THE MENTAL HEALTH NEEDS AND PRIORITIES OF MALE SURVIVORS OF INTIMATE PARTNER VIOLENCE

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To the participants of this study thank you very much for your time and contributions! This thesis would have not been possible without your contributions.

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ABSTRACT

BACKGROUND: Although the body of literature on Intimate Partner Violence (IPV) against heterosexual men has grown, their mental health needs and priorities in the aftermath of IPV remain under researched.

METHODOLOGY: Within the epistemological framework of critical realism, a qualitative research design was applied to explore the self-identified mental health needs and priorities of male survivors of IPV. A purposive sample of eleven survivors from the UK, between the ages of 40-70, was recruited remotely.

FINDINGS: Reflexive Thematic Analysis (RTA) was applied to analyse the findings. Four themes were constructed: a) "The many fragments of me – the toll of IPV", b) "an interplay with social structures", c) "breaking the silence: safe spaces to talk and IPV awareness", and d) "supporting male survivors -what should clinical psychologists know?". Participants' accounts demonstrate the detrimental impact of IPV on their mental health. Loneliness, social and resource losses, perception of loss of self-identity and self-esteem reported, highlight that a sole focus on symptom reduction may be inadequate to address the needs of male survivors of IPV. Participants described navigating societal structures, experiencing discrimination, disbelief and invisibility. A safe space to talk and increasing public and professional awareness of IPV against men were raised as the most immediate needs of survivors. In terms of therapeutic work, participants described the value of validation and being part of a group with other survivors. Socialisation of male gender may affect the time needed for men to open up within a therapeutic context.

CONCLUSIONS AND IMPLICATIONS: The findings highlight the complexity of survivors' needs requiring trauma-informed, evidence based, holistic care. Implementation of a gender inclusive approach and increase of public and professional awareness of IPV against men is needed.

Keywords: *Intimate Partner Violence, male survivors, mental health needs, male victimisation*

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CHAPTER 1: INTRODUCTION

1.1 Chapter Overview

In this chapter I discuss the position of the researcher, the epistemological position and provide clarification to the terms applied across this study. Following this, I present and discuss the literature about the impact of IPV on male survivors of IPV and their help-seeking experiences. In the second part of this chapter, I present the systematic literature review conducted on the positive experiences of help-seeking for men survivors of IPV. The research question and aims of the current study on the mental health needs of men survivors are discussed towards the end of this chapter.

1.2 Position of the Researcher

I acknowledge that my intersectionality, my experiences, values, beliefs, knowledge, and biases are likely to have influenced my approach to the study and to the interpretation of the data (Finlay, 2002). I am a heterosexual, middle-class, Greek woman, and I moved to the UK to pursue a career in clinical psychology and mental health research. I have not experienced intimate partner violence. I believe in the values of social justice, and I stand against oppression and discrimination. As I have seen and documented the impact of deprivation, oppression and discrimination on people’s life chances, quality of life, relationships and on their physical and mental health those values are important to me. I first became aware of the issue of IPV against heterosexual men during my academic Ph.D in child-to-parent violence. Up to this point, I was not aware that this phenomenon existed. Indeed, being a woman within a patriarchal society, I was initially surprised as it contradicted my previously established knowledge in domestic violence. Similarly with child-to-parent violence, intimate partner violence against heterosexual men was an under-researched topic and largely remains so today despite important developments (Hogan, 2016).

My previous involvement with IPV against men included a publication in an edited volume about the current state of knowledge about the prevalence, causes and dynamics of IPV, impact and links with other forms of family violence (Bates & Papamichail, 2022). However, my work was theoretical, and my contribution was about the links of IPV with other forms of family violence (e.g. child-to-parent violence, child maltreatment), and the impact of IPV on partners and children. Despite this, I was somewhat familiar with the literature of IPV against men. One of the reasons I decided to pursue this topic was that I wanted to raise awareness of this issue within clinical psychology. This is because -at least according to my limited experience- there seems to be a silence about this topic within clinical psychology. I have never encountered a presentation/discussion about working with male survivors of IPV. An additional reason was that I wanted to know more about how to work with male survivors of IPV within a therapeutic context. I have never come across a therapeutic intervention for male survivors of IPV despite knowing that there is a high prevalence and increased likelihood of being a survivor of IPV among men and women with mental health difficulties in comparison with individuals without mental health problems.

Before joining the professional doctorate in clinical psychology, I worked as a researcher in areas of interpersonal violence and mental health among others. My experience both as a practitioner and/or researcher in mental health and violence, allowed me to document the long-term impact of domestic violence or intimate partner violence, abuse and neglect, and unaddressed psychological distress. The axiological position from which this research project has emerged, is a product of my experience and ethical commitments as a practitioner-researcher. I believe that all individuals regardless of race, age, disability, ethnicity, nationality, gender, gender reassignment, sex, sexual orientation, religion or belief, have the right to a life free of abuse and/or violence. I stand against sexist, racist, homophobic, biphobic, transphobic and any kind of discriminatory language against anyone's protected characteristics.

When I decided to explore this topic, I was aware that it is a heated debate among some groups in social media. Based on my limited understanding, there are accounts who deny that men can be victims of IPV and accounts that devaluate / diminish the impact of such violence on men. On the other hand, there are accounts who exploit or use the existence of such adversity to attack women's rights and ridicule the impact of patriarchy on women and other social groups[1]. I fundamentally disagree with both positions and consider myself distant from either perspective. Despite my awareness of the heated nature of this topic and my experience in researching violence, I devalued the emotional impact of this work on me. I also devalued how uncomfortable and painful it would feel to be exposed to such painful experiences where the alleged perpetrator was a woman, the gender I identify with. During reflection, this discomfort and pain reminded me of the discomfort I feel as a White woman when I hear stories of racism and discrimination towards people from the global majority. The key to moving forward was sticking to my values and sitting with this discomfort. As DiAngelo wrote in her book about White Fragility, "the key to moving forward is what we do with our discomfort. We can use it as a door out—blame the messenger and disregard the message. Or we can use it as a door in by asking, why does this unsettle me?" (DiAngleo, 2018).

