0.47
Following a recommendation from a service worker or a friend	1 (12.5%)	1 (2.5%)	2 (4.2%)	p = 0.31

3.7 Crisis reporting

Four of the 52 male survivors reported a first incident of SVA within 48 hours. All incidents were committed by a single perpetrator, three were strangers and one a peer. Three of the male survivors experienced the SVA in childhood (prior to 18 years of age) and one in adulthood. All four survivors reported the SVA prior to accessing any support service. Whilst the incidents that resulted in crisis reporting were the first time the survivors had experienced SVA from that perpetrator, three had also experienced SVA in childhood from a different perpetrator yet had not sought help. The details of who the male survivors reported to during crisis, the outcome and what support services they went on to access and when is provided in Table 3.12. Only broad details are provided to protect participant anonymity.

Table 3.12: Helpseeking experiences of male survivors who reported a first incident of SVA within 48 hours (n = 4)

Relationship to perpetrator and development at stage at time of SVA	Crisis reporting			Accessing			
	Disclosure prior to reporting	Who they reported to and why	Response and outcome	Support service first accessed	Why the support service was accessed	Response and outcome	Other helpful services accessed
Stranger – during childhood	Yes – to a family member	Police – wanted to catch the perpetrator	Insensitive response from police and family. Survivor withdrew from social interaction and didn't	Specialist helpline 10 years post-SVA	Wanted to know what services were available to help him understand the SVA	Couldn't help him because there were no services available to support men, which left him frustrated and	ACC counselling and intentional peer support, over three decades post-SVA

			disclose further			continuing the search	
†Stranger – during adulthood	No	GP, police, and hospital staff – needed to attend to injuries inflicted during incident	Sensitive response and appropriate care. Set up ACC sensitive claims process	Three years post-SVA he felt ready to access an ACC registered psychologist	Wanted to address mental health and interpersonal relationship issues	Positive experience – helped to reduce mental health issues and maintain employment	No
†Peer at school – during childhood	No	Head of School – to stop it happening again	Didn't respond to his report – didn't tell anyone else as assumed he wouldn't be believed	ACC registered counsellor 10 years post-SVA	Reported to his GP 10 years later who set up an ACC sensitive claims process	Positive experience – reports feeling stronger and able to better manage his emotions	Non-specialist counselling
†Stranger – during childhood	Yes – to a family member	Police – family member took them to report the SVA	Sensitive response – investigation conducted	Mental health and addictions specialist several years later (exact timing not specified)	Was at breaking point	Couldn't help him as didn't meet threshold for service provision	Psychiatrist, ACC counsellor, intentional peer support

† Reported prior SVA from a different perpetrator and had not reported or accessed services regarding this incident(s)

3.8 Pathways to reporting and accessing support services

Figure 3.2 depicts the order in which male survivors disclosed, accessed services, and/or reported the sexual victimisation. The figure shows that disclosure, reporting and accessing services are interconnected and part of a helpseeking process, with 31 survivors (59.6%) carrying out all three helpseeking actions. Only six (11.5%) survivors performed one of these actions in isolation (two survivors accessed support services only, four disclosed only).

It is also clear that disclosure plays an important role in the helpseeking journey, acting as the first point of helpseeking for most male survivors (38; 73.1%) and featuring in the journeys of 47 (90.4%) survivors. Of course, not all male survivors in this study had reported, and not all will want to disclose. This should be borne in mind when interpreting these results.

3.8.1 What happened after disclosing first?

Of the 52 male survivors, the majority (38; 73.1%) first disclosed the sexual victimisation to a friend, family or whānau member, stranger, or service worker. Disclosure, therefore, featured heavily in the men's pathways to reporting and accessing services, whereby 34 (89.5%) of the 38 survivors who disclosed to someone first, went onto report and access support services. Specifically:

- 18 (47.4%) went on to report, all of whom (100%) accessed support services.
- 16 (42.1%) went on to access support, and of those 7 (43.75%) reported the SVA.

  - Only 4 (10.5%) took no further action after disclosure.

3.8.2 What happened after reporting first?

Five men reported first (9.6%), all of whom went onto to access services (100%). Specifically:

  - Three (60%) went on to disclose, all of whom (100%) accessed support services.
  - Two (40%) went onto access support only but did not disclose.

3.8.3 What happened after accessing support services first?

Nine (17.3%) male survivors accessed a support service first, of whom five (55.6%) went onto report. Specifically:

  - Five (55.6%) went onto disclose, three (60%) of whom went on to report.
  - Two (22.2%) went onto report only, one (50%) of whom later disclosed.
  - Two (22.2%) employed no other helpseeking behaviours after accessing services.

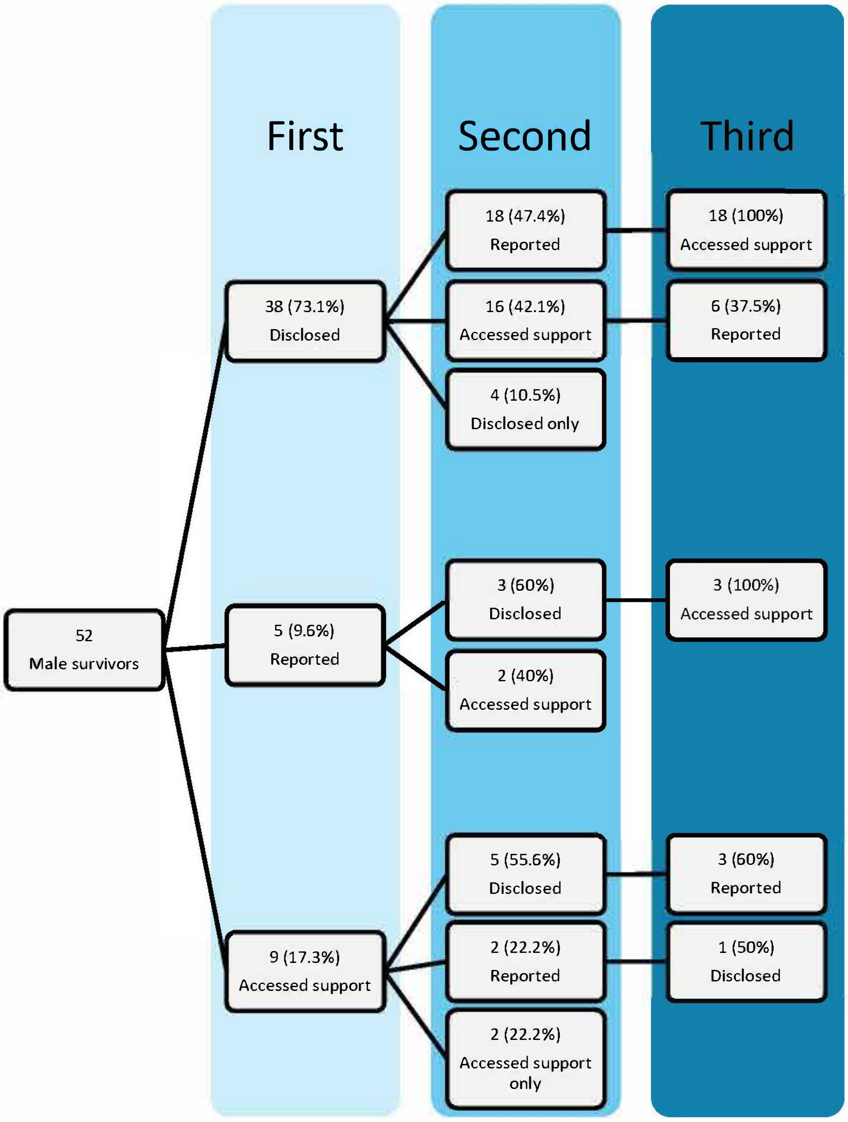

Figure 3.2. The order of disclosure, reporting, and accessing support services across all 52 male survivors

3.9 Section summary

This section set out to answer Research Question 1: *What are the demographic characteristics of the male survivors who took part in the study and how had they sought help?*

We were able to recruit a diverse sample of male survivors who differed across six demographic groups. Diversity was achieved across these groups as follows:

- **Age:** The ages of the male survivors ranged from a minimum of 19 to a maximum of 74 years and male survivors were represented in each of the age categories that we studied.
- **Gender:** Although the majority of the sample (46; 88.5%) identified as cisgender male, six (11.5%) identified as a-gender, non-binary or had a history of gender transition.
- **Sexual orientation:** Over half of the male survivors identified as heterosexual (31; 59.6%), with 20 (38.5%) identifying with a minority sexual orientation group.
- **Ethnicity:** The male survivors identified as New Zealand European/Pākehā/European (39; 75%) or Māori (13; 25%). We did not recruit anyone who identified as Pasifika in this study.
- **Disability:** Almost two thirds of the sample (33; 63.5%) reported experiencing one or more disabilities.
- **Rural and urban residence at time of the SVA:** The majority experienced SVA whilst living in an urban or suburban region (38; 73.1%) and seven (13.5%) lived in a rural setting in in Aotearoa New Zealand. In addition, eight (15.4%) had lived overseas.

Therefore, the methodological approach used in this study engaged a diverse sample of male survivors. The only group that was not recruited in this study was Pasifika male survivors. We reflect on what this means for further research in Section 7.

Other noteworthy points that arose from the content analysis were:

- Intersectionality was evident within the sample, with 21 (40.4%) of the male survivors identifying with two to four demographic groups that are commonly over-represented in the male survivor statistics.
- Four (7.7%) of the male survivors had not reported or accessed support services prior to engaging in this study, albeit they had disclosed the abuse to someone. Therefore, the study methodology engaged only a small number of men who had not attempted to report or access support services. The majority of the male survivors had reported the SVA (34; 65.4%), disclosed their victimisation to someone (47; 90.4%), or accessed a service for support with the SVA (48; 92%).
- The average time taken to report was 18 years, with 10 out of the 32 survivors who had reported and provided a timeline (31.3%) doing so within the first three years after the SVA, and most reporting within 40 years (22; 68.8%). Most male survivors reported to ACC (26; 81.3%) followed by the police and doctors (14/32; 43.8%). However, there were no services that male survivors were significantly more likely to report to in under three years when compared to over three years.
- The majority of male survivors who accessed a support service accessed at least one specialist support service (40; 83.3%), only 8 (16.7%) accessed non-specialist support only. Forty (83.3 %) of the male survivors who accessed services did so between 10-60

years after their experiences of SVA. Only 8 (16.7%) did so within the first five years. The most common reason for reporting was to address problem behaviours that had arisen from the SVA. There were no reasons associated with an increased likelihood of accessing services in under five years compared to over five years.

- Only four men reported a first incident of SVA within 48 hours. Three of these men had experienced SVA from a stranger and one from a peer. The motives for reporting were to catch the perpetrator, to stop the SVA happening again, to seek help for injuries or because a family member insisted. However, crisis reporting did not lead to accessing support services within a short period of time post-SVA. Whilst insensitive responses could delay further helpseeking, even those who experienced a positive response found that they still had to feel ready to access support services, which took considerable time. Once survivors accessed support, the majority (n = 3) went on to seek other support services which they found to be helpful.
- Disclosure, reporting and accessing support services were often interconnected helpseeking behaviours, with 31 (59.6%) survivors carrying out all three actions. Only six (11.5%) survivors performed one of these actions in isolation. Disclosure played an important role in the helpseeking journey: it was most commonly the first helpseeking action for the majority of male survivors (38; 73.1%) and it featured in the journeys of 47 survivors (90.4%). Of course, not all men reported or wanted to report, and this should be borne in mind when interpreting these results.

4. How the male survivors had experienced the barriers and facilitators to helpseeking

4.1 Introduction

This section of the report answers Research Question 2: *How had the male survivors experienced barriers and facilitators to helpseeking?* Using an inductive approach to thematic analysis we identified five key themes that answer this question from the 52 interviews with male survivors. The five themes describe the barriers and facilitators to reporting or accessing services. Table 4.1 provides an overview of the five themes and their subthemes.

The text that follows describes each theme in detail, using supporting quotes to illustrate the survivors' experiences. The themes are relevant to all diverse groups of male survivors. There were no themes that stood out as salient to a specific identity group. Furthermore, the majority of barriers and facilitators were relevant across the different stages of the helpseeking process. Subthemes that were relevant to a specific stage of the helpseeking process highlight this stage in their title (e.g., 'Attentive expert support is crucial during and after reporting'). Where theme findings are relevant to different stages of the helpseeking process we use the term helpseeking in the title to reflect this (e.g., Gender stereotypes are a barrier to helpseeking). Subthemes are presented as barriers or facilitators depending on how the male survivors mostly referred to them. It is acknowledged that in many cases a subtheme could be both a barrier and facilitator.

The notation […] is used where small sections of text have been removed to keep relevant material in one quote. For the sake of confidentiality, survivors are represented by an arbitrary number from 1-52.

Table 4.1: Summary of thematic findings: The key barriers and facilitators to helpseeking for the male survivors

Theme	Subtheme	Barriers or facilitators to helpseeking
1. Gendered social norms and myths are a barrier for helpseeking	1.1. Gender stereotypes are a barrier to helpseeking	**BARRIER:** The stereotype that sexual violence does not happen to men is a barrier
	1.2. Gendered myths about the outcomes of sexual victimisation are a barrier to helpseeking	**BARRIER:** Stereotypes that male survivors are likely to be gay or transgender or go on to perpetrate violence are barriers
	1.3. Gender-inclusive public education can raise awareness and facilitate helpseeking	**FACILITATOR:** The male survivors offered the solution of education to break down the stereotypes. Educating people that anyone, of any gender, can experience SVA was commonly proposed to break down this barrier and facilitate helpseeking
2. The presence and quality of formal and informal social support impacts helpseeking	2.1. A lack of informal social support reduces recognition of victimisation and hinders helpseeking	**BARRIER:** Not having appropriate people available to disclose to reduced opportunities for the male survivors to recognise what constitutes SVA and seek help

Theme	Subtheme	Barriers or facilitators to helpseeking
	2.2 Informal and formal social support with trusted others facilitates helpseeking	**FACILITATOR:** Disclosure was facilitated by trusted friends or family/whānau members, or through peer support work/groups, who could help the male survivor feel safe
	2.3. It's good to talk to caring and compassionate listeners	**FACILITATOR:** Male survivors found it good to talk to informal and formal supports, including strangers, when the person received their story with compassion and belief
	2.4. Insensitive responses to informal disclosures or reporting are a barrier to helpseeking	**BARRIER:** When informal disclosure or reporting was not received positively it could be a barrier to accessing services
3. The complex nature of trauma hinders timely helpseeking	3.1. The complexity of trauma masked its cause and hindered access to support services	**BARRIER:** The complex effects of trauma manifested in a range of symptoms across the lifespan. This made it difficult for the male survivors and others to identify the cause, thus acting as a barrier to early intervention via access to support services for SVA
	3.2. Coercion and control are a barrier to helpseeking	**BARRIER:** Helpseeking was delayed for male survivors who felt who felt controlled by perpetrators
	3.3. Recovery and helpseeking are slow and ongoing processes	**BARRIER:** The ongoing effects of trauma mean that recovery can be a slow journey for male survivors, with survivors having to feel safe and mentally strong to helpseek
4. Service provision, visibility and design need to be tailored to male survivors to facilitate access	4.1. Insufficient and unaffordable specialist service provision are barriers to accessing support services and healing	**BARRIER:** Male survivors described the barriers created by a lack of appropriate services for men and diverse groups of men, and services that were unaffordable. Services that can cater for the diversity of male survivors were called for
	4.2. The visibility of services impacts how easily male survivors can access them	**FACILITATOR:** Access to services was facilitated by visibility and clear messaging about who services provided for
	4.3. A choice of services designed to meet the complex needs of male survivors facilitates access	**FACILITATOR:** Male survivors described how choice of a range of services, designed to meet their complex needs, was required to enable access
5. Quality support from service workers can build agency and maintain male survivors' helpseeking	5.1. Attentive expert support is crucial throughout the reporting process	**FACILITATOR:** Appropriate support from trained service workers is particularly important to help the male survivors cope before, during and after reporting
	5.2. Helpseeking is facilitated by service workers who understand the trauma of male survivors	**FACILITATOR:** Service workers who are welcoming, knowledgeable, and competent in dealing with trauma facilitate male survivor's ability to helpseek

Theme	Subtheme	Barriers or facilitators to helpseeking
	5.3. Building agency facilitates effective helpseeking	**FACILITATOR:** Male survivors described how important it was for services to work with them in a way that built agency to encourage reporting and accessing of services

4.2 The key barriers and facilitators to helpseeking for the male survivors

4.2.1 Theme 1: Gendered social norms and myths are a barrier for helpseeking

The male survivors described a range of ways that social norms about gender and myths related to sexual victimisation and its likely outcomes were barriers to a range of helpseeking behaviours. This theme comprises three subthemes, which are summarised in Table 4.1 and expanded on below.

