



**MINISTRY OF SOCIAL
DEVELOPMENT**

TE MANATŪ WHAKAHIATO ORA

What is known about effective recovery services for men who have been sexually abused?

An evidence review

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It is our sincere hope that the information gathered in this report will contribute towards the further development of services to support men who have been sexually abused in childhood and/or as adults.

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

Purpose and scope of literature review

This literature review brings together current evidence about effective approaches to support men who have been sexually abused (as children and/or adults) in their journey of recovery. The Ministry of Social Development (MSD) commissioned this literature review to inform service planning.

Because of the limited evidence base we have taken a broad exploratory approach to examine what is known about supporting men, and what is considered emerging good practice.

Methodology

A wide range of academic and grey literature was reviewed. To inform our literature search and provide insights into effective supports and service design we consulted with five experts who have extensive experience as practitioners and researchers.

Prevalence and impact of sexual abuse of males

The sexual abuse of males is a significant and serious issue

The New Zealand Crime and Victims Survey (NZCVS) 2018 surveyed 8,030 people and found 12 percent of men had experienced one or more incidents of sexual violence at some point during their lives and 34 percent of women had experienced one or more incidents of sexual violence at some point during their lives (Ministry of Justice, 2018, p. 9).

International prevalence of sexual abuse rates for males under the age of 16 range from one in six to one in 10 (Dube et al., 2005; Dunne, Purdie, Cook, Boyle, & Najman, 2003; cited in Foster et al., 2012, p. 3).

The impact of sexual abuse on boys and men is multi-faceted and can cause severe trauma

Well-documented longer-term impacts of sexual abuse include post-traumatic stress, drug and alcohol misuse, psychological/mental health distress, employment and relationship breakdown, as well as self-harm/suicide (Ministry of Social Development, 2017a; Zijlstra, 2018, p. 12).

'Severe' childhood sexual abuse experienced by male survivors has also been linked with increased levels of shame, guilt, and dissociation (Dorahy & Clearwater, 2012). For some men this can result in intense shame and repressed rage (Lisak, 1995, cited in Hopton & Huta, 2013, p. 2).

Men need to know there is hope for recovery from the trauma of sexual abuse

A critical message to convey to men who have suffered sexual abuse is that there is hope for recovery. There are many men who have successfully gone through a process of recovery and men need to know this is possible. Due to misconceptions about the sexual abuse of males and the low levels of public awareness about this issue, men often feel isolated. It is important to let men know they are not alone and where they can find information and a range of services to support their recovery.

There are specific barriers for men disclosing abuse and seeking help which need to be addressed

Research shows that “men disclose sexual abuse at significantly lower rates than females throughout the life course” (O’Leary et al., 2017, pp. 2–3) often delaying the disclosure for “years or even decades” (Easton et al., 2014, p. 460).

Barriers to men telling others and seeking help are various, including not knowing where to get help and fear of how they will be perceived. Socially constructed ideas of ‘masculinity’ that promote ideals of toughness, dominance, and invulnerability can influence how men perceive themselves and how abuse impacts them in terms of stigma, shame and mental distress. This can prevent some men from disclosing sexual abuse and seeking help. These negative interpretations of ‘masculinity’ can influence responses from family, friends and some professionals who may not believe them, nor take their experiences as seriously as they should. The response and care men and boys initially receive when they seek support are crucial to their future wellbeing.

There are myths about the sexual abuse of males that can cause distress and prevent help-seeking

There are a number of myths about the sexual abuse of males that need to be debunked publicly as they cause distress to survivors and their family and friends. Myths such as ‘male abuse survivors go onto abuse’; ‘sexual abuse of boys and men is not very common’; ‘boys/men abused by men must be gay’. These myths have been discredited through numerous studies but they persist, and can impact the response to boys and men who disclose abuse.

Brief overview of recovery services for male survivors of sexual abuse in Aotearoa New Zealand

For long-term recovery, the primary men’s services for survivors in Aotearoa New Zealand are peer support services, most are affiliated with the national male survivor’s peer support network, *Male Survivors Aotearoa* (MSA). There is also *Mosaic*, which is developing its peer support service into a one-stop clinically-led support service for men in the Greater Wellington region. For the general population there are specialist counselling services (particularly via ACC sensitive claims service), and *Safe to talk—Kōrero mai ka ora* telephone and online service. There are no completed evaluations to date of these services to inform us about how effective they are for supporting men in their recovery. A study of MSA peer support services is also currently being undertaken by Associate Professor Louise Dixon, Dr Chris Bowden, Philip Chapman and David Mitchell.

While crisis support services are gender neutral, there is no information available about how many men use these services or their experiences of the services.

The recent evaluation of sexual violence survivors’ experiences of the justice system commissioned by the Ministry of Justice, indicates that systemic changes, particularly regarding the court system, are urgently required as is professional development for justice professionals.

What we know about the effectiveness of different service approaches

Evidence on effectiveness of therapeutic interventions

The therapy programme *Men & Healing in Canada*, for male survivors of sexual abuse, includes a phased approach to treatment, starting with intensive psycho-educational retreats and moving to therapeutic individual and group work led by qualified facilitators who have expertise working with men. Hopton and Huta (2013) evaluated this service and recommended completing phase I (eight weeks) followed by eight 10-week cycles of phase II to achieve reliable improvement across all symptoms. They considered this duration was a reflection of the “clinical reality that treatment and reliable recovery from a history of cumulative and complex trauma is a lengthy process” (Hopton & Huta, 2013, p. 14).

Evidence shows that post-traumatic stress disorder (PTSD) is very common among male survivors of sexual abuse. Regehr and colleagues conducted a systematic review of treating PTSD experienced by victims of rape and sexual assault (although mainly female participants). Their findings provide “tentative evidence that cognitive and behavioural interventions, in particular Cognitive Processing Therapy, Prolonged Exposure Therapy, Stress Inoculation Therapy, and Eye Movement Desensitization and Reprocessing can be associated with decreased symptoms of post-traumatic stress disorder (PTSD), depression and anxiety in victims of rape and sexual assault” (Regehr et al., 2013, p. 57).

Evidence on effectiveness of peer support services

We found no evaluative studies assessing the effectiveness of peer support services for male survivors nationally or internationally. As stated, study is currently being undertaken in Aotearoa New Zealand by Associate Professor Louise Dixon, Dr Chris Bowden, Philip Chapman and David Mitchell. This will provide valuable insights

Studies of peer support services for mental health consumers found improvements associated with hope, recovery, and empowerment (Lloyd-Evans et al., 2014) and higher levels of hopefulness for recovery (Chinman et al., 2014). These elements are considered fundamental to a successful peer support relationship for male survivors (*Male Survivors Aotearoa*, 2018a, p. 1).

Pfeiffer and colleagues’ (2011) meta-analysis of peer support interventions for depression found significantly improved depressive symptoms when compared to the “usual care for depression” which is relevant for male survivors as the link between sexual abuse and depression is well documented (eg Easton & Kong, 2017; Hopton & Huta, 2013; O’Leary et al., 2017; Turner et al., 2017).

A range of recovery approaches and service delivery models is required

Findings from the literature and consultations with experts point to the provision of a mix of recovery approaches such as individual and group programmes, intensive retreats, professionally facilitated peer support, and psychotherapy and other counselling approaches. Findings from consultations with experts point to the inclusion of practical techniques and activities such as meditation, mindfulness, art and physical activity.

A client-centred approach (which may include whānau, family, supporters) tailored to the individual’s needs relies on a good intake process with a needs-assessments conducted by a practitioner who can build a trusting relationship with their client. This includes providing men with choices and information about other services they may require.

Service developments should consider diversity among men, acknowledging and adapting services to meet the differences in men's cultural and sexual identities. Support of existing population-based organisations and the development of new organisations may be needed to offer effective support for Māori, Pacific, ethnic communities, Rainbow/Takatāpui communities, and for men with disabilities.

The findings reinforce the importance of a range of service delivery options, including outreach services, collaborative services and online services, as well as accessible and available service locations.

Advocates are required to help clients navigate services and the justice system, to help with brokerage of specialist services, and to offer practical support - particularly for men with complex needs such as mental health issues, intellectual disabilities, addictions, poverty, and homelessness.

Recommendations for service planning and development

The following recommendations draw on the findings of the literature review and consultations with experts.

Supporting more rigorous research and evaluation of recovery approaches and service models

The report recommends establishing a national programme of research and evaluation on male sexual abuse as part of a wider research and evaluation programme on sexual violence.

A stocktake and review of current service provision is required, with consideration of service availability and responsiveness across the country. This would allow a thorough understanding of the service landscape for diverse groups of men.

More research is required on what approaches work for male survivors and different groups of male survivors. There is a lack of studies that examine recovery approaches with men generally, indigenous men, Rainbow/Takatāpui communities, or men with disabilities.

More research is required on the impact of adult male sexual abuse to better understand recovery approaches as much of the current research focuses on childhood sexual abuse.

Supporting a range of recovery approaches and service models

Sexual abuse results in complex trauma and the needs of survivors are diverse and can differ at different times. Service planning and design needs to reflect this complexity by offering a range of recovery approaches and service models. The findings from the review support multi-dimensional recovery approaches that are tailored for men, and for diverse groups of men.

A range of service delivery models are useful to break down barriers to accessing services and to tailoring services for diverse groups of men. Some examples are: male-oriented services that specialise in working with men; tailoring the way a service is advertised; individual and group programmes; outreach; online; increasing availability of services (opening times, range of communication mediums, physical location/outreach services, immediate access) and giving attention to the ambience of the service.

Developing a national website for male survivors that provides comprehensive information for men, their families and supporters, and for professionals

A national website where male survivors, their families, whānau and friends could anonymously access information, self-help resources and services such as telephone and online crisis and counselling support would be useful. The website could include links to regional services, a range of culturally-appropriate services, and other support information.

For professionals, the website could be a source of current information, resources and professional development opportunities (eg e-learning packages, webinars, professional forums etc).

Supporting organisational and workforce development

Support is needed for the implementation of evidence-based practice, good practice guidelines within organisations, and professional development of the workforce within the sector.

While it was beyond the scope of this review to examine how the recently developed *Male Survivors Aotearoa* (MSA) good practice guidelines and *Male Survivors of Sexual Abuse* service guidelines are being implemented, we suggest that ways of supporting implementation at the organisational and workforce levels be considered (eg resourcing organisations to implement good practice and supporting workforce capacity and capability). The findings from this report indicate that the professional facilitation of peer support groups is important, therefore current facilitators should be supported to develop their skills in this area.

Support is also required to increase professional awareness of the prevalence and impact of male sexual abuse and how to respond to disclosures.

Men are likely to present with a variety of problems across diverse settings before speaking about their experience of sexual abuse, therefore it is important that the workforce across multiple agencies is able to empathise, provide a safe environment for the survivors and know where to refer them for support.

Supporting responsive practices and services for diverse groups of men

This involves:

- Recognising and understanding diversity both across and within broad population groups, for example iwi, Pacific cultures, diversity of rainbow communities, and the needs of people living with disabilities.
- Understanding the values, beliefs, world views and approaches to health and wellbeing combined with good practices, such as cultural and needs assessments.
- Supporting the implementation and continual development of good practice guidelines for all population groups.
- Supporting culturally-based organisations such as kaupapa Māori organisations to respond to the needs of men who have been sexually abused, and their whānau.

Supporting a primary prevention campaign to inform the public and challenge myths about male sexual abuse

Primary prevention initiatives to provide education about male sexual abuse should be part of a general public education campaign alongside education about sexual abuse of women and girls. This campaign should inform the public about the prevalence of sexual abuse of males, how to respond to disclosures of sexual abuse, debunk myths around sexual abuse of males, and provide information about the support available to aid recovery.

Including a focus on the prevention of sexual abuse of boys, men, and transgender people in the national Family Violence and Sexual Violence strategy

The government is currently developing a national *Family Violence and Sexual Violence strategy*. The interagency 'joint venture' on family and sexual violence recognises these issues are strongly linked to each other, as well as to child abuse. We suggest this strategy includes specific reference to the prevention of sexual abuse of boys and men, and recovery approaches that are tailored towards males in all their diversity. We also suggest a focus on transgender people.

Developing a national centre that includes a focus on sexual abuse of boys and men

We recommend that a national centre on family and sexual violence is established to support the governance and implementation of the new national strategy. The centre could oversee and coordinate a variety of functions including primary prevention, workforce development, and coordinating a national research and evaluation agenda.

Glossary of terms and acronyms

This glossary provides brief explanations of terms and what we mean when we use them in this review. We acknowledge there are different interpretations, and therefore 'definitions', of many of the terms outlined in the glossary below.

CSA	Childhood sexual abuse
Counsellor	Counsellor refers to practitioners who are registered with a professional body and have a range of qualifications including clinical psychology, psychotherapy, and different counselling approaches. Practitioners have different designations reflecting their qualifications and/or place of work such as 'clinicians', 'psychologists', 'psychotherapist' etc.
Gender and sex	<p>Gender is an ideology comprising "a set of powerfully held beliefs" (Mejía, 2005, p. 31) about how to act/be a 'male' or 'female'. These beliefs are expressed as characteristics of 'masculinity' and 'femininity' and shape ideas about 'gender roles' and 'gender identity'. We can see that ideas about 'masculinity' and 'femininity' can vary between and within different cultures and societies, and have changed over time.</p> <p>Dominant forms of 'masculinity' and 'femininity' become normalised and influence how we see ourselves (internalised), how we act, and relate to others. "These expectations are not fixed but are continually being constructed and reinforced through social relationships and economic and political power dynamics."¹</p> <p>We will see in the literature review that some of the traditional beliefs about 'masculinity' do not serve male survivors well and act as barriers to recovery, particularly regarding access to services.</p> <p>'Sex' is a medically constructed categorisation. Sex is often assigned based on the appearance of the genitalia, either in ultrasound or at birth.² 'Cisgender' refers to a gender assigned at birth. Some babies are born with ambiguous genitalia and an umbrella term for this is 'intersex'. While the tendency has been to assign intersex babies as 'boys' or 'girls' and conduct surgery while they are infants, there is a growing move against this (unless medically necessary) and instead to let the person decide when they are older.</p> <p>'Gender' is often conflated with 'sex', for example we are socialised to regard 'men' as "synonymous with masculinity, and [that]</p>

¹ Accessed at: <http://spl.ids.ac.uk/sexuality-and-social-justice-toolkit/1-issues-and-debates/what-link-between-sexuality-and-gender>

² Accessed at: <https://lgbtqia.ucdavis.edu/educated/glossary>

	masculinity is somehow an intrinsic property of maleness" (Mejía, 2005, p. 31).
Gender fluid, gender non-binary, gender non-conforming, or gender queer	Ideas about gender can be regarded as a continuum. People who do not identify and conform to their society's dominant ideals of masculinity and femininity may define themselves beyond traditional ideas of 'gender' and roles of 'men' and 'women'. Thus gender fluid, gender non-binary (not 'male' or 'female'), gender non-conforming, gender queer. See transgender entry for further definitions.
Heteronormativity	An ideology promoting conventional gender roles, heterosexuality and traditional families comprising couples of the opposite sex as the correct way for people to be (Oswald et al., 2005).
Hegemonic masculinity	'Hegemony' refers to dominance and power to control in a political and social context. "Hegemonic masculinity refers to the normative ideology that to be a man is to be dominant in society and that the subordination of women is required to maintain such power." (Connell & Messerschmidt, 2005; Mankowski & Maton, 2010; cited in Smith et al., 2015, p. 161). Patriarchal societies are based on ideas of hegemonic masculinity, that it is 'normal' and 'natural' for men to be dominant and this is legitimated and enforced via that society's political, religious and social institutions.
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual and many other terms such as non-binary and pansexual. We note there are variants of this acronym used in the literature and we have provided definitions within the text where required.
Mental health	Mental health is defined by the World Health Organization as "a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to their community" (Ministry of Health, 2016, p. ix).
Mental health disorder	Mental health disorder is "diagnosed most often by a psychiatrist, that may cause suffering or a poor ability to function in life. Such features may be persistent, relapsing or remitting, or occur as a single episode" (Ministry of Health, 2016, p. ix).
Male survivors of sexual abuse	We have used the term 'male survivors of sexual abuse' or variation 'male survivors' throughout the review which reflects the terms used by MSD and by other parts of the sector. However, we appreciate that these terms are not used by everyone. One of the experts interviewed as part of this review, Alexander Stevens II, said labelling men as 'victims' or 'survivors' can also be detrimental as there is no evidence to suggest that these labels are used by Māori or Pacific men.
Peer support	"Peer support is person-centred and underpinned by strength-based philosophies. The life experience of a peer support worker creates

	<p>common ground from which a trust relationship with the person is formed. Empowerment, empathy, hope and choice, along with mutuality, are the main drivers in purposeful peer support work. There is a great deal of strength gained from knowing someone who has walked where you are walking and now has a life of their choosing. In this way it is different from support work, it comes from a profoundly different philosophical base" (Te Pou, 2009, cited in Male Survivors Aotearoa, 2018a, p. 3).</p>
Post-traumatic stress disorder (PTSD)	<p>PTSD has been defined as "a mental health disorder that can follow exposure to a traumatic event and is characterised by re-experiencing of the event through nightmares and/or flashbacks; avoidance of stimuli reminiscent of the event, the numbing of emotional responses; and symptoms of hyper-arousal (eg being particularly watchful or on guard)" (Goldmann & Galea, 2014, cited in Mounsey et al., 2017).</p>
Psychosocial	<p>Psychosocial approaches "reflect the interrelationship between individual psychological and social factors. The psychosocial approach considers individuals in the context of the combined influence that psychological factors and the surrounding social environment have on their physical and mental wellness and their ability to function." (Ministry of Health, 2016, p. ix). The importance of trust and regaining a sense of power is central to 'psychosocial' recovery.</p>
Psychosocial counselling	<p>Typically refers to a systematic process that gives people an opportunity to explore, discover, and clarify ways of living more resourcefully, and with a greater sense of wellbeing (British Association for Counselling & Psychotherapy, 2017)³. Psychosocial counselling may involve a variety of different modalities, including but not limited to: group therapy, individual counselling, guided self-help, peer support, cognitive behaviour therapy, relaxation training, and problem-solving intervention.</p>
Rainbow communities	<p>Dickson (2016a) uses 'Rainbow' "to include all people in Aotearoa New Zealand under the sex, sexuality and gender diversity umbrellas" (2016a, p. 4). However, we combine it with Takatāpui (see below) for Aotearoa New Zealand and use Rainbow more widely to also cover people living in countries beyond New Zealand in addition to the terms used by specific authors/researchers.</p>
Sexual abuse/harm/violence	<p>Sexual abuse/harm/violence can be defined as non-consensual sexual behaviour involving "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-</p>

³ Accessed at: www.bacp.co.uk/student/what.php

	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, 2018, p. 6).
Stepped care approaches	Provision of different intensities of psychosocial interventions and mental health services to match the needs of the person (Ministry of Health, 2016).
Survivor	The term 'survivor' is used throughout this review in preference to 'victim', except where direct quotes from literature refer to 'victim'.
Takatāpui	<p>Takatāpui is a traditional Māori term meaning 'intimate companion of the same sex.' It has been reclaimed to embrace all Māori who identify with diverse sexes, genders and sexualities such as whakawāhine (trans women), tangata ira tāne (trans men), lesbian, gay, bisexual, transgender, intersex and queer. These are often grouped under the term "Rainbow communities".</p> <p>Being takatāpui is about whakapapa (descent from ancestors with sexual and gender fluidity); mana (authority and power to be who we are); identity (claiming all of who we are – culture, gender, sexuality and ability); and inclusion (unity across all iwi, sexes, genders and sexualities).⁴</p>
Talking therapies	Talking therapies "help people to understand and make changes to their thinking, behaviour and relationships in order to relieve distress and improve wellbeing.... Talking therapies, often called psychological therapies, have a strong international evidence base for improving mental health and addiction outcomes" (NZGG, 2008; NICE, 2009; NHS Scotland, 2011). ⁵
Transgender people	<p>Transgender people "are broadly defined as individuals who feel that their gender is not congruent with their biological sex" (Gentlewarrior and Fountain, 2009, pp. 1–2).</p> <p>Transgender: Adjective used most often as an umbrella term, and frequently abbreviated to "trans". This adjective describes a wide range of identities and experiences of people whose gender identity and/or expression differs from conventional expectations based on their assigned sex at birth. Not all trans people undergo medical transition (surgery or hormones).</p> <p>Some commonly held definitions:</p> <ol style="list-style-type: none"> 1. Someone whose determination of their sex and/or gender is not validated by dominant societal expectations; someone

⁴ Accessed at: <https://takatapui.nz/growing-up-takatapui#resource-intro>

⁵ Accessed at: www.tepou.co.nz/initiatives/talking-therapies/54

	<p>whose behaviour or expression does not “match” their assigned sex according to society.</p> <ol style="list-style-type: none"> 2. A gender outside of the man/woman binary. 3. Having no gender, or multiple genders.⁶
Transphobia	<p>“Transphobia is defined as any attitude or behaviour that is predicated in the assumption that biological sex and gender are binary and synonymous, resulting in the marginalization of transgender individuals at personal, familial and/or societal levels” (Gentlewarrior & Fountain, 2009, p. 2).</p>

⁶ Accessed at: <https://lgbtqia.ucdavis.edu/educated/glossary>

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1 Introduction

1.1 Purpose and key research questions

The purpose of this literature review is to bring together current evidence about effective approaches to support men who have been sexually abused (as children and/or as adults) in their journey of recovery. Due to the limited evidence base we have taken a broad exploratory approach to examine what is known about supporting men, and what are considered emerging good practices. To inform our literature search and provide insights into effective supports and service design we consulted with five experts who have extensive experience as practitioners and researchers.

The Ministry of Social Development (MSD) commissioned *Carswell Consultancy* to conduct this literature review to inform thinking and future service planning by MSD, non-governmental organisations and other government agencies such as the Ministry of Justice and Accident Compensation Commission (ACC).

The research questions guiding the review are:

- What are the characteristics of well-designed and effective services for adult male survivors of sexual abuse?
- What changes are happening, nationally and internationally, in the way that services are being designed, delivered, and commissioned?
- What does the literature say about the effectiveness of support services to adult male survivors of sexual abuse?

To help answer these questions MSD specified the following requirements:

- Describe the state of current services for men (including both specialist services for men as well as how men are served by services for the wider population) in New Zealand.
- Summarise evidence on the effectiveness of existing services and the characteristics and components of the services shown to be effective.
- Summarise the literature about services for which there is currently limited evidence of effectiveness, but which offer new or innovative approaches. This can include literature about what works for men that may not yet have been implemented into a service.
- Summarise evidence from other fields (such as new forms of therapies) that might be applicable to services for male survivors of sexual abuse. This can include literature that theorises about the general characteristics of effective services for affected men.

Before answering these questions, Section 2 examines what is known about the prevalence, impacts, and needs of men who have been sexually abused. This provides a foundation to better understand the severity of this issue and the types of services male survivors require to support their recovery.

1.2 Scope of this literature review

To answer the research questions and meet the specified requirements we drew on a range of material. We regard this as an exploratory piece of work, bringing together a range of literature and expert opinion to provide insights into recovery approaches and service delivery models for men who have been sexually abused. This section outlines the parameters of what is included and excluded from the scope.

The review focuses on supports for adult male survivors of sexual abuse aged over 18 years. Men may have experienced abuse when they were children (childhood sexual abuse: CSA) and/or when they were adults. The services and treatment for children and young people who have been sexually abused are specialist areas and are out-of-scope for this review.

There are different definitions of 'sexual abuse', and for the purposes of this review we have used MSD's definition. Sexual abuse can be defined as non-consensual sexual behaviour involving "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, 2018, p. 6).

MSD is particularly interested in understanding the effectiveness of services for a diverse range of men and identified Māori tāne, Pacific men, men living with disabilities, Rainbow/ Takatāpui as population groups to examine. We include specific evidence for these groups where available.

Although the scope relates to adult male survivors, we feel it is important to be inclusive of transgender people, particularly as this group is known to be highly vulnerable to sexual violence. While some transgender people may identify as male, others within the transgender community do not identify with the binary gender terms of 'male' and 'female', and identify as 'gender non-conforming', 'gender fluid', 'gender non-binary' or 'gender queer/questioning'.

Unfortunately, there are always limitations to the scope of a literature review, and we were not able to cover a wider diversity of men, for example men from different ethnic communities, nor men in various settings such as prisons and armed forces.

Out-of-scope is a review of the literature on the perpetrators of sexual abuse of males as children or adults, why they abuse, and the interface between being a victim and committing abuse. One of the myths surrounding male sexual abuse is that there is an inevitability that victims then go on to be abusers. While a high proportion of perpetrators have an abuse history (Dutton & Hart, 1992; Simons et al., 2002; and Mendel, 1995; cited in Fisher et al., 2009, p. 62) the vast majority of survivors do not go on to become abusers (Kaufman & Zigler, 1987; Lisak, Hopper, & Song, 1996; cited in Fisher et al., 2009, p. 62). However, fears and perceptions based on this myth can cause additional distress to male survivors (Elkins et al., 2017, p. 19).

A note on terminology used in this literature review

We have used the term 'male survivors of sexual abuse' or variations such as 'male survivors' throughout the review, which reflects the terms used by MSD and other parts of the sector. However, we appreciate that these terms are not used by everyone. One of the experts interviewed as part of this review, Alexander Stevens II, said labelling men as 'victims or

survivors' can be detrimental as there is no evidence to suggest that these labels are used by Māori or Pacific men.

Our literature review includes the perspectives of transgender people who "are broadly defined as individuals who feel that their gender is not congruent with their biological sex" (Gentlewarrior & Fountain, 2009, pp. 1–2). Many transgender people do not identify as 'male' or 'female' and instead use a variety of alternative terms as discussed above.

The inclusive Māori term 'Takatāpui' which traditionally means "intimate companion of the same sex ... has been reclaimed to embrace all Māori who identify with diverse genders and sexualities such as whakawāhine, tangata ira tāne, lesbian, gay, bisexual, trans, intersex and queer" (Dickson, 2016a, p. 5; Kerekere et al., 2017 n.p.). Dickson (2016) uses 'Rainbow' "to include all people in Aotearoa New Zealand under the sex, sexuality and gender diversity umbrellas" (2016a, p. 4). Assuming a similar inclusiveness, we adopt the term 'Rainbow/Takatāpui' in relation to Aotearoa New Zealand and otherwise use either Rainbow or the term employed by the authors of the studies we analysed.

Diversity and intersectionality

There is diversity within these groups as well as intersectionality between groups. Carswell, Donovan and Pimm (2018) note that one risk of categorising people into sub-populations is the potential perception of homogeneity which could lead to service providers expecting to be able to provide a generalised service to all members of that group "whereas in reality there is diversity within, as well as between the groups. For example, Māori have diverse iwi and geographical regions as well as differences between rural and city dwellers. For Pacific peoples, the category covers a variety of nationalities, ethnicities, languages, religions and cultures" (Carswell et al., 2018, pp. 18–19).