1.3 Epistemological Position and Ontology

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[1] In alignment with my values, the ethos and the values guiding this work, and to protect all stakeholders involved, it was decided not to mention and/or name any of these accounts.

Epistemology refers to the nature, scope and resources of knowledge and how we come to know reality (Audi, 2010), while ontology is the study of "being" and refers to the nature of reality and our assumptions about what exists in the world (Crotty, 1998).

The epistemological position of this study is critical realism (CR) (Archer, 2000; Bhaskar, 2008). I assume a realist ontology and a relativist epistemology (Bhaskar, 1978). Violence, abuse, mental health difficulties and relationships have a material reality, and I view them as "real" whilst, they are experienced uniquely by each individual and mediated by their intersectionality such as gender, race, age, history, socio-economic background, culture and era of living, among others (Finlay, 2006). My view of these phenomena as "real" has been shaped by my experience as a professional in mental health settings and as a researcher investigating alternative forms of family violence (child-to-parent violence), human trafficking as well as domestic violence against women. I view the suffering associated with exposure to violence, as well as the suffering associated with mental health difficulties as real, as it is real for the people experiencing it and creates real consequences to the lives of individuals. According to CR, ontology is distinct from epistemology; there is a reality that exists independently of our knowledge of it and our understanding about it. Knowledge is socially produced; therefore, it is fallible and changeable (Bhaskar, 2008).

Another main reason behind the choice of CR is its focus on the emancipatory potential of knowledge produced and its orientation towards human agency, self-determination, possibility and change (Archer, 2000). I assume that the participants in this study have the agency, self-determination and the potential for shaping their world; leaving the abusive relationship, seeking support, acknowledging experiences of victimisation or deciding to stay in the relationship and addressing/working on those problems with their partners like some survivors do, are all examples of agency and self-determination (Hogan, 2016). According to critical realism, “knowledge and researchers have real causal power in the world; this generates a moral obligation to use this power to change the world” for human betterment (Brunson, 2023, p. 15). Again, the focus on change, human agency and the emancipatory potential of knowledge have been shaped by my experience as a practitioner and by my values. Additionally, CR recognises that the researcher’s interpretations play a crucial role in the data analysis; I do not assign to being neutral and I acknowledge my active role in the knowledge production (Braun & Clarke, 2021; Finlay, 2006).

1.4 Language and Key Terms

1.4.1 IPV and domestic violence (dv) and abuse (dva).

For the purposes of this study, I have used the UK intergovernmental definition of DVA as the definition of IPV. According to this definition, “IPV is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between people aged 18 or over who are or have been intimate partners or family members, regardless of gender or sexuality” (Home Office, 2018). The reason behind choosing IPV instead of DVA to describe this phenomenon lies in the fact that IPV is the term most used within the literature of the topic studied (e.g., Bates, 2020; Hogan, 2016; Lysova et al., 2020). According to the literature, IPV is preferred as a term when referring to violence within intimate relationships that goes beyond distinctions of gender and sexuality (e.g. Hogan, 2016). DVA has been associated as a term with violence against women. When describing violence within intimate relationships against women, I apply the term DV and/or DVA.

1.4.2 Psychological distress, mental health problems or mental health difficulties.

Psychological distress, mental health difficulties or mental health problems are all used interchangeably to describe psychiatric symptomatology or sequelae. I view psychiatric diagnosis as a practical strategy to inform the design and evaluation of clinical interventions (e.g., Macneil et al., 2012). Also, it is a useful tool for communication among professionals and for supporting individuals to access safe, necessary and meaningful care (e.g., Craddock et al., 2014). However, I also view it through critical lens as there are well known issues with reliability and validity of psychiatric diagnoses (e.g., Aboraya et al., 2006; Kendell & Jablensky, 2003). Additionally, psychiatric diagnoses can be limiting, excluding individuals from accessing appropriate care as diagnostic categories may serve as gatekeepers among services (Rose, 2018). Last but not least, both DSM and ICD are based on Western and Eurocentric understanding of mental health and distress which results in misdiagnosis, underdiagnosis and/or exclusion (Kirmayer & Minas, 2000).

1.4.3 Need.

The empirical study of this project seeks to explore the self-identified mental health needs of male survivors of IPV. For the purposes of this study the definition of need applied is of combination of the perception of need within a public health context (Wright & Kyle, 2006), thus, something that can be addressed by an intervention and Maslow's theory of hierarchy of needs (1954) who perceived need as a motivational force, or an inner state that instigates a drive (Doyal & Gough, 1991). In this study, need is defined as a subjective perception of deficiency that has the capacity to be fulfilled by action/intervention and motivates the individual to seek resources and/or act to fulfil this need to achieve well-being, safety and improve their quality of life. Needs are universal but also culturally and contextually informed. I acknowledge that this definition is highly subjective, and it has its limitations. For instance, it encompasses varying perceptions and is based upon value judgements as to whether a need exists or whether someone has the resources to identify how to access their needs (e.g. digital literacy to identify support services or access information about IPV against men). Also, individual need reflects a Western Eurocentric view rooted in values such as individualism, autonomy and self-determination; in collectivist cultures the concept of individual need may be framed in relational, communal and spiritual dimensions (Christopher, 1999; Kirmayer, 2007).

1.4.4 Psychological support, therapy or intervention.

These terms are used interchangeably to describe group or one-to-one talking therapy. Psychological therapy is defined as “meeting with a therapist to talk about feelings and thoughts and how these affect behaviours and wellbeing” (Paterson et al., 2018, p. 5). Examples may include counselling, cognitive behavioural therapy (CBT), and psychodynamic psychotherapy, among others (NICE, 2014; NHS, 2018).