Subtheme 1.1: Gender stereotypes are a barrier to helpseeking

The male survivors described how dominant social norms about what it is to be a man created the stereotype that men should be strong, tough, and stoic. This led to gendered stereotypes that SVA does not happen to men:

> *"Men should not be victims, and if they are should be stoic and reticent about it" - #16.*

> *"You're a guy, it doesn't happen to guys. It doesn't happen to guys because we're big, strong men. You can take care of yourself boy because you're a man" - #15.*

Male survivors described how they had internalised stigma and shame associated with myths surrounding sexual victimisation, which prevented them from reporting, disclosing, or accessing services:

> *"I think it's just the stigma, it's that it shows weakness […] because somebody else took that from you and you couldn't really do anything to stop it" - #6.*

The idea that men should be strong and stoic not only impacted how men understood their own experiences, but also their helpseeking behaviours:

> *"Well, you're sort of putting your manhood at threat in a way to come out with all this stuff because as the victim, it's not the masculine stereotype" - #43.*

> *"[…] when you do go to groups and things like that you don't want to tell anyone for the fear of being judged by older adults and things like that. It's that whole toughen up kind of approach"- #36.*

This barrier also centred on the myth that women cannot perpetrate SVA:

> *"[…] you see a lot of media coverage of women who abuse men and it's touted as men being lucky" - #17.*

> *"I told him [best friend] like, I was having trouble with [female perpetrator] and stuff and he said words to the effect of well, it's your it's your job as a man to please your woman" - #20.*

Subtheme 1.2: Gendered myths about the outcomes of sexual victimisation are a barrier to helpseeking

Myths about the outcomes of SVA were also shaped by gender stereotypes about sexual victimisation. Across all sexualities and gender identities, assumptions that the experience of trauma had impacted their identity inhibited helpseeking. Some heterosexual cisgender men worried that people would think they were gay, while some gay, queer, and transgender men were concerned that people would conflate their identity with their victimisation:

> *"A lot of males who say they've been abused, are gay. There's still that perceived out there. I mean, I work on building sites, I know that's quite true. I'm not saying it's from everybody, but it's still a big macho image, and that's the biggest challenge for survivors I think" - #9.*

> *"[...] there is an overwhelming feeling that people are trans because of sexual abuse, so if I get the wrong people I don't want them to think that that's why I'm trans, because I was already completely socially transitioned before it happened. It's also why I don't like talking about it really, like a lot of people don't know it even happened to me 'cause people are weird" - #27.*

Male survivors also described the common myth that sexual victimisation leads men to sexually offend:

> *"[...] if you are a male and you are sexually abused, it is more dangerous to be the victim than it is to be the perpetrator. The stigma and the isolation, and the constant expectation that you're going to turn out to be someone that's going to be into sexually abusing people" - #37.*

> *"So then she [a mother] had this conversation with my ex-wife, and basically said "look out for [name]. Keep an eye on [name] because he was abused so he'll probably abuse your kids"." - #8.*

The small number of participants who had perpetrated SVA in addition to being victimised explained how unwelcome they felt at mainstream services for survivors:

> *"It was really hard [...] you feel like you're going to walk into a sexual violence service and be like, "I have had bad things happen to me but also I'm a perpetrator," and they're going to be like, "F**k off. You deserve whatever you get"." - #12*

Subtheme 1.3: Gender-inclusive public education can raise awareness and facilitate helpseeking

Male survivors proposed a solution to break down the barriers created by the prevailing gender stereotypes. They described how gender-inclusive public education is needed to help wider society understand the prevalence, nature, and outcomes of sexual victimisation, as well as what healthy relationships look like:

> *"I think just a greater awareness. Like talk about it. Get it out there. Plaster it everywhere. Bring it out in the open. Shine a big f**k-off torch on it […] Get it out in the open because nothing can be healed if you don't look at it. If you're denying it. When someone's being denied it can't be fixed" - #8.*

> *"I've seen lots of posters about women being abused, and even TV adverts of if she looks drunk, she is drunk, don't take her home […] but in five years I've seen one poster about men in the same situation" - #21.*

It was posed that public education would challenge myths, break through stigma, and legitimise men's experiences, helping men to identify their experiences as violence and abuse and seek help:

> *"It was that change in how people spoke about things that really woke me up and was like, okay, what I experienced is actually included in those terms as well because I thought that was exclusively to women […]. Mostly on social media. Just reading a few posts. It wasn't common, but the occasional post would come up where we'd talk about male survivors" - #6.*

The male survivors also described how public education could be used to normalise helpseeking for male survivors:

> *"Run campaigns like 'it's okay to not be okay'; run nationwide campaigns like that. Yeah, to run huge nationwide campaigns to highlight the fact that it's regardless of whether you're male or not, but just highlighting the fact that's it's okay for men to speak out" - #19.*

> *"[…] the visibility thing of just realising its [survivorship] normal would have helped a lot as well, like we were saying, even if there was billboard ads or something. Just having any sort of something I can relate it to that didn't make me feel so isolated, even if I didn't get direct help, and just realising in some way or another that other people go through it with lots of help" - #30.*

Some survivors stressed that clear step-by-step descriptions on how and where to get help and/or report abuse are needed if uptake in reporting or accessing was to be achieved in the current social context:

> *"I mean, yeah. It kind of makes me roll my eyes, this whole wanky, it's okay not to be okay, talk to your mates. But there's no guide on how to have those conversations or do the work to break down the stigma that makes it hard" - #2*

> *"I guess just like easily accessible information about like the process of reporting and about what people's rights are" - #11.*

4.2.2 Theme 2: The presence and quality of formal and informal social support impacts helpseeking

Male survivors described how a lack of informal social support from family/whānau and peers, or via more formal channels, reduced their opportunities to tell somebody about the SVA they had experienced. However, the quality of this formal and informal support mattered. Listeners who could make male survivors feel safe and believed and cared for were helpful, as opposed to those who were insensitive or critical. This theme comprises four subthemes, which are listed in Table 4.1 and expanded on below.

Subtheme 2.1: A lack of informal social support reduces recognition of victimisation and hinders helpseeking

A lack of access to positive family/whānau and peer support networks reduced opportunities for male survivors to understand their experiences as abusive and to tell somebody about it. Some survivors recalled how they isolated themselves or were isolated due to family/whānau adversity as children, which increased their vulnerability to abuse and served to keep them silent:

> *"I became reclusive if that's the word to use; withdrawn. Wouldn't mix with other children. Constantly in fear of being exposed by adults with that knowledge being made available. I was always in fear of that" - #25.*
>
> *"I'd come from a life of rejection from my adopted father and family, so when I got there to my grandparents I guess they made me feel a sense of belonging somewhere… I didn't know what to think or where to turn to, what to say, what to do. It was disbelief that my grandad that I doted on could do that" - #31.*

For some survivors, isolation from people outside the family or whānau in childhood prevented access to alternative family models and maintained their belief that victimisation was just part of normal family or whānau life. Exposure to alternative models came with age and maturity which helped the survivors overcome this barrier:

> *"I was living in a closed [religious] community. It was a cult. It was like a closed [religious] community […] what we were being told was normal, so it just is what it is and that's just how it was because that was the environment we were in" - #7.*
>
> *"I was 14 by the time I realised that I'd been raped. I knew exactly what had gone on, but when I was 14 and I heard the word 'rape' for the first time, when someone told me what it was […] I just broke down […] I went 14 years without realising what a word was because I was so sheltered, and even though it had been happening to me every week for years" - #21.*

Other male survivors compartmentalised their experiences and did not share them with others, which served to maintain their belief that they were the only one this happened to. This belief could be maintained for a long time and into adulthood and impact helpseeking:

> *"I kind of compartmentalised it through my childhood and just felt like it's only happening to me and I'm not going to talk to anyone about it, and I don't know how to talk about it" - #17.*

> *"I think that's one thing that helped me back is that I kept the secret for so long and I always thought I was the only one. Then not talking to anyone or going to groups and just letting it build up and build up and build up; that's just my opinion on that anyway" - #36.*

Subtheme 2.2: Informal and formal social support with trusted others facilitates helpseeking

Male survivors who had contact with a friend or family/whānau member who they trusted and shared a strong connection with was described as facilitating disclosure at any age, particularly when the person could empathise with the survivor and make them feel safe:

> *"I was about seven, and actually told my grandmother, because we were really, really close [...] we had a really, really strong relationship" - #19.*

As adults the male survivors often described having these supportive close connections with stable intimate partners and peers, who could also facilitate the male survivor's helpseeking:

> *"I think the first time I ever spoke to anyone about it, was to my wife. We may have been engaged at that particular point in time so I was about 29 years of age [...] I found someone with strength that I could, lay things on in a sense" - #32.*

Disclosure to these supportive people could facilitate reporting and accessing of services:

> *"I was talking about it to a flatmate of mine and it was his recommendation. He said, "If this is still bothering you after, at that point it was three years, go to the police. That way you can say you've done it and it might prevent a thing." Yeah so it was advice from someone I was living with" - #5.*

For some male survivors, developing a sense of community and trusting relationships occurred through formal peer support groups which provided them access to a safe community who validated their experience and to which they felt they belonged:

> *"it was great to see them and learn that there were other people like me out there and that they existed and that there was this network if I needed it to fall back on" - #29.*

> *"They give me tools to understand and process the information, and what to do to keep myself safe which is really good, and it also helps to just during the week at some stage just to sit down and talk to the people that have been through the same thing, to actually just sit there and talk [...] it's actually therapeutic for just sitting down and talking as well in a group like that, so it's quite good" - #15.*

Talking about experiences of victimisation could help alleviate shame and encourage further helpseeking:

> *"There was one particular fella [in prison], hard looking, real hard looking person, we sort of got on really well and he started telling me his life story [...] and I thought to myself then what I went through is nothing compared to what he went through. He told me afterwards, after I told him the same thing happened to me but not in such a bad way, and he said, "You know what you want to do, talk to someone about it. That's what I did." I went, "Okay." It was about three, maybe four weeks later, I got called into the counsellor and I just sort of told him" - #40.*

> *"[...] there's some things that like you can't understand unless you've been through them yourself and it's nice when you have someone that you don't have to explain it to them. They just know and I think that really helped" - #20.*

Subtheme 2.3: It's good to talk to caring and compassionate listeners

Male survivors described talking with a range of people about their experience of victimisation, but these were only positive experiences when they talked with caring and compassionate listeners. Positive, informal disclosures to friends, family/whānau or even strangers, could empower the survivors, keep them safe from further perpetration or provide hope and liberation:

> *"There's been times where I've shared it with complete strangers. I've just said, yeah I'm a survivor of childhood sexual abuse. It's such an empowering thing to say. I never realised how empowering it would be but it actually is" - #8.*

> *"It made me feel like I'm still human sort of thing, and that I've still got a life to live [...] She basically opened up the door for me, and basically not to give up and have hope in myself" - #13.*

Male survivors who felt believed when disclosing to service workers, at formal peer groups, or reporting, discussed how important that experience was because it validated their experience of victimisation and encouraged them to later access support services:

> *"Yeah a lot of, a lot of the people that were there [at the formal peer support group] just said, good on you. Well done for sharing, thanks for sharing. You know, we believe you, you know, it was very empowering to be told that [...] I think it had a positive impact [...] you know in terms of an ACC claim, getting some counselling, you know, that kind of stuff [...] that gave me enough fuel, if you like, you know emotional fuel to keep going and start the journey" - #45.*

> *"I didn't think anybody would ever believe anything I had to say about it. She [counsellor] did believe me. When she believed in what I was saying, this is the truth and accepted me as I wasn't lying to her, I felt vindicated if you like" - #31.*

Whilst most of the male survivors in this study described how they found it good to talk with caring and compassionate listeners, not everyone could or wanted to talk, which realistically requires providing choice in services for survivors:

> *"Because a lot of people think that because you tell your story – which is a stupid phrase – that that's healing. Now, often it actually re-traumatises. And so you get people who sit and listen to the story and you never hear from them again. So, that's not helpful, no" - #26.*

> *"I was visiting a psychotherapist for most of this year, and I still just couldn't, and even though I was completely introspective, I just can't. It's just something about it that I can't, like I'll beat around the bush to the point where I just won't mention it, and try to imply it, but I'm just being so vague on purpose that it's not communicating."- #30.*

Subtheme 2.4: Insensitive responses to informal disclosures or reporting are a barrier to helpseeking

Sometimes disclosure to friends or family/whānau, or reporting to professionals, discouraged the male survivors from further disclosure, reporting or accessing of support services. Those survivors who felt they were not believed or criticised when disclosing or reporting found it difficult to disclose or report after that:

> *"I remember asking a school friend once if a family member does this; they said no. I told my Nana the next day and once she called me a liar I didn't want to tell anyone ever again […] I told the person that was closest to me and they called me a liar so if I told someone that's not close to me they'll probably think the same so I'm not going to tell anyone" - #36.*

> *"I think more of the damage was actually done by the minimisation and the suggestions by people even in the police that I'd imagined it and dreamt it and seeding that sort of doubt in a child" - #4.*

For some male survivors, their family or the wider whānau insisted on a code of silence after disclosure or reporting, which could prevent survivors from reaching out to services:

> *"Certainly in my family there was a real omerta [code of silence] about it. I remember asking at one point, "Can I go and see somebody or have some support with this?" and being told it wasn't a good idea. So, I didn't" - #1.*

Indeed, survivors worried about how their disclosure or reporting could impact the family or whānau and their position within that group.

> *"I didn't want to affect my family; splitting my family up and all my cousins hating on me because of this" - #34.*

Disclosure and reporting to local services was avoided by some men due to the small network of people who may talk amongst themselves about the survivor and/or their family or whānau:

> *"[…] some members of the family, not me, didn't like the idea of the police. They were scared of the publicity" - #43.*
>
> *"I actually felt more comfortable going to a Pākehā organisation for help, opposed to a Māori organisation. […] when you are brought up in a small town where everybody knows everybody; of course people are going to talk, and I was afraid of that" - #19.*

4.2.3 Theme 3: The complex nature of trauma hinders timely helpseeking

Prompt helpseeking was hindered for male survivors by the complicated impact of trauma that manifested in many different ways throughout their lives. This resulted in a slow journey of recovery. This theme comprises three subthemes, which are listed in Table 4.1 and expanded on below.