Further, identities are complex intersections of multiple elements (sex and gender, ethnicities, religious beliefs, socio-economic status, age, abilities, education etc). While we have used population groupings to examine the literature, the lived experiences of people are far more complex and need service responses that can identify and understand different needs, be flexible, client-centred, and respectful.

Wharewera-Mika and McPhillips (2016) make the point that services need to be delivered in a culturally competent way, but this does not mean treating all members of a culture in the same way; "Rather, it presumes that difference and diversity between and within groups are valued, and acknowledges a positive integration of diversity, difference and multiculturalism within a system of care" (Wharewera-Mika & McPhillips, 2016, p. 42).

Scope of services included in the review

MSD requested that the literature review include services which go beyond MSD-funded services, and include services funded by other organisations such as the Ministry of Health and ACC. This allows for a more comprehensive examination of what works to support male survivors who may need different types of services on their journey to recovery. We note that this is not intended as a stocktake of current service provision in New Zealand, rather a scan of what services are available for men to support their recovery. A comprehensive stocktake is required.

Services within scope

Population-based services including:

- services for adult men (aged 18+)
- kaupapa Māori services
- Pacific peoples' services
- LGBTQIA+ services
- general population-based sexual abuse support services.

Service types:

- peer support services
- 1:1 non-clinical support (such as brief or limited counselling)
- telephone helplines and web-based services
- advocacy and navigator services
- crisis support services
- mental health services (including workplace-based programmes).

Service types excluded from scope

- primary prevention initiatives (such as awareness-raising campaigns and community education programmes)
- services that don't specifically support survivors of sexual abuse (for example alcohol and drug services)
- services for children.

1.3 Summary of methodology

To explore the available evidence on what is known about effective recovery services for men who have been sexually abused, we conducted a literature review and consulted with five experts about research and practice nationally and internationally (see section 1.4). This section outlines the methodology we used to reach our recommendations. A fuller description of the methodology can be found in the Appendix.

The original request for a literature review was supplemented with the knowledge of experts given the current lack of evidence for effective recovery approaches for men which is still in its 'infancy', as one expert put it. Much more is known about supporting girls and women. Both the experts and the literature highlighted the importance of and gratitude to the feminist movement's work on sexual violence and the development of services and recovery approaches (Fisher et al., 2009).

Answering the research questions required an exploratory approach to gather as much evidence as possible to inform service planning and development. We consulted the experts and the available literature about different types of recovery approaches (eg therapeutic modalities, psychosocial, peer support, indigenous models) and the effectiveness for different groupings of men and transgender people. Understanding that within and between 'groupings' there is diversity and intersections.

Some of the experts consulted have published research and for clarity we have clearly highlighted where information is from 'expert insights' via consultations, and where sources are from published material.

Overview of literature review methodology: A narrative literature review was conducted to critically analyse a range of literature to assess the current state of knowledge about effective recovery approaches for men who have been sexually abused.

Search strategy: We developed a search strategy in consultation with MSD which included confirming the objectives and scope of the study and the development of key search terms (see Appendix). The search criteria included:

Literature sources: national and international academic and grey literature including unpublished evaluations and good practice guidelines.

Relevance: literature was selected based on relevance to the research questions and scope of the review. A matrix defining relevance criteria (see Appendix) such as population group, and treatment and support approaches guided our search.

Timeframe: due to the limited number of studies, a search spanning 10 years was conducted to ensure inclusion of the studies available. There were some exceptions where older studies were considered relevant.

Language - English: The search criteria was limited to English language sources.

Where there is a lack of information about services and approaches for men, we have drawn on studies of female survivors of sexual abuse; or studies using similar recovery approaches used with men (eg peer support groups in mental health); or treating impacts (eg PTSD, depression) commonly identified with sexual abuse.

There are real limitations with using 'proxy' studies; eg while there are many similarities in the experiences of female and male survivors there are also differences for men and transgender people. Particularly regarding how ideals of masculinity and heteronormativity shape their experiences of abuse, disclosure and service access. We examine this in section 2.

Assessing the evidence for effectiveness

A range of study methodologies were included using qualitative and quantitative (or mixed) approaches; systematic reviews; meta-analyses; randomised controlled trials (RCTs); and quasi-experimental designs.

To evaluate the 'evidence' from such a wide range of studies we have endeavoured to be transparent and taken a critical analytical approach to discuss the methodologies used by each of the studies. We identify the pros and cons of the study design and the implications from their findings for developing long term recovery services for men who have been sexually abused.

A similarly broad-based approach was undertaken by Wharewera-Mika and McPhillips (2016), in their extensive study to identify good practices and approaches to work with victims of sexual assault in Aotearoa/New Zealand. They identified the need to broaden their search for studies beyond experimental designs.

"The highest level of scientific validation from a positivist point of view would have required the use of experimentally designed research producing statistically significant results, along with these results being replicated by further research and/or by delivery in different contexts. However, in their comprehensive review, Decker and Naugle (2009) were not able to identify any research relating to immediate

intervention following sexual assault which met these parameters. This was not surprising given the multiple difficulties in applying rigorous research design, primarily due to ethical constraints such as the lack of ethics in randomly allocating survivors to a no-treatment research control group. Therefore, we needed to look more broadly for research which could provide support for practices consistent with what that research might tell us, for example, survivor feedback, evaluations of service, and research about physiological and psychological impacts of trauma” (Wharewera-Mika and McPhillips, 2016, p. 8)

1.4 Introducing the experts consulted for this review

We consulted five experts to inform our literature search and provide insights about effective supports for male survivors of sexual abuse. The experts were chosen with MSD. Due to recent consultation by MSD with the New Zealand male survivors’ sector to develop service guidelines we focused on two experts from Aotearoa New Zealand – Philip Chapman, the inaugural Chair of *Male Survivors Aotearoa* (MSA) the national peer support network, and Alexander Stevens II who has expertise working as a practitioner and researcher with Māori, Pacific and LGBTQI communities. Three international experts were chosen for their extensive experience covering both academic and practitioner knowledge – Patrick O’Leary, Rick Goodwin, and Scott Easton. Brief profiles are below:

- **Philip Chapman (Aotearoa/New Zealand)** is the Chair of Male Survivors Aotearoa (MSA) and is committed to working with member organisations to establish a sustainable national network of support services for male survivors of sexual abuse. Philip is the founder of the Male Room and has more than 30 years’ experience in working with families and males in the Nelson region. Philip is Chair of the Men’s Shed in Nelson-Wakatu. He is also a Justice of the Peace, a director for the Primary Health Federation and works for the Nelson-Marlborough District Health Board as a men’s health promoter. Phillip has conducted research in the areas of men’s health, fathering and separated fathers, and men’s access to services.
- **Alexander Stevens II (Aotearoa/New Zealand)** is a practitioner and Kaupapa Māori researcher who has been working in the sector for over 20 years and specialises in working with Māori men who have been sexually abused. He has been providing free counselling in Manukau for the past six years for Māori men and members of the LGBTQI community, mostly via self-referrals, as there are very limited supports for men in New Zealand. In response to the lack of research on men and particularly Māori men, he completed a Master’s thesis developing a model of practice specifically for this group and is currently undertaking a PhD to develop frameworks and web-based tools to support Māori men who have been sexually abused.
- **Professor Patrick O’Leary (Australia)** of Griffith University has worked with the Australian Royal Commission into institutional responses to child abuse for several years and has also worked with the United Nations. Patrick has published extensively on the impact and treatment of sexual abuse of men, and identifying men’s needs and coping strategies, and has recently co-developed a tool for therapists to assess severity of mental health impact (O’Leary et al., 2017).

- **Associate Professor Scott Easton (United States)** of the Boston College School of Social Work chairs the College's health and mental health fields of practice. His primary research programme investigates risk and protection factors for mental health outcomes of adults who experienced early life course trauma. In 2010, he conducted the largest study to date on male survivors of child sexual abuse. He has published in the areas of impact and treatment of sexual abuse, especially for men's health, and has received funding from the US National Institute on Aging, John A. Hartford Foundation, and other sources. Because of his clinical and scholarly expertise, he was appointed by Cardinal Sean O'Malley to the Archdiocese Review Board of the Catholic Church of Boston. He is also an editorial board member of the *Journal of Loss and Trauma and Psychology of Men and Masculinity* and on the National Task Force on Trauma and Advanced Social Work Practice.
- **Rick Goodwin (Canada)** is the founder and Clinical Services Director of Men & Healing, as well as the past co-founder/Executive Director of The Men's Project (1997-2015). He also served as National Manager to 1in6 Canada (2012-2015). Rick conducts training courses across Canada for professionals on male sexual trauma, family violence and trauma recovery. He also provides training across the United States through 1in6 Inc. He facilitates both in-person and virtual group trauma treatment programmes for men. He has published several seminal works on how to work with men.

The experts agreed to be named in the review and were provided an opportunity to check material attributed to them. Their contribution was invaluable for providing in-depth overviews of the state of evidence-based practice (EBP) in this area and what was showing promise of effective supports for men. This helped to bring the wide range of literature together to focus on key elements of service design and delivery for men.

1.5 Outline of report

Section 2 provides an overview of what is currently known about prevalence, impacts, and the needs of men who have been sexually abused to better understand what types of services they require to support them in their recovery.

Section 3 provides an overview of the current initiatives and services for adult male survivors of sexual abuse in New Zealand.

Section 4 presents the national and international literature for evidence on the effectiveness of recovery responses including therapeutic approaches, peer support, helpline and online supports, and interagency responses.

Section 5 looks at the effectiveness of approaches to engage with diverse groups of men including Māori, Pacific peoples, Rainbow/Takatāpui communities, men with disabilities, and transgender people.

Section 6 provides reflections from the experts we consulted on the current state of knowledge about what supports men who have been sexually abused and their suggestions on key elements to consider for service development.

Section 7 concludes the review with recommendations for service system design including: service planning and delivery; workforce capability and capacity; and ongoing research and evaluation to address the gaps in evidence about effective services for men.

2 Prevalence and impacts of sexual abuse for men

Key findings

Prevalence of sexual abuse of males

The evidence shows that sexual abuse of males is a significant and serious issue with severe impacts for boys and men.

The New Zealand Crime and Victims Survey (NZCVS) 2018 surveyed 8,030 people and found 12 percent of men experienced one or more incidents of sexual violence at some point during their lives (Ministry of Justice, 2019, p. 9).

International prevalence of sexual abuse rates for males under the age of 16 range from one in six to one in 10 (Dube et al., 2005; Dunne, Purdie, Cook, Boyle, & Najman, 2003; cited in Foster et al., 2012, p. 3).

The impact of sexual abuse on boys and men's lives is multi-faceted and can cause severe trauma. Well-documented longer-term impacts of sexual abuse include post-traumatic stress, drug and alcohol misuse, psychological/mental health distress, employment and relationship breakdown, as well as self-harm/suicide (Ministry of Social Development, 2017a; Zijlstra, 2018, p. 12).

What helps men on their journey of recovery

An Australian study with 39 male survivors identified three key themes in relation to advice for other men to help them on their journey of recovery that have implications for service provision:

- the need to "break free from suppression, denial or secrecy by speaking with someone who could provide assistance" (O'Leary & Gould, 2010, p. 2677)
- "the importance of valuing oneself, maintaining hope and acknowledging the qualities that it had taken to survive" (O'Leary & Gould, 2010, p. 2678)
- the link between contact with other survivors and healing as well as the need to obtain professional assistance to pursue legal action (O'Leary & Gould, 2010).

Barriers to men getting the support they need

Barriers to men telling others and seeking help are varied including not knowing where to get help and fear of how they will be perceived. Socially constructed ideas of 'masculinity' that promote ideals of toughness, dominance and invulnerability can influence how men perceive themselves and how the abuse impacts on them in terms of stigma, shame, mental distress etc. This can prevent some men from disclosing sexual abuse and seeking help.

These negative interpretations of 'masculinity' can influence responses from family, friends and some professionals who may not believe these men, nor take their experiences as seriously as they should. The response and care men and boys initially receive when they seek support are crucial to their future wellbeing.

There are also a number of myths about the sexual abuse of males that have been discredited through numerous studies, but are persistent and can impact on the response to boys and men who disclose abuse.

2.1 Introduction

To better understand the needs of men who have been sexually abused and the types of services they require to support them in their recovery, we begin by examining what is known about the prevalence and impacts of sexual abuse on men. To identify how to better support different types of men we include sections on Māori, Pacific Peoples, Rainbow/Takatāpui and people with disabilities.

We acknowledge the higher prevalence of sexual abuse of girls and women and where studies have included both female and male participants, we endeavour to make clear to whom they are referring.

2.2 Prevalence of sexual abuse

2.2.1 Issues with definitions and data likely mean prevalence is underestimated

Identifying the prevalence of sexual abuse of children and adults is difficult since most abuse is not reported officially and is therefore not recorded in administrative data or records kept by Police, Ministry of Health and child protection services. To get an indication of how widespread a crime sexual abuse is, population-based surveys are necessary.

However, even with population-based surveys it is important to recognise there are limitations related to how sexual abuse is defined and how questions are asked. There are differences in how people define their experiences as sexual abuse, and whether they are comfortable, even in an anonymous survey, stating they have experienced abuse.

How data is collected is also important, for example questions about specific concrete sexual acts result in higher prevalence rates than vague questions (Fisher et al., 2009, p. 31). Fisher et al. review of literature found that:

for men, face-to-face interviews generally result in lower prevalence rate estimates than do more anonymous methods – whereas face-to-face interviews with women tend to yield higher rates (Hopper, 2007). This may be because in face-to-face situations men more easily “lose face” for having been abused (Fisher et al., 2009, p. 31).

2.2.2 Prevalence of sexual abuse by gender and ethnicity in Aotearoa New Zealand

The New Zealand Crime and Victim Survey 2018

The New Zealand Crime and Victim Survey (NZCVS) replaced the New Zealand Crime and Safety Survey (NZCASS) in 2018. NZCVS topline findings released in early 2019⁷ show the rate at which adults experience one or more incidents of sexual violence is considerably higher than NZCASS findings. The NZCVS 2018 “estimates that 23 percent of adults experienced one or more incidents of sexual violence at some point during their lives. Again, women (34 percent) were more likely than men (12 percent) to have experienced one or

⁷ Accessed at: www.justice.govt.nz/assets/Documents/Publications/NZCVS-2018-Topline-report.pdf

more incidents of sexual violence at some point during their lives.” (Ministry of Justice, 2019, p.9).

The Ministry of Justice cautions against making comparisons between the two surveys due to differences in methodology. The NZCVS is a new survey with some significant improvements in design compared with predecessors such as New Zealand Crime and Safety Survey (NZCASS). In particular, the NZCVS:

- has a larger annual sample;
- uses a different approach to coding offences that is more consistent with the Police approach;
- applies a much lower level of data imputations;
- covers additional offence types (eg fraud, cybercrime, trespass); and
- employs a different approach for collecting data from highly victimised people (allowing similar incidents to be reported as a group).

These differences mean that direct comparison of NZCVS results with NZCASS is potentially misleading, even within similar offence types (Ministry of Justice, 2018, pp. 12-13).

Therefore, we have not included the previous NZCASS survey findings as the Ministry of Justice recommends using the NZCVS findings going forward.

Māori

The NZCVS 2018 found that more Māori (29%) experience one or more incidents of sexual violence during their lifetime than the New Zealand average (23%) and at a rate slightly higher than the Pākehā average (26%) (Ministry of Justice, 2019, p. 84)

An earlier study found that Māori females are over-represented in the numbers of sexual violence survivors as both kōtiro and wāhine and are almost twice (28.9%) as likely to experience sexual assault than the general New Zealand population (15%) (Mayhew & Reilly, 2007; Fanslow, Robinson & Crengle, 2007, cited in Te Wiata & Smith, 2016, p. 1).

Pacific peoples

The NZCVS 2018 found fewer Pacific peoples (19.12%) experience one or more incidents of sexual violence during their lifetime than the New Zealand average (23%) (Ministry of Justice, 2019, p. 84).

A survey of young people in New Zealand conducted in 2012 found that one in six Pacific males reported having experienced unwanted sexual contact (Clark et al., 2015, p. 101).

A study of Pasifika victims of crime, including sexual crimes, found that most preferred to access informal support systems such as family, friends, and church ministers, but that they also wanted more information on formal support services, access to formal Pasifika services, and people in services who could speak their language (Wharewera-Mika & McPhillips, 2016, p. 48).

Far more research is required in Aotearoa New Zealand to understand these differences across ethnicities and genders.

2.2.3 International studies of prevalence of sexual abuse of males

Research suggests for boys and men:

- between one in six to 10 males are sexually abused under the age of 16 years (Dube et al., 2005; Dunne, Purdie, Cook, Boyle, & Najman, 2003)
- most sexual abuse of males happens during adolescence or pre-adolescence (Gonsiorek, Bera, & Le Tourneau, 1994)
- males are more likely than females to be subjected to clergy abuse as children, and prison-based sexual violence as adults (Heilpern, 1998; John Jay College of Criminal Justice, 2004; Mariner, 2001; Parkinson, Oates, & Jayakody, 2009; Yap et al., 2011)
- the risk of sexual assault declines with age for adult men relative to adult women (Australian Bureau of Statistics [ABS], 2006; Dal Grande et al., 1999, cited in Foster et al., 2012, p. 3).

2.2.4 International studies of prevalence of sexual abuse – Rainbow communities

There is a paucity of data internationally on the prevalence of Rainbow survivors of sexual assault as the research on sexual violence “has often failed to differentiate heterosexual and/or non-transgender respondents from lesbian, gay, bisexual and transgender ones. This lack of attention to LGBT survivors of sexual violence may be due in part to bias that results in rendering these survivors invisible” (Girshick, 2001; Waldner-Haugrud, 1999, cited in Gentlewarrior & Fountain, 2009, p. 2).

However, a 2006 survey of LGBT clients of an HIV treatment centre in New York found that 45 percent of gay and bisexual men stated that they had been forced to have anal penetrative sex (Heintz & Melendez, 2006, cited in Gentlewarrior and Fountain, 2009, p. 18).

Blondeel and colleagues (2018), concluded from their systematic global review of studies focused on violence motivated by perception of sexual orientation and gender identity that “more data are needed” because their findings showed that prevalence of sexual violence ranged from “5.6 percent (28/504) to 11.4 percent (55/484) for all sexual and gender minority groups (12 studies)” (2018, p. 32).

Transgender people

Evidence demonstrates that approximately half of transgender people are survivors of sexual abuse (Cook-Daniels & Munson, 2016, p. 30; Kenagy & Bostwick, 2005, cited in Jauk, 2013, p. 809; Munson & Cook-Daniels, 2015a, p. 8; Stotzer, 2009, p. 172) and there is “a high prevalence of sexual assault and rape starting at a young age” (Stotzer, 2009, pp. 171–172). FORGE, a US-based organisation focused on violence against transgender and gender non-binary people, conducted a survey in 2004 in the Milwaukee region to explore transgender people’s experiences of sexual violence. Cook-Daniels and Munson’s (2016) analysis of the FORGE survey, with 256 participants, found:

- two-thirds of the respondents had experienced sexual abuse
- most of them had experienced ‘repeated sexual violence’
- 78 percent had first experienced ‘unwanted sexual touch’ by age 12
- nearly 90 percent were assaulted by at least one male

- over 25 percent were assaulted by females
- many were abused by both men and women
- 12 percent were abused by other transgender people (Cook-Daniels and Munson, 2016, pp. 30–33).

2.2.5 International studies of prevalence of sexual abuse – people with disabilities

According to the post-Census 2013 Disability Survey, 1.1 million people (24 percent of the population) in New Zealand identified as disabled. In Māori and Pacific populations, the proportion is higher – 32 percent and 26 percent respectively (Robson, 2016 cited in Wharewera-Mika & McPhillips, 2016, p. 283).

Although there is a general lack of research on the topic, a clear link between disability and sexual violence has been established (Robson, 2016 cited in Wharewera-Mika & McPhillips, 2016, p. 289). Mencap (2001) states:

There is considerable evidence that people with a learning disability are at much greater risk of sexual abuse and assault than the general population. Research shows that the incidence of abuse among people with disabilities is as much as four times higher than it is among the non-disabled population. People with a learning disability are at the highest risk of abuse. (Mencap, 2001, p. 5).

The Australian Royal Commission into Institutional Responses to Child Sexual Abuse reported that 4.3 per cent of survivors told them they had disability at the time of the abuse (Australian Royal Commission, 2017, p. 9).

Prevalence of sexual violence is much higher among men living with disabilities than in the general male population and has been experienced in the following settings:

- Residential settings – such as nursing homes, care homes and specialist residences for those who have experienced:
 - brain injury (including stroke)
 - mental health
 - intellectual disabilities.
- Institutional settings – such as hospitals.
- Home-based environments – through care workers, landlords, intimate partners or family/whānau. Additionally, managers can facilitate abuse by failing to appropriately action reports of abuse.
- Community settings – ‘occurring opportunistically’ by someone unknown to survivor (Roguski, 2013, cited in Robson, 2016 in Wharewera-Mika & McPhillips, 2016, p. 284).

In a report to the UK Department of Health, O’Callaghan and colleagues (2006) highlighted how “few cases of abuse perpetrated against people with learning disabilities are ever prosecuted in the courts, either here [in the UK] or in other jurisdictions” (p.4). This needs to be considered in the context that much of the harassment and sexual abuse of people with disabilities goes unreported (Dickman et al., 2006).

2.3 Social contexts and locations of sexual abuse

Sexual abuse of males as children or adults can take place in many social contexts and locations, and awareness of this assists in developing prevention measures.

The Australian Royal Commission into Institutional Responses to Child Sexual Abuse listened to the personal stories of over 8,000 survivors (p. 7) and read over 1,000 written accounts (p. 7). The majority of survivors (64.3 percent) were male (p. 8) and 93.8 percent of survivors (male and female) said that they were abused by a male (p. 9). The Australian Royal Commission reported that despite their knowledge that thousands of children have been sexually abused in institutions across Australia for generations, they conclude: “the number of children who are sexually abused in familial or other circumstances far exceeds those who are abused in an institution” (Australian Royal Commission, 2017, p. 4).

Below is a range of settings from studies that examined sexual abuse. Some of the studies focused on specific populations such as males, children or elderly and specify the relationship to the perpetrator.

- **Within family or whānau** – CSA is often in family home or similar dwelling
 - Sibling abuse (Tener et al., 2017)
- **Intimate partner:**
 - Long-term relationships – female perpetrator/male victim, male perpetrator/gay or bisexual victim – usually takes place within the home
 - Dating type scenario – female perpetrator/male victim, male perpetrator/gay or bisexual victim, likely to take place at either person’s home (Davies, 2002)
- **Stranger attack** – usually the perpetrator is male or group of males (King & Woollett, 1997, cited in Davies, 2002, p. 207); could be outdoors in the street, in a park or other public areas (Davies, 2002, p. 207)
- **Prison attack** – by other prisoners (Fowler et al., 2010; Neal & Clements, 2010)
- **Institutional sexual abuse:**
 - State care (CSA) (eg Australian Royal Commission, 2017)
 - Church (CSA)
 - “Recognition of different spiritual consequences should be included alongside attention to physical and psychological consequences” (Rocío Figueroa Alvear & Tombs, 2016)
 - Nursing Homes (elderly sexual abuse) (Teaster et al., 2014)
- **War zone** (eg Tol et al., 2013) – relevance for NZ in terms of refugees needing support
- **Armed forces** (eg Suñis et al., 2013) – we note that the NZ Defence Force has established a Sexual Assault Response Team (SART) “to provide victim-focused care to Defence personnel who have been affected by sexual violence” (NZ Defence Force, 2016 n.p.)
- High proportions of transgender survivors of sexual abuse in the FORGE survey reported that they were assaulted by someone they knew:
 - 40 percent by a family member
 - 35 percent by ‘someone else you knew’

- 29 percent by an intimate partner
- 20 percent by 'a date' (Munson & Cook-Daniels, 2015b, p. 86).

2.4 Impacts of sexual abuse on male survivors

2.4.1 What is known about the impacts of sexual abuse

Symptoms common to all sexual abuse survivors, which differ from symptoms of other trauma, are "the strong element of self-blame, the individualised nature of this type of trauma, social support and social acceptance factors, and the higher incidence of concurrent depression" (Regehr et al., 2013, p. 5).

Longitudinal research and meta-analyses demonstrate that the negative effects of childhood sexual abuse increases with the severity of the abuse (Amado et al., 2015; Fergusson et al., 2013). Amado and colleagues (2015) found that abuse which involved penetration was associated with more severe psychological problems. They also found CSA survivors were 70 percent more likely to develop psychological problems including dysthymia (mild persistent depression) and anxiety disorders. Female survivors were significantly more likely to experience depression whereas male survivors were more likely to develop anxiety disorders.

Conversely, Fergusson and colleagues, whose 30-year longitudinal research was based in New Zealand, found that the effects of CSA were similar for males and females. The effects included: increased risks of mental health issues; a greater number of PTSD symptoms; lower self-esteem and lower life satisfaction; and higher rates of welfare dependence (Fergusson et al., 2013, p. 672).

Fisher, Goodwin and Patton (2009) in their book *Men & Healing: Theory, Research, and Practice in Working with Male Survivors of Childhood Sexual Abuse*, observe there are significant overlaps in the psychological and social impacts for men and women. The differences for males they identify include:

the nature of the abuse itself and the way that the victimisation of males intersects with their gender socialisation. Men abused in childhood face a number of harmful "myths," or as we will call them here cultural delusions, that act to amplify their trauma, limit the services available to them, and block their entry into a healing process. For many male survivors getting help is inconceivable (Fisher et al., 2009, p. 13).

Research on impacts of sexual abuse on boys and men

The effects of sexual abuse on men are multi-faceted and can vary depending on the severity of the assault, whether or not the abuse occurred in their childhood, the gender of the perpetrator and the sexual identity of the survivor (Amado et al., 2015; Davies, 2002; Fergusson et al., 2013). Long-term effects include "anxiety, depression, increased feelings of anger and vulnerability, loss of self-image, emotional distancing, self-blame, and self-harming behaviours" (Davies, 2005, p. abstract). Well-documented longer-term impacts of sexual violence include, experience of post-traumatic stress, drug and alcohol misuse, psychological/mental health distress, employment and relationship breakdown, as well as self-harm/suicide (Ministry of Social Development, 2017a; Zijlstra, 2018, p. 12). "One psychiatric outcome for male survivors that is well validated by research is a ten-fold

increase in suicidal ideation when compared to community populations” (O’Leary & Gould, 2009 cited in O’Leary & Gould, 2010, p. 2670).

The trauma caused by childhood sexual abuse experienced by a substantial number of boys can potentially impair mental health across the whole lifespan (Easton & Kong, 2017, p. 273). Aaron (2012) found that in terms of CSA affecting adult sexual behaviours (which range from withdrawal and dysfunction on one end of the spectrum to hypersexuality and compulsion on the other), the gender of the victim was strongly correlated with “the variable response of sexual inhibition vs. sexual hyperactivity to CSA” (2012, p. 200). Citing Heath, Bean, and Feinauer, 1996 and Najman et al., 2007, Aaron asserts that “boys are more likely to externalize their behavior through aggression, sexualized behavior, and compulsive behaviors, while girls are more likely to internalize their behavior through depressive and anxiety related symptoms” (Aaron, 2012, p. 200).