1.4.5 Hegemonic masculinity.

Hegemonic masculinity is a Western, Eurocentric concept that refers to the configuration of practices that represent the socially desirable way of being a man in a patriarchal social context, distinguished from less favourable masculinities. Hegemonic masculinity favours forms of masculinity that exhibit traits such as stoicism, emotional suppression, power, dominance and competitiveness (Connell, 1987). I acknowledge that the concept is contested and has limited applicability across non-Westernised contexts. It fails to account for the diverse expressions and multiple forms of masculinity and gender development and cannot be applied to global contexts (Beasley, 2008; Connell & Messerschmidt, 2005)

1.4.6 Intersectionality.

Intersectionality is a term coined by Crenshaw (1989) and it is a critical social theory that emerged from Black, feminist scholars. Intersectionality refers to the interrelationships of age, sex, gender, class, race, ethnicity and additional social identities. The focus is on how different types of discrimination intersect to oppress people, contributing to social inequality and injustice.

1.4.7 Cultural humility.

Cultural humility refers to an ongoing process of self-reflection to facilitate understanding of ourselves and others, of being aware of our own implicit cultural biases and limitations in understanding clients' different backgrounds, and of building authentic and trustworthy therapeutic relationships as professional clinical psychologists (Tervalon & Murray-Garcia, 1998).

1.4.8 Trauma-informed Care (TIC).

This study adopts SAMHSA's (2012) definition of TIC. TIC refers to an organisational and cultural approach and intervention framework that involves: "1) realizing the prevalence of trauma, 2) recognising how it affects all individuals, and 3) responding by incorporating this knowledge into practice" (SAMHSA, 2012, p. 4). There is a strong emphasis on physical and psychological safety and active promotion of safety, trust, collaboration, choice and empowerment to service users (e.g., SAMHSA, 2014; Sweeney & Taggart, 2018).

1.5 Context and Background

IPV is a major public health and societal issue that may affect all individuals irrespective of race, class, age, socioeconomic status, gender, sexual identity, and relationship status (Renner & Whitney, 2010). Globally, IPV has been recognised as a gendered issue, disproportionately affecting women (WHO, 2010). Therefore, the vast majority of what is currently known concerns heterosexual women in intimate relationships with men. Whilst the majority of IPV survivors are women and the majority of IPV perpetrators are men (Krug, et al., 2002), it is established by the research that men are also victims of IPV (Archer, 2000; WHO, 2012). For example, according to the Office for National Statistics (ONS) (2023/24), 1.61 million women (6.6.%) and 712,000 men (3%) have been victims of IPV in England and Wales. Despite this recognition, and the development of research during the last decades, male survivors of IPV remain what has been described as “hidden victims” while the literature on male survivors of IPV remains somewhat underdeveloped (Bates, 2020).

Most of the literature on IPV against heterosexual men focuses on prevalence of IPV, types, tactics and patterns suffered (e.g., physical, sexual, psychological, financial, stalking), experiences of victimisation (e.g., Bates, 2020; Hines & Douglas 2015; Hogan, 2016; Tsui, 2014) and experiences of seeking support for IPV.

1.6 Impact of IPV on Mental Health

IPV has been associated with various mental health difficulties inclusive of depression, anxiety, post-traumatic stress disorder (PTSD), eating disorders and psychosis (Campbell, 2002; WHO, 2013). It is well established that exposure to prolonged violence, abuse and the distress that accompanies these experiences, increases the risk of mental health difficulties (e.g., Dutton, et al., 2006). Furthermore, it is established that a dose–response relationship exists for both male and female survivors; greater severity, frequency or duration of violence leads to worse outcomes (e.g., Holtzworth-Munroe, 2005; Scott-Storey et al., 2018). However, the majority of what is known about the impact of IPV on survivors stems from research conducted with women survivors (Dixon & Graham-Kevan, 2011), while there is a dearth of studies investigating the self-identified mental health needs of male survivors of IPV.

A systematic review examining 106 studies published from 2006 to 2016, found that most studies were conducted with heterosexual women survivors of IPV (n = 70), 7 studies were conducted with male victims of IPV, while 11 studies were conducted with LGBTQ+ participants (Laskey et al., 2019). According to Dixon & Graham-Kevan, (2011) the scarcity of studies on the impact of IPV on men may be due to perceptions of men being victimised only in the context of self-defence. An additional reason may be that men's victimisation is viewed as trivial and less severe than women's victimisation (Hines et al., 2007) due to men's physical size and societal gender perceptions of men being less sensitive or less impacted by physical and psychological harm.

The available evidence demonstrates that male survivors describe significant mental -and physical- health outcomes. The existing studies show that there is a link between IPV and clinical levels of depression, anxiety, PTSD, suicidality and increased substance abuse among male survivors of IPV (Coker et al., 2005; Hines et al., 2007; Laskey et al. 2019; McLaughlin et al., 2012). However, the scarcity of data for male survivors does not allow for accurate prevalence estimates beyond the National Crime Survey data. A recent cross-sectional study that investigated the relationship between threatened and/or actual Legal and Administrative

Aggression (LA)[2] against male survivors of physical IPV by women partners/ ex-partners and men's mental health found that actual LA was related to an increase in symptoms of PTSD and depression among men (Berger et al., 2016). It is worth noting that the association of actual LA with an increase in symptoms of PTSD and depression for male survivors remained after controlling for other types of IPV victimisation and past traumatic experiences in the men's lives. However, the cross-sectional character of the study does not allow for causal conclusions about the impact of LA aggression on men's mental health. Also, the authors recruited men who sought help for IPV; we know from the literature that most male survivors of IPV do not seek help for such experiences (Wallace, 2014); we also know that men are less likely to seek help for mental health difficulties (Sagar-Ouriaghli et al., 2019), therefore the generalisability of results is limited. Furthermore, initiatives for evidence-based interventions to support male survivors of IPV are currently missing (Bates et al., 2017). To the best of my knowledge, I have not come across an evaluation of existing interventions (one-to-one or group interventions) for men survivors of IPV.