Subtheme 3.1: The complexity of trauma masked its cause and hindered access to support services

Trauma associated with sexual violence can be complex and lifelong. The male survivors described experiencing the serious impact of the trauma including addiction and a range of mental and physical health issues:

> *"You're looking at someone who is has been abused a number of times in his life so far. Yeah, the number of times I've tried to kill myself is three" - #14.*
>
> *"I've been suicidal my whole life. If by suicidal people mean fantasising endlessly about taking your own life and how to do it then yes. I've been in and out of suicide my entire life from the age of about 12" - #42.*

Some of the male survivors discussed how engaging in criminal activity was an attempt to mask the hurt caused by the sexual victimisation:

> *"I had a reputation. I had pride. I had all this mana all for the wrong reasons but I still chose to hide that; mask it and just bury it so that; if I buried it and masked it; hid it away from everyone; no one would know. I wouldn't have to speak about it" - #35.*

The realities of dealing with complex trauma meant that the male survivors often did not recognise their need for support:

> *"But I was in such a state that I didn't know what support I actually needed" - #1.*

Considering the complexity and depth of the trauma many participants talked about hitting 'rock bottom' which finally drove them to seek help:

> *"I was reaching an emotional crisis […] my marriage was imploding" - #4.*

> *"I began seeking help for depression, and through that help revealed that I had been abused" - #41.*

The male survivors often presented to services such as mental health care workers and crisis response teams in emergency departments that could help them with symptoms that were often seemingly unrelated to the SVA. Contacting services that do not specialise in SVA helped some male survivors to understand the link between their current crisis and prior sexual victimisation. It also helped them to understand how to access services that could support them with this experience and its related trauma:

> *"I developed an eating disorder and saw someone at [eating disorder clinical practice] for that at the time, and at the time it's this one thing and it's an eating disorder which, surprise, surprise with a little bit of digging from a counsellor turned out to be related to trauma" - #1.*

However, male survivors commonly described that no one asked them if they had ever experienced SVA:

> *"Had it been brought up I probably would have been open about it, but no, it was never brought up. Nobody asked. No [...] I got drunk again and tried [suicide] again. That put me into seeing a psychiatrist and then there was a very brief thing where he just talked about my medications. He didn't talk about anything aside from my medications. He just prescribed me a higher dose" - #6.*

This led to missed opportunities to identify trauma history in locations such as school, medical settings, or prison:

> *Interviewer: No one asked you here what was going on for you?*
>
> *Participant #40: No. Just didn't happen in prison. First time I seen a counsellor was the last time I went in. That was the only time I ever had, and that was just a short two sessions of half-an-hour.*

Subtheme 3.2: Coercion and control are a barrier to helpseeking

Male survivors often felt controlled by, fearful of or dependent on the perpetrator, which impacted whether they could get away from the abuser or tell someone what was happening to them:

> *"More than often or not he'd tell me that I'll end up in foster care if I told people. I obviously didn't want to go back to that abusive environment" - #36.*
>
> *"[...] when I was little, I was about seven, he used to feed me marijuana, and I'd be stoned as and then he'd abuse me and then I ended up getting addicted to marijuana" - #47.*

> *"Every morning she would put a bottle of wine in the fridge for me to start me off for the day. I always had a bottle of spirits in my bag when I was at school just to top me up and then at night it was just constant drinking [...]. Leaving that place was difficult because of the trying to source alcohol because it wasn't as easy to come by [...] I was locked in and there was nothing I could really do without exposing myself"- #6.*

Some of the male survivors felt empathy for the perpetrators and did not want to get them in serious trouble, especially where they were family or whānau members:

> *"I remember being very worried that [the intrafamilial perpetrator] was going to get into trouble, that I didn't want him in trouble, I just wanted it to stop and I just wanted someone to hear about what had happened to me" - #1.*

Some of the men, however, described feeling an over-riding sense of duty to prevent future harm to others, which encouraged them to overcome the control and fear and consider reporting the perpetrators:

> *"I sort of thought [...] if I don't say anything, I'm responsible for allowing this sort of abuse to continue. I'm not taking that too heavily on myself because I know it's not my fault" - #8.*

Subtheme 3.3: Recovery and helpseeking is a slow and ongoing process

The male survivors described how recovery from the SVA was a slow, unfolding, and ongoing process. Some of the male survivors noted that they had to feel safe and mentally strong before they could acknowledge what had happened to them to enable them to helpseek:

> *"I just felt strong enough to deal with it myself, to actually be able to face it and say it. But probably the most important thing is I felt strong enough to kind of relive it [...] I'm just stoked where I am today compared to where I was" - #17.*

For some of the men, getting physical distance and psychological space away from where and when the abuse took place helped them to disclose the abuse to others or report it:

> *"[...] another reason why it was a lot easier is I wasn't even in the same city when I went to the police and I was in a better mental space" - #5.*

The survivors explained that recovery is an ongoing process due to the damaging impact of trauma:

> *"[...] my biggest demon out of my abuse, I struggled, and I still do today, is self-esteem. A voice in my head today still tells me I'm a piece of s**t. Then there's this other voice that's been healing that goes, get away"- #31.*

> *"I still occasionally get triggered by things. I'm mindful that trauma is something that I will carry with me even though I have done so much work to mitigate those effects" - #1.*

With hindsight, the male survivors wished they had accessed support sooner:

> *"It would have been nice to have support in the earlier years where I think we could have avoided a lot of the bad behaviours that I got into […] The drinking, the drugs. I just sort of went off the rails completely here" - #6.*

> *"And I would also say to them try and get help as soon as possible because, I mean, for me it took getting hospital, like it took, like it kind of got exponentially worse until I was sent to hospital. If I'd, like I said, if I'd got help back then it probably wouldn't have come to that" - #20.*

4.2.4 Theme 4: Service provision, visibility and design need to be tailored to male survivors to facilitate access

Male survivors described how their search for support from services was hindered by a lack of available and visible services to support them with their specific experience of victimisation as diverse groups of men. This theme comprises three subthemes, which are listed in Table 4.1 and expanded on below.

Subtheme 4.1: Insufficient and unaffordable specialist service provision are barriers to accessing support services and healing

The male survivors talked about how difficult it was to find specialist services once they were ready to reach out for help, and how resilience and luck were required to find support:

> *"What gets in the way is the lack of resources […] I'm going to spend probably two days calling around, trawling for someone to talk to and to arrange appointments and stuff like that […] Ringing round services for a couple of days, that can be quite frustrating" - #4.*

> *"Not having immediate access is really horrible. It's the equivalent of turning up to the ER with half your leg missing and they're like, "Come back in a couple of weeks, we'll fix you up then" - #8.*

The lack of services was particularly pertinent for men who are transgender, gay, or bisexual:

> *"I just wanted someone who is good with the trans community in general because I'm trans and I'm tired of people telling me that I'm too complicated for them. That's really hard when you've seen them for three months and then finally disclose, actually talk about stuff that's bothering you and they freak out and I'm like, it's not your job to freak out"- #27.*

> *"I think my counsellor's straight so sometimes it feels like I have to do like cultural translation. In terms of like, I can't just say, this whatever happens, I have to explain what that means, you know [...] if I were given the option between a support service for men or specifically just for queer people of any gender, I'm gonna go to the queer one because they're gonna understand a lot of those things just right off the bat" - #2.*

Other male survivors discussed how they felt that they did not fit the criteria of mainstream support services because they were men, they worried that they were taking resources away from women, and that their male appearance would upset the female clients in those services where people attended in person:

> *"I felt as though what right did I have as a man to call and ask for help from someone, which was effectively a women's service or a service for women [...] Men don't get raped" - #4.*
>
> *"And especially by strictly women only type place, a lot of the people going there have probably been assaulted by people who look like me. And I could make other people uncomfortable and I would not want to do that" - #3.*

The men also described how greater options for bespoke specialised services and greater choice of service workers is needed to cater for the diversity of male survivors:

> *"I don't think you have a diverse enough base of specialists"- #17.*
>
> *"It's very easy for people to sit and go, "Oh well, we need more therapists," but it's like, yeah, what do those therapists look like? Do we have enough trans therapists? Do we have enough Māori therapists? Do we have enough people working in Pasifika modalities? Do we have the range that's needed?" - #1.*

Even when participants could find appropriate support the cost of the treatment was often prohibitive:

> *"I do know, you know, talking to people, the biggest thing that sort of perhaps stops people is the cost. I think I only had to subsidise about twenty dollars. The rest was paid for by ACC" - #50.*

While ACC sensitive claims was able to support some survivors, others were left without that support:

> *"Yeah, but the ACC doesn't cover it because one, it's not New Zealand-based. Well, that's the one, the only thing that matters" - #21.*

The bureaucracy involved in an ACC claim was described as off-putting by some male survivors:

> *"There was a lot of form filling in, and a tremendous amount of application process to get the help" - #41.*

Subtheme 4.2: The visibility of services impacts how easily male survivors can access them

Services that had poor visibility exacerbated the feeling among male survivors that they lacked the know-how to access support. The male survivors noted it was not easy to find information relevant to them as male survivors so they could find the right sources of support:

> *"I had a presumption there were services available but completely unaware how to reach out to them" - #5.*

> *"My counsellor said to me, "Hey, did you know ACC will help you out with what's happened to you?" and I was like, "I've never even heard of that. I didn't even know that was a thing"." - #17.*

Poor visibility included a lack of marketing or inadequate websites that were not user-friendly:

> *"I Googled, 'Male domestic violence victim,' or something and there were no results. All the results were female victims of male violence on Google and I was like, "There's literally nothing there." And so I just thought there's actually no place for male victims to talk about these things. There was nowhere to go" - #18.*

> *"[…] they don't have a great social media presence and their website looks like something out of the 1990s. It's not regularly updated so it makes it quite hard to get engaged even if you wanted to" - #29.*

Services that had good visibility facilitated access and comfort when coming for an appointment:

> *"I was just walking down the road and I'd seen their poster in the window because I just walked past" - #15.*

> *"Well, a good example was for this in their email, how it's saying, "These are some of the questions you might expect." That was really helpful for me"- #10.*

Male survivors described wanting services that clearly advertised key points, particularly who they worked with, staff details, and what the nature of their work with men entailed:

> *"If you are welcoming to male victims of sexual violence, say so. If you are welcoming of trans and non-binary victims of sexual violence, say so, because it's not obvious"- #1.*

> *"I guess a big thing for me was just kind of knowing the structure of a session, and the content within a session, because I remember […] the day of my first session being really anxious, like not knowing if I were going to become really emotional during it, and not knowing what was going to happen for that one hour" - #10.*

Subtheme 4.3: A choice of services designed to meet the complex needs of male survivors facilitates access

The male survivors described how they required easy access to a range of different services that were designed to meet their needs. The men described how quick and easy options to make initial contact with services helped to promote engagement:

> *"I think it was text with us, because that's sort of like an easy first step isn't it [...] it's quite good, because it's same as email, it's bam bam, and you get a response" - #9.*

The survivors also discussed how a 'one-stop shop' or 'wrap-around' and 'bridging services' were needed to help them address the multiple issues they experienced. Peer support was noted as a particularly useful way to bridge services and guide male survivors:

> *"[...] access to peer support will provide them with, not cushioning and not, not a cocoon but it provides them a level of support when they're accessing the service and to get what they need" - #45.*
>
> *"One of the things a lot of guys have been talking about is having a single service, a joined up, full wrap-around service" - #15.*

Choice in the type of services offered was also important, this included a range of modalities of therapy (e.g., talking, and non-talking therapies; individual or group work):

> *"Like I don't technically like doing group work and I don't want to necessarily. Like I do get triggered by other people's stories when I'm in a room and we're doing it" - #42.*
>
> *"EMDR [Eye Movement Desensitization and Reprocessing] really worked for me as a therapeutic practice because I didn't have to [talk]" - #1.*

Choice also included providing services with different objectives. For example, working with people who had been victimised and perpetrated SVA, and access to groups that provide more general social support were noted as options:

> *"I think there need to be more services about dealing with people who perpetrate and want to do better" - #12.*
>
> *"...having people around you that's not solely based on that topic. Like having a place for people to go* [...] *where you don't be judged and you don't have to relive the thing. But you have a common interest" - #51.*

Providing appropriate cultural environments was also important. In particular, Māori cultural spaces helped Māori male survivors to feel safe and comfortable, enabling disclosure and access to support:

> *"[...] because this particular workshop was held on a marae. So it made me feel even more comfortable because I could identify culturally as well to the space that was being used, and from that point; yeah, I just walked in, into the wharenui, and just felt at home. It was a safe haven I guess. It was a safe haven because when the abuse was happening there was no safe haven, there was nowhere to go" - #19.*

> *"Coming here to the whare; learning how to talk; learning how to articulate kōrero, and diving real deep into the emotions; the thoughts; the feelings; the underlying issues that are hardly spoken about is where my mahi is. That's where my mahi is" - #35.*

Relaxing spaces or spaces that allowed privacy facilitated comfort when accessing support:

> *"He'd always say, come ten minutes early, I won't be there. So I'd go down there and I'd just relax... It was about forty-five minutes between, so you'd never cross over with someone" - #50.*

Accessing spaces that dealt with multiple issues meant that some men felt safe because others did not know why they were attending that service:

> *"No one knew why I was there, so it's quite anonymous which I felt good [...] It was anonymous in public sight because he was just in another doctor's office. So, I just sat in with everybody in the waiting room and then he called me through, and it was just like normal which was really helpful because it didn't give me a sense that I was doing anything to be ashamed of" - #29.*

4.2.5 Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking

Male survivors noted the importance of having a sense of autonomy and agency when engaging with services. Working with well-trained staff who could help build an individual's agency was therefore a crucial aspect of support services for male survivors. This theme comprises three subthemes, which are listed in Table 4.1 and expanded on below.

Subtheme 5.1: Attentive expert support is crucial throughout the reporting process

Attentive support for male survivors from knowledgeable and caring service workers was key to helping male survivors through the difficult process of reporting and attending court when perpetrators were prosecuted. This was particularly necessary to counter the negative attitudes and emotions that many of the men held toward the police (including fear and mistrust) and the wider criminal justice system that prevented them from reporting.

> *"I had a lot of anxiety about telling the police because I really had no idea how that was going to go. I have heard all sorts of narratives about you go to the police and it's awful, they don't believe you, or you get asked a thousand questions" - #14.*

In particular, male survivors experienced a lack of confidentiality when reporting, lengthy drawn-out reporting processes with religious organisations, lack of action after reporting, or hostile court processes:

> *"Going to the police station with my friend was OK but then they started asking questions. My head was spinning in all directions after that. Just question after question after question" - #14.*

> *"[...] they figured out that they'd actually lost me in the system. Hence there was no notification that this was going to happen. I would have been there. I would have gone stood in the court to watch and so I was yeah really really distraught with that. I thought that was pretty appalling" - #32.*

Male survivors also described how a lack of victim support, advocacy and counselling throughout the reporting process left them feeling unsupported and unable to cope and re-traumatised:

> *"I felt I didn't have any support. There was no victim support. It might have been offered but it never got to me. So, I didn't have any kind of counselling at the time. I didn't have anyone to talk to [...] as result of the police internal examination, I have a real terror of gynaecological procedures" - #1.*

> *"They made an apology on behalf of the [religious organisation] and they provided an apology letter from [the perpetrator] which I didn't read at the time. When I did read it, it was very distressing because it was the complete non-apology. You know, it was "I didn't realise that what I was doing was wrong. I'm really sorry that I've hurt you."" - #32.*

The ideal services for male survivors involved attentive support when men report their experiences of SVA. Male survivors who were supported through the reporting and court process by intentional peer support workers, counsellors, or victim support advisors, reported that this was helpful before, during and after interactions with the criminal justice system:

> *"I was fairly frightened of contacting the police, but [counsellor] was with me" - #41.*

> *"Just the fact that [peer support worker] said hey, remember you have every right to do this. There's no statute of limitations on reporting historic sexual abuse. They explained a bit about the process and said that they are very understanding. They're not like normal police officers. They're not going to sit there and say that it didn't happen or anything like that. They're just going to listen to you and then after that initial thing you'll have a specialist [...] and I have confidence in what he was telling me and that empowered me to go" - #8.*

Subtheme 5.2: Helpseeking is facilitated by service workers who understand the trauma of male survivors

Interactions with service workers affected male survivors' helpseeking behaviour. For many male survivors, understanding and processing the trauma of SVA through therapeutic interventions was beneficial:

> *"It's nerve wracking but it's also quite empowering to be able to just talk about it and say this happened and I'm still here and I'm doing well in life" - #6.*
>
> *"So, although these things have happened to me, I actually look at it quite a bit quite differently. I'm not upset. I can't go back. I've actually ran with what I was given and actually, you know, turned it around to be something quite positive for me and the people around me" - #50.*

Interactions with service workers did not always go well. Male survivors described how general service workers and some specialists did not seem to have a good understanding of SVA or how to address victimisation, which could make them insensitive or appear dismissive and led to disengagement with that service and other services:

> *"The hardest question I was ever asked was when I was talking to that psychologist from ACC and he said something along the lines of, "Why don't you abuse your own son?" He didn't say that, but that was the inference from what he was saying. [...] It definitely put me off asking for help" - #17.*
>
> *"There was an assumption of why I was there before we got there. It was like workplace stress was the assumption. I sat down and was spoken to about taking ten deep breaths in the workplace and dealing with workplace stresses. It got a little bit further and I opened up a little bit more to the counsellor and told her what actually happened to me and why I was there. It's difficult to explain, it was like I definitely shocked the counsellor" - #29.*
>
> *"She's my GP, the one that I always go to. I know her quite well. I'm not having a go at her but she was visibly uncomfortable when I raised it with her and didn't really know. It was not a nice conversation" - #28.*

The men spoke about the need for there to be training for the wide array of service workers who will come into contact with male survivors so that they can respond to their needs appropriately and understand how trauma affects survivors:

> *"I'd tell them definitely to seek support but I'd tell them to go to someone who is trauma-informed. Be very careful about who you go to. I would definitely, and you know, I'd say to ask around people who know about who's competent, yeah" - #26.*
>
> *"You have to make sure that your staff are up to speed on the unique challenges that are faced by men and gender minorities and reporting sexual violence. As well as*

> *that trauma, there's those feelings of deep guilt and shame, that inability to talk about it, how it impacts on your sense of self as a sexual being" - #1.*

Subtheme 5.3: Building agency facilitates effective helpseeking

Male survivors described how they felt they lacked agency in the process of reporting and accessing services and how re-traumatising this was for them. Some survivors felt unsupported by organisational policies, rules and criteria which served to reduce the level of control and individual choice they had in order to get effective support within the system:

> *"The thing which is probably interesting for you is that I have had to disclose my sexual abuse to no less than six people to get the help that I'm trying to get at the moment"- #28.*
>
> *"It can take so long to have the courage to deal with people who have power over you. [...] I had 10 years of somebody constantly having power over me. I had no autonomy in my body. It was constantly like that. Being in a psychiatric hospital, I have no autonomy over my body. And then you walk into WINZ and they just wield such power over you, and you are helpless for a start, you're desperate, you want help" - #17.*
>
> *"I went to the GP and said, "Is this an avenue that I can explore?" and got told no, because I wasn't abused in New Zealand. [...] Like, s**t, did I need to be raped in the correct geographical area next time? Lesson learned there" - #1.*

Some male survivors described positive experiences that did promote agency and offered solutions as to how services can work with male survivors to build agency and autonomy. These centred on working at the survivor's pace, not forcing disclosure, believing them, working with people who understand SVA victimisation and providing survivors with the knowledge and tools to help themselves:

> *"[...] letting people know it's free, that it's there for you and you don't have to debase yourself or humiliate yourself. You can walk into a room and there's a dude or a woman who has experienced what you've experienced, and you don't have to unpack it all" - #17.*

Male survivors also described how they wanted to give back by helping other male survivors and making sure something valuable came from their own negative experience. Male survivors achieved a sense of agency via offering peer support, writing books or highlighting support for male survivors on social media:

> *"It was at that point where I was like I think the greatest thing about accessing help is, for me, it's always been the prospect of being able to give back, that at some point I'll be able to just talk to someone like this" - #17.*

> *"[...] to help somebody else, that was the other thing too, was just to help somebody. If you can help one person then it's worth it. That's the way I see it anyway. It's not a nice thing to go through, but you break out. It is what it is, isn't it"- #9.*

The agency afforded through the methodology in this study also gave the men the courage to speak up to help others:

> *"[...] you're listening to us and nobody listens to us. What you guys are doing is actually a huge deal for us, sending that application or whatever to want to come and do this was like a net positive for me. I was like, oh s**t, someone wants to listen? Well yeah, I'm going to have that conversation. What you guys are doing is really great. I've never had this conversation with anyone. So, I think it's brilliant"- #17.*

> *"I feel so strongly about this, about like society isn't doing anything about this problem, and here is finally some opportunity to do something about it and I can help to make something be done about it" - #18.*

4.3 Section summary

This section set out to answer Research Question 2: *How had the male survivors experienced barriers and facilitators to helpseeking?* Five themes were identified that described the male survivors' experiences of barriers and facilitators:

Theme 1: Gendered social norms and myths are a barrier for helpseeking:
- This theme showed that the male survivors found it difficult to seek help because their experiences of SVA went against the pejorative norm of manliness (i.e., men should be strong and powerful, stoic, and heterosexual) and the expected gendered (female) nature of SVA victimisation.
- This challenged their sense of masculinity and led to shame, silence, and a reluctance to seek timely help.