Severity of CSA⁸, as indicated by injury, more than one abuser, and being biologically related to the abuser, are factors associated with a higher number of mental health symptoms (O’Leary et al., 2010, p. 285). ‘Severe’ CSA experienced by male survivors has also been linked with increased levels of shame, guilt, and dissociation (Dorahy & Clearwater, 2012).

Numerous mental disorders and short- and long-term mental health, social and cognitive impairments have been documented as detrimental effects of CSA on men, including depression, post-traumatic stress disorder, substance abuse, psychiatric disorders and suicide attempts (Hopton & Huta, 2013, p. 2; O’Leary et al., 2017, p. 2; Turner et al., 2017, p. 64). Indeed, early exposure to chronic stress as experienced by child victims, both male and female, of sexual abuse appears to interfere with biological stress systems such as the sympathetic nervous system, serotonin system, and the limbic-hypothalamic-pituitary-adrenal axis, which results in changes in brain development and impaired neuropsychological functioning (Gabowitz, Zucker & Cook, 2008, cited in Hopton & Huta, 2013, p. 2).

The potential resulting psychosocial effects of prolonged and repeated trauma, including from sexual violence, can include feelings of helplessness and a loss of agency (Herman, 1992, cited in Hopton & Huta, 2013, p. 2). For some survivors this can result in intense shame and repressed rage (Lisak, 1995, cited in Hopton & Huta, 2013, p. 2).

2.4.2 Impacts of ideologies of hegemonic masculinity and heteronormativity

Traumatic events, including sexual abuse, generally involve “abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss” in which both male and female survivors are likely to experience feelings of “intense fear, horror, or helplessness” (Mejía, 2005, p. 30). However, for male survivors there is another level of complexity to their suffering in relation to the pervasive ideology of masculinity within many cultures which includes ideals of “toughness, fearlessness, and the denial of vulnerability” (Mejía, 2005, p. 31).

The possibility that sex could be unwanted by men or that men may be vulnerable to being pressured into sex against their will is rendered invisible and perhaps even considered implausible in societies, like New Zealand, whose social norms link masculinity with “being

⁸ The respondents in this study were 80.2 percent female and 19.8 percent male.

strong and in control”, and male sexuality with “being ever-present and driven” (Braun et al., 2009, p. 336).

Rather than acknowledging the ideology of masculinity, comprising “a set of powerfully held beliefs” (Mejía, 2005, p. 31), we are socialised to regard men as “synonymous with masculinity, and [that] masculinity is somehow an intrinsic property of maleness” (Mejía, 2005, p. 31).

Hegemonic masculinity refers to the normative ideology that to be a man is to be dominant in society and that the subordination of women is required to maintain such power (Connell & Messerschmidt, 2005; Mankowski & Maton, 2010; cited in Smith et al., 2015, p. 161).

Research has verified these issues have an impact on male survivors. Easton (2011) analysed an online survey of male survivors of CSA and found that “high conformity to masculine norms ... were related to higher levels of mental distress”.

Research has also revealed links between men with a history of CSA and experiences of “impaired masculine identity, stigma related to perceived homosexuality, self-identity disruptions, delays in disclosure, and lack of access to support resources” (Easton & Kong, 2017, p. 274).

O’Leary and colleagues’ empirical study verified findings in previous studies that male survivors may experience additional dimensions to their trauma related to hegemonic masculinity:

[i]mportant issues relating to gender, masculinity, male shame, and sexuality emerged and appear to be particular to male survivors. Most notably, the therapeutic literature (Lew, 2004; O’Leary, 2001) has found that male survivors may experience a pronounced sense of trauma in relation to not measuring up to prescriptions of hegemonic masculinity (Connell, 1995). Through both qualitative and quantitative data, our research empirically verified this perception of compromised masculinity with two different samples of men who were sexually abused in childhood” (O’Leary et al., 2017, p. 18).

The ideology of ‘heteronormativity’ can also cause distress for boys and men who have been sexually abused by men as they perceive themselves as ‘deviating’ from masculine norms of heterosexuality. Heteronormativity is an ideology promoting conventional gender roles, heterosexuality and traditional families comprising couples of the opposite sex as the correct way for people to be (Oswald et al., 2005).

Myths about male sexual assault and masculinity serve as ways for males to blame themselves for their assault. For example, a male victim in answering the question “Why did this happen to me?” may question his masculinity or his sexual orientation — attributions that are very specific to male victims. Further, more specific issues are raised in the treatment of male victims depending on factors such as the gender of the perpetrator or the victim’s sexual orientation. Attributions towards the assault made by a gay victim, for example, may revolve round feelings of internalised homophobia, while those made by

victims of female perpetrators may be very different, such as feelings of guilt about not enjoying a sexual interaction with a woman (Davies, 2002).

Although research has refuted the contention that the trauma of child sexual abuse causes homosexuality, bisexuality and transgender identities, these myths are still prevalent and need to be addressed (King, 2000, cited in Gentlewarrior & Fountain, 2009, p. 5).

Fisher, Goodwin and Patton's (2009) review of the literature and drawing on their own practice treating male survivors, identified 10 predominant myths or "cultural delusions" related to male sexual abuse that impact the trauma men experience. Some of these myths are described by other authors in this section and all relate to how males are socialised and our society's expectations of what it is to be a "man". Fisher and colleagues describe the tension between ideas of masculinity and experience of victimisation:

[c]ultural delusions about male sexual victimization are generated in the intersection between the traditional male code and the reality of male sexual victimization. Because the latter is utterly incompatible with the former, the delusions act either to deny or minimize the abuse, or else portray it as a failure of masculinity (Fisher et al., 2009, p. 56).

Fisher and colleagues debunk these cultural delusions with research, and state it is important to provide this information to male survivors:

As deVries (1996) emphasises, the interaction between an individual and his cultural environment plays a "key role" in how that individual copes with potentially traumatising experiences, including whether the person develops post-traumatic stress syndrome or not. Until the cultural delusions regarding male sexual victimisation are more widely identified and challenged, we can anticipate that large numbers of abused men will continue to suffer their traumatic consequences (Fisher et al., 2009, p. 57).

2.4.3 Specific impacts of sexual abuse for Māori

In addition to the general impacts of sexual abuse discussed above, there are particular impacts for Māori as "all forms of violence are considered a violation of mana and tapu" (Peri, Tate & Puku, 1997, cited in Te Wiata & Smith, 2016, p. 2) and are incongruent with Māori values. Thus, sexual violation can cause not only physical and psychological distress to Māori, but also cultural and spiritual distress. It is not only a violation of the individual, but of their whānau, tipuna and future generations (Te Wiata & Smith, 2016).

Alexander Stevens II observed that Māori males carrying trauma as a result of being sexually abused can be impacted by wider societal constructs of heteronormativity (for example boys/men who have been abused by other men may question their own sexuality and experience feelings of embarrassment or shame) and institutional racism. This may prevent them from seeking help as there is still a lot of shame and stigma around coming forward due to concepts of masculinity and what it is to be a man. The kiwi attitude is still very much "she'll be right" or "harden up". For boys who have been sexually abused by women there is a perception that they should "have enjoyed it" because a woman has brought them into

“manhood”. Te Wiata and Smith (2016) also suggest Māori men are less likely to report sexual abuse due to societal constructs of masculinity.

2.4.4 Specific impacts of sexual abuse for Pacific peoples

Sexual abuse is a complex issue for survivors and their families to deal with. For Pacific people, it impacts the core of their family and spiritual values. Thus, in an effort to maintain traditional values of respect, solidarity and resilience within families and their community, sexual abuse can become shrouded in secrecy, making it difficult for the survivor to access services (Wharewera-Mika & McPhillips, 2016, p.49). Wharewera-Mika and McPhillips (2016, p. 49), who partnered with Pacific researchers and communities to produce good practice guidelines for ‘Mainstream’ Sexual Violence Crisis Services, assert that multi-systemic approaches are required to understand the trauma caused by sexual violence on Pacific survivors’ traditional and spiritual values and also the impact on their families, church and community.

2.4.5 Specific impacts of sexual abuse for Rainbow/Takatāpui communities

Society’s heteronormative constructs of sexuality and gender identity have consequences in terms of sexual violence being inflicted on people who are perceived to ‘deviate’ from sexual and gender norms. This can “place gay and bisexual boys at greater risk for child sexual abuse” (Gentlewarrior & Fountain, 2009, p. 3).

Braun and colleagues (2009) thematically analysed qualitative data from interviews with 19 gay and bisexual men living in New Zealand, about their experiences of forced, coerced, or unwanted sex. The four general patterns that they identified were:

- (1) incidents involving physical force
- (2) experiences in which a man’s ability to refuse sex was compromised by intoxication
- (3) dynamics where young and inexperienced men were coerced or pressured into unwanted sex
- (4) situations in which men felt obligated to engage in unwanted sex or saw no other viable choice (Braun et al., 2009, pp. 336–337).

The researchers note the specific issues that were raised included “barriers to reporting sexual assault, power dynamics in intergenerational sex, and the difficulty of refusing unwanted sex” (Braun et al., 2009, p. 337). They also emphasise that “many of the factors identified as driving sexual coercion relate not to gay sexuality per se, but rather to masculine sexuality. Conversely, some of the factors relating to men’s vulnerability to coercion were exacerbated by some features of gay sexual culture; in particular those aspects associated with existing in a marginalized territory within a wider heteronormative context” (Braun et al., 2009, p. 337).

“Shame and self-blame are issues for many survivors. For LGBTIQ people, taught by homophobia, biphobia and transphobia to view their bodies and/or sexual desires and attractions as deviant and wrong, sexual violence adds an additional layer of shame” (Dickson, 2016, cited in Wharewera-Mika & McPhillips, 2016, p. 159).

International studies have found negative impacts including “mood disorders, chemical dependency, and HIV/ AIDS subsequent to high-risk sexual behaviours is associated with histories of CSA for gay and bisexual male survivors” (Gentlewarrior & Fountain, 2009, p. 5). Additionally, among gay and bisexual men, repeated CSA over time was linked with having a “HIV-positive status, a history of exchanging sex for payment, and current use of sex-related drugs” (Brennan, et al., 2007, cited in Gentlewarrior & Fountain, 2009, p. 5).

In an American study on gay sexual abuse survivors, internalised homophobia (negative attitudes toward homosexuality in others and toward homosexual features in oneself⁹) was found to be associated with “both depressive and post-traumatic stress disorder (PTSD) symptom severity” (Gold et al., 2007, p. 459) and “was consistently a stronger predictor of outcome than assault severity” (Gold et al., 2007, p. 557). The authors suggest that, when treating gay survivors, this may be an important construct to consider. Experiential avoidance (unwillingness to remain in contact with aversive bodily sensations, emotions, memories etc.¹⁰) was also found to be a strong “predictor of depression symptom severity” (Gold et al., 2007, p. 557).

Gender non-conformity and myths

Internationally, gender non-conformity is often the reason why transgender people are targeted by perpetrators (Kidd & Witten, 2007; Lombardi, et al., 2001; Mizock & Lewis, 2008, cited in Gentlewarrior & Fountain, 2009, p. 3). High proportions of trans survivors cite the “hatred or negative attitudes toward transgender people” (Stotzer, 2009, p. 172) as the perpetrators’ motivation. In one study 43 percent of transgender survivors of sexual abuse reported that the assault was due to the perpetrators' homophobia, while another 35 percent stated it was due to the perpetrators' transphobia (Xavier et al., 2005, cited in Stotzer, 2009, p. 172).

Many people, including trans people and therapists, seek explanations about gender non-conformity which often “focus on ‘what went wrong’ in the person’s development that led to a trans identity” (Munson & Cook-Daniels, 2015b, p. 83). This can lead to speculations about whether CSA causes “transness” which can be “deeply unsettling to some trans people”. Experiences of CSA are not determinative of gender identity. The myth that “being visibly or openly gender variant” causes sexual abuse is deeply resented by the transgender community as this is a victim-blaming attitude, and the fault clearly lies with perpetrators (Munson & Cook-Daniels, 2015b, p. 83).

Some transgender people become “conditioned to believe that abusive behaviour is normal” as a consequence of their lifelong experiences of abuse, including parental disapproval, bullying, anti-transgender insults, and other harassment. Thus, “they may not recognise that an interaction was abusive or sexually violent” or they may even believe that they deserve or are at fault themselves for the abuse, due to feelings of shame (Munson & Cook-Daniels, 2015b, pp. 83–84).

Sexual abuse can profoundly affect capacity for sexual feelings and sexual practices for all survivors. Sexual activity that was previously enjoyed may now be unwelcome or triggering. For transgender people, many of whom experience body dysphoria, sexual violence may

⁹ As defined by Shidlo, 1994, (cited in Gold, Marx & Lexington, 2007)

¹⁰ As defined by Hayes et al., 1996, (cited in Gold, Marx & Lexington, 2007)

result in trauma and further dissociation from their bodies particularly if a violation of the genitals occurred. An attack on the genitals could impact negatively on a transgender person's core identity. For example, "vaginal penetration uniquely emasculates a male-identified biogirl" (Munson & Cook-Daniels, 2015b, p. 85). "Trans individuals, who may have had conflicting feelings about their bodies before being assaulted, may be even more uncomfortable with or dysphoric about their bodies afterward" (Munson & Cook-Daniels, 2015b, p. 88). Sexual abuse can also affect their choices about their transition. Some may decide to delay transition, alternatively, some may view delaying in terms of giving more power to their past victimisation and others may view transition as part of their healing from the trauma (Cook-Daniels & Munson, 2016, p. 46).

2.5 Barriers to disclosure and service access for male survivors

There are numerous barriers for male survivors to overcome in seeking help (Easton et al., 2014; Rapsey et al., 2017; Sivagurunathan et al., 2018). Research shows that "men disclose sexual abuse at significantly lower rates than females throughout the life course" (O'Leary et al., 2017, pp. 2-3) often delaying the disclosure for "years or even decades" (Easton et al., 2014, p. 460). It is likely that barriers for men accessing support services include: stigma; the under-recognition and under-reporting of male sexual abuse; as well as the lack of male-focused services (Hopton & Huta, 2013, p. 13).

However, one of the main barriers to disclosing for men is the fear of how they will be perceived in our heteronormative society (see 2.4.2).

People with intellectual disabilities are more vulnerable to sexual assault and face more barriers than other survivors in terms of reporting the abuse. These include:

- not being able to fully recognise what has happened to them, and
- needing assistance or someone to report on their behalf (Mencap, 2001).

2.5.1 Transgender survivors

Cook-Daniels and Munson's (2016) survey of transgender community in the United States revealed that only nine percent of transgender survivors reported their abuse to the police and 47 percent never told anyone (Cook-Daniels & Munson, 2016, p. 33).

Not being believed is a pervasive problem for all survivors of sexual abuse, however it can be more pronounced for transgender survivors as perpetrators may emphasise societal transphobia to convince them that they will not be believed. "Adults who believe a gender non-conforming child is confused, oppositional, or sinful may make the same assumptions if that child also reports sexual abuse" (Munson & Cook-Daniels, 2015b, p. 89).

Munson and Cook-Daniels also found that 33 percent of transgender survivors they surveyed did not access support services due to "fear that the professionals who are supposed to serve them will be ignorant about transgender people at best or outright prejudiced or hostile at worst" (Munson & Cook-Daniels, 2015b, p. 78).

A New Zealand report found the experience of navigating mental health services in order to access transition-related healthcare can create a lack of trust for transgender people, so it is important that their additional complex fears about disclosing sexual violence and the impact

this might have on those services, are recognised (Wharewera-Mika & McPhillips, 2016, p. 55).

Transgender survivors face additional barriers when accessing sexual violence support services. Dickson's (2016a) New Zealand study found an uneasiness among the Rainbow community about how mainstream violence organisations might respond in terms of transphobia. For example, "non-binary people (people not identifying as male or female in terms of gender) being told they could not access sexual violence services unless they identified as female or male" (Dickson, 2016a, p. 14).

2.6 Needs of male survivors of sexual abuse

2.6.1 The survivors' journey

The recovery journey starts from the time of the abuse. Men have different support needs at different stages of their journey. Crisis support is required at the time of the incident if it has been disclosed, but could also be needed at other parts of the journey as men can be triggered into crisis by other events, for example by a medical examination which evokes aspects of the sexual abuse (Gallo-Silver et al., 2014).

The impacts of sexual abuse can be mitigated by early intervention, however the period between abuse and disclosure tends to be much longer for male survivors, if they disclose at all (Easton et al., 2011; O'Leary et al., 2017, 2010). The response and care they initially receive when they seek support are crucial to their future wellbeing.

Process of resilience – moving from challenges towards positive outcomes

Crete and Singh (2015) conducted a phenomenological study to explore "the lived experience of male survivors of childhood sexual abuse (CSA) who identified as resilient in their current relationships with female partners" (p. 341) and found that "resilience is not a fixed state but a multidimensional process that takes time" (p. 352). They identified seven relational movements from challenges towards positive outcomes:

1. From Past Abuse to Seeking Counselling to Process Abuse
 - A need to "process their feelings, grieve their lost childhoods, and learn healthier relational patterns with their partners" (p. 346).
2. From Isolation to Finding a Purpose and Advocating for Others
 - A need to connect with others.
3. From Self-Hatred and Shame to Acceptance and Mutual Empathy with the Partner
 - A need to challenge the false beliefs that he was "not a good person" or "basically evil" (p. 347).
4. From Insecurity to Greater Trust in Self and Partner
 - A need to develop and rebuild trust
5. From Restricted Emotionality to Deeper Connection with Partners
 - A need to overcome feelings of vulnerability to develop deeper emotional connection
6. From Identity Crisis to Reprocessing a Masculine Identity

- A need to redefine their image of manhood – go beyond societal stereotypes to accept that masculinity can take many forms.
7. From Negative Coping to a Positive Vision of the Future with a Partner
- A need to learn how to acknowledge their own needs (rather than suppress them) and learn how to receive love (Crete & Singh, 2015, pp. 346–350).

Exploring the coping strategies of male survivors

O’Leary and Gould (2010) thematically analysed qualitative interviews with 39 Australian male survivors of childhood sexual abuse about their coping mechanisms. They found that coping strategies developed and changed over time and could be categorised into two types: unproductive coping, associated with negative mental health outcomes, and positive coping which is associated with more constructive outcomes. However, rather than a simple linear progression, a degree of complexity was revealed by the data “with positive mechanisms sometimes emerging alongside, or even out of, negative strategies” (O’Leary & Gould, 2010, p. 2682).

The unproductive coping strategies comprised forms of suppression and denial including withdrawal, isolation and feelings of both hopelessness and helplessness, substance use, and sexual risk-taking. Conversely, the positive coping strategies involved reframing the sexual abuse through talking about it with someone they trusted, not necessarily a professional.

This study has implications for service provision in terms of the three themes that emerged in relation to advice for other men, the most prominent of which was the need to “break free from suppression, denial or secrecy by speaking with someone who could provide assistance” (O’Leary & Gould, 2010, p. 2677). Indeed, all 39 men suggested that although speaking about their experiences was very difficult, it was the key to more “productive coping” strategies (O’Leary & Gould, 2010, p. 2677).

The second theme was “the importance of valuing oneself, maintaining hope and acknowledging the qualities that it had taken to survive” (p. 2678) and the final theme was about the link between contact with other survivors and healing, as well as the need to obtain professional assistance to pursue legal action (O’Leary & Gould, 2010).

2.6.2 What men require when they disclose sexual abuse

Alexander Stevens II emphasises it is important to believe people who disclose sexual abuse. Often the responses from family and friends are “I don’t believe you” or “I don’t know what to do to help you”, or “I do know about it, but I don’t want to talk about it”. Stevens II states: “Men affected by sexual abuse have said that when they disclose, they want people to listen, acknowledge, offer support or help find support (at their own pace and time). The process of taking time to get the right kind of recovery in place can be due to a number of reasons, including men not wanting to name the abuser for fear of ‘unravelling’ other stuff (eg other people in the family who were also abused).”

Stevens II highlighted that research indicates that having one person who believes in your potential to recover can make a positive difference in a person’s mental health recovery, for example a support person (friend) or peer support worker/group. Further research is needed to understand what support and resources are needed to empower support people/crew to provide the right kind of support for men affected by sexual violence trauma.

Trauma-informed approaches to responding to disclosures and supporting male survivors

Trauma-informed approaches are advocated in the literature to underpin service provision (sexual violence specialist services and non-specialist services) to support male survivors in their journey of healing. A 'trauma lens' is used within 'trauma-informed approaches' to view the behaviours, emotions, responses, and attitudes of individuals, created in response to traumatic experiences, as an accumulation of survival skills (Clervil & DeCandia, 2013, cited in Elkins et al., 2017, p. 119). Trauma-informed care is defined as:

A strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper, Bassuk, & Olivet, 2010 cited in Elkins et al., 2017, p. 119).

Below are the six core principles of trauma-informed approaches with examples of what that means in terms of service provision:

- **Safety** (*physical, emotional and psychological*) – service providers are respectful and maintain confidentiality in a consistent manner.
- **Trust** – service providers are aware of the extensive and long-term impact of sexual violence and maintain boundaries within their well-defined roles.
- **Choice and control** – Service providers include survivors in decision-making so that the survivors feel in control and able to make informed choices.
- **Collaboration** – service providers adopt a partnership approach and provide opportunities for survivors to provide mutual support to other survivors.
- **Empowerment** – service providers validate survivors' resilience and help them build on their existing strengths.
- **Cultural relevance** – service providers are sensitive to survivors' particular needs. Men who have been sexually abused are a diverse group with a variety of different needs based on, for example, culture, ethnicity, sexuality and disability. Staff should be open to learning to be culturally competent (Bein, 2011, cited in Campbell, 2016, pp. 140–144).

Specific service needs of people living with disabilities

Wharewera-Mika and McPhillips (2016) report found that while people with disabilities have the same needs as other survivors, they may require additional supports related to their disabilities. They identified the following service elements as critically important:

- knowing that they can contact crisis support services and get help
- knowing that the policies and practices of those organisations won't impede gaining access to support
- having access in appropriate ways to all necessary information while using services, and to help them make informed decisions on appropriate referral options
- having safe, accessible routes into and within service facilities

- having appropriately trained staff who understand and can meet their needs (Wharewera-Mika & McPhillips, 2016, p. 66).

Specific service needs of Rainbow/Takatāpui communities

Qualitative data collated from Rainbow/Takatāpui community hui revealed that at every hui, the “gaps in Rainbow [/Takatāpui] knowledge and competency in services” were cited as “significant barriers” for Rainbow/Takatāpui survivors in terms of seeking help and reporting violence (Dickson, 2016a, p. 16). The most common recommendation across all hui was for special training to be provided to mainstream violence services in relation to gaining an understanding about the particular differences for Rainbow/Takatāpui survivors compared with other survivors. Additionally, there is a need to recognise the diversity within the Rainbow/Takatāpui community in New Zealand, in particular “trans, gender diverse, asexual and bisexual people; those with disabilities; and Māori, Pacifica and other non-Pākehā ethnicities” (Dickson, 2016a, p. 16).

3 Support services for male survivors of sexual abuse in Aotearoa New Zealand

Key findings

This section provides a brief overview of recovery services for adult male survivors of sexual abuse in Aotearoa New Zealand. This is not intended to be a comprehensive account of recent work in the sector, rather it highlights key milestones that may influence the development of sexual violence services.

For long-term recovery, the primary men's services for male survivors in Aotearoa New Zealand are peer support services.

Services for the general population include specialist counselling (eg ACC sensitive claims service), and the *Safe to talk—Kōrero mai ka ora* telephone and online service.

There are no completed evaluations to date of these services to inform us about how effective they are for supporting men in their recovery. A formative evaluation of MSD-funded Specialist Sexual Harm Services (SSHS), including the *Male Survivors Sexual Abuse* peer support services, was completed in 2018.¹¹

While crisis support services are gender neutral there is no information available about how many men use these services or their experiences of the services.

The recent evaluation of sexual violence survivors' experiences of the justice system, commissioned by the Ministry of Justice, indicates systemic changes, particularly regarding the court system, are urgently required as is professional development for some justice professionals.

There is a lack of services tailored for diverse groups of men such as Māori men, Pacific men, Rainbow/ Takatāpui communities, men with disabilities, and men from ethnic communities.

These findings indicate a national stocktake and review of current service provision is required to consider service availability and responsiveness across the country to gain a thorough understanding of the service landscape for diverse groups of men. The lack of knowledge about what works for whom strongly suggests an evaluation of current service provision and research about what approaches work for male survivors and diverse groups of men is much needed.

3.1 Introduction

This section provides an overview of current services for adult male survivors. The overview includes specialist services for men as well as services for the general population in Aotearoa New Zealand. We start with some background on government strategies and frameworks

¹¹ www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/specialist-services/evaluation-of-services.html

relevant to sexual violence services generally, with a focus on how this relates to the availability of services for male survivors.

This is not intended as a comprehensive account of recent work in the sector, rather it is a 'snapshot' of available information and highlights key milestones that may influence the development of sexual violence services.

3.2 Government strategies and funding of sexual violence recovery services

Social Services Committee inquiry into the funding of specialist sexual violence social services (2015)

In 2014, the Social Services Committee reinstated its inquiry into the funding of specialist sexual violence social services. The Committee made 32 recommendations to the Government and overall the inquiry found that:

- current specialist sexual violence social services do not provide adequate cover
- current funding approaches are insufficient
- having stable and effective services that are easily accessible would significantly reduce the harm and costs of sexual violence in New Zealand
- there were several service gaps, including service provision for adult male survivors.

The Government accepted the overarching findings of the Committee's report and accepted all the issues raised within its recommendations (Ministry of Social Development, 2017a, p. 46).

Budget 2016

On 18 May 2016, then Minister of Justice Amy Adams and then Minister of Social Development Anne Tolley announced that Budget 2016 would invest \$46 million over four years to better support victims and prevent sexual abuse.

The investment over four years was to support:

- crisis support sexual violence services for victims (*including Safe to talk—Kōrero mai ka ora* – a new national sexual violence helpline) (\$37.444m)
- services for those with concerning or harmful sexual behaviour (\$6.628m)
- services for male survivors of sexual abuse (\$1.900m).

The justice response to victims of sexual violence

In December 2015, the Law Commission reported on its review of the justice response to victims of sexual violence. The Law Commission made a number of recommendations aimed at improving social support for victims/survivors of sexual violence.

Family Violence, Sexual Violence and Violence within Whānau Workforce Capability Framework (2017)

The Family Violence, Sexual Violence and Violence within Whānau Workforce Capability Framework was developed by an expert design group of government and non-government specialists and published by the Ministry of Social Development in 2017. The vision for the Workforce Capability Framework is that it will:

- enable the Family Violence and Sexual Violence workforce to provide a consistent, effective and integrated response to eliminate family violence, sexual violence and violence within whānau in Aotearoa New Zealand
- inform and be modelled in other practice frameworks used in this country's family violence and sexual violence system (Ministry of Social Development, 2017b, p. 7).

The framework uses a systems approach at the legislative, organisational, workforce and practitioner levels to embed and support change (Ministry of Social Development, 2017b, p. 15).