1.7 Men Survivors of IPV and Help-seeking

There is a considerable number of studies that explored the help-seeking experiences of male survivors of IPV. This literature has established that male survivors of IPV face multiple barriers when seeking support and that their help-seeking experiences are overly reported as negative (Bates, 2020). Barriers to help-seeking include fear of disclosure, fear of being accused as a perpetrator of IPV, shame and emasculation, fear of disbelief, stigma of being a male victim of IPV and lack of awareness of experiencing IPV (Bates 2020; Brooks et al.,

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[2] According to Berger, Douglas, & Hines, (2016), LA aggression "occurs when one partner abuses the legal and administrative system (e.g., courts, law enforcement, child protection services) either during or after the termination of a relationship against their partner and this can often involve false allegations against the victims" (p.346—247).

2017; Hogan, 2016; Machado, 2017; McCarrick 2016). Other studies reported perceptions that men do not need support services (Barkhuizen, 2015). Several studies show that on many occasions, men are not aware of sources of support (e.g., Hogan, 2016). Experiences of help-seeking are, by the majority negative, especially regarding the criminal justice system (e.g., police, legal system) and to some extent social services (Tsui, 2014). Survivors report inappropriate service responses such as a lack of recognition and understanding of male victimisation within support services (Lysova et al., 2020), devaluation of their experiences, disbelief and suspicion (Bates, 2020; Hines et al., 2007; Hogan et al., 2021). Such experiences negatively affect male survivors' willingness to seek further help, impact on their mental health and increase the risk of re-traumatisation (Douglas & Hines, 2011).

1.8 Summary

The literature presented here briefly discusses the prevalence, the mental health impact, the challenges male survivors of IPV face when seeking help and identifies several gaps in the literature of IPV against men. As discussed earlier in this chapter, one of the main reasons I decided to explore this topic was my desire to know more about ways of working with male survivors of IPV within a therapeutic context and to inform therapeutic work with male survivors of IPV. Given that there are no studies evaluating interventions for male survivors of IPV or evidence-based models of care for this group, I decided to explore the components of positive help-seeking experiences for male survivors of IPV to inform future design of interventions. A qualitative systematic literature review (SLR) presented in the next part was undertaken to explore the existing literature on male survivors' positive help-seeking experiences. This is presented and discussed in the next part of this chapter.

1.9 Systematic Literature Review

The SLR presented in this section addresses the following research question: “What makes help-seeking a positive experience for male survivors of IPV?”. According to Cipriani and Geddes (2003, p 146), “SLRs are syntheses of primary research studies that use specific, explicit and therefore reproducible methodological strategies to identify, assemble, critically appraise and synthesise all relevant issues on a specific topic.” SLRs are described as sitting at the “top of the hierarchy of evidence” (Murad et al., 2006) as -if conducted appropriately- they produce the most compelling form of scientific knowledge on a specific topic (Lame, 2019). They are being chosen as a method when the researcher’s goal is to summarise existing evidence and provide a reliable and unbiased assessment and overview of the available evidence on a research question (Boland et al., 2017). As such, SLRs are particularly important for mental health care professionals and clinical psychologists as they facilitate evidence based and evidence informed practice. The objectives of this SLR were to identify qualitative and mixed-method studies that reported qualitative data of males’ survivors of IPV positive experiences of help-seeking -both formal and informal-, and to explore and synthesise their findings thematically. This review is inclusive of all studies that found and reported at least one positive help-seeking experience for male survivors of IPV.

1.9.1 Method.

To map the existing literature, I undertook an initial literature search on male survivors’ positive help-seeking experiences using Google Scholar, Prospero and Cochrane Library (Schiavo, 2019; The Cochrane Library, 2024). This was to ensure there were no other SLR’s exploring the topic of positive help-seeking experiences for male survivors of IPV. This SLR applied a meta-synthesis method; this method “systematically reviews and integrates findings from qualitative studies” and provides in-depth insight into a studied phenomenon (Lachal et al., 2017, p.1). This review includes qualitative and mixed methods studies (as long as they reported qualitative data) and focuses on adult male survivors of IPV within heterosexual relationships. The reason why this review focuses only on heterosexual men, is that according to the literature, gender and heterosexist stereotypes underpin men's help-seeking behaviour for mental health and interpersonal and intimate partner victimisation (Bates, 2020; Scott-Storey et al., 2023). These stereotypes are often internalised by men and affect their help-seeking choices and preferences (e.g. Hogan et al., 2021). Western and non-western studies were included as it was deemed important to capture the commonalities in what positive help-seeking looks like for male survivors of IPV despite the differences in service provision and legislation. Studies included from the last 25 years (2000-present) were included. The reason behind this choice is twofold: 1) although IPV against men has been recognised in the 1970s (Steinmetz, 1977), empirical knowledge on this subject have started developing in 2000s (e.g., Archer, 2000; Dutton & Nicholls, 2005) and 2) I wanted to capture contemporary studies relevant to current service practices and attitudes towards men's IPV victimisation. Studies written in a non-English language were excluded due to the time and resource constrains of this project. This SLR's inclusion and exclusion criteria are presented in Table 1 below.

Table 1

Systematic Literature review inclusion and exclusion criteria

Inclusion	Exclusion
The studies must be published in the English language.	The study recruited participants under the age of 18
The studies must be peer-reviewed	The study is purely quantitative
Empirical qualitative methodology	The study was published in a language other than English

Empirical mixed methods study as long as they present qualitative data Participants must have identified as a male victimised by a female perpetrator in the context of IPV The papers must include original data Studies’ sample must be/include adult male survivors of IPV, aged 18 and older From 2000-now	The study was published before 2000 The study investigates types of male victimization alternative to IPV The sample consists of male survivors of IPV from non-female/non-heterosexual perpetrators The study is mixed methods, but the authors do not present qualitative data The study does not provide findings on positive help-seeking experiences