Theme 2: The presence and quality of formal and informal social support impacts helpseeking:
- This theme showed that if the survivors did seek help, their informal social networks were not always knowledgeable and responsive, and mainstream services and service workers were often ill equipped to engage or respond to them appropriately.
- However, talking to compassionate and engaged listeners encouraged survivors to report and access services, and formal peer support provided a good mechanism to get social support for those who did not have it via other means.

Theme 3: The complex nature of trauma hinders timely helpseeking:
- This theme showed that the complexity of SVA and its consequences meant that some survivors were unaware of the need to seek help to deal with the trauma of SVA, resulting in delayed helpseeking.
- This delay allowed a long tail of negative symptoms and traumatic events to build up, which masked the underlying trauma of SVA and further delayed helpseeking.

- Thus, non-specialist service workers were most often left to join the dots for the survivors, or men eventually sought help when hitting “rock bottom”.

Theme 4: Service provision, visibility and design need to be tailored to male survivors to facilitate access:

- This theme showed that specialist services that were affordable and could respond appropriately were limited in number. Furthermore, there were a lack of bespoke services and service workers who could support men, and minority groups of men.
- Indeed, the survivors did not feel comfortable at mainstream SVA services that typically catered for women or cisgender heterosexual people.
- Access to specialist services was made further difficult by a lack of marketing and unclear male-friendly messaging about service objectives and provision.
- Wrap-around services (e.g., combined peer support, counselling, advice, financial, health and/or family support) that provide men with a choice of treatment modalities and services (e.g., talking, and non-talking therapies; individual or group work) were preferred in addition to those that adopted a trauma-informed approach.

Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking:

- This theme showed that quality services could build agency and encouraged helpseeking. Attentive expert support throughout the reporting and court process helped survivors to engage.
- Similarly, specialist and non-specialist service workers who welcomed, listened, affirmed, and validated the survivors' experience and could cope with disclosure, built trust and furthered engagement with services.
- Opportunities for male survivors to make a difference for other male survivors also afforded them with agency, such as providing peer support and engaging in the research project itself**.**

A detailed summary of each theme and the implications for practice, policy, service provision is provided in Section 7. The themes are also incorporated in the case studies about example journeys of male survivors presented in Section 6.

5. How the service workers' views compare to the male survivors' experiences

5.1 Introduction

This section of the report answers Research question 3: *How do service workers' views on barriers and facilitators to helpseeking compare to the male survivors' experiences?* We performed a deductive thematic analysis of 13 meaningful responses to an online questionnaire (see Appendix C). We directly compared the service workers' comments to the themes identified from the interviews with male survivors in Section 4. This approach provides an understanding of the similarities and differences between the groups whilst centring the results on the male survivors' voices.

The service workers' perspectives are described below with supporting quotes. The notation […] is used where small sections of answers have been removed to keep relevant material in one quote. Service workers are allocated arbitrary numbers from #SW1 to #SW13 to identify their quotes. The demographic details of the 13 service workers are detailed in Table 5.1. Job descriptions are presented generically as specialist or non-specialist service worker only (rather than peer support worker etc.) to protect participant anonymity.

Table 5.1: Demographic details of 13 service workers who provided meaningful responses to the online questionnaire

Service worker #	**Service provided**	**Length of service experience (years)**	**Workers have experience of engagement with male survivors from the following groups:**					
			Age range (years)	**Ethnicity**	**Gender identity**	**Sexual orientation**	**Disability**	**Residential location**
1	Non-specialist	8	16–44	Māori, New Zealand European, Pasifika	Transgender men and women, non-binary people, Cisgender men and women	Gay and bisexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban
2	Specialist	15	All ages	Māori, New Zealand European, Pasifika	Not reported	Gay, bisexual, and heterosexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban
3	Specialist	3	16–44	Māori, New Zealand European, Pasifika	Transgender men and women, non-binary people, Cisgender men and women	Gay, bisexual, and heterosexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban
4	Specialist	12	25 +	New Zealand European	Not reported	Gay, bisexual, and heterosexual	Not reported	Rural, urban, and sub-urban

Service worker #	Service provided	Length of service experience (years)	Workers have experience of engagement with male survivors from the following groups:					
			Age range (years)	Ethnicity	Gender identity	Sexual orientation	Disability	Residential location
5	Specialist	8	All ages	Māori, New Zealand European, Pasifika	Not reported	Bisexual, and heterosexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban
6	Non-specialist	0.3	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
7	Specialist	20	All ages	Māori, New Zealand European, Pasifika	Transgender men and women, non-binary people, Cisgender men and women	Gay, bisexual, and heterosexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban
8	Specialist	10	All ages	Māori, New Zealand European, Pasifika	Not reported	Gay, bisexual, and heterosexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban
9	Specialist	17	16–24	Māori, New Zealand European,	Not reported	Gay, bisexual, and heterosexual	People with learning disabilities	Rural, urban, and sub-urban
10	Specialist	5	All ages	Māori, New Zealand European, Pasifika	Transgender men and women, non-binary people, Cisgender men and women	Gay, bisexual, and heterosexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban
11	Specialist	15	16 - 44	New Zealand European	Not reported	Heterosexual	Not reported	Not reported
12	Specialist	17	16- 64	Māori, New Zealand European, Pasifika	Transgender men and women, non-binary people, Cisgender men and women	Gay, bisexual, and heterosexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban
13	Specialist	13	16- 64	Māori, New Zealand European, Pasifika	Transgender men and women, non-binary people, Cisgender men and women	Gay, bisexual, and heterosexual	People with learning and/or physical disabilities	Rural, urban, and sub-urban

5.2 Comparing the views of service workers to the themes from interviews with male survivors

5.2.1 Theme 1: Gendered social norms and myths are a barrier for male survivors seeking help

The majority of the service workers (n = 11/13) commented on how gendered presumptions create myths around SVA. The service workers supported the points that male survivors made about how these gendered myths can impact helpseeking and the need for gender-inclusive public education about the nature and outcomes of sexual victimisation.

Subtheme 1.1: Gender stereotypes are a barrier to helpseeking

Approximately half of the service workers (n = 6/13) described how social norms about what it is to be a man create the myth that men are tough and don't need support for SVA. In addition, they referred to myths that men can only be the perpetrators of SVA based on the presumption that women do not perpetrate this abuse and that victimisation does not happen to men or boys.

When describing these myths, the service workers did not make any direct comparisons between the rates of SVA to men compared to women and girls. Instead, they centred their comments on how these societal presumptions create barriers to helpseeking for male survivors and maintain a social silence about the issue:

> *Q: In your experience, what are the main things that make it harder for male survivors to access services or agencies for support with SVA?*
>
> *A: "Attitude of society that males don't get abused or it is their fault" - #SW7.*
>
> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA? How might this be achieved?*
>
> *A: "Lots of understanding and training to de myth male culture. This is an area that is judged by society, that is why it can still happen" - #SW2.*

The service workers also noted that this myth is likely to be experienced by individual men or boys who believe they are alone in such experiences, which forms another aspect of these myths as a barrier to helpseeking:

> *Q: In your experience, what are the main things that make it harder for male survivors to tell, or report to, services or agencies?*
>
> *A: "Thinking it never happens to other men. Shame" - #SW12.*

The service workers expressed that male survivors also have considerable concerns about how they are perceived by society and their peers due to the gendered norms and myths, which act as a barrier to their helpseeking:

> *Q: In your experience, what are the main things that make it easier for male survivors to tell, or report to, services or agencies?*
>
> *A: "Public awareness and sensitivity that males are frequently victims, that it goes unreported due to reluctance to reveal abuse and perception it reflects on them badly as a male, concern what peers would think" - #SW9.*

This was noted as especially the case for those male survivors who have experienced abuse from women:

> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA?*
>
> *A: "Men are often not believed. They are expected to harden up. Men are even more reluctant to report if the abuse has been from a woman" - #SW4.*

There was, however, a sense of optimism in some of the comments from service workers. As a case in point, the following comment demonstrates how the myth that men or boys do not experience SVA has become less common recently:

> *Q: In your experience does accessing a service or agency for support with SVA encourage male survivors to report?*
>
> *A: "Yes […] As long as it has been a positive experience and they have not been fobbed off - which has improved over the past several years with greater awareness and acceptance that men are also victims of abuse" - #SW7.*

Subtheme 1.2: Gendered myths about the outcomes of sexual victimisation are a barrier to helpseeking

Some service workers (n = 3/13) commented on myths about the outcomes of sexual violence or abuse. The service workers did not highlight the myth that transgender men are perceived to have transitioned due to the trauma of SVA noted by transgender participants. Instead, comments centred on concerns about being blamed as a barrier to helpseeking:

> *Q: In your experience, what are the main things that make it harder for male survivors to tell, or report to, services or agencies?*
>
> *A: "My impression is that they are often reluctant to tell police, particularly teen boys – often too embarrassed and feel they will be blamed" - #SW7.*

Subtheme 1.3: Gender-inclusive public education can raise awareness and facilitate helpseeking

Many of the service workers (n = 9/13) supported the subtheme that described how gender-inclusive public education could be used to normalise male survivors' helpseeking:

> *Q: In an ideal world what would be in place to help men report SVA and access support services or agencies?*

> *A: "Information, awareness campaigns, stories of men who have reported and accessed support in media and more normalised" - #SW1.*
>
> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA? How might this be achieved?*
>
> *A: "Socialisation of: [sexual assault] can happen to anyone and it is ok to ask for help" - #SW12.*

It was suggested that advertising campaigns could be used to overcome myths:

> *Q: In your experience, what are the main things that make it harder for male survivors to tell, or report to, services or agencies?*
>
> *A: "In the public arena, there is NO effective advertising campaigns for male survivors – men are essentially presented as perpetrators" - #SW5.*

A note of optimism was again evident in service worker comments. For example, one service worker noted how public awareness of male survivors has increased:

> *Q: In your experience, does reporting, or telling services and agencies encourage male survivors to access support for the SVA?*
>
> *A: "I think public awareness and engaging the conversation about men's sexual victimisation has allowed the issue to be increasingly opened up" - #SW5.*

5.2.2 Theme 2: The presence and quality of formal and informal social support impacts helpseeking

Approximately half of the service workers (n = 6/13) commented on the importance of social support in enabling survivors' helpseeking. As with the male survivors, these comments cover the positive and negative role that family/whānau, friends or service workers can play in helpseeking that can overlap with the support role of service workers.

Subtheme 2.1: A lack of informal social support reduces recognition of victimisation and hinders helpseeking

Only one service worker touched on the relationship between disclosure to supportive others and reduced helpseeking and healing:

> *Q: Is there anything else you would like to tell us about what helps, or what hinders men reporting or accessing support services for SVA?*
>
> *A: "Many of them then told no one for years, while their life got completely off track" - #SW8.*

Subtheme 2.2: Informal and formal social support with trusted others facilitates helpseeking

Four service workers commented on how social support enabled male survivors to access support services. For example:

> *Q: In your experience, which services or agencies do male survivors tell, or report, their experiences of SVA to?*
>
> *A: "Friends/ partners who then support them to access services" - #SW12.*
>
> *Q: In your experience, do male survivors know what steps to take in order to access services or agencies for support with SVA?*
>
> *A: "Not always, often they will come with a friend, or because they have been told about the service from a trusted provider, friend or whānau member" - #SW3.*

Subtheme 2.3: It's good to talk to caring and compassionate listeners

Two service workers commented on the value of male survivors of talking about their experience of victimisation. As in the interviews with male survivors, these two service workers noted that the people receiving a disclosure must be engaging listeners and believe and validate the male survivor's experience:

> *Q: In your experience, what are the main things that make it easier for male survivors to access services or agencies for support with SVA?*
>
> *A: "Feeling safe. Being believed and validated. […] Staff who are polite and able to engage over the phone" - #SW8.*
>
> *Q: In your experience, what are the main things that make it easier for male survivors to access services or agencies for support with SVA?*
>
> *A: "People who believe them and take them seriously" - #SW3.*

Subtheme 2.4: Insensitive responses to informal disclosures or reporting are a barrier to helpseeking

Three service workers commented on how male survivors could experience insensitive responses to their disclosure or didn't disclose for fear of being blamed. For example:

> *Q: Is there anything else you would like to tell us about what helps, or what hinders men reporting or accessing support services for SVA?*
>
> *A: "Many of the men I see had their first disclosure handled very badly, weren't believed, were told they were the troublemaker etc. Some feel that they traumatised the person that they disclosed to… […] …First disclosures are often to friends/family or non-specialist organisations so education needs to be across the board" - #SW8.*

> *Q: Please tell us why male survivors may access non-specialist support services or agencies instead of specialist support services or agencies.*
>
> *A: "The GP shows the survivor that he/she is willing to help with disclosure. This would not apply to all GPs as some are insensitive to the needs of male victims" - #SW11.*

5.2.3 Theme 3: The complex nature of trauma hinders timely helpseeking

Over half of the service workers (n = 8/13) made comments relating to how male survivors can experience ongoing trauma and related symptoms that slow down and prolong their helpseeking.