The need to reframe views of gendered patterns of violence is acknowledged in this Framework:

Throughout the literature, family violence and sexual violence are often presented as gendered issues in that most perpetrators are male, and most victims are women and children. While this analysis is correct, this focus can lead to male victims and female perpetrators becoming 'invisible' in the literature and to services.

It's more helpful perhaps to 'reframe' our view to see family violence and sexual violence as a violation that negatively impacts on all victims – including boys and men – who suffer this abuse. This view acknowledges the gendered nature of family violence and sexual violence but allows a broader parameter when defining 'victim/survivor' or 'perpetrator' (Ministry of Social Development, 2017b, p. 13).

In terms of primary and specialist response, the framework includes the practitioner understanding that "men can be victims of their female or male partner" in their indicators of excellence in practice. Information on Rainbow/Takatāpui identities and advice about debunking rape myths are also included (Ministry of Social Development, 2017b, p. 19).

Ministry of Social Development leading development of services to support men

The Ministry of Social Development¹² is leading the development of services to support male survivors of sexual abuse and their support networks.

The aim is to provide services for male survivors of sexual abuse that are:

¹² www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/specialist-services/male-survivors.html

- accessible and more readily available
- responsive, evidence-based and in accordance with good practice
- delivered by an appropriately skilled workforce
- part of the wider service system responding to sexual violence
- able to support survivors.

MSD contributes funding to sexual violence support services that provide crisis response and longer-term recovery. MSD specifically provides support to the male survivors of sexual abuse peer support services and to sexual harm crisis support services; non-mandated harmful sexual behaviour services; and the national helpline *Safe to talk—Kōrero mai ka ora*.

Information about the use of sexual harm crisis services by male survivors is largely unknown. We note that many of these organisations were set up by women for women and, while all who hold crisis contracts with MSD are expected to see both women and men, they may be perceived by some men to be only for women. Consultations with experts highlighted that this can be a barrier to access for some men internationally. Even with the use of gender-neutral language, men may assume a sexual violence service is only for women.

MSD is a major funder of male survivor peer support services and has contributed to this sector's service development through commissioning research and evaluation and assisting workforce development through co-development of the *Male Survivors of Sexual Abuse Service Guidelines* with the sector (Ministry of Social Development, 2018). **Error! Reference source not found.**¹ provides the intervention logic and theory of change for male survivors' peer support which tells the narrative of how change will occur.

Table 1: High-level intervention logic and theory of change (Ministry of Social Development, 2018, p. 10)

If we	We will help improve	Which will contribute to	For the ultimate goal of
<p>Deliver client-centric peer support and peer group support services that are:</p> <ul style="list-style-type: none"> • Culturally responsive • Age relevant • Sexual orientation, and gender sensitive • Available nationally • Easy to access • Sustainable • Competently delivered 	<p>Male survivors of sexual abuse to:</p> <ul style="list-style-type: none"> • Feel listened to, understood and respected • Make sense of what has happened to them • Be more confident and able to cope • Recognise their needs; and • Know where to get the support they may need 	<p>Enabling male survivors of sexual abuse to enjoy:</p> <ul style="list-style-type: none"> • Greater independence and autonomy • A greater sense of self-worth • Healthier relationships • Increased understanding and support from family/whānau and community • Increased connection and belonging • An enhanced capacity and sense of hope • Improved access to the range and level of services they need. 	<p>Enabling the well-being of male survivors of sexual abuse.</p>

The national network *Male Survivors Aotearoa* developed its own guidelines in 2018: 'Peer Support Practice Guidelines Including Organisational Quality Standards for the Provision of Support Services for Male Survivors of Sexual Violence' (*Male Survivors Aotearoa*, 2018b). These guidelines are discussed in section 3.7.

3.3 Te Ohaaki a Hine – National Network Ending Sexual Violence Together (TOAH-NNEST)

Te Ohaaki a Hine – National Network Ending Sexual Violence Together (TOAH-NNEST), is a bi-cultural umbrella group for those working in the sector, particularly the specialist community service providers funded by MSD. This network represents approximately 40 specialist not-for-profit organisations, and many individual specialists working throughout Aotearoa New Zealand in whānau/families, hapū, iwi and communities.

TOAH-NNEST launched *The Good Practice Project* in 2009 which developed 'The Good Practice Guidelines – Mainstream Crisis Support Services Responding to Sexual Violence Perpetrated Against Adults'. The principles and guidelines were updated in early 2015 based on a sector survey and the participation of the project advisory group, resulting in 'Good Practice Responding to Sexual Violence: Guidelines for 'mainstream' crisis support services for survivors' (Wharewera-Mika & McPhillips, 2016).

The focus of the update was to “expand the cultural reach of the guidelines through providing resources to increase the capability of services to respond appropriately to the cultural diversity of survivors using the services” (Wharewera-Mika & McPhillips, 2016, p. 41). The updated comprehensive guidelines for ‘inclusive practice’ emphasise responsiveness and cultural sensitivity to diversity. The guidelines are designed to equip frontline staff and services with information about appropriate and safe practices to improve the experiences of survivors from a number of different communities and cultures including: Men; Māori; Pacific peoples; LGBTI+; Disability (Wharewera-Mika & McPhillips, 2016, p. 41)

3.4 Justice sector responses for sexual violence victims

A study conducted in 2018 (Gravitas, 2018) about the experiences of sexual abuse survivors of the New Zealand justice system (police, courts, Crown prosecutors, defence lawyers), commissioned by the Ministry of Justice, highlighted the need for more support for victims during the often very lengthy court process and post-sentencing follow-up period. The research was based on in-depth interviews with 37 survivors, eight of whom were men. While the findings were not differentiated by gender, the participant interviews showed that the experiences of the Court system and cross-examination could be traumatic and re-victimise them. Their experiences show that systemic issues need to be addressed and workforce development is required with some justice professionals. The professionals within the justice system who specialise in working with sexual violence victims, such as specialist Police and Court Sexual Victim Advisors, generally received good feedback from study participants. This demonstrates that an understanding of, and sensitivity to, the impact of sexual violence is important. Key findings of this study include:

- Most participants found that making an initial complaint was straightforward. They valued that Police treated them with courtesy and compassion and with respect for their dignity and privacy. In very few cases victims were unhappy with their treatment.
- Lack of information and understanding of how the process would work and what to expect going forward was problematic for a number of those we spoke with.
- Court Victim Advisors were generally described as being valuable sources of information and support, however there appeared to be some variability in how much time was spent with victims and the level of support offered to each.
- Court system: One of the most difficult aspects of the justice process for victims was the lengthy timeframes between charges being laid and dates for court hearings. Victims described the process of waiting for court appearances as effectively holding them back from making progress in other aspects of their lives, hence there was a strong desire to have matters addressed as expediently as possible. Delays to proceedings going ahead, often notified close to court dates, had a detrimental impact on victims’ mental and emotional wellbeing.
- Due to the long timeframes involved, often repeated delays, fear of – or actual – contact with the offender or offender’s supporters, the harsh experience of cross-examination, disappointing outcomes at sentencing and lack of support at the end of the process, victims often did not feel that their needs were recognised or met by the system. For those we spoke with, there was often a sense that the rights of offenders took precedence in the current justice system.

- On reflection, many participants would still seek a justice response to a sexual violation even given the difficulties they had faced, however, they expressed that they would be better able to cope if they were more fully informed about all stages of the process, what to expect, what their rights are, and how to properly prepare for every element of the process, most particularly when giving evidence in court.
- One of the biggest disadvantages faced by victims, based on this research, is their lack of understanding of, and access to, information about the judicial system, the process, and their role and entitlements. Importantly, victims are not well placed to 'know what they don't know', nor are they well placed, as traumatised people, to seek out information or advocate for themselves. It seems, based on these findings, that an active stance from justice organisations and staff is required towards ensuring delivery of rights and entitlements to victims.
- There was often a sense of 'let down' post sentencing. For some people, they were left alone, feeling under-resourced to cope with the aftermath of the process. Several research participants suggested that offers of counselling or similar support at this point would be of value" (Gravitas, 2018, pp. 3–11).

A pilot of a client-centred approach at Department of Corrections found issues with implications for workforce development including a general lack of awareness of:

- Male survivors of CSA (although they were cognisant of female survivors). Additionally, males were often perceived as perpetrators.
- The strong correlation between male survivors of CSA and later problems including mental health issues, violence and drug/alcohol abuse.
- The negative impact of widely held myths and stereotypes on both male survivors and service providers.

The pilot also identified that policies, protocols and staff training needs to be developed by agencies to raise awareness of male survivors of CSA and their requirements, particularly around aiding early disclosure, providing therapeutic pathways, and the flexibility required in terms of the time allocated to support deeply traumatised men (Mitchell et al., 2014, p. 5).

3.5 ACC sensitive claims counselling

In November 2014, the Accident Compensation Corporation (ACC) introduced the *Integrated Services for Sensitive Claims* (ISSC) contract to provide immediate, holistic and tailored support to survivors of sexual violence. Many of the barriers for clients have been removed to ensure choice and consistency across New Zealand. The ISSC is a way of ACC working with suppliers and providers who offer an approved suite of support services that can be tailored to individual client needs. The services offered include access to social work support, family/whānau support and cultural advice, alongside one-on-one therapy.

The ACC website [Findsupport.co.nz](https://www.findsupport.co.nz) supports survivors of sexual violence to find a therapist by location, gender of, and language spoken by therapists, and experience of working with particular groups, for example particular ethnicities, older people, prisoners. A search of this database provides a guide to available suppliers who can support different groups by location (note we have not analysed this by location).

Some suppliers provide services in more than one location. Therefore, while there are approximately 181 suppliers contracted to ACC, they provide services in approximately 300 locations. We note that a therapist may work with multiple suppliers. For example, three suppliers may use the same therapist who has expertise working with male survivors. As such, three suppliers would offer this expertise, however there is only one full-time equivalent of capacity between them.

The available data on the ACC website is intended for survivors of sexual violence as an entry point for receiving support. The information on the website is focused at the contracted supplier level, so we were not able to identify the proportion of the therapists with expertise in working with male survivors.

Accessing ACC support involves contacting a GP, DHB or a sensitive claim-registered provider. There is no requirement for a survivor to have contacted the Police, and there is no 'burden of proof' required on the survivor's part. Survivors are able to access up to 14 hours of support, as well as additional supports including social work and family/whānau support, without the requirement of a mental injury diagnosis. For survivors to have access to longer term support or other ACC entitlements, a mental injury causally linked to the history of sexual violence must be established, and this is done via a supported assessment completed by the provider.

3.6 Health sector responses to sexual abuse

Health professionals play an important role in the recovery from sexual abuse in a number of ways, such as providing medical care, medico-legal services including forensic examinations, screening/assessment and appropriate responses and referrals to specialist services. Men may disclose recent or historic sexual abuse to health professionals. A comprehensive overview of Aotearoa/New Zealand's current provision of health sector services for men who have been sexually abused is out of scope for this review and would require more research. This section provides a brief overview of services to the general population.

The Ministry of Health Guidelines on family violence assessment and intervention for child abuse and intimate partner violence (IPV) provides health professionals with guidance and resources to identify abuse and appropriately respond (Fanslow et al., 2016). The recommendations for a routine enquiry to identify child abuse and IPV (including sexual violence) for different groups are summarised below. We note that men are not routinely asked about IPV unless they present with injuries, whereas women are always asked, due to the differences in prevalence and severity of IPV for men. The guidance focuses on IPV, and more tailored guidance for men who have experienced sexual violence may be required for those presenting with a range of issues, not just physical injuries. Our review did not include an examination of models for screening men for sexual abuse and we recommend more research to be done in this area.

Children – child abuse and neglect: Routine enquiry about child abuse and neglect is not recommended. Health care providers do, however, need to be alert for signs and symptoms that require further assessment, or that might be indicative of violence and abuse. Health care providers should also review the child's medical records, as previous presentations or admissions may indicate risk (Fanslow et al., 2016, p. 31).

Young people aged 12-15 years – about possible IPV: The different profile of abuse that young people may experience (for example, violence by peers/bullying, violence by family/whānau, dating violence) requires a developmentally appropriate assessment to be undertaken if signs and symptoms of abuse are detected (Fanslow et al., 2016, p. 53).... Males and females over 14 years need to be questioned about IPV when presenting with acute injuries, given the common occurrence of early peer dating and sexual relationships, as well as vulnerability to grooming and abuse by adults (Fanslow et al., 2016, p. 92).

Females aged 16 years and older: Routine enquiry about intimate partner violence (IPV) is an essential component of clinical care for all females aged 16 years and over (Fanslow et al., 2016, p. 92).

Males aged 16 years older: Those who present with signs and symptoms indicative of IPV should be questionedRoutine enquiry is not recommended because of the differences in prevalence and severity of violence against men. However, if signs and symptoms of IPV are present, males should also be questioned about the occurrence of IPV, or other experiences of violence (Fanslow et al., 2016, p. 53).

The Sexual Assault Assessment and Treatment Services (SAATS) are operated on a regional basis by District Health Boards (DHBs) to provide free expert medical care after recent or historic sexual assault.¹³ SAATS are a collaboration between health services, ACC and New Zealand Police. Patients may self-refer or be referred to SAATS by health professionals (or other professionals such as police) where sexual abuse has been disclosed to respond to acute and non-acute cases (Fanslow et al., 2016, p. 59).

Medical Sexual Assault Clinicians Aotearoa (MEDSAC, formerly DSAC) is the recognised expert body on sexual assault/abuse medicine by the Ministry of Health, ACC, New Zealand Police, Health and Disability Commissioner and World Health Organisation. MEDSAC is an incorporated society and registered charity with over 190 clinician members who provide medical care and forensic examinations for any person who may have experienced sexual assault or abuse. MEDSAC is the key medical forensic advisor to SAATS and provide training, accreditation and support to clinicians working with SAATS.¹⁴

3.7 Helplines and online supports

Many of the sexual abuse support services in New Zealand provide telephone support. Although the male survivors peer support services in New Zealand are generally very small in terms of size of organisation (with some being a sub-part of a wider men's support service),

¹³ www.saats-link.nz/

Examples of DHB SAATS can be found at:

www.midcentraldhb.govt.nz/HealthServices/ChildHealth/Pages/Sexual-Assault-and-Treatment-Service.aspx#

www.scdhb.health.nz/services/mental-health-and-addictions/sexual-abuse-assessment-and-treatment

¹⁴ https://medsac.org.nz/Category?Action=View&Category_id=63

many offer personal phone numbers which can be used in crisis situations outside normal operating hours.

Safe to talk—Kōrero mai ka ora helpline – is a national, free, 24/7 confidential sexual harm helpline that provides contact with a trained specialist. Data from November 2018 shows that, to date, 20 percent of calls have been received from males. It is not specified whether they are survivors of abuse, supporters or professionals. Nor is gender differentiated by age to determine how many are boys, adolescents, adult men, or older men. This would be useful data to collect in the future.

The *Safe to talk—Kōrero mai ka ora* website (<https://safetotalk.nz/>) lists the following services:

- Information about medical, emotional, and behavioural issues related to harmful experiences
- Explanations of what you might expect if you report to the police
- Referrals to specialists in your area
- Information for family and friends wanting to help someone
- Information, and contact with a specialist, for people worried about their own sexually harmful thoughts or behaviour
- Information on or connection with/referral to medical practitioners for medical care or forensic medical examination. This can happen without police involvement or someone us still deciding whether to contact police.

They provide a free 0800 number that can be accessed by landline or mobile. Alternatively, people can connect through text, email or webchat if they prefer. There is video using both male and female avatars and voices which explains their non-judgemental service and the choices available to the callers including:

- How much or how little to say – including not saying anything
- Whether to speak to a male or female counsellor
- Whether to remain anonymous
- Whether to speak in English or if they prefer to speak in another language, that can be arranged.

The *Safe to talk—Kōrero mai ka ora* website has a quick exit button and information on how to cover your tracks for people who are worried about others finding out which websites they have visited (“Safe to talk—Kōrero mai ka ora” n.d.).

3.8 Peer support services for male survivors of sexual abuse

Peer support services are the most visible types of service that specialise in working with men in this country.¹⁵ This section provides a brief overview of peer support services and

¹⁵ We appreciate that individual counsellors and counselling services may also specialise in working with men.

insights from one of the experts consulted for this review, Philip Chapman. Philip is the inaugural Chair of *Male Survivors Aotearoa* (MSA).

Peer support has been described by Te Pou as:

*... person-centred and underpinned by strength-based philosophies. The life experience of the peer support worker creates common ground from which the trust relationship with the person is formed. Empowerment, empathy, hope and choice along with mutuality are the main drivers in purposeful peer support work. There is a great deal of strength gained from **knowing someone who has walked where you are walking and now has a life of their choosing**. In this way it is different from support work, as it comes from a profoundly different philosophical base (Te Pou, 2009, cited in *Male Survivors Aotearoa*, 2018b, p. 3 [emphasis in original]).*

Male Survivors of Sexual Abuse peer support services receive funding from MSD. There is a national male survivors peer support network, *Male Survivors Aotearoa*¹⁶, that has six affiliated not-for-profit organisations in the following locations:

- Canterbury: *Male Survivors Canterbury*, established in 1991 and registered as *Male Survivors of Sexual Abuse Trust* in 1997 as a Charitable Trust. Now operating from the *Canterbury Men's Centre*.
- Auckland: established in 2007 and now known as *Better Blokes Inc.*; extended to Northland (Whangarei) in 2012
- Waikato: *Male Support Services Trust* established in 2008
- Wellington: *Road Forward Trust*
- Nelson: *The Male Room Inc.* began to offer support services to male survivors in 2012
- Otago-Southland: *Male Survivors of Sexual Abuse Trust* was established in 2013.

There are other male-focused peer support services such as *MOSIAC* (see next section) in Wellington that are not affiliated to the network.

The third National Hui of organisations in 2015 agreed to establish the national organisation – *Male Survivors of Sexual Abuse, Aotearoa New Zealand* (MSSAT Aotearoa), now *Male Survivors Aotearoa* (MSA). The MSA website provides the following overview of their establishment as a national network and development of service provision and workforce development:

From 2015 to the present time MSSAT Aotearoa has focussed on the establishment of its national governance frameworks, formation of national policies and protocols; the establishment of a national qualifications framework for its peer-workers; and the development of a national case management system. Recently MSSAT Aotearoa has embarked on a

¹⁶ Information describing the development of MSA is sourced from their website <https://malesurvivor.nz/our-organisation/>

service development programme with the Ministry of Social Development, which hopefully will enable a services funding model that will enable MSSAT Aotearoa to fulfil its ambition of providing "all male survivors of sexual abuse with access to a sustainable national network of appropriate, high quality support services".¹⁷

Expert insights

Philip Chapman provided insights into key elements of MSA service provision, which includes having a well-developed workforce with specialist knowledge about working with male survivors. The importance of using a client-centred approach involves tailoring services for men by providing them with choices and brokering other services they may need. An example is the *Male Room* in Nelson where Philip works which offers one-to-one and group peer support, individual counselling, support work with family and whānau, and service brokerage to meet men's other support needs. He explained that building a relationship with men is essential to supporting them in the recovery process.

Other key features of an accessible service include ensuring the service is available to men when they need it, and they are not limited by opening times, geographical location, or travelling costs. Specific ways the *Male Room* in Nelson makes their service more accessible are:

- availability through a 24/7 service that will see men immediately
- being able to go out to see men where they feel comfortable and providing them with choices about where to meet (outreach)
- friendly, relaxed environment at their premises which makes services more approachable and encourages men to use the service
- provision of telephone and Skype counselling
- not excluding men who show signs of anger and accepting anger as a normal reaction to abuse.

Philip Chapman said there are still lots of gaps in relation to services for male survivors and gaps in the workforce (particularly attracting more men to work in the area), resourcing, and primary prevention to debunk myths about male sexual abuse. He observed from years of experience in the sector that general services (both specialist sexual violence services and non-specialist services) still need more knowledge about the prevalence and impact of sexual abuse on men. Men may disclose to different professionals from non-specialist services, and it was very important they knew how to respond. In his experience men may take a long time to disclose abuse but when they decided they wanted to do so getting an appropriate response was vital to seeking ongoing support for their recovery journey.

Philip said that the myths and stereotypes that are still pervasive in our society regarding what it is to be a 'real man' and a 'Kiwi bloke' do not reflect the reality for men who are, of course, diverse. These gender constructs have not served male

¹⁷ <https://malesurvivor.nz/our-organisation/>

survivors well, with their focus on negative stereotypes of men as being tough, silent, hard and violent. These stereotypes have led to narrow views of how to respond to 'men' such as appealing to their 'blokieness' and overplaying the comedy element to try and engage them in services. He called for more sophisticated and realistic approaches that appeal to a broad range of men alongside a better understanding of the impact of sexual abuse on men and boys.

Part of educating services and the public generally is challenging myths about sexual abuse of males such as 'abuse survivors go onto abuse'; 'sexual abuse of boys and men is not very common'; 'boys/men abused by men must be gay'. These myths have been debunked through numerous studies but persist and can impact on the response to boys and men who disclose abuse.

MSA-developed Peer Support Practice Guidelines

Male Survivors Aotearoa developed guidelines for member organisations in 2018. The Peer Support Practice Guidelines include Organisational Quality Standards for the Provision of Support Services for Male Survivors of Sexual Violence (*Male Survivors Aotearoa*, 2018b). The guidelines bring together practice wisdom from the field along with literature on male sexual abuse and peer support. In addition, the Organisational Quality Standards outline standards for outcomes and evaluation.

Six core values that underpin *Male Survivors Aotearoa* approach to peer support are:

Mutuality – Peer support relies on authentic two-way relationships between people through 'the kinship of common experience'; trust-based relationships that enable peers to share their experience in a way that is mutually beneficial.

Recovery and hope – Peer support is sustained by the belief that there is always hope and that resilience and meaningful recovery is possible for everyone.

Knowledge – Peer support provides access to the essential learning, knowledge and wisdom that comes from sharing personal lived experience of sexual harm and the recovery process.

Self-determination – Peer support recognises the rights of people to make free choices about their lives and to be free from coercion on the basis of their mental distress or victimisation.

Participation – Peer support recognises that people are often their own best resources and acknowledges the right of survivors to choose and lead their own recovery process.

Equality – Peer support asserts the fundamental right of people who experience sexual harm to have equal opportunities to other citizens and to be free of discrimination (*Male Survivors Aotearoa*, 2018b).

MSA is conducting further research to identify a ready model of peer support in New Zealand

MSA is undertaking a study with Victoria University: *Examining the journeys of adult male survivors of sexual abuse and the services they need: Identifying effective practice and gaps from a ready model of peer support in New Zealand*. The research is led by Associate Professor Louise Dixon and co-investigators are Dr Chris Bowden, Philip Chapman and David

Mitchell. The research is funded by MSD and aims to understand how peer support workers work with men to achieve effective outcomes and to identify gaps evident in meeting men's needs (Dixon et al., 2018, p. 3). This is a much-needed study given the lack of evidence on the effectiveness of peer support for male survivors of sexual abuse. Evaluations of peer support services in related fields are discussed in section 4.

MSD commissioned Malatest International to evaluate its funded Specialist Sexual Harm Services (SSHS), including the Male Survivors of Sexual Abuse peer support services and Safe to talk- Kōrero mai ka ora.¹⁸ A formative evaluation was completed in 2018, and a process evaluation was published in 2019.

3.9 Mosaic clinically-led support services

Mosaic is a registered charity that specialises in working with male survivors of sexual abuse in the Greater Wellington region. They have the facility to work nationally via their helpline and online services. Their website provides an example of a comprehensive approach to supporting male survivors, providing information and resources for men, their family and supporters, and professionals. They also provide men with the *Living Well*¹⁹ app for recovery. All their services are free.

Development of therapeutic peer support

Mosaic's approach to recovery originated out of the New Zealand peer support group model which they are developing to incorporate a therapeutic component based on the tri-phasic clinically-led peer support model practised by *Men & Healing* in Ottawa (Fisher et al., 2009) and *Living Well* in Brisbane.

Mosaic is developing a 'wrap-around one-stop-shop' so men only have to present to one agency to get support and don't have to be referred to other agencies for specialist counselling services. To facilitate this *Mosaic* is also in the process of becoming an ACC sensitive claims provider.

Clinical Advisory Board

To guide and support the addition of a therapeutic component to their service *Mosaic* have formed a Clinical Advisory Board (CAB). Instituting a CAB is identified as best practice by the Survivors & Mates Support Network²⁰ (SAMSN) which helps male survivors with psychologist-led, facilitated peer-support groups based in Sydney. The CAB sits alongside the governance board and only comments on clinical matters.

¹⁸ www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/specialist-services/evaluation-of-services.html

¹⁹ www.livingwell.org.au/

²⁰ www.samsn.org.au/

Enhancing capability to respond to diverse groups of men who have been sexually abused

Mosaic has been gifted the name *Tiaki Tangata* by Ngāti Toa Iwi and they regard this taonga as a reflection of their commitment to becoming a bi-cultural service. Currently about 30 percent of their clients are Māori. *Mosaic* plans to adapt the Te Ao Mārama treatment model developed by Alexander Stevens II.

To be more responsive to their Pacific clients they employ a Pacific person at their Porirua office and are training a volunteer Pacific peer support worker.

To enhance their engagement with the Rainbow (LGBTQI+) community *Mosaic* conducted a "Rainbow review" over the past 12 months using focus groups with community members to inform their service response. This has resulted in the incorporation of findings into their practice and published material, and the establishment of a new role, Rainbow Liaison & Youth Worker.

Workforce capability development

Mosaic recognises that implementing a therapeutic service that is also culturally responsive will require further staff training. They have engaged Rick Goodwin of Men & Healing (Ottawa) to provide training in the tri-phasic trauma-informed model. Alexander Stevens II has been engaged to train all their staff in Te Ao Mārama treatment model and he is also a member of the CAB.

3.10 Kaupapa Māori services provision of sexual abuse services

The following kaupapa Māori services provide sexual abuse services throughout Aotearoa:

- *Te Puna Oranga*, Christchurch: Kaupapa Māori individual and whānau services. Immediate 24/7 crisis response and support for individuals and whānau who have experienced rape and sexual violence.
- *Korowai Tumanako*, Auckland, Whangarei, Kaikohe, Hokianga, Kaitia, Whangaroa: Kaupapa Māori service designed to support iwi, hapū and whānau affected by sexual violence, on their journey toward greater wellbeing. They have a strong focus on prevention education.
- *Āwhina Whānau Services*, Hastings, Hawkes Bay: Māori values-based organisation, mandated by Ngāti Kahungunu Iwi which includes sexual abuse counselling and crisis support services for anyone that has been sexually or physically abused.
- *Te Whare Ruruhou O Meri*, Far North, Northland: Kaupapa Māori service providing crisis support services to anyone that has been sexually violated or abused.
- *Tu Tama Wahine o Taranaki*, New Plymouth: Kaupapa Māori organisation providing Whānau Ora services to whānau within the Taranaki community including *Korero Awhina* counselling for those affected by sexual or physical violence.
- *Tu Wahine Trust*, West Auckland: Kaupapa Māori counselling, therapy and support for survivors of sexual harm (mahi tukino) and violence within whānau.