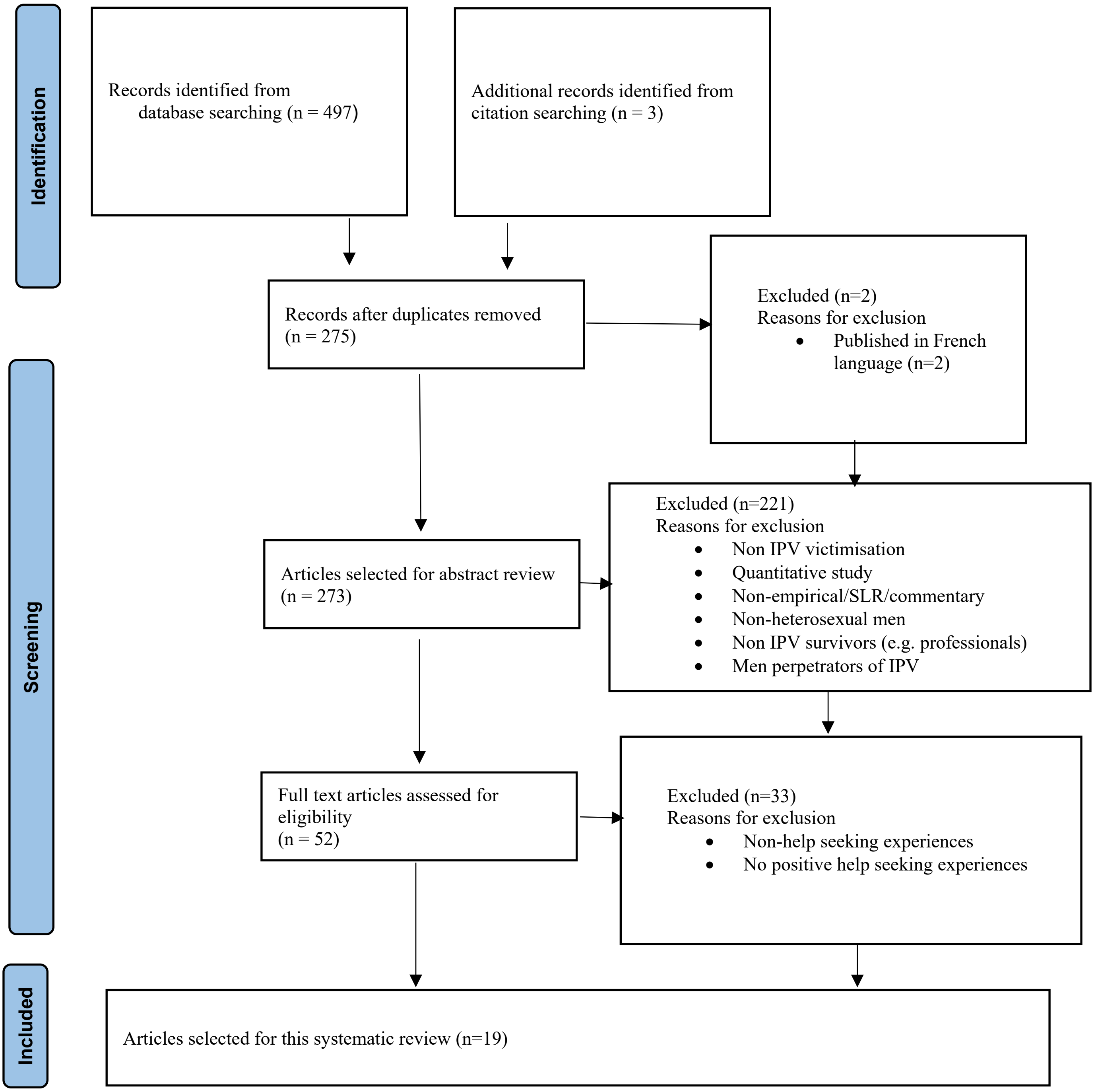
1.9.2 Search strategy.

A database search was conducted using CINAHL (11/11/24), Scopus (11/11/24), PsycArticles (11/11/24), PubMed (11/11/24), Medline (19/11/24). From my previous experience and reading in the area of domestic violence and in the topic of IPV against men specifically (e.g., Bates & Papamichail, 2022), it was anticipated that the clinical psychology literature in the topic is underdeveloped. During the initial development of this study, this was confirmed through initial searches of references and citations. Additionally, this decision was informed by my desire to adopt an interdisciplinary approach to capture the complexity of the issue. While psychological databases can provide important insights into mental health, limiting the scope to psychology alone would risk overlooking broader social, legal and systemic dimensions of positive help-seeking for male survivors of IPV. Therefore, it was decided to include multidisciplinary studies and keep the search wide-ranging. The databases I selected include studies from disciplines such as psychology, medicine, applied social sciences and social work. There were considerations to include PsycINFO, but the researcher had no institutional access to this database. Alerts were set up to enable inclusion of studies if relevant. The terms applied are presented in Figure 2 below. The SPIDER tool (Cooke, et al., 2012) was used to clarify the guiding question and the search terms. The SPIDER supported the researcher to brainstorm relevant search terms in a structured way and contributed towards a more systematic process to meta-synthesis. The search strategy included reviewing subject headings and thesaurus terms. Through engagement with the literature and review of the key words linked to relevant papers, additional terms were identified (e.g., relational violence, spouse abuse). Boolean operators (e.g., “AND”/ “OR”) were applied within the search terms.