Subtheme 3.1: The complexity of trauma masked its cause and hindered access to support services

Around half of the service workers (n = 6/13) described what male survivors called the 'long tail' of trauma that follows the SVA. They noted how trauma can be complex and underlie many difficulties faced by survivors and lead to their life going 'off track':

> *Q: In your experience, do male survivors know what steps to take in order to report SVA to services and agencies?*
>
> *A: "Some do not realise it is their abuse that is behind their current difficulties" - #SW4.*

Workers described the need for direct but sensitive questions about a male survivor's history of SVA to be asked of men:

> *Q: In your experience, what are the main things that make it harder for male survivors to tell, or report to, services or agencies?*
>
> *A: "Doctors don't often ask men about this area, whereas we do ask women" - #SW7.*
>
> *Q: In your experience, what are the main things that make it easier for male survivors to tell, or report to, services or agencies?*
>
> *A: "The person they are talking to being the one to bring the subject up in an open way or a clinic that specifically advertises that they will see people with a history of sexual abuse" - #SW7.*

Subtheme 3.2: Coercion and control are a barrier to helpseeking

Several of the service workers (n = 4/13) described how survivors who had experienced coercion and control as part of the SVA, or who feared control from powerful institutions, faced increased difficulty in seeking help for the SVA. These comments tended to focus on fears of reprisals from the perpetrator(s) or the ability that institutions had to impact the male survivors' lives:

> *Q: In your experience, what are the main things that make it harder for male survivors to tell, or report to, services or agencies?*
>
> *A: "Location, fear of reprisal or future actions that will impact their lives. Institutions of power, WINZ, Police, Oranga Tamariki" - #SW3.*

Subtheme 3.3: Recovery and helpseeking are slow and ongoing processes

Three of the service workers commented about how disclosure and recovery from SVA can be an ongoing process for male survivors. These service workers had all commented on the need for sensitive but direct questions to be posed to male survivors (in subtheme 3.1). One of these service workers focused on how taking a first step in the helpseeking process can take survivors a long time:

> *Q: In your experience, do male survivors know what steps to take in order to access services or agencies for support with SVA?*
>
> *A: "Yes, but they can take years to actually make the approach" - #SW8.*

Another service worker commented on how an initial disclosure only occurs when the male survivor is ready, which can then open up other helpseeking options and the start of recovery:

> *Q: In your experience does accessing a service or agency for support with SVA encourage male survivors to report?*
>
> *A: "No [...] Sometimes the survivor is not ready to take it further and disclosing is the first step toward knowing what they wish to do, and what supports are available" - #SW3.*

5.2.4 Theme 4: Service provision, visibility and design need to be tailored to male survivors to facilitate access

Most service workers (n = 11/13) made one or more comments about the need for more accessible and affordable specialist services designed for male survivors. Service workers supported the points that male survivors made about there being a lack of visible services and choice of service workers to address their experience of victimisation as men, or as specific groups of men such as transgender men.

Subtheme 4.1: Insufficient and unaffordable specialist service provision are barriers to accessing support services and healing

Issues about the availability of support services and their relevance to male survivors was commented on by 10 of the service workers. Three of the service workers commented on an absence of specialist services or how existing non-specialist services were too overloaded to support male survivors. For example:

> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA? How might this be achieved?*

> *A: "An increase in services around the country" - #SW8.*
>
> *Q: Please name any support services or agencies that male survivors do not access for support with SVA and why.*
>
> *A: "DHB mental teams seem too busy and overwhelmed to cope with fall out issues from sexual violence" - #SW7.*

Service workers also noted how male survivors required a choice of workers, based on their demographic characteristics, to increase engagement and maintain helpseeking:

> *Q: In your experience, what are the main things that make it easier for male survivors to access services or agencies for support with SVA?*
>
> *A: "Knowledge that there will be male support people if they wish to talk to a male, autonomy and confidentiality" - #SW3.*

Similarly, three of the service workers specified the need for services or service workers that could meet the bespoke needs of transgender men and non-binary people, or other minority groups of men such as gay and bisexual men. Although the male survivors often indicated that they would like to work with service workers who they could identify with, the workers pointed to their need to be upskilled so they can respond to all groups of men. For example:

> *Q: Please name any services or agencies that male survivors prefer to access for support with SVA and why.*
>
> *A: "Agencies that will provide male centred support, have knowledge of transgender/non-binary information to provide knowledgeable support" - #SW3.*
>
> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA? How might this be achieved?*
>
> *A: "Rainbow competency training for staff" - #SW1.*

One service worker picked up on the issue that the male survivors had raised about men feeling uncomfortable at mainstream services which typically catered mainly for women and suggested a unisex (or all gender) approach to service provision and design. This is in contrast to male survivors who noted they felt uncomfortable at mainstream services:

> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA?*
>
> *A: "Creating services that provide support to both men and women rather than separating them from each other." - #SW6.*

Affordability was noted by two of the service workers but was mostly focused on funding to create services rather than affordability as a barrier for individual male survivors, as the male survivors had noted. For example:

> *Q: In an ideal world what would be in place to help men report SVA and access support services or agencies?*
>
> *A: "A free confidential phone service that can link through directly to specialist staff." - #SW10.*

Subtheme 4.2: The visibility of services impacts how easily male survivors can access them

Around half of the service workers (n = 7/13) commented about how visibility of services is essential for engaging male survivors, complementing the point raised by the survivors that they may not have the know-how to access services when first considering helpseeking:

> *Q: Please tell us why male survivors may access non-specialist support services or agencies instead of specialist support services or agencies.*
>
> *A: "A lot of men I work with do not have much knowledge around counselling and have a fear of the process" - #SW2.*
>
> *Q: In your experience, do male survivors know what steps to take in order to report SVA to services and agencies?*
>
> *A: "No, they do not, they are often surprised that there is help for men and those identifying as male." - #SW3.*

Service workers commented that key aspects of visibility were having clear information on platforms like websites and posters as well as being transparent about whether the service supports male survivors, including specific demographic groups:

> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA? How might this be achieved?*
>
> *A: "Visibility in posters, websites, information etc" - #SW1.*
>
> *Q: In your experience, what are the main things that make it easier for male survivors to tell, or report to, services or agencies?*
>
> *A: "Being named or knowing a service supports men and/or gender diverse people" - #SW1.*

Subtheme 4.3: A choice of services designed to meet the complex needs of male survivors facilitates access

Around half of the service workers (n = 6/13) commented on how service design could better meet the needs of male survivors. Whilst the male survivors concentrated on the need for wrap-around services and a choice of treatment modalities (e.g., individual or group), the service workers discussed the need for men to have a choice in the medium through which services are provided to make them easily accessible:

> *Q: How might this be achieved?*
>
> *A: "There needs to be male providers of support and counselling present in the buildings/offices, options to engage via Zoom, FaceTime etc, that helps them build trust" - #SW3.*

Three of the service workers specifically noted the need for culturally competent services for male survivors of particular ethnicities. For example:

> *Q: In your experience, what are the main things that make it easier for male survivors to access services or agencies for support with SVA?*
>
> *A: "Culturally appropriate services" - #SW4.*
>
> *Q: In your experience, what are the main things that make it harder for male survivors to tell, or report to, services or agencies?*
>
> *A: "Lack of staffing. Lack of specialist workforce. Cultural issues – we particularly notice this in Asian males" - #SW13.*

Four of the service workers specified how services can become more male-friendly. For example:

> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA?*
>
> *A: "Yes [...] Focusing on male-friendly environs" - #SW5.*
>
> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA?*
>
> *A: "Clinics in 'neutral facilities', i.e. not as part of Women's Health" - #SW13.*

5.2.5 Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking

All but one of the service workers (n = 12/13) emphasised how important it was that services provided support for male survivors. They highlighted survivors' fears about reporting to police or other official agencies, the relevance of validation and a sense of safety when accessing services, and the crucial role of autonomy and agency for male survivors.

Subtheme 5.1: Attentive expert support is crucial throughout the reporting process

The male survivors noted how attentive expert support through the reporting and court process helped men to engage. The service workers (n = 4/13) supported the idea that these processes were experienced as difficult by male survivors and that survivors would benefit from support from well-trained service workers. For example:

> *Q: In an ideal world what would be in place to help men report SVA and access support services or agencies?*
>
> *A: "Safe agencies, doctors, police trained in that area" - #SW2.*
>
> *Q: Do services need to be more male-friendly in order to encourage male survivors to report or access support for SVA?*
>
> *A: "Yes, many places are not trained in this area to be person-friendly, I think the problem has been male-friendly and men have been too embarrassed to speak about the harm" - #SW2.*

Indeed, the service workers noted how male survivors do not report due to fear and mistrust of services or agencies, warranting the need for attentive support. For example:

> *Q: Please tell us if there are any services or agencies that male survivors do not tell, or report to, and why.*
>
> *A: "Police, WINZ, Oranga Tamariki, because they don't trust the system approach and they are worried that it is not confidential" - #SW3.*

Subtheme 5.2: Helpseeking is facilitated by service workers who understand the trauma of male survivors

Most of the service workers (n = 11/13) commented on the importance of the connection between male survivors and services in facilitating the survivors' helpseeking. Six of the service workers noted that male survivors have a need to feel validated and safe when seeking support. For example:

> *Q: In your experience, what are the main things that make it easier for male survivors to access services or agencies for support with SVA?*
>
> *A: "The agency personnel having empathy/sympathy with the victim" - #SW11.*

Subtheme 5.3: Building agency facilitates effective helpseeking

Two of the service workers supported the male survivors' claims that a sense of autonomy and agency is crucial to effective reporting and accessing of services. The service workers highlighted that survivors require knowledge about which services they can choose from, and agency in the timing of support:

Q: In your experience does accessing a service or agency for support with SVA encourage male survivors to report?

A: "Sometimes the survivor is not ready to take it further and disclosing is the first step toward knowing what they wish to do, and what supports are available. This allows the men to develop an understanding of what has happened and also allows autonomy in their decision making of what they wish to do from this point" - #SW3.

Q: In your experience, does reporting, or telling services and agencies encourage male survivors to access support for the SVA?

A: "Yes […] It makes them aware counselling is available without cost via ACC. Gives them control over the timing of this also" - #SW10.

5.3 Section summary

This section set out to answer Research Question 3: How do service workers' views on barriers and facilitators to helpseeking compare to the male survivors' experiences?

The five themes identified by the male survivors in Section 4 of this report were endorsed by the service workers. Some additional points were also identified, which can be summarised as:

- Optimism over a perceived recent increase in public awareness about men's sexual victimisation.
- Service workers should sensitively phrase direct questions to invite disclosure from male survivors and to promote early intervention.
- Funding is required to increase bespoke and appropriate services for male survivors.
- All gender services and workers who are trained to work with diverse populations provide good opportunities to increase provision for male survivors.
- There is a need for quick and easy access to services via a range of modalities (Zoom, telephone, face-to-face).

The five themes from the male survivors' experiences are incorporated in the case studies about example journeys of male survivors presented in Section 6.

6. Case studies: Examples of the barriers and facilitators to helpseeking

6.1 Introduction

Four hypothetical case studies are provided to illustrate some of the typical barriers and facilitators that the male survivors experienced during their journey of recovery from SVA. Each case study is centred on one of four issues highlighted by male survivors in this research project: 1) worrying about not being believed; 2) accessing crisis support immediately; 3) support throughout reporting and court processes; and 4) specialist support for transgender men.

The case studies blend aspects of several survivors' journeys. Providing a high level of detail about one male survivor would breach confidentiality so we combined different cases based on the Ellis (1999 method) to bring the issues raised by the male survivors in this study to life.

6.2 Case studies

6.2.1 Case study 1: Tamati delayed reporting because he thought he would not be believed after being abused by a relative

Tamati delayed reporting for 30 years because he thought he would not be believed. Eventually, his positive experiences with informal and formal peer support enabled him to heal. Now he is working to help others like him.

Tamati is a 54-year-old Māori man who identifies as being attracted to women but who has never been married. Tamati was sexually abused by an uncle between the ages of 8 to 12. When he was 12, Tamati decided to tell his Nan, the person he felt closest to in the world, about the SVA. His Nan didn't believe him and called him a liar. Tamati decided not to tell anyone else as he thought other people would not believe him either:

> *"[…] she called me a liar I didn't want to tell anyone ever again […] I told the person that was closest to me and they called me a liar so if I told someone that's not close to me they'll probably think the same so I'm not going to tell anyone" - #36 (Theme 2: Insensitive responses to informal disclosures or reporting are a barrier to helpseeking).*

Tamati shied away from peers at school withdrawing from social interactions as he was unable to trust others:

> *"I became reclusive if that's the word to use; withdrawn. Wouldn't mix with other children." - #25 (Theme 2: A lack of informal social support reduces recognition of victimisation and hinders helpseeking).*

Not sharing his experiences with others really took its toll on Tamati's health and wellbeing. It served to maintain his belief that this didn't happen to other men and he experienced a great sense of shame and feelings of responsibility for the SVA. This belief was maintained well into adulthood and prevented him from seeking help:

> *"I kind of compartmentalised it through my childhood and just felt like it's only happening to me and I'm not going to talk to anyone about it, and I don't know how to talk about it" - #17 (Theme 2: A lack of informal social support reduces recognition of victimisation and hinders helpseeking).*

Tamati was not asked anything about his experiences at school even when he was starting to disengage from studying and truant. This prevented him from reporting to the school or accessing support services. This felt like a missed opportunity for him, he believes that if someone had asked him directly about potential experiences of SVA and provided support in finding the right services that would have helped him to understand what he needed:

> *"But I was in such a state that I didn't know what support I actually needed" - #1 (Theme 3: The complexity of trauma masked its cause and hindered access to support services).*

Tamati used alcohol and cannabis regularly through his teenage and adult years to distract himself from the hurt and anxiety he was feeling. He experienced mental health issues and suicidal ideation, attempting to suicide on more than one occasion. There were missed opportunities by professionals to help identify the cause of Tamati's distress along the way:

> *"Had it been brought up I probably would have been open about it, but no, it was never brought up. Nobody asked. No [...] I got drunk again and tried [suicide] again. That put me into seeing a psychiatrist and then there was a very brief thing where he just talked about my medications. He didn't talk about anything aside from my medications. He just prescribed me a higher dose" - #6 (Theme 3: The complexity of trauma masked Its cause and hindered access to support services).*

Eventually, in his early-forties, Tamati confided in a friend who had showed great kindness towards him and who he had learned to trust over time. The friend encouraged Tamati to go to the police and start attending a formal peer support group for male survivors. He found this group really helpful even though it was difficult for him to talk about what had happened because of expectations put on men to be 'real men':

> *"[...] when you do go to groups and things like that you don't want to tell anyone for the fear of being judged by older adults and things like that. It's that whole toughen up kind of approach"- #36 (Theme 1: Gender stereotypes are a barrier to helpseeking).*

Tamati continued going to the peer support group for several years and felt validated when he opened up:

> *"Yeah a lot of, a lot of the people that were there [at the formal peer support group] just said, good on you. Well done for sharing, thanks for sharing. You know, we believe you, you know, it was very empowering to be told that" - #45 (Theme 2: It's good to talk to caring and compassionate listeners).*

Tamati is now studying to become a social worker and wants to help other Māori male survivors who have experienced family violence because there is currently a lack of services for survivors like him:

> *"It's very easy for people to sit and go, "Oh well, we need more therapists," but it's like, yeah, what do those therapists look like? Do we have enough trans therapists? Do we have enough Māori therapists? Do we have enough people working in Pasifika modalities? Do we have the range that's needed?" - #1 (Theme 4: Insufficient and unaffordable specialist service provision are barriers to accessing support services and healing).*

6.2.2 Case study 2: Vince accessed crisis support immediately after being attacked by a stranger

Vince was attacked by a stranger in early adulthood. His injuries led him to report to medical professionals and the police, who he found to be very helpful. Despite being guided about which services he could access for support, it took Vince several years to feel ready to engage with a service to heal from the SVA.

Vince is a single, 32-year-old New Zealand European man who identifies as heterosexual. Vince has experienced two major forms of SVA, as have many survivors. During his childhood Vince experienced SVA from a family member over a five-year period. He has never disclosed or reported this SVA because he didn't want to expose his relatives and hurt his family:

> *"I didn't want to affect my family; splitting my family up and all my cousins hating on me because of this" - #34 (Theme 4: Insensitive responses to informal disclosures or reporting are a barrier to helpseeking).*

Following this childhood SVA, Vince has experienced severe depression since his teenage years. He has been through several periods of unemployment due to poor mental health, but for short periods of time managed to sustain work as a labourer and lived in hostel accommodation with lots of people coming and going. One evening, as Vince was sleeping in his room, a stranger he had seen around the hostel broke in and overpowered him before sexually assaulting and violently attacking him. Vince was unconscious for a several hours after the attack and his injuries were quite severe. Vince was so worried about his injuries the next day that he decided to visit his local GP, with whom he had established a good relationship over the years. He reported the incident to the GP who admitted Vince to hospital and helped him report the crime to the police and to access crisis support:

> *"I remember she was really supportive which was good because you know, it was terrifying talking about it" #3 (Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking)*

Vince reported that he also received attentive care from the hospital staff and the police, who took his report seriously yet didn't put him under too much pressure to make a formal report. The police helped Vince to make a claim via the Sensitive Claims Process through ACC, which he understood would enable him to access specialist counselling from an ACC-registered counsellor when he was ready. However, despite reporting the crime and receiving good care from the relevant service workers, Vince didn't feel ready to access specialist counselling for some time:

> *"When I was in hospital the police were there and everything and straight away they set up an ACC sensitive claims case for me and were like you can access this whenever you're ready. Doesn't expire. They were really cool. I was shocked at how just chill they were about the whole thing. At first they were like, look we would like you to press charges and to allow us to pursue an investigation because this is something, we would like you to pursue. We understand if you don't want to but very few men in your position follow through and we feel like you have the fortitude to do it if you would like to" - #7 (Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking).*

Again, one of Vince's biggest concerns that held him back from accessing support was that people would think he should have been able to stop the attack from occurring:

> *"I think it's just the stigma, it's that it shows weakness… because somebody else took that from you and you couldn't really do anything to stop it" - #6 (Theme 1: Gender stereotypes are a barrier to helpseeking).*

After several years Vince decided he needed to reach out to support services as his depression was getting worse and he had started to have panic attacks every night. However, he was relieved that he was not pressured to access support earlier than he wanted to, as it was something he felt he needed to do on his own terms with the right type of service worker:

> *"Because a lot of people think that because you tell your story – which is a stupid phrase – that that's healing. Now, often it actually re-traumatises. And so you get people who sit and listen to the story and you never hear from them again. So, that's not helpful" - #26 (Theme 2: It's good to talk to caring and compassionate listeners).*

Vince eventually felt strong enough to engage with a service who provided trauma-informed counselling for male survivors of SVA. After exploring his options, Vince had decided a trauma approach could work well for him. However, the counsellor's expertise was in childhood SVA and so at first Vince was unsure if this person would be the right fit for him as the most recent incident had occurred in adulthood. However, as a male survivor, Vince felt there was a lack of services which could fit his needs exactly and so he decided to try the service. Over time Vince also disclosed the SVA that had taken place in his childhood to the counsellor, which he found beneficial to his mental and physical health and wellbeing. After many years of counselling support, Vince is doing well and offered the following advice to other male survivors:

> *"I'd tell them definitely to seek support but I'd tell them to go to someone who is trauma-informed. Be very careful about who you go to. I would definitely, and you know, I'd say to ask around people who know about who's competent, yeah" - #26*

> *(Theme 5: Helpseeking is facilitated by service workers who understand the trauma of male survivors).*

6.2.3 Case study 3: Tim found formal support helpful when reporting and going through the court process

Tim struggled to break free from the control his perpetrator held over him and the myths that society held about women not being perpetrators to report the abuse. He found formal support helpful when reporting and going through the court process.