Expert insights

Alexander Stevens II, an expert consulted for this review, observed a lack of culturally appropriate services for Māori (as a population) and specifically for Māori men. Most sexual violence services are for women and those services available for men may not have the cultural expertise to work with Māori. This can result in Māori men seeking help being turned away from services not set up to cater to their needs.

Further, because the sexual abuse of men and boys is not talked about much, and the voices of men who have been abused are not often heard, the public and some professionals do not believe it is an issue or take it seriously. Stevens II noted that some police do not seem to want to engage, and that cases of men being sexually abused aren't always taken seriously. Not being 'believed' is also a problem.

Stevens II observed issues around health professionals not feeling comfortable asking men if they have been abused, and they are even less likely or comfortable asking men if they have been sexually abused. Research has identified the mental health impacts of sexual abuse, and men who have been abused can present with high rates of anxiety, schizophrenia, depression and suicide attempts. Therefore, it is important for health professionals to be educated in this area and have the skills and cultural competency to engage 'men' in all their diversity. New Zealand has high rates of suicide and Stevens II queries whether some of this may result from sexual abuse.

Stevens II highlights the multiple barriers Māori men experience accessing services and getting the support they require due to narrow conservative concepts of heteronormative masculinity, homophobia, and institutional racism (including unconscious and conscious bias). Funding diverse services, research and workforce development are essential to improving the sector's knowledge on these themes as well as service access and provision.

3.11 Specialist services for Pacific men who have been sexually abused

We did not find any support services catering specifically for Pacific men who have been sexual abused. However, there are Pacific social services that provide counselling and general support which may be supporting men.

An example is *Fonua Ola*²¹, a social service for Pacific by Pacific which operates in the Auckland region. While it does not specifically mention sexual abuse, it provides counselling for trauma resulting from physical and emotional abuse, including social work support, youth programme, building financial capability, family violence intervention, Whānau Ora support and group parenting programme. *Fonua Ola* services are free for the community and funded through partnerships with Oranga Tamariki–Ministry for Children, Ministry of Social Development and Pasifika Futures.

²¹ www.fonuaola.org.nz/about

3.12 Specialist services for Rainbow/Takatāpui survivors

The only specialist service for Rainbow/Takatāpui communities in New Zealand that offers support for survivors of sexual abuse is *Rainbow Youth*²², which as the name suggests, only caters for LGBTIQ survivors of sexual abuse up to the age of 27 years. *Rainbow Youth* offers counselling services for abuse and trauma (including sexual abuse and PTSD). They are ACC registered for sensitive counselling claims. They operate in the Auckland region and also offer phone and Skype services where fees apply.

3.13 Specialist services for men living with disabilities

To date we have not found any services specifically for sexual abuse survivors with physical or intellectual disabilities. More research is required to understand the capability and capacity of services such as the male survivors peer support network to work with men with different kinds of disabilities. We note that some ACC registered therapists are listed as having experience working with clients with intellectual disabilities.

²² www.ry.org.nz/

4 What is known about the effectiveness of recovery approaches for men

Key findings

Evidence on effectiveness of therapeutic interventions

The therapy programme *Men & Healing* in Canada, for male survivors of sexual abuse has a phased approach to treatment, starting with intensive psycho-educational retreats and moving to therapeutic individual and group work led by qualified facilitators with expertise in working with men. Hopton and Huta (2013) evaluated this service and recommended completing phase I (eight weeks) followed by eight 10-week cycles of phase II to achieve reliable improvement across all symptoms. They considered this duration was a reflection of the “clinical reality that treatment and reliable recovery from a history of cumulative and complex trauma is a lengthy process” (Hopton & Huta, 2013, p. 14).

A systematic review of treating PTSD experienced by victims of rape and sexual assault (although mainly female participants) provided “tentative evidence that cognitive and behavioural interventions ... can be associated with decreased symptoms of PTSD, depression and anxiety in victims of rape and sexual assault” (Regehr et al., 2013, p. 57).

Evidence on effectiveness of peer support services

We found no completed evaluative studies assessing the effectiveness of peer support services for male survivors to date. A study of peer support services is currently being undertaken in Aotearoa New Zealand by Associate Professor Louise Dixon, Dr Chris Bowden, Philip Chapman and David Mitchell.

Studies of peer support services for mental health consumers found improvements associated with hope, recovery, and empowerment (Lloyd-Evans et al., 2014) and higher levels of hopefulness for recovery (Chinman et al., 2014). These elements are considered fundamental to a successful peer support relationship for male survivors (Male Survivors Aotearoa, 2018a, p. 1).

Pfeiffer and colleagues’ (2011) meta-analysis of peer support interventions for depression found significantly improved depressive symptoms when compared to the “usual care for depression” which is relevant for male survivors as the link between sexual abuse and depression is well documented (eg Easton & Kong, 2017; Hopton & Huta, 2013; O’Leary et al., 2017; Turner et al., 2017).

Evidence of effectiveness of telephone helplines and online support services

A review of the effectiveness of telephone helplines and online support services by Haisman and colleagues (2017) identified elements likely to be valued by male survivors as a way of finding out information and making the first steps towards getting support anonymously. For example: accessibility; affordability; confidentiality; non-judgemental and impartial support;

access to accurate information, advice and support; access and referrals to other services; and a sense of social connectedness to counter the sense of isolation that many male survivors experience.

Evidence of effectiveness of Sexual Assault Response Teams (SART)

Evaluations of SART services found improvements in service provision and the quality of care regarding improved communication and improved SART members' competencies working with sexual abuse victims via sharing learning/understanding with other SART members.

Implications of findings for service provision for men

The review of evidence-based practices for recovery approaches for male survivors highlighted a number of implications for service development:

- **More research is required on what approaches work for male survivors and different types of male survivors.**
- **Recovery from complex trauma such as sexual abuse takes time** so service planning should be prepared for long-term service provision.
- **A range of therapeutic interventions showed promise as did peer support services for reducing mental health symptoms.** Only the two Men's Project/Men & Healing evaluations focused on male survivors of sexual abuse. Therefore, more understanding of the effectiveness of therapeutic approaches and peer support services for male survivors is required.
- **Workforce capability to work with men and diverse groups of men is required** – surprisingly few studies discussed the importance of the relationship between therapists and survivors for developing engagement and trust (eg therapeutic alliance). Zijlstra (2018) study found an empathetic attitude among professionals was important.

4.1 Introduction

This section examines evidence for effective service provision for male survivors of sexual abuse. The available literature on evidence-based practice (EBP) for male survivors is still sparse, as highlighted by the small number of studies we found. All experts consulted for this review confirmed that more rigorous research was required to identify EBP and effective service provision for male survivors. As Patrick O'Leary noted, there is a lot of practice wisdom within services that support men which identifies evidence for good practice, but a lack of research evidence.

To assess 'effectiveness' we have taken a critical/analytical approach to discuss the methodologies used by each of the studies. We identify the pros and cons of the study design and the implications from their findings for developing long term recovery services for men who have been sexually abused.

Only two studies directly relate to male survivors and they both examined the same service at different stages of its development (*Men's Project* in Canada which later became *Men & Healing*). It is likely that there are unpublished evaluations of men's services which we were unable to access. To provide an indication of what recovery approaches may be effective for men we have also examined literature relating to evaluations of similar services, for example

services for female sexual abuse survivors or gender-neutral services. We discuss the commonalities between the needs of the client group of the evaluated services and the needs of male survivors to identify the relevant implications for service development (see sections on analysis and relevance for male survivors).

We have broadly categorised studies under the following service types, although some services may combine a number of these service responses:

- Therapeutic services for sexual abuse survivors
 - *Evaluation of an intervention designed for men who were abused in childhood and are experiencing symptoms of post-traumatic stress disorder* (Hopton & Huta, 2013)
 - *Evaluation of the Men's Project, a Pilot Men's Project of Cornwall and Ottawa* (Barbara Herring & Associates, 2002)
 - *Interventions to reduce distress in adult victims of rape and sexual violence: A systematic review* (Regehr et al., 2013)
 - *A randomised clinical trial of cognitive processing therapy for veterans with PTSD related to military sexual trauma* (Suñis et al., 2013)
 - *An evaluation of cognitive processing therapy for the treatment of PTSD related to child sexual abuse* (Chard, 2005)
- Peer support services
 - *A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness* (Lloyd-Evans et al., 2014)
 - *Peer support services for individuals with serious mental illnesses: Assessing the evidence* (Chinman et al., 2014)
 - *Efficacy of peer support interventions for depression: A meta-analysis* (Pfeiffer et al., 2011)
- Telephone helplines and online services
 - *What is known about the effectiveness of social sector telephone helplines? Rapid evidence-based literature review* (Haisman et al., 2017)
 - *All-Wales Domestic Abuse and Sexual Violence Helpline evaluation: Summary of main findings* (Cordis Bright, 2014)
- Sexual Assault Response Teams
 - *Sexual Assault Response Teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation* (Greeson & Campbell, 2013)
- Sexual Assault Centre
 - *Evaluation of a Centre for Sexual and Family Violence: Perspectives of victims and professionals* (Zijlstra, 2018)

4.2 Effectiveness of therapeutic services for sexual abuse survivors

There are a variety of treatment modalities for sexual abuse survivors, including a number of therapies predominantly based on "psychodynamic, cognitive-behavioural or feminist-informed theoretical frameworks" (Regehr et al., 2013, p. 5). Some treatments have been adapted and others have been specifically designed for survivors of sexual abuse. Evidence

has shown that the trauma associated with sexual abuse can be different to other types of trauma in terms of “the strong element of self-blame, the individualized nature of this type of trauma, social support and social acceptance factors, and the higher incidence of concurrent depression” (Regehr et al., 2013, p. 5).

In this section we examine five studies of therapeutic interventions.

The first two studies, by Hopton and Huta (2013) and Herring and Associates (2002), are evaluations related to *Men & Healing*, formerly the *Men’s Project*, in Canada.

The third study is a systematic review of psychotherapeutic interventions for adult survivors of sexual violence (excluding studies of participants who primarily identified as survivors of childhood sexual abuse).

The fourth is a randomised controlled trial (RCT) of a specific cognitive processing therapy for military veteran survivors of sexual abuse with PTSD.

The final study also evaluates cognitive processing therapy for the treatment of PTSD, but this time with survivors of childhood sexual abuse. Following the evaluation summaries, we will discuss the relevance of the findings for services for male survivors.

4.2.1 Evaluations of Men’s Project/Men & Healing

Evaluation of an intervention designed for men who were abused in childhood and are experiencing symptoms of post-traumatic stress disorder (Hopton & Huta, 2013)

Hopton and Huta (2013) conducted an empirical evaluation of a therapeutic male-centred intervention developed by *Men & Healing* to treat men who had experienced abuse in their childhood (primarily sexual, but also physical and/or emotional) and are experiencing PTSD symptoms. The *Men & Healing* model, which adapts several concepts from Transactional Analysis (Berne, 1964) to trauma work, comprises two phases: Phase I uses a psychoeducational framework, and Phase II involves process-oriented group therapy.

Phase I is an eight-week course of weekly two-hour group sessions each with a different theme starting with ‘Understanding Trauma and Recovery’. These psychoeducational group sessions are tailored specifically for men and focus on developing effective coping skills, reducing risky behaviours such as self-harm or substance abuse, and increasing awareness of the impacts of childhood abuse on development, emotions, identity, and relationships.

In Phase II the men within the group decide what material to talk about in each session. They process their trauma through talking about memories of the trauma, the associated emotions, and the impact it has had on their lives. The goal of Phase II is to complete a ‘testimony’ – “a cohesive narrative of the trauma and its effects, written down by the participant with the support of the facilitator and then shared orally with the group” (Hopton & Huta, 2013, p. 8). The reciting of the testimony is regarded as a ‘rite of passage’ and the participant and facilitator decide together, considering the participant’s ability to regulate their emotions, when the participant is ready to complete the testimony. Phase II is open-ended but runs in 10-week cycles. At the end of each cycle, the participant usually decides in consultation with the group therapist whether or not to continue with the treatment.

Hopton and Huta (2013) evaluated the programme using semi-structured interviews and asking the participants to complete the Beck Depression Inventory (BDI-II) and the Impact

of Events Scale-Revised (IES-R) at the beginning for baseline measurements. The participants then completed the BDI-II and IES-R at 10-week intervals throughout the programme. The results showed “significant improvement on all symptoms” over the course of the treatment (2013, p. 11). However, rates of improvement varied²³. Hopton and Huta maintain that to “achieve reliable improvement across all symptoms, completion of Phase I and eight 10-week cycles of Phase II is recommended (this reflects the greater time needed for overall IES-R score to decrease)” (2013, p. 14). The researchers also conclude that their findings emphasise the “clinical reality that treatment and reliable recovery from a history of cumulative and complex trauma is a lengthy process” (2013, p. 14).

The participants were 260 self-referred men with experience of childhood abuse seeking treatment for PTSD symptoms. Thirteen percent reported having experienced emotional and/or physical but *not* sexual, abuse. The researchers re-ran the analysis to exclude that group and found that all symptoms remained in the ‘significantly improved’ range (Hopton & Huta, 2013, p. 12).

Of the 260 original participants, 114 completed at least one 10-week cycle of treatment thus providing data at two time points (pre-Phase I and post-Phase I). Of these, 49 completed at least one full cycle (10 weeks) of Phase II so provided data at time point 3.

Limitations

Hopton and Huta acknowledge a need for replicating the study by adding “at least a waitlist comparison group, to control for the degree to which symptoms may improve over time on their own, and ideally also a group receiving a generic form of weekly contact that is not tailored to PTSD symptoms, to control for the effects of simply having regular contact with an individual from a helping profession” (Hopton & Huta, 2013, p. 14). However, delaying treatment to create an artificial waitlist in order to meet research standards has ethical implications. Another potential limitation is that all the outcomes were based on self-report measures. However, as very few exclusion criteria were used, Hopton and Huta’s results “are highly generalizable to ‘real-life’ community settings” (2013, p. 15).

Evaluation of the Men’s Project, a Pilot Men’s Project of Cornwall and Ottawa (Barbara Herring & Associates, 2002)

This is an evaluation of a project whose primary service was a *Men & Healing* group counselling programme, which was an earlier iteration of the therapeutic male-centred model developed by *Men & Healing* evaluated by Hopton and Huta and summarised above. The *Men’s Project* counselling approach encouraged the men to work toward a testimonial that the participant presented to the group when he was ready. The evaluators reflected that the men drew upon this testimonial approach when relaying very personal information within the focus group. Many men spoke about the importance of ground rules and their use of such was observed in the focus group despite the group comprising men who had never previously met.

²³ “Reliable reduction in symptoms of Avoidance and Intrusions symptoms requires Phase I + one 10-week cycle of Phase II, which reflects a comparably rapid rate of improvement; while Hyperarousal symptoms require Phase I + three cycles of Phase II. Finally, reliable change on depressive symptoms measured by the BDI-II requires Phase I + five cycles of Phase II” (Hopton & Huta, 2013, p. 13).

Herring and Associates' evaluation was based on a client focus group held in Ottawa in which 18 men participated (more than twice the number expected), and 'several' telephone interviews. Responses from the telephone interviewees were found to be consistent with those from the focus group members.

The men spoke about their experiences prior to finding the *Men's Project*, which included: feeling isolated; keeping their childhood sexual abuse secret, being pathologised and misdiagnosed in the mental health system, addiction issues, and incarceration. The men found the project through referral or self-search. When speaking about the staff they described them as empathic, well-informed and skilled.

There was "100 percent agreement from both the group and telephone-interviewees that this programme was, from their perspective, tremendously successful and much needed" (Herring & Associates, 2002 n.p.). The men spoke about how comfortable and safe they felt within the group.

The evaluators considered that the way in which the men created time for each other within the focus group, as well as what they spoke about, indicated "a very successful outcome of the Men's Project program and the men's unfolding healing process" (Herring & Associates, 2002 n.p.).

Limitations

The findings were primarily from one very large focus group. The ideal number of focus group participants is between five and eight. Having 18 men in one focus group may have limited the opportunity for each participant to share their insights. However, the evaluators highlighted how the men used processes adopted from their group counselling session to create time for each other in the focus group. The higher than anticipated turnout of men suggests that they wanted to provide feedback, and the feedback was very positive.

4.2.2 Evidence for psychotherapeutic/psychosocial interventions for adult survivors of sexual abuse

Interventions to reduce distress in adult victims of rape and sexual violence: A systematic review (Regehr et al., 2013)

Regehr and colleagues' objective was to "examine the effectiveness of psychotherapeutic interventions in reducing symptoms of distress and trauma for victims of sexual assault and rape" (2013, p. 5). They included all forms of psychotherapy or psychosocial interventions and participants could be male or female adults. They were primarily interested in PTSD symptoms as the outcome measure, but also examined symptoms of depression, anxiety, guilt, fear, and disassociation, as secondary outcome measures.

Six studies met the eligibility criteria, and data from a total of 358 participants was available for analysis. The studies included four RCTs and two quasi-experimental designs which used a "naturally occurring" control group in terms of people on the waiting list at the same treatment centre for the same period of time as the active cohort receiving the treatment.

Although males were included in the search criteria the eligible studies were focused solely on females. The researchers were unable to find a study evaluating psychodynamic therapy that met their inclusion criteria. The interventions included are as follows: (number of studies in brackets)

- Cognitive Processing Therapy (CPT) (2)

- Prolonged Exposure (PE) (3)
- Supportive Psychotherapy (SP) / Supportive Counselling (SC) (1)
- Assertiveness Training (AT) (1)
- Eye Movement Desensitisation Reprocessing therapy (EMDR) (2)
- Stress Inoculation Training/Therapy (SIT) (2)

CPT is an intervention developed by Resick and Schnicke (1993) which “elicits memories of the event and then directly confronts conflicts and maladaptive beliefs” (Resick, 1993, cited in Regehr et al., 2013, p. 13). CPT consists of two integrated components:

- 1) exposure of the client to his/her own trauma memories, often through writing and reading aloud a detailed account of the event which includes sensory details, and
- 2) cognitive therapy (Regehr et al., 2013, p. 13).

PE comprises four elements: “education about common reactions to trauma; training in relaxing breathing; repeated in vivo exposure to stimuli that provoke anxiety due to their association with a traumatic event; and repeated imaginal exposure to traumatic memories (Regehr et al., 2013, p. 13).

SP/SC (which are provided in both individual and group modalities) involve survivors being given “the opportunity to describe their traumatic experience, the symptoms they experience as a result of the traumatic event, and the reactions of others. The treatment aims to normalise experiences, offer a safe, supportive environment, and to promote helpful approaches to managing symptoms and situations (Regehr et al., 2013, p. 14).

AT intervention combines skills-building exercises (Lange & Jakubowski, 1976, cited in Regehr et al., 2013, p. 13) and techniques from Rational Emotive Therapy (Ellis, 1977, cited in Regehr et al., 2013, p. 13). “Through behavioral rehearsal, clients are helped to speak assertively to others about their assault(s), both in terms of correcting blaming attitudes and asking for social support (Rothbaum, 2000, cited in Regehr et al., 2013, p. 13).

EMDR desensitises and redirects a client’s attention relating to the traumatic experience. It requires a client to imagine aspects of the trauma to re-experience the associated negative sensations before visually tracking the therapist’s fingers. This process is repeated until the client’s rate of distress level is substantially diminished (Regehr et al., 2013, p. 13).

SIT comprises three interlocking and overlapping phases: education, coping skills and new strategies. The model was later modified to include covert modelling, role playing, and guided self-dialogue specifically to treat rape victims (Regehr et al., 2013, pp. 13–14).

Results in terms of analysis pooling for the various treatments across RCT and quasi-experimental designs demonstrated improvements for the following conditions:

- PTSD (all six studies)
- Depression (all six studies)
- Anxiety (three studies)
- Guilt cognitions (one study)
- Dissociation (one study)

In relation to the specific therapy modalities, the pooled analysis of RCTs gave the following results:

- PE demonstrated improvements in:
 - PTSD
 - depression
 - anxiety
 - guilt cognitions
 - dissociation
- EMDR demonstrated improvements in:
 - PTSD
 - depression
 - anxiety
 - dissociation
- CPT demonstrated improvements in:
 - PTSD
 - depression
 - guilt cognitions

The two SIT studies were necessarily excluded from the pooling analyses (as they were not RCTs but quasi-experimental). However, the authors provide narrative accounts:

SIT was found to be “effective in producing lasting improvement, particularly with fear and anxiety, in only six therapy sessions” (Resick, 1988, cited in Regehr et al., 2013, p. 51). In the second study, SIT was found “to be superior to other treatments, notably PE (n = 9), as well as waitlist control, but this effect seemed only to last a short time (until post-treatment). At long-term follow-up, participants who had engaged in PE treatment appeared to have better outcomes” (Foa, 1991, cited in Regehr et al., 2013, p. 51). Unfortunately, the authors did not explain for which conditions/symptoms SIT was found to be superior in the second study.

The authors discuss the scarcity of studies and acknowledge that it may be partially due to “the nature of sexual violence itself” (2013, p. 54) as well as the fact that many of the “services provided are through community-based agencies that do not attract research grant funding” (2013, p. 54). Additionally, they cite the high treatment dropout rates as challenging for researchers and “ethical concerns regarding excluding those in acute need from available interventions or deferring interventions in waitlist conditions” (Regehr et al., 2013, p. 54).

Although they emphasise the need for further good quality research, Regehr and colleagues conclude that their systematic review provides “tentative evidence that cognitive and behavioural interventions, in particular Cognitive Processing Therapy, Prolonged Exposure Therapy, Stress Inoculation Therapy, and Eye Movement Desensitisation and Reprocessing can be associated with decreased symptoms of Post-traumatic Stress Disorder (PTSD), depression and anxiety in victims of rape and sexual assault” (Regehr et al., 2013, p. 57).

Limitations

As the purpose of Regehr et al review was to “isolate interventions specific for adult victims of sexual assault and rape”, it may not be surprising that [their] searches identified only six studies, given that the majority of primary studies have not adequately differentiated this

group from populations affected by other traumatic events (Regehr et al., 2013, p. 55). They also advise caution when interpreting the results since, although the studies were considered rigorous, there were some weaknesses:

- the sample sizes in both treatment and control groups were small in some studies
- there were high dropout rates in the treatment groups
- the use of stringent exclusion criteria, and high refusal rates for participation in treatment which probably made the sample less representative of all sexual violence survivors
- all studies were based in the United States.

A randomised clinical trial of cognitive processing therapy for veterans with PTSD related to military sexual trauma (Suñis et al., 2013)

Suñis and colleagues (2013) used RCT methodology to measure the effects of cognitive processing therapy (CPT) in the treatment of PTSD related to military sexual trauma (MST), via self-report and clinician assessment. However, instead of using a control group that received no treatment, the comparison group received present-centred therapy (PCT). CPT, as detailed in the previous study, was developed by Resick and Schnicke (1993) and this was further adapted by Resick, Monson, and Chard (2008) specifically for the treatment of PTSD in veterans and military personnel.

The adaptation of CPT for treating veterans and military personnel acknowledges the unique aspects of the military environment. In terms of MST, the “relatively closed environment” in which military personnel work and live together may have caused additional trauma for the survivor who could not avoid contact with the perpetrator. If the perpetrator was more senior than the survivor, they may have had the power to “drastically influence the survivor’s military career” (Suñis et al., 2013, p. 29). For this study, MST was “defined as an attempted or completed sexual assault that occurred while the veteran was on active duty” (Suñis et al., 2013, p. 32).

Suñis et al explain that CPT “provides a framework for conceptualising PTSD as a disorder of non-recovery from trauma. Interventions include education, cognitive restructuring, and writing trauma narratives” (2013, p. 32). In contrast, the therapeutic focus of PCT is deliberately redirected away from trauma to concentrate on current issues in the patient’s life and provide general support and education.

Four highly qualified mental health providers trained in both CPT and PCT protocols provided treatment in the study. All the sessions were videotaped (with consent) and the video recordings were used in weekly supervision sessions for the therapists. Additionally, a randomly selected 12 percent of the recordings were rated by an independent expert in terms of treatment fidelity. One therapist was removed from the study, and their data excluded, because they were deemed not to be “delivering CPT as intended” (Suñis et al., 2013, p. 32).

This exclusion reduced the number of participants from 129 to 86 (73 female, **13 male**). All participants were randomly assigned 12 sessions of either CPT or PCT. The measured outcomes were assessments, both self-reported and clinician-assessed, which were made at baseline, immediately after the final therapy session, and then two, four, and six months post-treatment.

The therapies were conducted on an outpatient basis at the Dallas Veterans Affairs Medical Centre. Participants, both male and female, who were primarily eligible²⁴ on account of having "veteran status with a current diagnosis of PTSD related to MST" (Suñis et al., 2013, p. 29) were recruited mainly through posted advertisements as well as other study promotional activity. However, because "the male sample was small and no significant gender differences were detected on baseline demographics or outcome measures, male and female samples were combined for analyses" (Suñis et al., 2013, p. 33).

The results showed a significantly greater reduction in self-reported PTSD symptom severity for those who received CPT compared to those who received PCT. However, this significant reduction was indicated only through self-report, not through clinician assessment. "No statistically significant differences were observed longitudinally between treatment groups for clinician-reported PTSD symptom severity" (Suñis et al., 2013, p. 34). Additionally, all "primary outcome measures improved significantly, both clinically and statistically, across time in both treatment groups" (Suñis et al., 2013, p. 28). So, both CPT and PCT provided improvements with "pre- and post-treatment effect sizes ... mostly moderate to large ... [although they] trended larger in the CPT group" (Suñis et al., 2013, p. 28). The researchers conclude that "although the study was impacted by treatment fidelity issues, the results provide preliminary evidence for the effectiveness of CPT in reducing self-reported PTSD symptoms in a population of veterans with MST" (Suñis et al., 2013, p. 28).

Limitations

Suñis et al report that there was a 35 percent dropout rate in the CPT group (compared with an 18 percent dropout rate in the PCT group) which was "higher than in other randomised control trials of CPT" (2013, p. 35). The vast majority of the CPT dropouts occurred between the third and sixth sessions. Although the researchers did not collect data on the reasons for the dropouts, they "hypothesise that this is related to the fact that participants write their trauma narratives as homework for sessions three and four. The writing of trauma narratives can be an especially challenging component of this therapy approach in terms of the emotional demands involved" (2013, p. 35).

It is surprising that the authors are not taking into account the disadvantages of CPT. They conclude that the results of their study support the "effectiveness of CPT in the treatment of PTSD related to sexual trauma" (Suñis et al., 2013, p. 35). However, there was no significant difference between CPT and PCT except in self-reported symptom severity. Furthermore, it would appear that for 35 percent of the participants, the process of CPT, particularly perhaps writing their trauma narratives, may have actually caused them further trauma. For one participant, their psychiatric hospitalisation was deemed 'possibly related' to CPT (Suñis et al., 2013, p. 33).