Three papers were identified from the reference lists of studies found through the databases. The total number of studies was 500. Those studies were reviewed on the criterion of relevancy of the title and the abstract. For the majority of studies, screening the title and the abstract was adequate to determine the relevance to this review. A second reviewer was involved at this stage. After the title and abstract screening was completed by the author, the second reviewer, a psychology graduate with experience in systematic literature reviews, checked the titles and the abstracts of 30% (n=150) of the studies to evaluate whether they should be included in this review. There were no disagreements with the second reviewer. Zotero software (Corporation for Digital Scholarship, 2023) was used during this process and duplicates were removed. The screening process identified 52 studies that were fully assessed. Of those, 19 papers were included in this review; the rest were excluded either because they did not describe any help-seeking experiences or because they did not find/report at least one positive, help-seeking experience. This process is presented in Figure 1 below:

Figure 1

Systematic literature review PRISMA flow chart



1.9.3 Results.

Nineteen studies were identified as suitable for this review. Of these papers only one applied mixed methodology design (Ambrozewicz et al., 2024); this study was included because it reported qualitative data based on the criteria outlined previously. Most of the studies (n=9) were conducted in the UK. Two studies recruited participants from four English speaking countries, namely Canada, Australia, US and the UK. Ethnic, racial and religious minorities were not well represented among the studies. A total of 665 male survivors of IPV were participants among the 19 studies included in this review. The age range of participants ranged from 18 to 82 years. There were inconsistencies among the studies in reporting demographics such as the age of participants. One study did not report any demographic details of participants (i.e. Mwayuli et al., 2019), another study reported only the range of relationship length and the range of time since relationship ended (i.e. Morgan & Welles, 2016), while McCarrick et al., (2016) reported only their participants age range. Nevertheless, based on those studies who provided detailed demographic information about their participants and the mean age of their participants (n=8), it seems that most participants were in their 40s. Furthermore, several qualitative data analysis approaches were applied, including thematic analysis, narrative analysis, interpretative phenomenological analysis (IPA). Most studies (N=14) applied thematic analysis (e.g., Braun & Clarke, 2006; Hammond et al., 2023; Moustakas, 1994).

Figure 2

Search terms applied

‘Sample’	(TITLE-ABS-KEY ("men victims" OR "male victims" OR "men survivors" OR "male survivors" OR "abused men" OR "male victimisation")
‘Phenomenon’	AND TITLE-ABS-KEY ("domestic abuse" OR "intimate partner violence" OR "domestic violence" OR "spouse abuse" OR "partner abuse" OR "relational violence")
‘Design’	
‘Evaluation’	AND TITLE-ABS-KEY ("Help-seek*" OR "Help*" OR "help seeking" OR "process" OR "help-seeking" OR "domestic abuse services" OR "perceptions" OR "experiences" OR "domestic violence services")
‘Research type’	AND TITLE-ABS-KEY ("qualitative" OR "mixed method*"))
Limiters Publication year:	✓
2000-2024	

Table 2

Summary of studies

Title, author, country	Aim	Research Methodology	Participants/Sample	Data Collection	Data Analysis	Summary of findings	Strengths & limitations
Male victims of female-perpetrated intimate partner violence, help-seeking, and reporting behaviours: A qualitative study. Walker et al. (2020) Australia	To explore men's experience of IPV, help-seeking, and reporting behaviours, utilizing the terminology "boundary crossings" instead of IPV after consultation with support workers of men survivors of IPV.	Qualitative	Snowballing sampling n=143 Age range= 18-77. (M=40.14, SD =13.90) In a current intimate relationship =60.9% Never been married= 32.2% Married or living with a partner but not formally married = 32.2% Education University degree= 60.5%. 91.9% were living in an Australian state or territory; 8.1%=USA and/or Canada. 1.6% = Aboriginal or Torres Strait Islander.	Anonymous, online, open-ended survey	Thematic Analysis (Braun & Clarke, 2006)	A variety of reactions from social networks to disclosure, including support, disbelief, victim-blaming, and indifference were reported. Societal perceptions of IPV negatively affect male survivors of IPV and their help-seeking behaviours. The majority of participants described the police's and criminal justice's response as inadequate and the police's reactions to their victimisation as doubtful and ridiculing.	+Large N of participants +Consultation by experts by experience (EbEs) (professionals) to decide on the terminology applied in the study +Highlights secondary victimisation by police and support services. + An independent researcher, not involved in the initial coding, coded 30% of the data, increasing inter-rater reliability. -Brief mention on ethical approval- no mention on safeguarding, debriefing or signposting to services. -Data from participants is limited in depth and breadth. -No mention on member checking. Researchers have not critically discussed their own role, potential bias and

							influence during analysis and selection of data for presentation. -Researchers do not own positionality with the research -Researchers have not obtain ethnicity data other than whether the participants identified as Aboriginal and Torres Strait Islanders
Men's experiences of help-seeking for female-perpetrated intimate partner violence: A qualitative exploration Hogan et al. (2021) UK	To explore men's survivors of IPV help-seeking experiences and their views of utilising support services	Qualitative	Purposive & snowballing sampling n=26 Age range=24–74 (Mean=47) White British=19 White Other=5 British Pakistani=1 Black Afro-Caribbean=1. Full-time employment=15 Unemployed=6 Full-time student=1 Part-time student =1 Retired=3 Relationship status: Single=14 In a relationship =7 Engaged=1 Married=4. Education: No qual. =2 GCSEs =1 Ordinary National =1 A Level =3 NVQ =3	Individual, semi-structured interviews	Reflexive Thematic Analysis (Braun & Clarke, 2019)	Participants reported that the lack of recognition and understanding of male IPV victimisation was a particular concern to them. Negative help-seeking included being treated with suspicion and contempt. Positive experiences included being believed and being part of a support group among others.	+ Large N of participants + Brief discussion on how anonymity was obtained +Participants were given the autonomy to choose between face-to-face interviews, Skype remote interviews and telephone interviews. +Clear and detailed analytical process. +Reflective journal. +Clear clinical implications -Limited transferability: only 2 out of 26 participants from the global majority -Lack of information about how inter-rated disagreements were resolved between the 3 researchers.