Tim is a 24-year-old European man who moved to Aotearoa New Zealand with his whole family when he was a young child. Tim was groomed into a relationship when he was 16 years old by a middle-aged woman who was a friend of the family. They ended up living together after Tim moved out of home to get away from his physically violent stepfather and falling out with his mother, leaving him with little family support.

Tim's abuser would coerce him in to having sex with her. She would also provide him with drugs and alcohol on a daily basis and often threatened to stop supplying him, which was a problem because Tim was an alcoholic by that point:

> *"Every morning she would put a bottle of wine in the fridge for me to start me off for the day. I always had a bottle of spirits in my bag when I was at school just to top me up and then at night it was just constant drinking.... Leaving that place was difficult because of the trying to source alcohol because it wasn't as easy to come by [...] I was locked in and there was nothing I could really do without exposing myself"- #6 (Theme 3: Coercion and control are a barrier to helpseeking).*

Tim found it hard explaining the nature of the abusive relationship he had found himself in because people assumed it was positive to drink like grown-ups and have a relationship with an older girlfriend:

> *"I told him [best friend] like, I was having trouble with [female perpetrator] and stuff and he said words to the effect of well, it's your job as a man to please your woman" - #20 (Theme 1: Gender stereotypes are a barrier to helpseeking).*

Eventually Tim escaped the relationship and moved to a different city to get away from the unhelpful social circles which contributed to his alcoholism. After discussing the abusive relationship with his new flatmates, Tim made the decision to report his abuser to the police:

> *"I was talking about it to a flatmate of mine and it was his recommendation. He said, "If this is still bothering you after, at that point it was three years, go to the police. That way you can say you've done it and it might prevent a thing." Yeah so it was advice from someone I was living with" - #5 (Theme 2: A lack of informal social support reduces recognition of victimisation and hinders helpseeking).*

With the support of his flatmate, Tim went to the police. Initially he found it overwhelming because so much information had to be gathered to determine the timeline and what charges could be applied:

> *"Going to the police station with my friend was OK but then they started asking questions. My head was spinning in all directions after that. Just question after question after question." - #14 (Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking).*

The police referred Tim to a local branch of a formal peer support organisation, and he found it really helpful to have an informed sounding board throughout the ongoing process building up to his abuser being charged and the court case that followed:

> *"Just the fact that [peer support worker] said hey, remember you have every right to do this. There's no statute of limitations on reporting historic sexual abuse. They explained a bit about the process and said that they are very understanding." - #8 (Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking).*

Victim support during the court process was critical for Tim as he built a close relationship with his advisor, who kept him well informed:

> *"[...] the court victims advisor [...] keeps you up to date all the time. She's there on court day. You know, she sits with you before you go and give evidence, she comes to see you afterwards. And she would ring me all the time" - #45 (Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking)*

Tim feels like he is on a journey to healing following all the support he received when working with the police and throughout the court process. Having recently reconnected with his family, Tim has been able to talk through what happened to him even though his abusive relationship remains difficult to talk about.

6.2.4 Case study 4: Joe felt at home when accessing services that catered specifically for transgender men

Joe has received support from a range of services that have helped him deal with the trauma of being abused in care as a child. The most helpful services for him have been those that specialise in supporting transgender men and other people from rainbow communities.

Joe is a 36-year-old transgender man who has Māori ancestry but grew up overseas, disconnected from his whānau. Joe was assigned female at birth and transitioned gender in his mid-twenties and has lived openly as a man since then. Joe was sexually abused by staff and other children over many years whilst in a group care home as a young child. Joe tried talking to staff at the group care home about the abuse at the time but felt dismissed. He moved to

Aotearoa New Zealand to live with extended family as a teenager and has loving relationships with his whānau.

Joe has worked in hospitality since his early twenties. He first started seeking help for the SVA when he was offered counselling through work because his manager noticed Joe experiencing the impact of flashbacks to the abuse. Joe found the counselling somewhat helpful, but the counsellor wasn't a specialist in SVA, and he only had a few sessions with her:

> *"There was an assumption of why I was there before we got there. It was like workplace stress was the assumption. I sat down and was spoken to about taking ten deep breaths in the workplace and dealing with workplace stresses. It got a little bit further and I opened up a little bit more to the counsellor and told her what actually happened to me and why I was there. It's difficult to explain, it was like I definitely shocked the counsellor" - #29 (Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking).*

Since then, Joe has received a diagnosis of complex post-traumatic stress disorder from a psychiatrist who he was seeing when working towards transitioning gender. Being diagnosed with complex post-traumatic stress disorder helped Joe make sense of the trauma from the long-term abuse as a distinct set of issues from his absolute certainty about his male gender from an early age. Joe shared his advice for other male survivors whether or not they are transgender:

> *"And I would also say to them try and get help as soon as possible because, I mean, for me it took getting hospital, like it took, like it kind of got exponentially worse until I was sent to hospital. If I'd, like I said, if I'd got help back then it probably wouldn't have come to that" - #20 (Theme 3: The complexity of trauma masked its cause and hindered access to support services).*

Unfortunately, ACC won't fund ongoing specialist counselling for Joe because the funding is only for people who have experienced abuse within Aotearoa New Zealand:

> *"Yeah, but the ACC doesn't cover it because one, it's not New Zealand based. Well, that's the one, the only thing that matters" - #21 (Theme 4: Insufficient and unaffordable specialist service provision are barriers to accessing support services and healing).*

However, Joe has been able to access long-term support from an SVA service with a dedicated team to support survivors from rainbow communities. Joe found that he felt at home in this service because his gender journey as a transgender man is understood by the staff and they also have specialist skills in supporting people like Joe who have experienced SVA:

> *"Because if I were given the option between a support service for men or specifically just for queer people of any gender, I'm gonna go to the queer one because they're gonna understand a lot of those things just right off the bat." - #2 (Theme 5: Quality*

> *support from service workers can build agency and maintain male survivors' helpseeking)*

Joe praised the growth in specialist SVA services specific to rainbow communities because he was able to continue working through the trauma of his experiences without any presumptions about his gender:

> *"[…] we're reaching out to get help as men who have experienced sexual harm and sexual violence, that our experiences are not the cause of our gender identity, they're not the cause of our sexual identity." - #1 (Theme 1: Gender stereotypes are a barrier to helpseeking)*

Joe also noted that it took him a while to find a specialist SVA service that was welcoming of transgender people because it can be hard to know this from the information on services' websites:

> *"Be explicit about it. If you are welcoming to male victims of sexual violence, say so. If you are welcoming of trans and non-binary victims of sexual violence, say so, because it's not obvious." - #1 (Theme 4: Insufficient and unaffordable specialist service provision are barriers to accessing support services and healing)*

7. Discussion

This research project aimed to understand the barriers and facilitators to reporting and accessing support services for adult male survivors of SVA. We investigated SVA across a diverse range of male survivors, intending the findings to broadly inform the design of effective and responsive services for all male survivors, and to guide future research. We interviewed 52 individual male survivors one-to-one and surveyed 13 specialist and non-specialist service workers via an anonymous online questionnaire to answer three specific research questions:

1. What are the demographic characteristics of the male survivors who took part in the study and how had they sought help?
2. How had the male survivors experienced barriers and facilitators to helpseeking?
3. How do service workers' views on barriers and facilitators to helpseeking compare to the male survivors' experiences?

7.1 Key findings and implications

A detailed description of the findings associated with each of the three research questions can be found in sections 3-5. The take-home points and their implications for practice, policy and future research are outlined below.

7.1.1 Research Question 1

Research Question 1 aimed to understand the demographic make-up of the male survivors and how they sought help.

We were able to recruit a diverse sample of male survivors who differed across age, gender, sexual orientation, ethnicity, disability, and rural and urban residence at the time of the SVA. This included four (7.7%) men who had never reported or accessed support services prior to engaging in this study. Intersectionality was evident within the sample, with 21 (40.4%) of the male survivors identifying with two to four demographic groups that are commonly over-represented in male survivor statistics. It can therefore be concluded that the novel trauma-informed methodological approach used was successful in engaging a diverse sample of male survivors in Aotearoa New Zealand and demonstrates the need to provide services that can support men who identify with different demographic groups. The only group that was not recruited was Pasifika male survivors. We consider methodological limitations and implications for future research in more detail in Section 7.3.

The majority of the male survivors either reported the SVA (34; 65.4%) and/or accessed a service for support (48; 92%). Thirty-two of the 34 survivors provided an estimate of the time it took them to first report, with an average estimate of 18 years. The majority (22; 68.8%) reported the SVA between 10 and 50 years post-SVA. Most reported to ACC (26/32; 81.3%) followed by the police and doctors (14/32; 43.8%). The most common reasons for reporting were to access financial aid (18; 56.3%) and to prevent harm to others (8; 25%). The majority of male survivors who accessed a support service did so between 5 and 60 years post-SVA, and most accessed a specialist SVA support service (40; 83.3%). The most common reason for accessing was to address problem behaviours that had arisen from the SVA. In terms of crisis support, only four men reported within 48 hours of experiencing a first incident of SVA. However, even crisis reporting did not lead to accessing support services quickly, rather the survivors had to feel ready to access support services. Typically, it took the male survivors a long time to feel ready to report or access support services. Once survivors accessed support, the majority (n = 3) went on to seek other support services which they found to be helpful.

Finally, the majority of male survivors disclosed their victimisation to someone (47; 90.4%). Disclosure played an important role in the helpseeking journey and was most commonly the first helpseeking action for the majority of male survivors (38; 73.1%). Disclosure, reporting and accessing support services are, therefore, interconnected helpseeking behaviours. Thus, increasing disclosure could serve to increase reporting and accessing of support services. Indeed, 31 (59.6%) survivors carried out all three actions, whilst only 6 (11.5%) survivors performed one of these actions in isolation. However, not all men disclosed or wanted to disclose, and some of the survivors noted that it is important that pressure is not placed on survivors to disclose or report before they feel ready to do so.

7.1.2 Research Questions 2 and 3

Research Question 2 aimed to understand how the male survivors experience the barriers and facilitators to helpseeking. Research Question 3 sought to understand whether the service workers' experiences compared to the male survivors' experiences.

The service workers endorsed the five themes identified from the male survivors' interviews, only a few additional points were identified for three of the themes. Therefore, in the interests of conciseness we present a summary of the key findings for both research questions below.

Five themes describe the male survivors' experiences:

1. **Theme 1:** Gendered social norms and myths are a barrier for helpseeking.
2. **Theme 2:** The presence and quality of formal and informal social support impacts helpseeking.
3. **Theme 3:** The complex nature of trauma hinders timely helpseeking.
4. **Theme 4:** Service provision, visibility and design need to be tailored to male survivors to facilitate access.
5. **Theme 5:** Quality support from service workers can build agency and maintain male survivors' helpseeking.

Table 4.1 (see Section 4) provides a summary of the themes and their respective subthemes. Themes 1, 2 and 4 feature a number of barriers that hindered the male survivors' helpseeking and a variety of facilitators that increased their likelihood of effective helpseeking. Theme 3 identifies barriers only and Theme 5 identifies facilitators only. For the most part, the same barriers and facilitators were relevant for reporting and accessing services. However, one subtheme details a facilitator that was found to be specific to reporting, namely:

- Subtheme 5.1: Attentive expert support is crucial throughout the reporting process.

Four subthemes identify barriers and facilitators that are specific to accessing services. These are:

- Subtheme 3.1: The complexity of trauma masked its cause and hindered access to support services.
- Subtheme 4.1: Insufficient and unaffordable specialist service provision are barriers to accessing support services and healing.
- Subtheme 4.2: The visibility of services impacts how easily male survivors can access them.
- Subtheme 4.3: A choice of services designed to meet the complex needs of male survivors facilitates access.

A summary of each theme along with its implications for practice, policy and service provision is provided below.

Theme 1: Gendered social norms and myths are a barrier for helpseeking.

This theme shows how the survivors' experiences were shaped by dominant constructs of masculinity, or what it means to be a man. In line with wider research in western societies about male gender role identity (Pleck, 1981; Connell, 2005; Steinberg & Diekman, 2016), the prescriptive masculine norms that guided the male survivors' helpseeking were ideas that 'real men' are strong and powerful, stoic, and heterosexual.

Hegemonic masculinity underpinned the various myths and associated stigma that the male survivors noted about SVA and its effects. Experiencing SVA therefore challenged the men's masculinity and induced shame, silence and reduced their willingness to seek help. Again, this is in accordance with previous research (Mahalik et al., 2003). Thus, changing male survivors' helpseeking behaviour does not just lie with changing the individual man, but rather requires change at different levels of our ecology, targeting societal, community, relationship, and individual levels (Bronfenbrenner, 1979; Centre for Disease Control and Prevention, 2021; Dutton, 2006).

Indeed, the male survivors put forward the solution of gender-inclusive societal education to change prescriptive norms about masculinity and what SVA and its consequences are. They also signalled the need to provide male survivors with clear 'how to' guides to promote know-how about talking to others, reporting, and accessing services for SVA. This theme also showed that male survivors are a diverse group and therefore any education campaigns need to recognise this diversity and embrace a gender-responsive approach to addressing the issue.

The service workers had a sense of optimism that the gendered stereotyping of sexual victimisation has recently started to change and that there is an increase in public awareness about men's sexual victimisation. They attributed this change to increased public awareness about the victimisation of men and men's helpseeking, supporting the male survivors' conclusions that there is a need for gender-inclusive public education to change gendered myths about SVA and increase men's helpseeking.

Theme 2: The presence and quality of formal and informal social support impacts helpseeking.

This theme highlights the importance of social support and talking in promoting the helpseeking behaviour of male survivors. Whilst a lack of access to supportive friends, family or whānau could negatively impact men's helpseeking, disclosure to trusted, empathic people who made them feel safe helped the survivors to recognise the victimisation and its impact and seek support. For those male survivors who had little social support, access to formalised peer support models was a great way to gain this. Therefore, this theme highlights the need to increase social support opportunities for men. However, although survivors reported that it was good to talk, it was only good when the listener was compassionate and engaged. Insensitive responses to disclosure from a range of people, including service workers, hindered helpseeking and healing. Only disclosure that was received well by the listener encouraged male survivors to report and access services.

Therefore, whilst this theme demonstrates the need to increase men's disclosure to increase their reporting and engagement with services, it also shows how important it is that listeners respond with compassion. Gender-inclusive education aimed at the entire population and service workers could improve the chances that listeners receive male survivors' disclosure well. Finally, as talking was not something all survivors wanted to, or could, engage with, it is important to provide male survivors with choice of treatment modality.

Theme 3: The complex nature of trauma hinders timely helpseeking.