An evaluation of cognitive processing therapy for the treatment of PTSD related to child sexual abuse (Chard, 2005)

Similar to the two studies summarised above, Chard (2005) also examined the effects of Cognitive Processing Therapy (CPT) for the treatment of PTSD using an RCT. However, in this study CPT-SA, a specifically adapted version of CPT (Resick and Schnicke, 1993), was used that was "designed to focus on the areas of trauma symptom response that appear to be commonly found in child abuse survivors" (Chard, 2005, p. 967). **The participants were 71**

²⁴ For the full inclusion and exclusion criteria see Suñis et al. (2013) p. 29.

women randomly selected into either the active condition (36 participants) or a control group – minimal attention (MA) (35 participants). Participants in the active condition received group and individual CPT for 17 weeks, whereas the control (MA) group received only weekly 5-10-minute telephone calls for 17 weeks.

Participants were assessed before the treatment, immediately after the treatment as well as at follow-ups three months and one-year post-treatment. The results showed significant differences between the CPT-SA and MA groups. For the CPT-SA group there was “significant statistical and clinical gains on symptom measures of PTSD, depression, and dissociation from pre-treatment to post-treatment” (Chard, 2005, p. 969) and the results were maintained for at least one year.

A distinctive characteristic of this study was that it incorporated a combination of group and individual therapy within the ‘active condition’. The participants received 90-minute group therapy sessions per week for the 17-week period and 60-minute individual therapy sessions each week for the first nine weeks and again on the seventeenth week. Chard considers that this combination may have positively affected the dropout rate as it provided “clients with individual time to process, as well as cohesion, normalizing, and universalizing with other women in the group milieu” (2005, p. 966).

Limitations

The seven therapists used in this study were the principal researcher, Kathleen Chard, and “six graduate students in psychology with a background in cognitive-behavioral interventions” (Chard, 2005, p. 967). Chard provided “weekly adherence supervision” (p. 967) for these six graduate students. Thus, not only were six of the seven therapists relatively inexperienced, but they were all closely associated with this study. The potential unconscious bias this may have fostered was not discussed.

Ethical considerations

The research design randomly selected women with PTSD diagnoses who were recruited specifically for this study (treatment as usual option) into either:

- the active condition in which they would receive a 17-week CPT programme combining both group and individual therapy, or
- the control group in which they would receive minimal attention (MA) comprising one 10-15-minute telephone call per week for 17 weeks.

There seems to have been no ethical considerations about this, or at least there was no discussion about the ethics of the research design in the article. This was not a ‘naturally occurring’ waiting list control, it was created specifically for this study, yet there was no discussion about the effects this may have had on participants in the control group.

Similarly, Chard disclosed that “further analyses of participants revealed that the treatment dropouts had significantly higher pre-treatment PTSD scores than individuals who completed the study” (2005, pp. 968–969), yet there was no discussion about the possible reasons for this phenomenon and the potential consequences for the participants who dropped out. It suggests that perhaps CPT may only be appropriate for those with less severe PTSD symptoms.

4.2.3 Analysis and relevance to male survivors of sexual abuse

The Hopton and Huta (2013) and Herring & Associates studies were focused exclusively on men and so were highly relevant to male survivors, however they were both also focused exclusively on abuse that occurred in childhood. Hopton and Huta evaluation results showed “significant improvement on all symptoms” for PTSD over the course of the treatment (2013, p. 11). Their findings indicate that a male-orientated therapeutic approach delivered in individual and group settings over a substantial period does support recovery for male survivors. Participants in the Herring & Associates study, a smaller qualitative study, identified the programme as highly successful for them.

The other three studies reviewed in this section examined therapeutic treatments for PTSD, which were included as this is very common among male survivors. Only one of these studies (the Suris et al. research) included male participants, however as there were so few males (thirteen out of eighty-six) and no significant gender differences identified, the male results were combined with the female results for analysis. The authors noted the problem and recommend:

To prevent underrepresentation of men in the burgeoning research literature on MST-related PTSD, researchers must develop effective recruitment strategies for this specific population that may be less willing to disclose MST and seek treatment (Suñis et al., 2013, p. 35).

Further attention needs to be given to the diversity of men, as they tend to be presented as a homogenous group which does not account for diversity in terms of age, culture, ethnicity, sexual orientation, and gender identity (eg transgender/ gender fluid). However, we acknowledge the difficulties of having a representative diverse participant group given the issues with recruiting male survivors.

Three out of the five studies evaluated Cognitive Processing Therapy (CPT) for the treatment of PTSD and all of them demonstrated improvements. Although the study designs were deemed to be robust, the sample sizes tended to be small. Chard (2005) used a version of CPT that combined group and individual therapy, the benefits of which she considers were factors in the lower-than-usual dropout rate. However, when CPT was compared with an alternative therapy (PCT) rather than a no-treatment control group, as in the Suñis and colleagues’ study, there were no significant differences in the clinician-assessed outcomes.

The studies covered by the Regehr et al. (2013) systematic review, had a waitlist control group that was ‘naturally occurring’ (they were patients on a waiting list for the therapy at the centre where the therapy was being delivered). However, Chard (2005) randomly selected participants with a diagnosis of PTSD into either the active condition or the control group which she called a ‘waitlist’. Other studies, for example, Hopton and Huta (2013), chose against random selection due to ethical as well as practical concerns. Regehr et al. also acknowledged ethical concerns of excluding patients from treatment.

The majority of the studies used an RCT design, which is often regarded as the ‘gold standard’ in bio-medical scientific research. However, there are “multiple difficulties in applying rigorous research design [to matters concerning sexual assault] primarily due to ethical constraints such as the lack of ethics in randomly allocating survivors to a no-treatment research control group” (Wharewera-Mika & McPhillips, 2016, p. 8).

4.3 Effectiveness of peer support services

Due to the lack of studies evaluating the effectiveness of peer support for male survivors or other survivors of sexual abuse, we have examined the literature evaluating the effectiveness of peer support in relation to mental health as the links between sexual abuse and mental health issues are well documented. The current research being conducted in New Zealand by Dixon and colleagues (2018) on effective peer support for male survivors will be important for informing evidence-based practice.

Although mutual support among people who share similar experiences may not be new, organised peer support networks did not exist before the mid-1930s when *Alcoholics Anonymous* (AA) was established in the United States. Early peer support services were focused on helping people suffering from addiction and mental health issues. Indeed, researchers found that AA groups accounted for 87 percent of all peer support groups in cities across the US in 2000 (Davidson, Pennebaker & Dickerson (2000) cited in Patton & Goodwin, 2008, p. 14). Peer support groups are now used more widely for physical as well as mental health issues, often initiated due to dissatisfaction with mainstream services, and the inadequacy of such services to address people's psychosocial needs without judgment or stigmatisation (Patton & Goodwin, 2008).

Peer support appears to be the most common form of specialist recovery service for men in New Zealand. The current lack of evaluations of peer support services for male survivors is concerning and may be partially due to outcome evaluations reportedly being "notoriously difficult to conduct in the arena of peer support" (Kurtz (1997) cited in Patton & Goodwin, 2008, p. 37). However, "mental health peer-support is similar to peer-support with survivors of sexual violence in the sense that isolation, stigma and limited social networks of participants appear to be key factors in the creation of both" (Patton & Goodwin, 2008, p. 60).

4.3.1 Systematic reviews of peer support services used in mental health recovery

Two literature reviews were carried out in 2014 by two separate groups of researchers into peer support services for people with severe/serious mental illness. As there are slight differences in what was included in terms of mental illness and how peer support services were defined and/or categorised by each research team, we summarise each review separately before analysing the two studies and discussing their relevance for male survivors.

In addition, a 2011 meta-analysis of the efficacy of peer support interventions for depression is also discussed below.

A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness (Lloyd-Evans et al., 2014)

The first study was conducted by Lloyd-Evans and colleagues who used the term 'severe mental illness'. They only included studies with adult participants with "schizophrenia spectrum or bipolar disorder, or studies with mixed populations of people using secondary mental health services [and] ... excluded studies including only participants with unipolar depression or personality disorders" (Lloyd-Evans et al., 2014, pp. 2–3). The only types of interventions included were "community-based peer support designed to facilitate recovery

from severe mental illness" (Lloyd-Evans et al., 2014, p. 3). Thus, other peer support services, including those relating to drug and alcohol use, were excluded (Lloyd-Evans et al., 2014).

Lloyd-Evans et al. (2014) used three distinct categories of peer support:

- i) Mutual support groups in which relationships are thought to be reciprocal in nature, even if some participants are viewed as more experienced or skilled than others;
- ii) Peer support services in which support is primarily uni-directional, with one or more clearly defined peer supporters offering support to one or more programme participants (support is separate from or additional to standard care provided by mental health services);
- iii) Peer mental health service providers: people who have used mental health services and are employed to provide part or all of the standard care delivered by a mental health care service (ie the difference from standard care should be the provider rather than the role) (p. 2).

In terms of methodology, the researchers only included RCTs. In total they included 18 trials comprising 5,597 participants. Of the 18 trials, four were 'mutual support groups', 11 were 'peer support services' and three were 'peer mental health service providers'. The types of outcomes measured by the studies were: Hospitalisation, Employment, Overall psychiatric symptoms, Symptoms of psychosis, Depression and anxiety, Quality of Life, Recovery (self-rated), Hope, Empowerment, and Satisfaction with services (Lloyd-Evans et al., 2014).

Lloyd-Evans and colleagues' analysis showed that in addition to a "substantial variation between trials in participants' characteristics and programme content", there were also several methodological flaws including that the "outcomes were incompletely reported [and] there was high risk of bias". Their results showed "little or no evidence that peer support was associated with positive effects on hospitalisation, overall symptoms or satisfaction with services". There was, however, positive associations found between peer support and the outcomes of hope, recovery and empowerment "at and beyond the end of the intervention, although this was not consistent within or across different types of peer support" (2014, p. 1).

The researchers concluded that despite the popularity of peer support internationally, "there is little evidence from current trials about the effects of peer support for people with severe mental illness". They caution that "although there are few positive findings, this review has important implications for policy and practice: current evidence does not support recommendations or mandatory requirements from policymakers for mental health services to provide peer support programmes" (Lloyd-Evans et al., 2014, p. 10).

Peer support services for individuals with serious mental illnesses: Assessing the evidence (Chinman et al., 2014)

Chinman and colleagues (2014), in contrast to Lloyd-Evans et al. (2014), used the term 'serious' rather than 'severe' mental illness but basically covered the same range of disorders. The researchers adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) definitions as used within the Assessing the Evidence Base (AEB) Series of which their review is part. SAMHSA describes peer support services as "a direct service that is delivered by a person with a serious mental illness to a person with a serious

mental disorder (primarily schizophrenia, schizoaffective, or bipolar disorder) or a co-occurring mental and substance use disorder” (Chinman et al., 2014, pp. 429–430). The peer support workers in this review were hired while they were on their own recovery journeys to offer support to others with serious mental illness. Thus, the peer provider and the recipient are at different levels in terms of skills and where they are on their journey. It is an asymmetrical relationship in which both parties are *not* expected to receive mutual benefit (Chinman et al., 2014).

Chinman et al. (2014) divided the review of studies into three categories of peer support services:

- i) Peers as additional to traditional services (peers added)
- ii) Peers assuming a regular provider position (peers in existing roles)
- iii) Peers delivering structured curricula (peers delivering curricula)

There are many similarities between these categories and those in the Lloyd-Evans and colleagues’ study – see table below.

Chinman and colleagues’ study (2014)		Lloyd-Evans and colleagues’ study (2014)
Peers as additional to traditional services (peers added)	similar to:	Peer-support services in which support is primarily uni-directional, with one or more clearly defined peer supporters offering support to one or more programme participants.
Peers assuming a regular provider position (peers in existing roles)	similar to:	Peer mental health service providers: people who have used mental health services and are employed to provide part or all of the standard care delivered by a mental health care service.

The third category of Chinman et al.’s. study was not covered in the Lloyd-Evans and colleagues’ study. It refers to peer-led structured programmes, such as Building Recovery of Individual Dreams and Goals (BRIDGES) which is “an eight-week class taught by peers that addresses mental illness treatments, recovery, job readiness, communication, and assertiveness” (Chinman et al., 2014, p. 436). Likewise, the first category in the Lloyd-Evans et al. study (mutual support groups) was not covered by Chinman et al. as they only included peer support workers who were hired to provide (non-reciprocal) support as discussed above.

In terms of methodology, Chinman et al. included RCTs, quasi-experimental studies, and correlational/descriptive studies. They analysed 20 articles across the three peer support services. See 2 below for details.

Table 2: Analysis of peer support services by study type and service type

Peer support service type	No. of studies	RCTs	Quasi-experimental	Correlational/ Descriptive
Peers added	13	6	6	1
Peers in existing roles	3	2	0	1
Peers delivering curricula	4	3	0	1

Although the studies were “across the range of methodological rigor” (p. 439) the researchers conclude there is moderate evidence that peer support is effective in the ‘peers added’ and ‘peers delivering curricula’ types of service. Although one negative impact was reported by one study reviewed where “the presence of a peer was associated with an increase in psychiatric hospitalisation days” (p. 433), the positive associations demonstrated between peer support and the outcomes were:

- Reduced inpatient service use
- Improved relationship with providers
- Better engagement with care
- Higher levels of empowerment
- Higher levels of patient activation
- Higher levels of hopefulness for recovery.

One of the weaknesses of the research design of the studies reviewed in terms of ‘peers delivering curricula’ was that it was not possible “to differentiate the contributions of peers from the effects of the overall program” (p. 439). The effectiveness of peers in existing clinical roles was mixed as only one out of the three studies found positive outcomes (Chinman et al., 2014).

The researchers were encouraged by the results and concluded that “peer support services have demonstrated many notable outcomes” (p. 429). However, they call for more rigorous research which clearly differentiates the contributions of the peer role to strengthen the evidence (Chinman et al., 2014).

4.3.2 Analysis and relevance to male survivors of sexual abuse

Lloyd-Evans et al. (2014) conclude from their systematic review that there is a lack of empirical evidence regarding the effectiveness of peer support programmes for people with severe mental illness. However, if we remove the outcomes that are clinically related and specific to mental health, we are left with four outcomes: Quality of Life, Recovery (self-rated), Hope, and Empowerment. Three of these showed positive associations with peer support: Empowerment, Recovery and Hope.

Chinman et al.,(2014) were more encouraged by the positive outcomes associated with peer support, although they mitigate their endorsement due to lack of rigour in some studies. If we, again, remove those clinically related and specific to mental health from the positive outcomes demonstrated, we are left with higher levels of empowerment and higher levels of hopefulness for recovery.

Thus, both studies report similar non-clinical outcomes of peer support in terms of empowerment, recovery and hope. These relate directly to three of the seven outcomes in the high-level intervention logic (HLIL) which was co-developed by MSA and MSD (see **Error! Reference source not found.1**). 'Empowerment' relates to the first outcome on HLIL of "greater independence and autonomy", 'Recovery' relates to the first, the sixth and particularly to the second "a greater sense of self-worth" and 'Hope' directly relates to the sixth "an enhanced capacity and sense of hope". Indeed, MSA use 'hope', 'growth' and 'recovery' to define success in the peer support relationship. For male survivors "it is the lived experience of the peer support worker, their first-hand understanding of their survivor's experience, that is the essential ingredient for establishing a successful (hope, growth and recovery focussed) peer support relationship" (Male Survivors Aotearoa, 2018a, p. 1).

The positive links between peer support and the outcomes of hope, empowerment and recovery are encouraging. Further, the correlations between the impact of sexual abuse on men and mental illness are well documented (Dorahy & Clearwater, 2012; Easton et al., 2013, 2011; Lalor & McElvaney, 2010; Mitchell et al., 2014; O'Leary et al., 2017, 2010; Willis et al., 2014). These studies focused on severe/serious mental illness and it is important to note sexual abuse impacts on men in different ways and does not necessarily lead to the severity of disorders reviewed.

4.3.3 Systemic review of peer support interventions for depression

Efficacy of peer support interventions for depression: A meta-analysis (Pfeiffer et al., 2011)

Pfeiffer et al. (2011) analysed seven RCTs that compared peer support to "usual care for depression" involving 869 participants and seven RCTs that compared peer support to group cognitive behavioural therapy (CBT) involving 301 participants. Unfortunately, the authors do not provide a definition of "usual care for depression". Peer support services for depression were defined as "placing individuals with current depression in regular contact with at least one other person with either current or prior depression" (p. 3). Using all formats (that is pairs, groups, in-person or via telephone), the authors define peer support services as bringing together "non-professionals with similar stressors or health problems for the purpose of mutual support or uni-directional support from an experienced peer to a novice peer" (Pfeiffer et al., 2011, p. 2).

Pfeiffer and colleagues (2011) found that "peer support interventions were superior to usual care in reducing depressive symptoms", however, there were no significant differences between peer support and group CBT. The researchers conclude that the results "indicate that peer support interventions improve depression symptoms more than usual care alone and that the effects may be comparable to those of group cognitive behavioral therapy" (p. 6).

4.3.4 Analysis and relevance to male survivors of sexual abuse

It is encouraging that peer support interventions significantly improved depressive symptoms when compared to the "usual care for depression". This is relevant to male survivors as the link between sexual abuse and depression is well documented (eg Easton & Kong, 2017; Hopton & Huta, 2013; O'Leary et al., 2017; Turner et al., 2017).

4.4 Effectiveness of helplines and online services

Many of the organisations that offer support services to survivors of sexual abuse include a 24-hour freephone helpline. Sexual violence helplines “are used in times of crisis ... and provide services including outreach, brief intervention that includes safety planning, information and advice, follow-up and planned interventions such as counselling” (Haisman et al., 2017, p. 12). In terms of sexual violence, “crisis is not defined by an actual event, but by a person’s (and their family and whānau) response to that event. A response can happen immediately after the event or be triggered at multiple points beyond the event” (Ministry of Social Development, 2017a, p. 12).

4.4.1 Rapid evidence-based literature review on effectiveness of helplines and digital services

A literature review was conducted in 2017 to collate evidence on what makes for effective social sector telephone helplines and associated digital services. The ten studies reviewed included an evaluation of a domestic and sexual violence helpline commissioned by the Welsh government. However, this service was provided by an organisation called ‘*Welsh Women’s Aid*’ which suggests the focus was helping women exclusively. Although the other nine studies were not related to sexual violence, the general findings in terms of characteristics of helplines valued by service users are of relevance to our review. We will first summarise the general findings about helplines before examining, in greater detail, the Welsh study.

What is known about the effectiveness of social sector telephone helplines? Rapid evidence-based literature review (Haisman et al., 2017)

Haisman and colleagues (2017) reviewed 10 studies that evaluated the effectiveness of specific telephone helpline services:

- one study reported on domestic abuse and sexual violence in Wales
- three studies reported on UK and Netherlands telephone-based helplines to help protect children and to report child abuse
- two studies reported on telephone-based helplines for older people in the UK
- one study reported briefly on four family helplines available in the UK
- two studies reported on telephone-based interventions to support carers of people with Alzheimer’s and dementia
- one reported on New Zealand-based helplines: a review of Youthline service (2008)(Haisman et al., 2017, p. 11).

Haisman and colleagues (2017) identified the predominant characteristics that service users valued as follows:

- Accessibility:
 - Helplines can provide broad geographical coverage which is an advantage for people who cannot afford transport and/or live in rural areas
 - No formal access criteria need to be met (eg there are no barriers such as requiring a referral, meeting a threshold, or diagnostic criteria)
 - Convenience (eg, for those who have a disability or care responsibilities)
 - Helplines that are 24/7 can be accessed at any time
 - For crisis-led services the 24/7 timeframe allows for immediacy of access

- Affordability: freephone numbers and online services remove money as a barrier
- Confidentiality and in some cases anonymity is highly valued by some callers as it allows them to seek help and avoid embarrassment, stigmatisation, or repercussions
- Non-judgmental (including avoiding judgements based on appearance) and impartial support
- Access to accurate information, advice and support
- Access to other services – referrals, information about where to get help (provision of continuum of service delivery)
 - For agencies working with helplines, quality of service delivery, reach to target users, effective referral delivery and working in partnership with other services were valued
- Social connectedness (Haisman et al., 2017, pp. 4–5).

The authors acknowledge how the confidentiality features integral to most helpline services limit the ability to measure the effectiveness of outcomes.

They nevertheless conclude that there is “an emerging body of evidence that indicates delivery of some types of services via telephone and/or internet can be just as beneficial as face-to-face” (Haisman et al., 2017, p. 8). They highlight the key messages from the literature as follows:

- [T]he importance of providing service users with a choice of modes of communication to facilitate access and engagement and to be responsive to their needs.
- Developments in ICT are providing opportunities to enhance the ways we connect and share information. [...]
- [S]ervices that include their users in design, development and even implementation are going to be better placed to provide services that meet their needs (Haisman et al., 2017, p. 8).

All-Wales Domestic Abuse and Sexual Violence Helpline evaluation: Summary of main findings (Cordis Bright, 2014)

The evaluation of a domestic abuse and sexual violence telephone helpline in Wales included in the Haisman and colleagues’ review was conducted by *Cordis Bright Consulting*. The helpline evolved over time in both its delivery and implementation with main changes including moving from a 12- to 24-hour day service in 2005, extending its remit to include sexual violence from 2011 and developing partnership working and integration into the wider network of Welsh Domestic Abuse and Sexual Violence (DA/SV) services (Haisman et al., 2017, p. 48).

This evaluation included qualitative data from an online survey about the helpline service. Although the sample was small, the findings showed positive benefits for survivors of family and sexual violence, including that:

- they felt supported and safe having called the helpline

- they felt confident dealing with their situation
- they were:
 - aware of services to support them
 - knowledgeable about their rights
 - able to recognise the signs of abuse and violence
 - knowledgeable about what to do next
 - positive about the future
 - in control of the situation, having called the Helpline (Cordis Bright Consulting, 2014, p. 5; Haisman et al., 2017, p. 6).

In addition to the positive findings for those experiencing family and sexual violence, the evaluators identified that the helpline met the needs of professionals working on behalf of violence survivors (Haisman et al., 2017).

Cordis Bright (2014) identified aspects for improvement which included:

- Reviewing the effectiveness of current marketing activity
- Developing an awareness raising/marketing plan
- Developing a SMART logic model (and outcome framework) to guide future monitoring and evaluation activity (although the difficulty in doing so was acknowledged due to the transitory nature of the service and the vulnerability of callers)
- Improving the helpline website by:
 - having a separate page containing information specifically for agencies
 - having a feedback form on the website for enquirers to provide information about the content on the site and their experience of calling the helpline
 - developing an online resource portal to fit with the planned role of the helpline as a first point of contact
- Reducing duplication between national and local helplines (Cordis Bright (2014) cited in Haisman et al., 2017).

4.4.2 Analysis and relevance to male survivors of sexual abuse

Although only one in 10 of the evaluations reviewed by Haisman and colleagues (2017) was relevant to sexual abuse survivors, and that was targeted primarily for women, the characteristics of the service identified as beneficial by users are likely to also be valued by men. Similarly, the benefits identified by Welsh family and sexual violence survivors via the online survey are likely to be considered important to male survivors. However, it is possible that there would be other benefits, specific to males, that were not incorporated in this service.

Emerging evidence is supporting the benefits of telephone helplines and online services, however, the identified difficulties of evaluating the outcomes of such services in terms of the integral confidentiality and the vulnerability of service users are also applicable to services for male survivors.

4.5 Sexual Assault Response Teams (SART)

In this section we summarise two evaluations of sexual assault centres: Sexual Assault Response Teams (SARTs) in the US and the *Centre for Sexual and Family Violence* (CSFV) in the Netherlands. The first is an empirical review of the effectiveness of SARTs. The second is an in-depth qualitative study of the CSFV in the Netherlands. Following on from the summaries, we analyse the studies and discuss their relevance to services for male survivors.

4.5.1 Systematic review of the effectiveness of SARTS

Sexual Assault Response Teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation (Greeson & Campbell, 2013)

Although SARTs are not a uniform intervention, since their operations vary across the US, the common factor is a “collaborative, multidisciplinary effort to improve the community response to sexual assault” (Greeson & Campbell, 2013, p. 85). The core members of SARTs are typically police, prosecutors, rape victim advocates, and medical and forensic examiners. Representatives from organisations such as religious groups, mental health providers and organisations that serve marginalised groups are sometimes involved.

The researchers in this study reviewed “evaluation reports and peer-reviewed publications that (1) reported on systematic data collection and (2) examined SARTs’ effectiveness and/or challenges faced” (Greeson & Campbell, 2013, p. 85). The studies reviewed focused on “effectiveness across three domains: improving multidisciplinary relationships among responders, legal outcomes, and victims’ help-seeking experiences” (Greeson & Campbell, 2013, p. 85).

Greeson and Campbell (2013) reviewed eight articles in total, however only five focused on effectiveness (the remaining three were focused on the challenges). Of the five, there were four covering the effectiveness of multidisciplinary teams in terms of improvements in relationships among responders and improvements in victims’ help-seeking experiences. The fifth was an archival analysis of legal records examining improvements in legal outcomes. The four articles dealing with improvements in relationships among responders and victims’ help-seeking experiences were:

- Comparative study of 22 co-ordinated communities and 12 unco-ordinated communities using open-ended telephone interviews with rape crisis centre victim advocates.
- Evaluation of “a policy initiative that spurred the implementation of both sexual assault nurse examiner (SANE) programs and SART meetings in three pilot sites in Illinois” (p. 85) using open-ended telephone interviews with 16 multidisciplinary stakeholders.
- Evaluation of a funding initiative to support SARTs using open-ended telephone interviews with 22 SART grantees (all were rape crisis centre staff).
- Quasi-experimental study comparing sexual assault cases in three different communities before and after the implementation of a SANE or a SANE/SART intervention via analysis of archival police and medical records.

The first three studies were analysed in relation to evaluating improvements in relationships among responders. Findings were positive for SART across all three in terms of:

- Improved communication among co-ordinated professionals, ie SART stakeholders
- Better understanding of each member's perspectives regarding the response to rape
- Improved cross-system relationships through the increased contact among SART members.

All four studies were analysed in relation to evaluating improvements in victims' help-seeking experiences. Findings were positive for SART across all four in terms of:

- Improved communication between survivors and sexual assault responders
- Improved members' response to survivors due to "an increased understanding of other SART members' perspectives" (p. 88)
- A less traumatic process for the survivor due to, for example, "survivors telling their story fewer times and shorter wait times for forensic exams" (p. 89)
- More services being offered to survivors by combined SANE/SART compared to SANE only or no SANE/no SART.

The key limitation of these studies was that none examined "the impact of SART on survivors' help-seeking experiences from the perspectives of the survivors themselves" (p. 88). The researchers' overall conclusion is that the findings "suggest that SARTs are a promising practice but face many challenges" (p. 83). The challenges identified were: organisational barriers; acquiring broad-based participation; conflicting goals; role confusion and conflict, and confidentiality. In relation to policy implications, the authors cite more funding and resources are needed for SARTs. Additional recommendations include:

- Training in terms of "strategies for engaging resistant stakeholders in the SART process" (p. 92) and strategies for conflict resolution and competing goals resolution.
- Review of the different disciplines' confidentiality requirements to find a potential strategy "for multidisciplinary information sharing that respect victims' confidentiality" (p. 92).
- Increased opportunities for "networking and information sharing between different SARTs" (p. 93).