			City and Guilds =2 Level 4 Certificate =1 Undergrad. Degree =7 Postgrad. Qual. =5 Prefer not to answer =1				
An Exploration of the Needs of Men Experiencing Domestic Abuse: An Interpretive Phenomenological Analysis. Wallace et al. 2019 UK	To explore the needs of men experiencing IPV from a female partner	Qualitative	Purposive sampling n=6 Age range= 40-60. White British=6. Wales resident=6 Recruitment from IPV services/onsite	Individual interviews loose interview guide framework (Smith et al., 2009)	IPA (Smith et al., 2009)	Four main themes were generated. Gender norms and perceptions of domestic violence inhibited participants to accept their victimisation. Loss of identity, isolation, and low self-worth were reported as impact of IPV on participants.	*Focuses and highlights the needs of men survivors of IPV *Reflective journal and debriefing was kept by first author enhancing dependability and credibility *audit trail kept*Clear implications for professionals, services, and policymakers Brief mention on ethical approval -no elaboration on ethics. Unclear information about data collection/interview type Lacks information about liaising with IPV services for recruitment and access to IPV services where interviews were conducted Lack of information on ethical issues when recruiting on site Limited transferability to survivors of IPV from ethnic and racial minorities as all participants were White British residing in

							Wales, No mention on member checking
Barriers to and facilitators of help-seeking behavior among Israeli men who experience intimate partner violence: A qualitative study Gueta & Shlichove (2022) Israel	To obtain an understanding of the help-seeking decisions, barriers, and facilitators of formal and informal help-seeking among male IPV victims in Israel	Qualitative	Purposive, snowballing and convenience sampling. n=17. Age range= 29 to 59 (M = 38). Ethnicity: second-generation Mizrahi families =9, second generation Ashkenazy families =8. Academic education=11. Married and/or divorced=16. Employed=17	Semi-structured, face-to-face and telephone (4) interviews	Thematic Analysis (Braun & Clarke, 2006)	Findings reveal that help-seeking process by men survivors of IPV is a complex process, shaped by many factors such as lack of awareness of help-seeking needs, help-seeking expectations, and actual help-seeking attempts.	+ Provides the views of male survivors of IPV outside Westernised, English speaking countries. + Clearly stated research questions and aims. + Brief discussion on ethical considerations. + Clear and transparent research process. +Member checking. +Researchers kept research journal reflecting on own assumptions and social graces. +Researchers own their positionality. -More clarity needed about participants' demographics - No involvement of EbEs. - Limited transferability, study is contextually bound.
The Process of Leaving Abuse: Midlife and Older Male Experiences of Female-Perpetrated Intimate Partner Violence. Carthy et al. (2023) UK	To explore the journey of leaving abuse	Qualitative (narrative approach)	Purposive sampling n=12, Age range=45-65 (M=52.5). White/Caucasian=11. In employment/education=6	Cannot tell/ remote interviews	Narrative approach (Crossley, 2000)	Findings describe the process of leaving abuse and help-seeking experiences by midlife men survivors of IPV. Informal networks of support very important for men for leaving the	+ Brief discussion on ethics, confidentiality, debriefing, signposting to services. +Reflection and debriefing by researchers. -Lack of adequate information about participants' demographics.

						relationship. Lack of support and understanding for their experiences is prominent.	-No time period was stipulated for when the participants had to have left their abusive relationship and no discussion how this was addressed ethically. -No mention on member checking. -Limited transferability/sample was predominantly White (11 out of 12 participants)
This Society Ignores Our Victimization: Understanding the Experiences of Korean Male Victims of Intimate Partner Violence. Park et al. (2021) South Korea	To explore men’s IPV experiences within the context of Korean society	Qualitative/ Phenomenology	Purposive sampling n=11 Age range=21- 32 years Non-married/no children. Ethnicity: Korean=11.	Semi-structured, face-to-face and telephone (n=10) interviews	Phenomenological method Giorgi (1997)	Findings indicate that it took participants a long time to realise that they were experiencing IPV because they perceived themselves as physically stronger than their female partners. Participants reported they had difficulty asking for help due to social stigma and fear of being perceived as unmanly by the Korean society.	+ Offers the perspective and experiences of male survivors who were not married and not had children with the alleged perpetrator. + Provides insights of male survivors from a non-Western country. +Brief discussion on ethics, informed consent, confidentiality, safety and signposting. +Member checking. +A third, independent researcher checked the coding structure. +Researchers provide a clear, transparent account on the process of recruitment and data analysis. -Participants were compensated financially

							for their participation in the study; however, the researchers do not address how this affected the study ethically and how it affected recruitment.
Disclosure of victimization experiences of Chinese male survivors of intimate partner abuse Simon & Wallace, (2018) China	To contribute to the literature on IPA against men in the Chinese context and to explore individual, organizational and cultural factors that facilitate or prevent the disclosure of male survivors of their victimization during the help seeking process.	Qualitative	Purposive and snowballing sampling n=8 Age range=39 - 67 years. Employed=4 Unemployed= 2 Retired=2 Married=4 Divorced=4 Residency Hong Kong=8. Education University graduate= 2, post-secondary =1, Senior secondary= 3, Junior secondary= 2.	Semi-structured interviews	Thematic analysis (Braun & Clarke, 2006)	Key factors for disclosure of victimisation include severity of victimisation and cultural gender role adherence and expectations. Also, behaviours of helping professionals affect disclosure.	+ Provides insights from a non-Western country. +Brief discussion on ethics, consent and confidentiality +Clear and transparent about coding process and theme generation, +Transparency about recruitment process, + Member checking. + 2 researchers independently coded data. +Clear clinical implication -Does not address limitations of the study. -Researchers have not critically discussed their own role, potential bias and influence.
Barriers to Men's Help Seeking for Intimate Partner Violence. Taylor et al. (2022). UK	To explore the barriers to help seeking reported by men who have experienced IPV in opposite-sex relationships and the role of masculinity narratives and	Qualitative	Purposive sampling n=147 Age range 27 - 74 years (M = 47.38, SD = 8.83) British =85% European =5% US =4% Australia/New Zealand= 1% Canada= 1%	Anonymous, online qualitative survey	Thematic analysis (Braun & Clarke, 2006)	Findings indicate that participants experienced discrimination by services due to their gender. Their own beliefs about gender social roles were also an inhibitor in seeking help.	+ Large number of participants. +Transparency about the qualitative questionnaire design. +The study adds on diversity of experiences as 13% of the sample first disclosed their