This theme shows how male survivors can take a long time to disclose and seek support for their experiences of victimisation, especially those coerced and controlled by the perpetrator through manipulation or fear. This time period, without appropriate intervention, allowed negative symptoms and further traumatic events to build up. This long tail of negative symptoms and events further reduced the likelihood that male survivors would seek help because these issues masked the underlying trauma of SVA. Thus, non-specialist service workers were most often left to join the dots for the survivors, which did not happen very often, or men eventually sought help when experiencing a mental health crisis, sometimes involving suicide attempts.

Therefore, this theme demonstrates the need for early intervention to reduce the long tail of trauma and harm and to promote the health and wellbeing of male survivors. There is a need for a range of specialist and non-specialist service workers to have a gender-inclusive understanding of SVA and be able to provide gender-responsive care, including learning about appropriate ways to invite disclosure from male survivors and routine screening for SVA.

The service workers agreed that it can take male survivors a long time to seek help and that the impact of traumatic events would build up during this time, which made helpseeking even more difficult. They discussed the need to ask direct, yet sensitively phrased questions, to invite disclosure and promote early intervention which could reduce the long tail and promote the wellbeing of male survivors.

Theme 4: Service provision, visibility and design need to be tailored to male survivors to facilitate access.

This theme shows how the male survivors were hindered by a lack of affordable and bespoke services and service workers who could support men, and minority groups of men. The survivors did not always feel comfortable at mainstream SVA services that typically catered for women or cisgender heterosexual people. Indeed, transgender men struggled with services that were specifically for men in general. The male survivors preferred to work with people with whom they shared a connection or key demographics, and who they felt could understand their position. This theme highlights the need for more specialist services that provide men with a choice of service workers from a range of demographic backgrounds.

In addition, access to specialist services was hindered by a lack of marketing and unclear messaging about service objectives and provision. Thus, there is a need to improve the advertisement of services and to clearly articulate who they work with and what they do, using male -friendly language. Service design that promoted quick and easy initial access helped men assess suitable services and maintain their motivation to seek help.

The survivors also indicated that their diversity and the long tail of trauma symptoms necessitates a wrap-around approach to service design (e.g., combined peer support, counselling, advice, financial, health and/or family support). This means that men should be provided with a choice of treatment modalities (e.g., talking, and non-talking therapies; individual or group work), services, including those that provide bridging support (i.e., regular contact whilst the survivor waits to work with the support service to promote engagement and retention) and general social support, and those that can work with survivors who have also perpetrated SVA.

Men also described ideal service design as that which embodies a trauma-informed approach (i.e., that meets the trauma-informed principles described in Section 1 of this report and in Section 7.2 below) and ensures privacy, confidentiality, trust, relaxation and meets cultural needs.

The service workers commented on the need for government funding to create bespoke and appropriate services for male survivors. In addition, in line with the male survivors, the service workers noted that survivors should be provided with a choice of service workers of different demographics. However, unlike the survivors, they focused on the need for service workers to be trained to work with male survivors from different gender identity and sexual orientation groups, so that staff can provide for all groups of people and increase provision for male survivors. Finally, the service workers also raised the point that quick and easy access to services needs to be improved via providing survivors with a choice in the medium by which services are delivered (e.g., online, telephone, face-to-face).

Theme 5: Quality support from service workers can build agency and maintain male survivors' helpseeking.

This theme shows how important it is for male survivors to experience attentive expert support through the reporting and court process to help them engage. Specialist and non-specialist service workers who welcomed, listened, affirmed, and validated the survivors' experience and could cope with disclosure, built trust and furthered engagement with services. As non-specialist service workers were often described as not engaging with survivors in this way, there is a need to adequately train all service workers who are likely to come into contact with male survivors, in addition to providing men with specialist support throughout the reporting and court process. Indeed, negative interactions reduced agency and could re-traumatise the male survivors. There is a need to resource the reporting and court processes to afford male survivors this attentive service.

The male survivors also described the importance of gaining agency through their interactions with services and workers. For example, opportunities for men to make a difference for other men, such as providing peer support and engaging in the research project, gave them agency. Thus, this theme shows that the ongoing journey of recovery for male survivors can be helped through providing opportunities that afford men with agency over and above accessing services for personal support.

7.2 Recommendations for practice and policy

The findings highlight the need for a range of practice and policy initiatives that can work to overcome the barriers that male survivors face when reporting and accessing support services and facilitate helpseeking. The findings and potential implications were shared with 38 stakeholders in a sense-making workshop (see Section 2) who corroborated and shaped the recommendations listed below.

Gender-inclusive societal education initiatives

The findings showed that male survivors' helpseeking was greatly influenced by their ability to disclose to others, their awareness and knowledge of SVA and their perseverance in attempting to access services. Furthermore, they showed there is a need to refute the myths and change social norms about masculinity and what SVA and its outcomes look like to encourage male survivors' disclosure and listeners to respond in a compassionate and knowledgeable manner. Thus, we recommend that SVA victimisation and perpetration be understood as a gender-inclusive problem and a public health issue, with prevention approached via the use of social-ecological frameworks (a framework that describes how several factors at different levels of the environment may interact to affect outcomes; see Centre for Disease Control and Prevention, 2021).

Initiatives that educate everyone that SVA happens to a diverse group of male survivors, as well as diverse groups of female survivors, and can be perpetrated by a person of any gender, is required to achieve change and ensure early intervention to reduce the long tail of trauma that builds up for male survivors over time through delayed helpseeking. Gender-inclusive societal education has great potential to reduce some of the barriers and increase some of the facilitators raised in this study, via:

- Reducing hegemonic masculine norms in society through initiatives that aim to reduce sexism.
- Educating the public about SVA: what it is and its outcomes, including that SVA can happen to a range of diverse men.
- Normalising helpseeking behaviours for male survivors.
- Providing men with the know-how so they can talk to others about their experience of victimisation, report, and access services.
- Helping listeners understand the power of disclosure and how to talk, listen and respond to male survivors in ways that facilitate their helpseeking and access to services.

  - Promoting early intervention for survivors of SVA.

Gender-inclusive training of service workers

In line with the need to understand SVA as a gender-inclusive public health issue, the findings showed that men come into contact with non-specialist service providers to address a range of issues which provide opportunities for disclosure. However, many opportunities for disclosure are missed due to a lack of understanding or know-how on the part of the service provider. This strongly endorses the need for specialist and non-specialist service workers to receive training to understand:

  - That male survivors exist.
  - SVA, its outcomes and how to respond appropriately to male survivors and how to encourage and maintain survivor engagement with support services.
  - The diverse range of male survivors and their intersectionality and how to support them effectively.
  - How to ask men sensitively about their SVA experiences to encourage disclosure.

We therefore recommend that service workers who may come into contact with male survivors across their helpseeking process are trained to understand and respond appropriately. Importantly, because the roles and functions of different services workers will vary it is imperative that as part of this training that service workers are also trained to understand their roles and limits and when to signpost and refer survivors to other service workers to ensure safety standards are met. This was raised as an important point by the stakeholders at the sense-making workshop.

Initiatives to increase social support for male survivors

The findings highlighted the power of social support when disclosure was received with empathy and compassion. Indeed, it was evident that formal models of peer support were particularly useful, especially for those men who had little in the way of informal social support. Based on the findings we recommend that social support be increased for male survivors via:

  - Government funding and resourcing of formalised peer support groups for survivors of SVA.
  - Ensuring there are sufficient expert support ‘navigators’ to guide male survivors through the reporting and court process.
  - Provision of ongoing societal education initiatives and campaigns that encourage men to reach out and not isolate themselves, and that encourage listeners to talk and respond effectively to men’s disclosures.

Bespoke and accessible service provision

The findings showed that the male survivors and service workers wanted access to a choice of service workers demonstrating a range of demographic backgrounds, treatment modalities, and to have accessible services. Considering the intersectionality evident in the male survivors’ demographics it would seem that choice is essential to enable the men’s empowerment and autonomy. Based on the findings we recommend that accessible services for male survivors can be achieved via:

- Explicit legislation, policy, practices, and procedures relevant to male survivors.
- Targeted funding for support services for male survivors, and, as raised at the sense-making workshop, including funding for the administration of those services.
- Providing free services for male survivors including transgender survivors.
- Increasing access to services in different locations, especially for male survivors living in small and remote communities where anonymity is difficult.
- Providing men with choice of support services. For example, all-gender SVA services; generic trauma services; specialist services that can work with male survivors and minority groups of survivors in a bespoke way. We draw no conclusions about whether universal services open to all genders, or bespoke services for a specific gender are preferred, but rather that providing survivors with a choice of options is optimum.
- Providing wrap-around services and bridging support. As noted at the sense-making workshop, bridging support should not be a holding space for male survivors but also an opportunity to provide support.
- Ensuring the visibility of services through advertising, clearly available staff profiles, male-friendly language, and clear messaging about service objectives and provision, and staff characteristics.
- Promoting quick and easy initial access (e.g., communication via texts) to help men assess their suitability for services quickly.
- Providing male survivors with access to attentive expert support including ‘advocates’ and ‘navigators’ throughout the reporting and court process, including keeping in touch post-process completion.

Design of trauma-informed services and activities

Finally, the results also highlighted how effective the trauma-informed research methodology was in recruiting a diverse group of male survivors, four of whom who had never reported or accessed support services before. In addition, the male survivors described ideal service design as that which embodies a trauma-informed approach that ensures aspects such as privacy, confidentiality, trust, peer support, collaborative decision making, choice, relaxation and cultural needs are met. Based on these findings we recommend that policy and support services should be designed to:

- Ensure male survivors have access to trauma-informed services that are culturally and psychologically safe, confidential, trustworthy, and non-retraumatising.
- Provide male-friendly services and transgender friendly services.
- Deliver survivor friendly, survivor-informed, and survivor-centred police reporting and court processes.
- Provide male survivors with access to gender-inclusive and responsive trained service workers who identify with a range of demographic characteristics in order to provide choice.
- Provide male survivors with access to a range of treatment modalities in order to provide choice.
- Encourage appropriate screening for SVA and trauma, and/or facilitate disclosure of SVA from men and promote early intervention.

  - Develop a workforce of trauma-informed service workers who understand how best to empower and scaffold men to report whilst affording autonomy and agency through respecting men's choices not to report.
  - Provide access to wrap-around services that afford men with a choice of treatment modalities (e.g., talking, and non-talking therapies; individual or group work) and bridging support.
  - Provide opportunities for male survivors to connect with other survivors and become change-makers, champions, and models for other men to afford agency throughout their journey of healing (i.e., peer support opportunities (sharing their journeys of recovery and healing), input into advisory boards and services, engaging in research).

7.3 Methodological considerations and limitations

This study explored the feasibility of recruiting a diverse group of male survivors via novel trauma-informed methodology. This included recruiting male survivors in partnership with services who worked with students, rainbow communities, and mainstream specialist and non-specialist services. As diversity across age, ethnicity, gender identity, sexual orientation, learning abilities and geographical location was achieved, we conclude that our trauma-informed approach worked well to engage a diverse group of male survivors.

The sample included four men who had never reported or accessed support services for SVA, demonstrating the importance of recruiting survivors through general services in addition to specialist services to gather a comprehensive sample for research purposes. This also underscores how the research project itself provided a mechanism through which male survivors could seek support and agency and heal, the very outcome that practice and policy needs to achieve for men. Such findings support the need to train researchers and service workers across a variety of services in how to effectively respond to men's disclosures of SVA from a trauma-informed perspective.

However, despite broad coverage across these categories, it should be noted that some specific demographic groups were not represented in this study. Indeed it relies on a selected sample of male survivors who came forward for this study and does not capture the experiences of survivors who have not. For example, whilst our project was designed to recruit male survivors with physical or learning disabilities via mainstream services, we did not have the resources available to produce study materials that were accessible to deaf or blind people. We therefore could not circulate our project advertisements through specialist group mediums to increase engagement from deaf or blind men.

The full range of accessible formats would have been required to enable the engagement of a wider range of male survivors with a disability. Co-design with men who are deaf and men with disabilities would have ensured that the research project was both fully accessible, and oriented to the particular experience and concerns of these men (e.g., having a sign language video, interpreters available, providing materials in braille).

Furthermore, we did not recruit any male survivors who identified as Pasifika, despite accessing services that Pasifika men attended. Therefore, whilst the methodology worked well to recruit a broad range of men, collaboration through co-design with members of the Pasifika community was needed. This could help to build trust with the community, ensure relevant language and symbols are used in study advertisements, and have enabled the research team to recruit via services and geographical areas that work with Pasifika men.

Adopting culturally-specific research designs, Kaupapa Māori and pan-Pacific research methods (e.g., vanua, kakala, talanoa) based on shared values of respect, reciprocity, collective responsibility, humility, service, and spirituality (Naepi, 2015), can increase the likelihood of working effectively with specific demographic groups of men. Indeed, although we are pleased that this foundational study enabled us to engage with a significant number of Māori men, we are cognisant that Kaupapa Māori research is a critical next step to ensure greater understanding of SVA from a Te Ao Māori perspective and to inform the development of bi-cultural supports and services.

Finally, whilst the inductive methodological approach allowed the participant voice to be heard, it is likely that it resulted in some wider contextual issues not being explored by this research. Therefore, we urge caution when interpreting the results, whereby the themes raised do not represent an exhaustive collection of themes but rather areas of importance raised by the participants within the timeframe and context of this particular study.

7.4 Conclusion

This research confirms that SVA is a gender-inclusive problem, highlighting that a diverse group of male survivors' needs have to be understood in order to develop targeted and effective prevention and early intervention initiatives. The findings also strengthen the argument that there is a need to understand and respond to SVA as a public health issue, which includes delivering far-reaching education initiatives. Indeed, gender-inclusive societal and service worker education is essential to encourage early intervention. Furthermore, as positive social support is shown to be a key factor in encouraging disclosure, both social support and disclosure should be viewed as an important part of the helpseeking process. Greater focus on these factors will increase reporting and accessing of support services.

Disclosure preceded reporting for many of the male survivors, and thus should be encouraged as a step towards increasing reporting rates. It is concerning that research suggesting men's low reporting rates of intimate partner violence (which includes SVA; see Dixon et al., 2020) equates to this not being seen as a prevalent problem for men and thus not requiring significant intervention or resources (Dobash & Dobash, 2004). We caution against such conclusions being applied to SVA victimisation.

Considering the many barriers associated with reporting, achieving accurate prevalence rates of victimisation is likely unattainable. Even when utilising gold standard methodology that employs nationally representative samples, methodological challenges lead to under-reporting of intimate partner violence, especially for men (Esquivel-Sanotveña & Dixon, 2012). We therefore suggest there is a need to move beyond relying on the data in official reports to determine provision of resources for SVA and accept that surveys and reports will continue to underestimate victimisation rates, especially for male survivors. We propose it is better to simply consider that SVA is a problem for men and move toward understanding and responding to that problem without reliance on reporting rates.

Services need to be bespoke, accessible and trauma-informed to enable men to access them effectively. The findings support the need to move past the question of ‘how many men?’ and put in place effective societal education campaigns, training for specialist and non-specialist service workers and a range of services and resources which, together, can serve to increase reporting and promote helpseeking and early intervention.

Based on the findings of this study, educating widely, and promoting social support for male survivors will likely lead to increases in disclosure and therefore reporting and accessing of services. To sum up, we suggest that the goal should be to provide services and resources that enable male survivors to reduce their ongoing trauma and improve their health and wellbeing, rather than focusing on gathering accurate prevalence rates of victimisation in order to design a response.

Finally, this research project merely marks the beginning of a research journey with this under-researched population. Future research is needed to better understand the nuanced experiences of specific groups of men and to produce findings that are representative of the population to inform best practice and policy.

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Appendices

Appendix A: Key questions in interviews with male survivors

Timeline of events

1. To help me understand what has happened and who you may have received help from, could you tell me some very general information about what happened, such as: when the SVA first occurred, where you lived, your relationship to the person that harmed you, and if it happened again.

For those male survivors who disclosed or reported

2. When did you first tell someone about the sexual violence and abuse?
    a. Who was it?
    b. Why did you decide to tell them/report to them?
    c. What influenced your decision?
        i. [If a service or agency]: did you know how to go about contacting them and telling them what happened?
        ii. How did you know to do this?
    d. Was there anything that made it easier for you to tell/ report to them?
    e. Was there anything that made it more difficult for you to tell/ report to them?
    f. How did they respond to you?
    g. What happened after you told someone/reported it?
    h. How has telling them impacted you?

[Repeat if the male survivor told more than once]

    i. [If reported to more than one service/agency]: Did you prefer telling one service over any other? Why?
        i. [If only reported to one service/agency]: With all that you know now, is there any service or agency you would prefer to talk to about the sexual violence and abuse? Why?
    j. Is there any service or agency that you do not want to talk to about the abuse? Why?
    k. Were there any services or agencies that you thought about telling/reporting to but did not? Why?