4.5.2 Evaluation of a SART in the Netherlands

Evaluation of a Centre for Sexual and Family Violence: Perspectives of victims and professionals (Zijlstra, 2018)

This doctoral thesis is an in-depth qualitative study of one sexual assault centre – the *Centre for Sexual and Family Violence* (CSFV) in Nijmegen which was one of the first to be established in the Netherlands. As the name suggests, the centre deals with family violence and intimate partner violence as well as sexual violence.

The most relevant findings for this review are those relating to the experiences of the professionals working in collaborative teams, and the experiences of the survivors. The

evaluation of the collaborative team of professionals found similar findings to Greeson and Campbell (2013):

Improvements:

- Collaboration enhances communication and competencies, which helps to improve quality of care for sexual abuse survivors.

Challenges:

- Professional roles need to be clearly defined to avoid role conflict – mutual trust and understanding among professionals needs to be developed.
- The strong connection between medical and legal services tends to cause additional tensions when pressing charges and maintaining professional confidentiality.
- Finding a balance between attending to professional interests and working together for the overarching aim of providing survivor-centred care. Harmonising the shared vision of the Centre with separate professional interests.

In terms of recovery processes and responses to sexual assault, Zijlstra (2018) found that sexual violence survivors “experience a dynamic post-assault process” ranging from denial to acknowledgement. The author asserts that “acknowledgement of the violence is of the utmost importance because it decreases feelings of self-blame, increases feelings of safety and encourages victims to take the assault seriously” (p. 129). This is particularly important because the trauma of sexual violence (and family violence) has a strong negative impact on the survivor’s sense of self in terms of “feelings of self-blame” (p. 130) which may develop as a result of other people’s reactions. Responses to sexual violence are individual and affected by multiple factors including “the type of assault, previous experiences with violence, and the extent of social support” (p. 129). However, Zijlstra emphasises that there is no other traumatic event in which the survivor is “held responsible to such a large degree” (p. 130) and she maintains that victim-blaming attitudes are still very common. Zijlstra attests that such negative reactions and self-blame increase anxiety, depression, symptoms of PTSD and the risk of re-victimisation (Zijlstra, 2018).

Zijlstra (2018) emphasises the importance of the care provider’s attitude towards survivors following a sexual assault, who are “often in a state of confusion, fear, loneliness, anger, panic and bewilderment” with profound feelings of “shame and self-blame”. Before disclosing, survivors weigh up the “advantages and disadvantages of disclosure, often fearing that professionals will harm them further and expecting negative responses, such as victim-blaming comments, disbelief, pity or taking over control” (p. 130). Zijlstra’s study “confirms these fears” (2018, p. 130).

Zijlstra concludes that “good care has at least the following three qualities:

- an empathetic attitude among care providers
- high-quality inter-professional collaboration, with inter-professional learning playing an important part
- continuity of formal and informal care” (p. 130).

4.5.3 Analysis and relevance to male survivors of sexual abuse

While the participants in the above studies on SART responses were female, the improvements to 'relationships among responders' and 'victims' help-seeking experiences' identified by Greeson and Campbell (2013) would also be beneficial for male survivors. Further, Zijlstra's (2018) conclusions about the three factors that constitute 'good care' align with Greeson and Campbell's study and apply to male survivors.

The positive findings on collaborative responses add weight to developing similar types of responses for men. The studies noted that the SART services were gender neutral, however, none of the studies included male participants and the proportion of their service users who are men is not known. There are some additional considerations when working with men as outlined in section 2 of this report, such as barriers to men accessing services for fear of how they may be perceived. Some male survivors may also regard sexual assault services as exclusively for women which prevents them from accessing them. Advice from experts indicates services that specialise in working with male survivors are required and this needs to be 'advertised' so men are aware that this service is open to them.

More generally, workforces across health, justice, and social services need to be aware of the prevalence of sexual abuse of males and be trained to respond appropriately when men disclose sexual abuse. Javaid's work on workforce responses to sexual abuse of men indicates workers can hold biases informed by social norms of heteronormativity and hegemonic masculinity where "[m]ale rape is constructed as abnormal, a deviation from heteronormativity, which in turn places male rape victims at the periphery of normalcy to reinforce the notion that 'real' heterosexual men cannot be raped" (Javaid, 2018, p. 89).

5 What is known about recovery approaches for different groups of men

Key findings

Recovery approaches that are responsive to different male survivors' needs

It is important to provide recovery approaches and frameworks that are culturally appropriate for men who have been sexually abused.

A mix of recovery approaches that are responsive to where men are at in their journey of recovery, including therapeutic approaches such as psychotherapy and peer support services.

A client-centred approach (which may include whānau, family, supporters) tailored to a man's needs relies on a good intake process with needs assessments conducted by a practitioner who is able to build a trusting relationship with their client. This includes providing men with choices and information about other services they may require.

Service developments should consider diversity, acknowledging and adapting services to meet the differences in men's cultural and sexual identities. Support of existing population-based organisations and the development of new organisations may be needed to offer effective support for Māori, Pacific, Rainbow/Takatāpui communities, and for men with disabilities.

A range of service delivery approaches important for enabling access to services

The findings reinforce the importance of having a range of service delivery approaches including outreach services, collaboration between services to enhance delivery, online services as well as accessible and available service locations.

Advocates are required to help clients navigate services and the justice system, to help with brokerage of specialist services, and to offer practical support – particularly for men with complex needs such as mental health issues, intellectual disabilities, addictions, poverty, and homelessness.

5.1 Introduction

This section looks at recovery approaches to engage with diverse groups of men including kaupapa Māori approaches, Pacific peoples, Rainbow/Takatāpui communities, and for men with disabilities. Some of the approaches are new and innovative, based on practice wisdom, indigenous knowledge and feedback from men who have sexually abused. Supporting these approaches through research and evaluation would enable identification of what is working well, areas for development and improvement, and wider sharing of the knowledge on which these approaches are based to improve practice and service delivery to help survivors.

The TOAH-NNEST review of sexual violence services recommended services that recognised the diversity of male survivors and adapted services to meet their diverse needs, including accessibility issues. Men who have been sexually abused are a diverse group with diverse needs, especially given that the men who are most likely to have experienced child sexual abuse and to face difficulties in accessing support are men who are socially disadvantaged, that is indigenous men, men with disabilities, mental illness, same-sex attracted, men from culturally and linguistically diverse communities, men in prison or in the military, those living in rural and regional areas, young men, and male sex workers (Wharewera-Mika & McPhillips, 2016, p. 61).

5.2 Māori approaches to recovery

Te Ao Māori perspectives on health and wellbeing emphasise connectedness – seamless connections between mind, body, spirit and whānau. Each of these four dimensions is interwoven and inseparable and needs to be kept in balance in order to maintain good health. Mason Durie's widely used *Te Whare Tapa Whā* model depicts these four dimensions as the strong equal cornerstones of a house. If one should become damaged in any way the person or collective becomes unbalanced. Unlike Western health systems, for Māori each of the dimensions are equally important.

Te Wiata and Smith (2016) held a series of hui for Māori representatives from a variety of sexual violence response services and kaumātua (key community figures – Māori elders). Participants, regardless of whether they worked within a kaupapa Māori, bi-cultural or tauiwi environment, consistently emphasised the need for an holistic approach rooted in Te Ao Māori. In particular, the need to acknowledge the impact of sexual violence on wairua (spirit/soul) and the importance of whanāu and whakapapa in the healing process was emphasised.

5.2.1 Te Ao Mārama – an indigenous framework for recovery

Alexander Stevens II (2014) has found there are limitations to how indigenous frameworks such as *Te Whare Tapa Whā* and *Te Wheke* can address male sexual abuse. To better respond to Māori men's needs Stevens II (2014) developed a framework and tool, Te Ao Mārama (the natural world). Te Ao Mārama is based on the ancestral knowledge of both Māori and the Ojibwa people (one of the largest groups of indigenous people that live between the United States and Canada). The framework is represented by a medicine wheel, which is designed to support Māori men to find a way through the experience of sexual abuse and a life after therapy. The framework was developed as part of Stevens II Master's thesis and is based on his evaluations and review of literature, collected from the fields of indigenous knowledge, health science and social science in New Zealand and internationally (Stevens II, 2014).

Figure 1: Te Ao Mārama, developed by Alexander Stevens II (2014)

TE AO MARAMA	
Community Wellbeing	Stage 1: Involves understanding the community or environment the person is in.
Intellectual Wellbeing	Stage 2: Involves understanding the affects of being sexually abused and to find a way forward through goals and objectives
Social Supports & Wellbeing	Stage 3: Involves social supports to work with the client with their recovery, goals and objectives.
Mental Wellbeing	Stage 4: Involves supporting the mental wellbeing of the individual as they progress through each season and understand what has happened. It is also the stage where we understand what support the client needs going forward to uphold their mental wellness as they meet their goals and objectives to completion.
Physical Wellbeing	The final stage involves a reflective process of what has taken place to support them and to also ensure physical activity is utilised to create / maintain health.
Spiritual Wellbeing	Spiritual wellbeing can be thought of as time / space and boundaries to allow the person to work through each season and gain an understanding of what is taking place



Te Ao Mārama is divided into six components. The first component is environment in green (the wider community) and then the four seasons: Spring in white (intellectual wellbeing), Summer in yellow (social supports), Autumn in brown (mental health), and Winter in black (physical health). Flowing between all seasons is water, which can be seen as wairua or spirit. This represents the life force that flows between the environment and connects each season, and which nourishes the individual and allows them to be at the centre of their wellbeing gaining the benefits of all seasons at the same time.

Another important component of the Te Ao Mārama is an active process for both health/social professionals and their clients to engage and participate together, similar to a kaiārahi/navigator role. This participation seeks to work towards creating a respectful partnership from the first engagement (at the environment stage), through each season which provides the client with "services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori," (Health and Disability Commissioner, 2009, p. 53)

Stevens' II Te Ao Mārama framework was also informed by a previous Master's study (Stevens, 2012) which aimed to capture the lived experience of the effect of mispronunciation of a Māori names when accessing health and social services. The desired outcome of the research was to inform medical and social service practice, by encouraging

professionals to find solutions to support better outcomes for their Māori clients from their first kānohi ki te kānohi (face-to-face) interaction.

Stevens II is currently completing a PhD titled *An exploration to develop an indigenous website to support Māori/Pacific men and their communities affected by childhood sexual violence*. The PhD looks at how a website can provide wrap-around support for Māori / Pacific men affected by sexual abuse, their support people and community services. This doctoral research is underpinned by Te Ao Mārama.

5.2.2 Good Practice – essential elements required for Māori

Sexual violence against Māori affects the wellbeing of whānau, hapū and iwi in addition to the individual and so healing requires a whānau ora approach. Support services for Māori “will be enhanced by having an understanding of, and respect for Māori processes such as pōwhiri (a process of meeting in a way which acknowledges each person’s mana and tapu), whakawhānaungatanga (connecting in a meaningful way), and ‘hohourongo’ (a conflict resolution process)” (Wharewera-Mika & McPhillips, 2016, p. 43).

More broadly, most current measures of whānau wellbeing are limited in their ability to capture the idiosyncrasies of whānau relationships which, for example, often extend across many households rather than being contained within a single household (Hodgson & Birks, 2002). Thus, developing measures that take into account the wider impacts of sexual abuse on whānau, hapū, iwi and communities, and having systems in place for monitoring and evaluating the effectiveness of services for Māori will provide more nuanced data (and therefore more tailored services, supports and interventions), to ensure effectiveness and accountability.

Cultural competence is the key to good practice for Māori. Mainstream services should engage with Māori practitioners, kaumātua, local iwi, and kaupapa Māori services for guidance and cultural supervision to support the delivery of culturally-appropriate services for Māori. Cultural competence for non-Māori practitioners includes acknowledging their limitations in terms of operating within a different worldview and accepting the validity of Te Ao Māori in clinical interventions.

Wharewera-Mika and McPhillips (2016) advocate for prioritising an ongoing Te Tiriti partnership and relationship development between mainstream and Māori services. This includes referring all service requests by Māori to local kaupapa Māori sexual violence services or, if that is not available, to other Māori therapists with experience of working with sexual violence survivors (Wharewera-Mika & McPhillips, 2016).

Implications for workforce development

Wharewera-Mika and McPhillips (2016) state that the main priority should be on the development and growth of kaupapa Māori sexual violence services. For mainstream services, the focus should be on cultural supervision and “continual development of cultural competence” (Wharewera-Mika & McPhillips, 2016, p. 45). For Māori practitioners the focus should be on upskilling to increase their capability and capacity to work with Māori. This includes:

- “increasing proficiency in te reo Māori me ona tikanga [Māori language and culture]

- accessing and developing proficiency/training in culturally-specific resources, such as those developed by 'Te Whānau o Te Kakano' and other kaupapa Māori services" (Wharewera-Mika & McPhillips, 2016, p. 45).

Guidelines for sector development

Wharewera-Mika and McPhillips reiterate an earlier TOAH-NNEST report recommendation to support "the investment in Māori/whānau-led solutions informed by Te Ohaakii a Hine as a prevention model for tangata whenua".

This includes actively advocating for:

- "Better resourcing for kaupapa Māori services. There is currently a dearth of kaupapa Māori sexual violence services throughout Aotearoa NZ. This is largely due to funding constraints across the whole of the sexual violence sector and also supported by Government policy to rationalise funding streams.
- Promoting support for Māori by Māori who are cognisant of Māori tikanga and values that can assist them navigate a pathway forward with police, the courts, statutory and medical organisations, and other support services.
- Ensuring kaupapa Māori processes such as hohourongo (Māori conflict resolution process) can be accessed and recognised, as opposed to only Tauīwi restorative justice processes.
- Relationship building with Māori services and the Māori community that is genuine and meaningful to both parties. Relationship building must not be dependent on current service delivery to Māori clients. Confining proactive relationship building with the Māori community to times of crisis would be akin to tokenism.
- Supporting the development of a separate set of Good Practice Guidelines for Kaupapa Māori Sexual Violence services providing crisis support.
- Ensuring that Good Practice Guidelines for mainstream services working with Māori are consistent with these Good Practice Guidelines for Kaupapa Māori Sexual Violence services providing crisis support" (2016, pp. 45–46).

We would also add developing measures that take the wider impacts of sexual abuse on whānau, hapū, iwi and communities into account, and having systems in place for monitoring and evaluating the effectiveness of services for Māori will provide more nuanced data (and therefore more tailored services, supports and interventions), and ensure effectiveness and accountability.

5.3 Pacific peoples' approaches to recovery

The information in this section is drawn from the second phase of the TOAH-NNEST project on Good Practice Responding to Sexual Violence: Guidelines for 'mainstream' crisis support services for survivors which incorporated 'inclusive practices' to "expand the cultural reach of the guidelines through providing resources to increase the capability of services to respond appropriately to the cultural diversity of survivors using the services" (Wharewera-Mika & McPhillips, 2016, p. 41).

5.3.1 Cultural approaches

Pacific peoples traditionally take a holistic approach to health and wellbeing which includes a spiritual dimension. For example, the Fonofale model is an interpretation of the Samoan health perspective which, similar to the Māori 'Te Whare Tapa Whā', uses a house to illustrate interconnectedness. Here, 'family' forms the foundation, 'culture' the roof with physical and spiritual dimensions, among others, forming the pillars connecting the two (Wharewera-Mika & McPhillips, 2016, p. 48).

Relationships are fundamental to Pacific cultures. For example, the Samoan worldview and the Samoan relational self cannot be separated from the va. "Va is the space between, the between-ness, not empty space, not space that separates but space that relates, that holds separate entities and things together ... giving meaning to things" ("The Concept of Va in Pacific Health," n.d.). There is an obligation to maintain 'va' as sacred space, "to tend and care for it and keep it clear so that real meeting, connection and healing can take place" (Wharewera-Mika & McPhillips, 2016, p. 106). However, sexual violence fundamentally breaches this obligation.

Working with Pacific survivors and their families requires honouring the 'va' and providing a platform of reverence that ensures survivors' experiences can be told with dignity, pride and strength. This is talanoa (talking story) which begins with the survivor and moves to include others from his world when he is ready. Key Samoan values such as fa'amafafa'ina (empathy), pa utonu (compassion) and faipe e fa'aliafa'atasi ma le malosi (respect) align well with the value base of most counselling and support work with survivors of sexual violence (Wharewera-Mika & McPhillips, 2016, pp. 48–51).

Pacific survivors may be guarded, protective and fearful when accessing mainstream services due to negative experiences associated with stereotyping and a lack of cultural understanding and competency. Their previous experiences of discrimination and stigma should be acknowledged. Young Pacific survivors tend to be very concerned about confidentiality and potential stigma for themselves and their families. They prefer support services to be available online, at youth centres, and at universities (Wharewera-Mika & McPhillips, 2016, pp. 50–51).

5.3.2 Good Practice – essential elements required for Pacific

A cultural assessment should be carried out at the beginning of treatment including checking with the survivor about the correct pronunciation of his name and his Pacific ethnic identity. It is important for practitioners to understand that there is diversity of Pacific ethnic identities as well as differences between island-born and New Zealand-born people. Practitioners should gain an awareness of any stereotypes they might personally hold about the Pacific community. As discussed above, honouring the sacred space of 'va' is very important, as is providing a platform for talanoa.

Similar to other good practice, a Pacific survivor-led process is essential to ensuring all information about medical and legal rights and obligations is provided. It is important that Pacific survivors decide who is 'part of their process' – they will identify their key support person if a medical examination is required.

Language barriers may be encountered, particularly by island-born Pacific families, so interpreters may be required. Additionally, it is important to match the gender of the

practitioner with the gender of the survivor – ie males work with males. If gender is unclear, guidance should be sought from the survivor (Wharewera-Mika & McPhillips, 2016, pp. 50–51).

Implications for workforce development

Cultural competency workshops should be provided by professional Pacific counsellors, psychologists or other Pacific community or church leaders who have the required skills, knowledge and awareness of the impact of sexual violence. The content should include cultural sensitivity to Pacific values relating to the significance of including family early in the process, spirituality, the role of the Church, and Christian values.

Employing more Pacific counsellors and support workers – young to support young survivors and more mature to work with families – would improve access to sexual violence support services for Pacific people. It is important to note that some experienced Pacific practitioners may be available although they have not applied for ACC registration due to language requirements for the application and reports (Wharewera-Mika & McPhillips, 2016, pp. 51–52).

Guidelines for sector and community development

Education about sexual violence in terms of how to support Pacific survivors as well as information about legal and medical processes and the services available to them, including specialist cultural Pacific advisors, should be provided to mainstream sexual violence crisis support services. Enhanced online and digital services would help Pacific survivors to confidentially access information about crisis support services.

The *Pasifika Counsellors, Psychotherapists, and Family Therapist network* established through the TOAH-NNEST project could be supported to ensure continued development. They could help improve access to Pacific survivors by encouraging each other to “write about their sexual violence practice, engage in research that demonstrates the cultural, spiritual creativity and effectiveness of their approaches, and disseminate information about their work” (Wharewera-Mika & McPhillips, 2016, p. 52).

To help reduce misunderstandings and increase knowledge about different cultures, ethnicities and diversity “more opportunities for talanoa and dialogue across perceived cultural differences would be valuable” for all practitioners and support staff to understand about other peoples’ world views (Wharewera-Mika & McPhillips, 2016, p. 53).

5.4 Approaches to recovery for survivors with disabilities

This section summarises a systematic review relating to violence against persons with disabilities. It included sexual violence and covered both prevention and response interventions. The two studies from the review that evaluated services for sexual abuse survivors with disabilities will be further examined (How could she possibly manage in court?). An intervention programme assisting complainants with intellectual disabilities in sexual assault cases in the Western Cape (Dickman et al., 2006) and Evaluating a survivors group pilot for women with significant intellectual disabilities who have been sexually abused (Peckham et al., 2007). Finally, the relevance to male survivors will be discussed.

5.4.1 Systematic reviews and evaluations of effectiveness of interventions

A systematic review of the effectiveness of interventions to prevent and respond to violence against persons with disabilities (Mikton et al., 2014)

Mikton and colleagues (2014) begin by lamenting the lack of research into violence against persons with disabilities despite the fact that they “make up some 15 percent of the world’s population and are at higher risk of violence” (2014, p. 1).

Although the literature search for their systematic review identified 736 titles, only 10 studies met the inclusion conditions. The eligibility criteria were “interventions to *prevent* all the main forms of interpersonal violence (ie child maltreatment, youth violence, intimate partner violence, sexual violence, and elder maltreatment ...) against people with all the main forms of disabilities (physical impairments, sensory impairments, mental health conditions, and intellectual impairments) compared with either no intervention or services as usual, using outcomes that are both distal (measures of risk factors for violence) and proximal (measures of actual violence) based on all types of study designs, except for surveys of participants’ satisfaction” (Mikton et al., 2014, p. 4 italics added).

The researchers assessed all of the studies using the “Quality Assessment Tool for Quantitative Studies—Effective Public Health Practice Project [QATQS-EPHPP, 2013]” (p. 6) and found they were all rated as ‘weak’. Additionally, the researchers asserted that “none of the studies could be considered effective after taking risk of bias into account” (pp. 1–2) using the same tool. They concluded that “the current evidence base offers little guidance to policymakers, programme commissioners, and persons with disabilities for selecting interventions” (Mikton et al., 2014, p. 2).

Nevertheless, given the scarcity of studies on sexual abuse survivors with disabilities, it is of value to examine the two relevant studies Mikton and colleagues reviewed which focus on sexual abuse survivors.

“How could she possibly manage in court?” An intervention programme assisting complainants with intellectual disabilities in sexual assault cases in the Western Cape (Dickman et al., 2006)

Dickman and colleagues (2006) examined 100 legal cases of alleged sexual abuse of people with intellectual disability that went to trial in South Africa. The control group comprised cases of alleged sexual abuse in the general population that went to trial. The intervention was the *Sexual Assault Victim Empowerment programme (SAVE)* run by *Cape Mental Health Society* which “assists complainants with intellectual disabilities in sexual assault cases by providing psycho-legal assessment and expert evidence as well as support and court preparation for the complainant and family” (Mikton et al., 2014, p. 6). The outcome measure was the rate of conviction. The rate of conviction for the intervention group was very similar to that for the general population in such cases (25 compared with 28 percent).

This result may seem like SAVE had little to no effect. However, the fact that generally convictions for sexual assault on people with intellectual disabilities are “exceedingly rare” (Mikton et al., 2014, p. 10) suggests that the SAVE programme is very effective.

Nonetheless, it is important to note that due to the high cost of the programme, only cases where there is “a strong likelihood that there will be a court case” are included (Dickman et al., 2006, p. 118).

Although this study was dismissed by Mikton and colleagues because it didn't rate well using the 'Quality Assessment Tool for Quantitative Studies', they rated the study as 'effective' "without taking risk of bias into account" (p. 10). Additionally, there may be valuable qualitative data about the effectiveness of the SAVE programme, that were not considered by the reviewers, in terms of helping survivors navigate the court system and handle legal issues. This includes assessing 'ability to consent', which is a complex multi-factor assessment instead of the simple diagnostic assessment favoured by the court system.

Evaluating a survivors group pilot for women with significant intellectual disabilities who have been sexually abused (Peckham et al., 2007)

The second study on sexual abuse survivors with disabilities in Mikton and colleagues' (2014) review was a small UK pilot study by Peckham et al. (2007). This study evaluated a survivor's group (SG) for women with an intellectual disability, as well as an educational support group (ESG) for their carers, in terms of building trust and rapport, providing education about sexual abuse, and helping reprocess the trauma of the sexual abuse. The study design was cohort (pre- and post-intervention) comprising five measures: double baseline, mid-treatment, post-treatment, and follow-up. There were only seven participants in each group (SG and ESG) and no control groups.

The outcomes were measured using a range of tools: Impact of Events (IES); Culture-Free Self-Esteem Inventories (CFSEI); Novaco Anger Scale (NAS); Beck Depression Inventory (BDI); and Challenging Behavior Interview (CBI). The results showed that "Improvements occurred in sexual knowledge, trauma and depression. Neither self-esteem nor anger improved for most of the SG and challenging behaviour worsened at first before improving" (Peckham et al., 2007, p. 308).

Similar to the Dickman et al. (2006) study, Mikton and colleagues rated this study as 'effective' "without taking risk of bias into account" (2014, p. 10) although the effectiveness assessment taking risk of bias into account was 'unclear'.

5.4.2 Analysis and relevance to male survivors of sexual abuse

People with disabilities are more vulnerable to sexual assault and face more barriers than other survivors in terms of reporting the abuse. Barriers include not being able to fully recognise what has happened to them, and needing assistance or someone to report on their behalf (Mencap, 2001). Recognising the sexual abuse of people with disabilities is also hindered by the myths surrounding this issue ranging from descriptions of rampant sexuality to asexuality (Dickman et al., 2006). These issues are likely to apply or even be heightened for male survivors of sexual abuse with disabilities.

Only two of the studies included in the Mikton and colleagues' (2014) review related to sexual abuse survivors and both were focused on females. However, the first study by Dickman et al. (2006) showed the importance of interventions such as SAVE to assist sexual abuse survivors with intellectual disabilities to navigate the legal system.

Although no studies in the Mikton and colleagues review could provide a high quality of evidence for effectiveness, the Dickman and colleagues' evaluation is one which provides useful and interesting qualitative data about issues facing sexual abuse survivors with disabilities.

5.5 Rainbow/Takatāpui communities' approaches to recovery

5.5.1 Service elements and good practice identified by Rainbow/Takatāpui community members

Services required to support Rainbow/Takatāpui survivors as suggested by members of the Rainbow/Takatāpui community include:

- An online database about services that are safe for Rainbow/Takatāpui SSA to access
- Anonymous digital services (eg online, email) to assist Rainbow/Takatāpui SSA to find clear and accessible pathways
- Culturally appropriate and diverse services for Rainbow/Takatāpui SSA of all sexualities and genders that have inclusive policies, are transparent about who services are for (particularly in terms of transgender survivors), are visible and accessible, and have ongoing engagement with Rainbow/Takatāpui community groups. Services that celebrate rather than just tolerate the Rainbow/Takatāpui community, for example using positive images in their public spaces
- Culturally appropriate responses from all "helping" services such as New Zealand Police, victim support, courts, counselling and health, including mental health and sexual health services
- Access to safe and appropriate housing for Rainbow/Takatāpui people experiencing violence
- Māori, Pacifica, Asian and other non-Pākehā social service providers providing services appropriate for Rainbow/Takatāpui people, led by people inside those communities. Using Māori identity terms like Takatāpui and Pacifica identity terms, for example Fa'afafine (Samoa, American Samoa and Tokelau)
- Alternatives to the criminal justice system which provide community accountability and restorative practices (including tikanga-based practices) to address violence
- All services accessible to people with disabilities and ongoing relationships between disability services and SSA support services that include Rainbow/Takatāpui survivors (Dickson, 2016a; Wharewera-Mika & McPhillips, 2016).

Dickson (2016) makes the following recommendations for service development in relation to supporting Rainbow/Takatāpui survivors, based on research undertaken by her organisation, *Hohou Te Rongo Kahukura – Outing Violence*:

- Include sex, sexuality and gender diverse people's experiences of partner and sexual violence at strategic, policy and service planning levels
- Maintain ongoing relationships with Rainbow/Takatāpui communities
- Training on preventing and responding to sex, sexuality and gender diverse people's experiences of sexual violence.
 - for "mainstream" violence services
 - for Rainbow/Takatāpui community agencies

- Culturally appropriate and diverse resources
 - for Rainbow/Takatāpui communities which explore healthy relationships and outing violence
 - for Rainbow/Takatāpui survivors' friends, family and whānau about how to support them
- Working with *Hohou Te Rongo Kahukura – Outing Violence* to create a central hub for information, resources and training to improve responses for Rainbow/Takatāpui SSA. (Dickson, 2016a, pp. 6–7).

Workforce capability

Training should include Rainbow issues so that professionals can recognise homophobic, bi-phobic and transphobic practices or barriers (Dickson, 2016b).

5.5.2 Transgender survivors' recovery approaches

Healing modalities

The US FORGE survey showed that transgender survivors seek emotional support from a variety of sources:

- 73 percent had accessed one-on-one therapy as one form of emotional support
- 55 percent stated friends were a source of emotional support
- 45 percent used self-help books
- 43 percent stated partner(s) were a source of emotional support
- 32 percent used websites
- 27 percent stated networking with other survivors (Cook-Daniels & Munson, 2016, p. 37).

Munson and Cook-Daniels recommend a number of healing modalities with the caveat that “[t]here are more ways to heal and recover from sexual assault or abuse than there are survivors. What any given survivor finds helpful may seem strange or even counterproductive to another” (2015a, p. 51). They include: talk therapy; medication (for sleep disturbances and other symptoms of PTSD); body-based therapies such as massage; movement-based therapies, including yoga, martial arts, and walking; faith-based support via diverse focused spiritual resources which are available online and in person; and peer support (2015a, p. 56).

Emerging good practice

Cook-Daniels and Munson (2016) have published ‘A Guide for Facilitators of Transgender Community Groups Supporting Sexual Violence Survivors’ which is very comprehensive.

As gender-specific bathrooms are a source of stress for many transgender people, a relatively simple adjustment to make transgender survivors feel comfortable, would be to have gender-neutral bathrooms available (Munson & Cook-Daniels, 2015b, p. 99).

Cook-Daniels and Munson suggest that if transgender survivors want to create their own peer-support group they could use a model called Hachoka, “which is the Lakota [Native American] word for sacred circle. In a Hachoka, a group of people meet on a regular basis to support each other in healing (this could be a single-focus group or focus on healing whatever participants bring to the circle)” (2016, p. 53). They recommend psychiatrist Lewis

Mehl-Madrona's books, "which seek to suffuse Native American healing knowledge into modern medicine" (2016, p. 53).

It is essential that transgender survivors feel that they are believed when they disclose sexual abuse and so Cook-Daniels and Munson (2016) offer the following advice for professionals:

If people talk about experiences that include discrimination, harassment, verbal abuse, physical abuse, sexual abuse, or any other experiences about their life or history, it is critical to believe them. This may sound really simple and obvious, but often, survivors are not believed. In fact, frequently survivors are told they are lying, exaggerating, or making up the abuse narrative to gain attention, or for some other reason. If you find the story incredible and therefore have trouble "believing" it, keep a mantra repeating in your head: "How would I respond if this were true?" That may help you continue to respond attentively and compassionately. Remember that you do not need to determine what really happened; your role is to support the person who is feeling pain (Cook-Daniels & Munson, 2016, p. 86).

6 Experts' reflections on what supports men's recovery from sexual abuse

6.1 Introduction

This section provides reflections from the experts we consulted on the state of knowledge about what supports men who have been sexually abused, and their suggestions on key elements to consider for service development.

6.2 Current state of knowledge about supporting men's recovery from sexual abuse

All the experts identified a lack of evidence-based research and evaluation about what supports male survivors' recovery to inform models of practice and service design. There is a particular lack of knowledge about what supports indigenous men.

The experts noted that the limited rigour of current research makes conclusions difficult. However, they also said the evidence base was slowly growing and there is now more understanding of how sexual abuse impacts males and the processes of recovery. While they called for more rigorous research, they also highlighted the importance of practice wisdom and incorporating knowledge from practitioners and male survivors. There are emerging themes about what good approaches and practice looks like. However, there are also different views on the effectiveness of approaches which emphasise the need for more research and examination of recovery approaches that are accessible, engaging, and responsive to diverse groups of men.

Patrick O'Leary, who was involved with the Australian Royal Commission on child abuse, referred to the substantive evidence provided by men during that inquiry and subsequent recommendations on service provision and workforce development (64 percent of the approximately 9,000 survivors who gave evidence were men). There is no doubt the *New Zealand Royal Commission on child abuse in state and religious institutions* will provide evidence and direction on what supports (and prevention measures) are required for males, females and gender fluid people in this country.

6.3 Giving hope, debunking the myths, and reframing experiences of abuse

A critical message from the experts to male survivors is that 'you are not alone' and 'there is hope for recovery'. Men need to know that there can be paths to healing, and the research shows this in regard to coping and resiliency factors. There are many men who have successfully gone through a process of recovery and men need to know this is possible. A good place to start is better information about the prevalence of sexual abuse of boys and men. It is important to debunk myths (or 'cultural delusions') such as men cannot be raped, male victims go on to be perpetrators, or male rape 'causes' homosexuality. Scott Easton said male sexual abuse should be identified as a pressing public health issue.

The experts talked about reframing and reinterpreting the experience of sexual abuse. Easton said it was important to address cognitive distortions, some of which develop as a

result of childhood sexual abuse. Boys and men often feel alone and immense shame, and may feel like there is something wrong with them. He observed that sharing statistics can be incredibly liberating as it shows men they are not alone. Likewise, media coverage of high-profile cases such as those involving the Catholic Church also let men know they are not alone.

Easton thought therapeutic approaches such as psychoanalysis that uses cognitive behavioural therapy (CBT) and possibly other modalities were important to address cognitive distortions from men's experiences of childhood sexual abuse and highlighted some of the distortions men may need to address in therapy:

- **Male survivors need to know it is not their fault** and the only person responsible is the perpetrator, often someone much older and with a power differential. Men often blame themselves and think that they could have stopped it, even when abuse occurred when they were a child or youth.
- **There is a need to identify the criteria for consent and articulate what is 'sexual abuse'**. Boys and men can have difficulties defining their experience as abuse due to myths such as 'males cannot be abused'. There are also issues for boys and men identifying abuse if, during physical interaction, the victim had any kind of physical pleasure. This can make them feel guilty and therefore they do not define it as sexual abuse. This is a physiological reaction beyond their control and does not negate the lack of consent or magnitude of the violation.
- **Cognition regarding sexual identity** – it is important to let men know that the sexual abuse does not determine their future sexual or gender identity. If the perpetrator was a man, it is not determinative that they will "become homosexual". Research has identified this concern as a significant issue for male survivors that can impact on their healthy sexual development. However, if the perpetrator of male child abuse is female, it may have equally detrimental consequences on a man's sexual development and can impact their future relationships with women.
- **Men may feel like 'damaged goods' so it is important to focus on their strengths** and for recovery approaches to show how they can get power back into their own life and own story, for example using account making and narrative therapy.
- **Masculine norms** – how much male survivors buy into traditional, hyper-masculine norms is a determinant of long-term mental health. Deconstructing and reframing those norms is important; being 'strong' and 'productive' can mean going to counselling.
- **Victimhood** – It is important to help the boys/men realise that although they may have a mindset that they were victimised, their stories often contain evidence that they used strengths, abilities, and personal assets to survive the experience. Empowering them to see their own unique capacities (and not buy into a deficits-oriented, pathological view of self) can be critical to healing and recovery.

Easton said it was also important to address these cognitive distortions with survivors' partners and supporters as social networks are imperative to wellbeing.

6.4 Recovery approaches

There were some differences in the experts' emphasis on recovery approaches with some favouring a more psychoanalytic approach and forms of counselling while others have found many men respond well to practical, proactive approaches, group forums and peer support. These approaches are not mutually exclusive. Rick Goodwin who directs Men & Healing in Canada, discussed the development of their phased approach which currently incorporates an intensive psycho-educational weekend retreat with male survivors which is professionally facilitated by qualified therapists. Men can then choose to go into a therapeutic group programme for as long as they require.

Goodwin said they had found from many years of working with male survivors that a mix of individual and group work was ideal. He used the analogy of a tree to explain to men the benefits of both approaches: individual counselling is like the tap roots of a tree as it provides depth; while group work is like the horizontal roots of a tree as it provides breadth. Both are necessary, and one doesn't replace the other.

Rick Goodwin said *Men & Healing* had a third phase involving a peer support group to follow up after phase II. However, they eventually stopped it as they found there were problems without professional facilitation. For example, the men in the peer support group found it difficult to deal with other men who had more complex problems with the potential to cause disruptions. Rick, along with the other experts, thought peer support offered a lot to men in terms of solidarity and support. Having professional facilitation to provide structure and direction of the peer support group was important to ensure it was more effective.

Patrick O'Leary said that professional facilitation of peer support groups was an important quality control mechanism based on work from the Australian Royal Commission on child abuse. To ensure organisations and their staff were delivering good practice there is a strong move in Australia for accreditation of services for survivors. Understanding what 'trauma informed' means is critically important when developing service responses.

Philip Chapman discussed models such as intentional peer support and the upskilling of peer support group facilitators. The good practice guidelines for peer support of male survivors produced by MSA are part of developing this workforce in New Zealand. Ensuring the implementation of the guidelines and supporting the sector's professional development will be essential for delivering effective and safe services for men. The service sector guidelines co-developed by the Ministry of Social Development will also be important in this regard.

O'Leary said emerging research on trauma is finding that counselling or talking based therapies is not for everyone, particularly indigenous men. This is interesting and may indicate the models of counselling (or their implementation) are not resonating with indigenous and other groups of men. Alexander Steven's work with Māori men is important in this regard as he has developed Te Ao Mārama framework for practitioners.

O'Leary also observed evidence from practice wisdom rather than research evidence was showing multidimensional approaches with men can work which combine methods, for example: professionally facilitated peer support, bush therapy, meditation, physical activity, and art. More research is needed on these differential responses to survivors. Patrick said, "our society's constructs of masculinity condition men to act, solve, do, therefore proactive, practical approaches tend to gel with some men".

6.5 Service design and delivery

Information from the experts pointed towards specialist services for men to both increase the likelihood that men would access the service and to provide the expertise to work with male survivors. As discussed in the review of the literature, a gendered perspective was required to develop therapeutic models suitable for male survivors.

Sexual abuse results in complex trauma and the needs of survivors are diverse and can differ at different times. Service planning and design needs to reflect this complexity by offering a range of different recovery approaches and service models. The experts concurred with the literature on the barriers for men accessing services and suggested a variety of service models to address this:

Web-based services and resources – the experts identified the importance of web-based resources, self-help books and helplines as a means for men to find out more information and anonymously find resources for their own recovery. They may also act as a stepping stone to future help-seeking. Web resources that cater for different groups of men are important, such as Alexander Stevens' development of a website for Māori men.

Advertising the service so that it clearly states it caters for men – the experts thought how the service was advertised and the name of the service was very important. Some said having sexual abuse in the name of the service could put some men off as they may not want to be seen going to this service. Having more general names for services was likely to encourage men to access them such as *Men & Healing*, *Men's Health*, *Male Room* and *Living Well*.

Outreach initiatives – Rick Goodwin's *Men & Healing* organisation collaborates with other services such as homeless organisations and prisons to provide outreach services. Rick said 'you have to go where the men are and not expect them to come to your service'.

Culturally responsiveness services – the ability for services and the workforce to work holistically and in a culturally-appropriate way with Māori and Pacific men and men from other ethnic backgrounds, including from refugee communities. This may require supporting and developing culturally-specific services such as kaupapa Māori services to work with men who have been abused.

Services that are responsive to members of the Rainbow community – this could be within a men's service for male-identified Rainbow survivors or as separate services.

Goodwin said at *Men & Healing* they have found there is no need for separate group programming for male-identified Rainbow survivors. In the early years they offered dedicated gay/bisexual men's programming however as the demand for this particular service diminished, they became clinically more skilled at holding mixed groups. Rick said that "with strong facilitation, a properly resourced group programme should allow for the diversity of male-identified folks to be in the same programme". He observed there are advantages to having diversity within a group, "in many ways, the binary of gay/straight is questionable, and enforcing this division through separate programming may be limiting for the men involved As well male survivors often have questions as to their sexuality and sexual expression – these issues are best addressed in a diverse circle".

Goodwin emphasised that as a clinic, they cannot properly engage with this population without proper training and guidance. *Men & Healing* is "a male-identified service, we do ask

that for group inclusion (remember we offer a range of individual therapy) we do need to ask whether the person identifies as being male. Here are the elements of the assessment interview we use to help determine whether they would be a proper “fit” for group services:

- What is their lived experience (outward representation) as a male – from their upbringing to the present?
- What is their internal identification as a male – from their upbringing to the present?
- How do they see their comfort and fit with regard to participating in a men’s group regarding discussions of male identity, internalised codes and values?

From these responses, along with other presenting material in the assessment interview, the therapist can properly decide whether the client can be invited to group programming.” (Rick Goodwin personal communication)

Summary of recovery approaches recommended by the experts:

- Trauma-informed, life course approach which recognises men require sustainable strategies to support them over their lifetime.
- Provision of a mix of recovery approaches such as individual and group programmes, intensive retreats, professionally facilitated peer support, psychotherapy and other counselling approaches, and the inclusion of practical techniques and activities such as meditation, mindfulness, art and physical activity.
- Provision of advocacy to navigate services, brokerage of services, and practical support particularly with men who have complex needs such as mental health issues, intellectual disabilities, addictions, poverty, and homelessness. Survivors also require support and advocacy with navigating justice services as going through the police, forensic and court processes can be very difficult and take a long time.

7 Recommendations for service planning and development

The following recommendations for consideration draw on the findings from the literature review and consultations with the experts.

7.1 Supporting more rigorous research and evaluation of recovery approaches and service models

Establish a national programme of research and evaluation on male sexual abuse as part of a wider research and evaluation programme on sexual violence.

Prepare a stocktake and review of current service provision with consideration to service availability and responsiveness across the country is required to gain a thorough understanding of the service landscape for diverse groups of men.

More research is required on what approaches work for male survivors and different groups of male survivors. There is a lack of studies that examine recovery approaches with men generally, indigenous men, Rainbow/Takatāpui communities, and men with disabilities.

More research on the impact of adult male sexual abuse is needed to better understand recovery approaches as much of the current research focuses on childhood sexual abuse.

7.2 Supporting a range of recovery approaches and service models

Sexual abuse results in complex trauma and the needs of survivors are diverse and can differ at different times. Service planning and design needs to reflect this complexity by offering a range of different recovery approaches and service models. The findings from the review support multi-dimensional recovery approaches that are tailored for men, and for diverse groups of men. Further, service responses need to be based on a good understanding of what trauma-informed means.

A range of service delivery models are also useful to break down barriers to accessing services and to tailoring services for diverse groups of men. Some examples are: male-orientated services; tailoring the way the service is advertised; individual and group programmes; outreach; online services; increasing availability of service (opening times, location, immediate access); consider direct and indirect costs to service users; and giving attention to the ambience of the service.

7.3 Developing a national website for male survivors that provides comprehensive information for men, their families and supporters, and for professionals

A national website where male survivors, their families, whānau and friends could anonymously access information, self-help resources, and services such as telephone and

online crisis and counselling support would be useful. The website could include links to regional services, a range of culturally-appropriate services and other support information.

For professionals the website could be a source of current information, resources and professional development opportunities (eg e-learning packages, webinars, professional forums etc).

A good example of the type of features the website could include is *Living Well* (www.livingwell.org.au/) based in Brisbane. It provides a range of information, encouragement and support to men who have experienced childhood sexual abuse or adulthood sexual assault. *Living Well* also assists supporters of these men; their partners, friends, family and service providers. Their website is comprehensive and links to other services, sources of information and a downloadable app. There is an e-learning portal for practitioners working with men (managed in collaboration with Griffith University, *1in6*, and *Survivors Manchester*).

Services include:

- Face-to-face counselling for individuals, couples, or families (based in south-east Queensland)
- Online counselling via email, Skype or text-based chat (Australia-wide)
- Telephone counselling (Australia-wide)
- Groups for men, their partners, and for professionals
- Training and consultancy including workshops, presentations and webinars.

Other organisations with good examples of websites for male survivors include:

- **Survivors Manchester**, based in Manchester, UK www.survivorsmanchester.org.uk/
- **1in6**, USA <https://1in6.org>
- **MaleSurvivor**, New Jersey, USA www.malesurvivor.org
- **Men & Healing**, Canada <https://menandhealing.ca>
- **Male Support Services**, Waikato, NZ <http://waikatosurvivors.org.nz>
- **Mosaic**, Greater Wellington, NZ www.mosaic-wgtn.org.nz/

7.4 Supporting organisational and workforce development

Government supports implementation of evidence-based practice and good practice guidelines within organisations and professional development of the workforce within the sector.

While it was beyond the scope of this review to examine how the recently developed MSA good practice guidelines and male survivors of sexual abuse service guidelines are being implemented, we suggest that ways of supporting implementation at organisational and workforce levels are considered. For example, resourcing organisations to implement good practice and support workforce capacity and capability, including opportunities for professional development. The findings from this report indicate that the professional facilitation of peer support groups is important. Where required current peer support group facilitators should be supported to develop their competencies and qualifications in this area.

Support professional awareness of prevalence and impact of male sexual abuse and how to respond to disclosures.

Men are likely to present with a variety of problems across diverse settings, before having spoken about their experience of sexual abuse. So it is important that the workforce over multiple agencies is able to empathise and provide a safe environment for survivors and know where to refer them for support. Providing safe environments is essential in supporting male survivors as “sexual violence is a topic that carries a lot of stigma” and stigma is often a barrier to men seeking help. Additionally, the trauma of sexual violence impacts negatively on the survivor’s sense of self in terms of “feelings of self-blame” which often develop from other people’s (including care providers) reactions and judgements (Zijlstra, 2018, p. 130).

7.5 Supporting responsive practices and services for diverse groups of men

It is critical to recognise and understand diversity both across and within broad population groupings, for example different iwi, Pacific cultures, diversity of Rainbow/Takatāpui communities, and the needs of people living with disabilities. Understanding the values, beliefs, world views and approaches to health and wellbeing should be combined with good practices such as cultural and needs assessments.

It is important that culturally-based organisations such as kaupapa Māori organisations are supported to respond to the needs of men who have been sexually abused and the needs of their whānau.

Provision of support for the implementation and continual development of good practice guidelines for Māori and Pacific peoples such as those developed by the sexual violence sector and outlined by the TOAH-NNEST reports. These could be further enhanced by supporting research and evaluation of the use of recovery frameworks for men affected by sexual abuse such as Te Ao Mārama developed by Alexander Stevens II.

Good practices were also identified for people with disabilities and Rainbow/Takatāpui communities. It is important to ensure that good practice guidelines are developed for the New Zealand context through consultation with these groups and supported to become embedded and implemented within appropriate organisations.

7.6 Supporting a primary prevention campaign to inform the public and challenge myths about male sexual abuse

While examining primary prevention initiatives was outside the scope of our review, it is apparent that this will be a valuable part of any future strategies to address male sexual abuse and should be part of a general public education campaign alongside education about sexual abuse of women and girls. This campaign should inform the public about the prevalence of sexual abuse of males, how to respond to disclosures of sexual abuse, debunk myths around sexual abuse of males, and provide information about support available to aid recovery.

Consideration of appropriate and tailored information for different communities to know where they can get support for recovery will be important.

7.7 A national Family Violence and Sexual Violence strategy to include a focus on the prevention of sexual abuse of boys, men and transgender people

The government is currently developing a national *Family and Sexual Violence strategy*. The interagency joint venture on family and sexual violence recognises these issues are strongly linked to each other, as well as to child abuse. We suggest this strategy includes specific reference to the prevention of sexual abuse of boys and men, and recovery approaches that are tailored towards males in all their diversity. We suggest this strategy includes a specific focus on transgender people.

Family violence and sexual violence are complex issues or 'wicked problems' that require a long-term strategic approach with dedicated resources. We therefore strongly recommend a bi-partisan approach is sought to implement the strategy.

7.8 Developing a national centre that includes a focus on sexual abuse of boys and men

We recommend that a national centre on family and sexual violence is established to support the governance and implementation of the new national strategy.

Of interest is the Australian Royal Commission into Institutional Responses to Child Sexual Abuse recommendation 9.9 on 'National leadership to reduce stigma, promote help-seeking and support good practice' (Australian Royal Commission, 2017, p. 135). This recommendation advocates for the development of a national centre to oversee and coordinate a variety of functions including primary prevention, workforce development, coordinating a national research and evaluation agenda.

Recommendation 9.9

The Australian Government, in conjunction with state and territory governments, should establish and fund a national centre to raise awareness and understanding of the impacts of child sexual abuse, support help-seeking and guide best practice advocacy and support and therapeutic treatment. The national centre's functions should be to:

- a. raise community awareness and promote de-stigmatising messages about the impacts of child sexual abuse
- b. increase practitioners' knowledge and competence in responding to child and adult victims and survivors by translating knowledge about the impacts of child sexual abuse and the evidence on effective responses into practice and policy. This should include activities to:
 - i. identify, translate and promote research in easily available and accessible formats for advocacy and support and therapeutic treatment practitioners
 - ii. produce national training materials and best practice clinical resources
 - iii. partner with training organisations to conduct training and workforce development programs
 - iv. influence national tertiary curricula to incorporate child sexual abuse and trauma-informed care
 - v. inform government policymaking
- c. lead the development of better service models and interventions through coordinating a national research agenda and conducting high-quality program evaluation.

The national centre should partner with survivors in all its work, valuing their knowledge and experience.

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Appendix: Literature review methodology

Criteria for selecting literature

A narrative literature review was conducted to critically analyse a range of literature to assess the current state of knowledge about effective recovery approaches for men who have been sexually abused.

We specified the following criteria when selecting literature for inclusion:

Timeframe -10 years: A brief scan of the literature highlighted that there is both a lack of material on service effectiveness for men and that some of the studies are relatively old. The search spanned a timeframe of 10 years to ensure inclusion of the studies that are available. There were some exceptions where older studies were considered highly relevant.

Language - English: The search criteria was limited to English language sources.

Relevance to research questions: Relevance to the scope of the review is essential and will relate to the research questions in order of priority. **Error! Reference source not found.**³ identifies considerations for each of the research questions when selecting material to include in the review.

Table 3: Considerations for selecting literature related to each of the research questions

Research questions	Considerations for selection
1. Describe the state of current services for men (including both specialist services for men as well as how men are served by services for the wider population), in New Zealand.	<ul style="list-style-type: none"> • Identify services available for male survivors in NZ • Identify specialist services for sexual abuse survivors, services for population groups such as Māori, Pacific, LGBTQI • Identify types of services available eg counselling, peer support, navigator, clinical etc • Identify accessibility in terms of location, affordability, approachability, availability
2. Summarise evidence on the effectiveness of those existing services and the characteristics and components of services shown to be effective.	<ul style="list-style-type: none"> • Identify secondary analysis identifying evidence on effectiveness of services for male survivors eg meta-analysis, systematic reviews, literature reviews • Identify primary analysis of service effectiveness through service evaluations and research • From available evidence identify key characteristics and components of services identified as effective for male survivors and for different population groups

<p>3. Summarise literature about services for which there is currently limited evidence of effectiveness, but which offer new or innovative approaches. This can include literature about what works for men that may not yet have been implemented into a service.</p>	<ul style="list-style-type: none"> • Identify new and innovative approaches • Summarise available evidence on effectiveness and promising approaches for supporting male survivors
<p>4. Summarise evidence from other fields (such as new forms of therapies) that might be applicable to services for male survivors of sexual abuse. This can include literature that theorises about the general characteristics of effective services for men.</p>	<ul style="list-style-type: none"> • Identify literature that considers characteristics of effective services for men • Focus on relatable services that address complex trauma • Take into consideration different population groups such as Māori, Pacific, LGBTQI

Assessing the evidence for effectiveness

A range of study methodologies were included using qualitative and quantitative (or mixed) approaches; systematic reviews; meta-analyses; randomised controlled trials (RCTs); and quasi-experimental designs.

To evaluate the 'evidence' from such a wide range of studies we have endeavoured to be transparent and taken a critical analytical approach to discuss the methodologies used by each of the studies. We identify the pros and cons of the study design and the implications from their findings for developing long term recovery services for men who have been sexually abused.

Much of the current evidence about what are effective services for men comes from smaller qualitative and mixed method research and evaluation where survivors of sexual abuse were asked what helped them on their journey to recovery. We did not want to exclude these valuable insights from our search by taking a traditional hierarchical approach to evidence assessment that only values experimental designs. Qualitative methods can provide rich information about *how* interventions work, what contributes to positive changes for participants, and also provides a forum for feedback on service engagement and delivery from a service users perspective. There is also much to be gained by listening to the practice wisdom of practitioners and researchers in this sector.

We synthesised the available literature with expert feedback to provide both a current snapshot of knowledge about effective recovery approaches and practices along with directions for future research and service development for men and transgender people.

Search terms

Boolean logic was used to add and exclude key terms to narrow the scope. Table 4 sets out terms and variables used in the search. Search criteria was further developed based on consultations with key experts and the Boolean logic was refined.

Table 4: Search terms for literature review

Primary term		Secondary term		Tertiary term		Variables
Men OR man OR male OR mascul* OR transgender	AND	Rape OR sexual violation OR sexual assault OR sexual abuse OR sexual violence OR sexual harm OR sexual harassment	AND	Survivor OR victim	AND	Support services
						Treatment
						Recovery
						Innovative approach
						Māori
						Cultural responsiveness
						Effective services
						Evaluation
						Systematic review
						LGBTIQ
						Pasifika/Pacific people
						Disability
						Childhood

Search strategy

Expert interviews

We consulted with five (New Zealand and international) experts around their recommendations for academic and grey literature. In particular it was important to hear

from experts who are knowledgeable about what supports Māori men. Experts were identified in consultation with MSD.

Literature search

Both academic and grey literature was searched and chosen for inclusion in the review based on search criteria and an assessment of relevance, robustness of methodology, and innovative approaches.

Mendeley was used to manage the literature search and to collate and analyse relevant sources.

Academic literature search strategy

The *EBSCO online research database* was used to identify academic literature including systematic reviews and individual studies including databases such as:

- *Academic OneFile*
- *Austrom*
- *CINAHL*
- *Cochrane Library*
- *ProQuest*
- *PubMed*
- *ScienceDirect*
- *Social Care Online*
- *Social Services Abstracts*

Grey literature search strategy

The search for grey literature included examining relevant organisational websites for evaluations, reports, and case studies that looked at effectiveness of initiatives and identified good practices.

We developed a list of New Zealand websites that provide support to male survivors of sexual abuse along with a brief description of their services and whether they publish research and evaluation. We also included some prominent international website services.

A Google and Google Scholar search was also completed to identify any other potentially relevant material not identified through the targeted searches.