For those male survivors who did not disclose or report, or only did so after a long time

3. Why did you not tell anyone or report it?
    a. Did you know of any services or agencies that you could have got in touch with (earlier) to tell them about the sexual violence and abuse?
    b. Were there any services or agencies that you thought about reporting to but did not?
    c. Did you know how to get in touch with services or agencies if you had wanted to?
    d. Was there anything that made it difficult for you to tell?
    e. Was there anything that encouraged you to tell, even though you did not go through with it (earlier)?

   f. Is there any service or agency that you do not want to report the sexual violence and abuse to? Why?
   g. How has not telling or reporting the SVA (earlier) affected you?
   h. Do you think telling or reporting (earlier) would have made a difference? Why/how?
   i. If you were to report now, is there any service or agency you may prefer to report to? Why them over others?

For those male survivors who accessed support services

4. When did you first get support for your experience of SVA or any related issues?
   a. Which service or agency did you get support from?
   b. What were the main issue/s that the service or agency supported you with?
   c. Why did you decide to get support from them? What influenced your decision?
      ii. Did you know which services or agencies could support you with the SVA? How?
      iii. Did you know how to go about asking them for support? How?
   d. Did anything make it easier for you to get support from that service/agency?
   e. Did anything make it difficult for you to get support from that service/agency?
   f. How did they respond to you?
   g. Did they help you to get support with anything else?
   h. How has getting support from them impacted you?
   i. Are there any issue/s that you have not been able to get support with that would improve your health and wellbeing if addressed?
   j. Did you prefer working with one service/agency over any other?
   k. Were there any services or agencies that you thought about getting support from but did not? Why?

[Repeat if the male survivor accessed more than one service or agency]

For those male survivors who did not seek support, or only did so after a long time

5. Why did you not get support from a service or agency?
   a. Did you know of any services or agencies that you could have got in touch with for support with the SVA or any related issues?
   b. Were there any services or agencies that you thought about getting support from but did not?
   c. Did you know how to ask services or agencies for support if you had wanted to? (i.e., how to contact them or what steps to follow to make contact)?
   d. Was there anything that made it difficult for you to access support from any service or agency?
   e. Are there any issue/s that you have not been able to get support with that would improve your health and wellbeing if addressed?

Closing questions

1. Overall, do you feel you have got the right help at the right time?

2. In an ideal world, what would be in place to help men report and access service/s that could help them with the SVA?
3. What advice would you have for someone else thinking about reporting and accessing services for the SVA?
4. How might services or agencies be more friendly to men to help them report or access services?

Appendix B: Coding dictionary

Variable	Source	Instruction	Codes
Recruiting organisation	Expression of interest form	Categorise the organisation that the survivor was recruited through in this study using codes 1-5.	1. Services that provide formal peer support for men 2. University student health and counselling services 3. Services that provided interventions for family and sexual violence 4. Residential rehabilitation and community-based social support organisations 5. Rainbow community support organisations
Age category	Expression of interest form	Categorise the male survivor's age in years using codes 1-4.	1. ≥ 24 2. 25 – 39 3. 40 – 64 4. 65 +
Gender	Expression of interest form	Record the category that the male survivor selected when asked to select their gender identity from a pre-determined list. Record more than one option where the survivor selected more than one option.	1. Male (cisgender men) 2. Non-binary 3. Agender 4. Female
Transgender status	Expression of interest form	Record the category that the male survivor selected when asked if they had a history of gender transition from a pre-determined list.	1. History of gender transition: Yes 2. History of gender transition: No 3. History of gender transition: I don't know
Intersex status	Expression of interest form	Record the category that the male survivor selected when asked if they had an intersex variation or differences in sex development from a pre-determined list.	1. Intersex variation: Yes 2. Intersex variation: No 3. No Intersex variation stated: I don't know
Gender minority	Expression of interest form	Collating information from the 'gender' and 'transition status' variable data, categorise the survivor's gender identity using the following codes:	1. Gender minority: The survivor selects 'agender (3), non-binary (2), or yes to a history of gender transition (1)'. 2. Cisgender male: The survivors selects 'male' (1) and no history of gender transition (2).
Sexual orientation	Expression of interest form	Record the category that the male survivor selected when asked to select their sexual orientation from a pre-determined list. Record more than option where the survivor selected more than one option. If they did not select a response, code as 7.	1. Asexual and/or aromantic 2. Bisexual 3. Gay 4. Heterosexual 5. Queer 6. Pansexual 7. Did not provide a response
Heterosexual	Expression of interest form	Using the 'sexual orientation' data, categorise the survivor's sexual orientation using the following codes:	1. Heterosexual identity: The survivor selected heterosexual (4) only 2. Other sexual identity: The survivor selected asexual, bisexual, gay, (1-3) queer, pansexual (5-6).

Variable	Source	Instruction	Codes
Ethnicity	Expression of interest form	Record the category that male survivor selected when asked to select their ethnic group from a pre-determined list using the following codes. Record more than one option where the survivor selected more than one option.	1. Māori: The survivor selected Māori alone or in combination with other ethnic groups. 2. The survivor selected ethnic groups of New Zealand European/Pākehā or European but not Māori.
Main activity or job in the previous 12 months	Expression of interest form	Record the category that the male survivor selected when asked to report their main occupation in the last 12 months from a pre-determined list. Record more than one option where the survivor selected more than one option.	1. Student 2. Wage or salary earner 3. Unemployed 4. Self-employed 5. Retired 6. Other
Disability	Expression of interest form and interviews with survivors	Categorise any disabilities disclosed by the male survivor using the following codes. Record more than one option where the survivor selected more than one option:	1. Physical disability. A disability that affects mobility, physical capacity, or dexterity. 2. Neurodiverse: Variations in neurology negatively impacted sociability, attention and/or social interactions. 3. Mood disorder or mental distress: Characterised by pervasive and abnormal thoughts, feelings, and behaviours. 4. Sensory impairment: An impairment that negatively affected the function of the survivor's senses. 5. Learning disability: A disability that impaired the survivor's cognitive abilities including learning and literacy. 6. No disability noted.
Residential location at the time of SVA	Expression of interest form and interviews with survivors	Categorise the geographical location disclosed by the male survivor using the following codes. Record more than one option where the survivor selected more than one option.	1. Rural Aotearoa New Zealand (located outside towns or cities) 2.Urban or suburban Aotearoa New Zealand 3. Overseas
Life stage of male survivor at the time of SVA	Interviews with survivors	Categorise the life stage during which the male survivor experienced SVA using the following codes. Record more than one option where the survivor selected more than one option.	1. Childhood – childhood, inclusive of 11 years and under 2. Adolescence – teenager, between 12 and 18 years 3. Adulthood – inclusive of 18 years and upwards
Degree of victimisation	Interviews with survivors	Categorise the nature of the SVA based on the number of incidents of SVA and number of perpetrators who enacted the SVA over time, using the following codes:	1. Single victimisation – a single incident of SVA with only one perpetrator. 2. Multiple victimisation – a single incident of SVA involving more than one perpetrator. 3. Repeat victimisation – more than one incidence of SVA by the same perpetrator(s). 4. Re-victimisation – more than one incidence of SVA, by different perpetrators.

Variable	Source	Instruction	Codes
		The categories were adapted from Hamilton and Browne (1998).	
Number of perpetrator(s)	Interviews with survivors	Categorise the total number of perpetrators that the survivor described assaulted them in their lifetime using the following codes:	1. One 2. Two 3. Three 4. Three plus
Gender of the perpetrator(s)	Interviews with survivors	Categorise the gender of perpetrator(s) that the survivor disclosed or inferred from titles or pronouns used (e.g., she/he; mother/father) using the following codes. Record more than one option where the survivor selected more than one option. If they did not disclose a response, code as 4.	1. Male perpetrator(s) 2. Female perpetrator(s) 3. Both male and female perpetrator(s) 4. Not disclosed
Living arrangement at time of abuse	Interviews with survivors	Categorise the type of living or housing arrangement(s) disclosed by the survivor at the time the SVA occurred using the following codes:	1. Living in state care, transition home, or foster home 2. Living in a religious congregation 3. Living with parents/grandparents or had moved out of parental home
Disclosure	Interviews with survivors	Categorise the presence or absence of the survivor's disclosure of SVA using the following codes:	1. Disclosure occurred when the survivor noted that they talked about the experience of DVA to a person or service provider who was not able to initiate a formal process that can result in an investigation, funding or provision of services, or provide redress. Whilst the individual or worker may be able to refer the survivor onto a support service or assist them in reporting the incident(s) of SVA, this is not the same as being able to initiate a formal process. 2. Did not disclose when the above criteria was not met.
Reporting	Interviews with survivors	Categorise the presence or absence of the survivor's reporting of SVA using the following codes:	1.Reporting occurred when the survivor told an organisation or service provider about the sexual victimisation with the goal of receiving some sort of formal action that the service can deliver on. 2.Did not disclose when the above criteria was not met.
Accessing support services	Interviews with survivors	Categorise the presence or absence of the survivor's access of support services for support with the SVA or related issues using the following codes:	1. Accessed: when the survivors mention having accessed support services when they said that they had engaged (spoke to, got in touch with via phone, email, face-to-face meeting) with at least one support service to help them with the SVA or related issues. This could be a specialist or non-specialist support service. 2. Did not access: when the above criteria was not met

Variable	Source	Instruction	Codes
Specialist SVA services or therapists	Interviews with survivors	Categorise the type of specialist service that the survivor disclosed the SVA to. Specialist service refers to a service where the staff are trained to offer support to specifically address the issue of SVA and issues arising from it (e.g., rape crisis services, peer support for male survivors). Code using the following codes:	1. Peer support for survivors of SVA: Those services who employ intentional peer support models for supporting survivors. 2. SVA specialist services or therapist: Those private or individual therapists who have expertise in the support or treatment of SVA. 3. ACC referred or ACC registered therapists: Therapists who have a sensitive claims provider contract with ACC to provide funded therapy for SVA victimisation.
Non-specialist services or therapists	Interviews with survivors	Categorise the type of non-specialist specialist service that the survivor disclosed the SVA to. Non-specialist services are those services that provide care for problems other than SVA and are not trained to offer support to specifically address the issue of SVA (e.g., non-specialist counsellor, community mental health worker, GP). Code using the following codes:	1. Drug and alcohol addictions specialists. 2. Non-specialist counsellors, psychologists, psychiatrists: Those private or individual therapists without expertise in supporting or treating SVA. 3. Prison or Corrections Department counsellors. 4. Non-specialist helplines: Those helplines that provide support for general issues, such as crisis support, listening lines, helplines for gender transition support. 5. Anger management therapy. 6. Family mediation or therapy. 7. Emergency crisis support, community mental health: Those support services or therapists that survivors are referred to through medical or district health boards.
Time taken to report	Interviews with survivors	Categorise the approximate time that survivors said it took them to first formally report their experiences of SVA since first experiencing the SVA.	Note the approximate years reported.
Time taken to access services	Interviews with survivors	Categorise the approximate time that survivors said it took them to first access support services for their experiences of SVA.	Note the approximate years reported.
Reasons for reporting	Interviews with survivors	Categorise the reasons that the survivor noted as to why they formally reported their experiences of SVA using the following codes:	1. Parents/caregivers led them to report: When parents took the survivor to police station, police were called, caregivers insisted or motivated the survivor to report. 2. Stranger attack: when a stranger attacked the survivor. 3. Police contacted the survivor to enquire as part of an ongoing investigation: Survivors reported their experiences of SVA when they were asked for information about the perpetrator and SVA. 4. To stop perpetrator(s) or seek actions against the perpetrator(s): The survivor reported their own experiences of SVA to prevent perpetrator(s) from abusing or grooming others, to initiate their arrest/punishment, for justice, or have the perpetrator removed from

Variable	Source	Instruction	Codes
			their position or employment. 5. To access financial aid: The survivor reported their experiences of SVA to organisations that could provide financial aid for ongoing therapy or facilitate access to those who provide specialised therapy. 6. Someone noticed changes in behaviour, bruising, or marks. The survivor noted how other people noticed changes in their behaviour or injuries and encourage them to report.
Reasons for accessing support services for SVA	Interviews with survivors	Code as present when one or more of the reasons were mentioned as the cause or motivation for survivors accessing services their experiences of SVA.	1. Wanted to talk or be heard: The survivor noted how they wanted to access service so their story and voice could be heard. 2. To address problems or behaviours that had arisen for them from the SVA: They wanted support for the symptoms of SVA. 3. Wanted to address interpersonal issues: They specifically wanted support in addressing marriage breakdown, conflict resolution, or employer relationship issues. 4. Referred to a support service through interaction with the criminal justice system: An organisation with whom they were in contact with referred the men to access support for SVA (e.g., Department of Corrections). 5. Following a recommendation from a service worker or a friend: A friend or service worker recommended they access a support service 6. Wanted ongoing support, and/or to find others with a similar experience: The survivor wanted ongoing or long-term support through a service or survivors of SVA peer group.

Appendix C: Key questions in online survey for service workers

This questionnaire is split into three sections, and we will ask you for your details and descriptions on:

1. Information about your role and the service(s) you provide.

2. The barriers and facilitators for male survivors reporting sexual violence and abuse.

3. The barriers and facilitators for male survivors accessing support services for sexual violence and abuse.

Section 1:

1. Do you currently offer a service that provides specialised support for sexual violence and abuse that is open to male survivors?

   If yes:

      What service do you provide that is open to male survivors?

      How long have you worked in such a role?

2. Do you currently provide a general service that men who have experienced sexual violence and abuse may access (e.g., counselling service, family violence service, addictions service)?

   If yes:

      What service do you provide that is open to male survivors?

      How long have you worked in such a role?

3. Have you ever offered a service that specialised in support for sexual violence and abuse which was open to male survivors, or worked with men who have experienced sexual violence and abuse?

   If yes:

      What service do you provide that is open to male survivors?

      How long have you worked in such a role?

4. Please indicate how often you work with the following groups of male survivors (rate as often, sometimes, never).

a) 16-24 years old; 25-44 year old; 45-64 year old; 65 year old or older
b) Māori; Pasifika; New Zealand European; Other please state
c) Transgender men (women who were assigned male at birth); Transgender women (women who were assigned male at birth); people with non-binary genders; Cisgender men (men who were assigned male at birth); Cisgender women (women who were assigned male at birth); Other please state
d) Gay; Bisexual; heterosexual/Straight; Other please state
e) Residing in rural areas; residing in cities or suburban areas
f) Victimised in childhood; Victimised in adulthood
g) People with a learning disability; People with a physical disability

Section 2:

1. In your experience, which services or agencies do male survivors tell, or report, their experiences of sexual violence and abuse to? Please select the services/agencies, and add to the list with the 'other' option if needed.

    - Police
    - Oranga Tamariki (formerly CYFs)
    - Safe to Talk (specialist sexual violence and abuse helpline)
    - Specialist sexual violence and abuse counselling or peer support services
    - Work and Income New Zealand (WINZ)
    - Accident Compensation Corporation (ACC)
    - Medical professionals (GPs, emergency clinicians, family planning clinicians)
    - Other(s), please state
    - Male survivors don't report to services and agencies.

2. Please tell us which services or agencies male survivors prefer to tell, or report to, and why.
3. Please tell us if there are any services or agencies that male survivors do not tell, or report to, and why.
4. In your experience, what are the main things that make it easier for male survivors to tell, or report to, services or agencies?
5. In your experience, what are the main things that make it harder for male survivors to tell, or report to, services or agencies?
6. In your experience, do male survivors know what steps to take in order to report sexual violence and abuse to services and agencies?
7. In your experience, does reporting, or telling services and agencies encourage male survivors to access support for the sexual violence and abuse?

    If yes:

        Please describe why you think this is, and the impact this has on the men.

Section 3:

1. Please name any support services or agencies that male survivors access for support with sexual violence and abuse.
2. Please name any services or agencies that male survivors prefer to access for support with sexual violence and abuse and why.
3. Please name any support services or agencies that male survivors do not access for support with sexual violence and abuse and why.
4. In your experience, what are the main things that make it easier for male survivors to access services or agencies for support with sexual violence and abuse?
5. In your experience, what are the main things that make it harder for male survivors to access services or agencies for support with sexual violence and abuse?
6. In your experience, do male survivors know what steps to take in order to access services or agencies for support with sexual violence and abuse?
7. Please name any non-specialist support services or agencies that male survivors commonly access instead of specialist support services or agencies.
8. In your experience does accessing a service or agency for support with sexual violence and abuse encourage male survivors to report?

   If yes:

      Please describe why you think this is and the impact this has on the men.

9. In an ideal world what would be in place to help men report sexual violence and abuse and access support services or agencies?
10. Do services need to be more male-friendly in order to encourage male survivors to report or access support for sexual violence and abuse?

    If yes:

       How might this be achieved