	stigma on help seeking		Other= 4% Relationship status In a current relationship =46%			Positive experiences included validation, understanding and inclusive practice by services.	victimisation to this study -No mention on ethical approval and no discussion on ethics -Researchers have not critically discussed their own role, potential bias and influence during analysis and selection of data for presentation -Further reflexivity is required regarding the researcher's position, - No opportunity for follow-up questions to explore responses in more depth. -No mention on member checking
"No one would ever believe me": An exploration of the impact of intimate partner violence victimization on men. Bates (2020) UK	To explore men's experiences of IPV; to explore the impact of such experiences, the barriers to help-seeking and leaving the relationships, and the impact of societal perceptions on their experience	Qualitative	Purposive sampling. n=162 Age range=20 - 82 (M = 44; SD = 10.62). White = 77.6% Mixed Ethnic background =5.6%, Asian =1.9% Black =0.6% Other = 2% No answer =13%. British =57.9% USA = 15.1% Australia/New Zealand =10.7% Canada =5.7% Europe =7.5% Other =3.1% Declined to respond=1.2%	Anonymous online qualitative survey	Thematic Analysis (Braun & Clarke, 2006)	Findings indicate negative impact of IPV on men's physical and mental health, future relationships and relationships with children and family and friends. Perceptions of the wider society seeing them as "abusers" or "weak" also were also described as barriers to help-seeking. Positive experiences of help-seeking included	+Large sample size. +Sample includes non-help-seeking participants which is important in capturing diversity of experiences. +Underscores the impact of IPV in future relationships. +Offers clinical and policy implications. -Brief mention on ethical approval by institution but no discussion on ethics. -Data somewhat limited in depth. Lack of ethnic and racial diversity

			Relationship status In a current relationship = 39.8%			understanding and validation.	-No mention about member checking -No discussion on researcher positionality
“I am able to regain myself”: A phenomenological study of Malaysian male domestic violence survivors. Lokithasan et al. (2024) Malaysia	To add to the literature on male IPV victims through the qualitative study of male IPV victims in Malaysia and to understand how men survivors of IPV in Malaysia experience personal recovery from IPV	Qualitative (transcendental phenomenological)	Purposive sampling, n=6, Age range=28-39 Employment status Employed=6 Education University=5 Malaysian Education Cerificate=1 Race Malay= 2 Indian=3 Chinese=1	Semi-structured interviews	Thematic analysis Moustakas’s (1994) modification of the Stevick Colaizzi–Keen method	Profound mental health difficulties noted. Support from friends and family was highlighted as very important to overcome the abusive relationship and had positive impact on participants.	+3 interviews per participants were conducted +Brief discussion on ethics approval, anonymity, debriefing and signposting. +Detailed and transparent recruitment and data analysis processes. +Triangulation of data by conducting in depth, repeated interviews and analysing field notes, observations. +Member checking +Reflection took place with qualified counsellors. -Little and descriptive data on positive help-seeking experiences -Age range of participants limited to 28-39 excluding younger and mainly older participants' experiences.
A Qualitative Study of the Male Victims’ Experiences With the Criminal Justice Response to Intimate Partner Abuse in Four	To explore men’s help-seeking behaviour within the criminal justice system and their perceptions of the helpfulness of	Qualitative	Purposive and snowballing n=38 Age range= 28-63 (M= 49) Australia=10	Open ended questions / 12 web-based, video-enabled, focus groups	Thematic Analysis (Braun & Clarke, 2006)	Overall negative experiences when seeking help from the police. Majority of participants have not sought help from police and	+Findings indicate that the experiences of men with the criminal justice services are similar across these 4 English speaking countries.

English-Speaking Countries Lysova et al. (2020) Australia, Canada, UK, and the US.	professional's responses		Canada=9 UK =9 US = 10			those who did reported not being taken seriously, being arrested despite being the victim. Not seeking help from the police associated with hegemonic masculinity ideas. Negative experiences were noted with courts; participants reported that courts are biased and siding with the woman. Only a minority had positive experiences.	+Data recruitment process is clear and transparent. +Sample size is large for qualitative study. +Consideration was given to participants anonymity. -Participants' demographic details are limited. -Authors do not acknowledge limitations of their study. -No mention on member checking. -No mention on reflection. -The findings around positive experiences are limited and descriptive.
Intimate partner violence against men: A sociolegal perspective of their experiences in Mathira East Sub-County, Central Kenya. Mwayuli et al. (2019) Kenya	To explore the acknowledgment process of men as victims of IPV from their perspective	Qualitative (phenomenology)	Purposive sampling n=15	Case narratives	Thematic analysis (type not stated)	Participants in the study used various resources to help themselves deal with IPV but their perceptions about these resources were negative especially regarding the police and the court system. Lack of knowledge of non-physical forms of IPV by participants was noted.	+Provides important insights from Kenya, adding to the diversity of experiences and perceptions. +Brief discussion and consideration of ethics. +Research questions are clearly stated. -No demographic details of participants provided. -Lack of information about how themes were generated. -No mention on member checking. -No mention on reflection.

							-Brief mention on limitations (only one limitation addressed i.e. sample size)
Examining Men's Experiences of Abuse from a Female Intimate Partner in Four English-Speaking Countries. Dixon et al. (2022) Canada, Australia, UK, USA	To examine the experiences of men who are abused by a female intimate partner in four English-speaking countries	Qualitative (phenomenology)	Purposive, convenience and snowballing. n=41. Age range= 28 -63 years (M= 48.7, SD = 7.5). UK-White= 80% USA White= 91% Canada-White= 67% In Australia: White Australian= 36% White EU= 45% Employment status: Employed=88%.	Broad, open interview questions/ 12 remote, focus groups	Thematic Analysis (Braun & Clarke, 2006)	Participants highlighted their lack of knowledge about what constituted abuse up to when violence became physical. They also described professional gender bias against them as a barrier to help-seeking. Positive professional experiences were noted by a minority of participants and those included understanding and offering practical help. Promoting knowledge for IPV was raised as an important factor that aids help-seeking and autonomy.	+Large sample size from 4 different countries +Focus group methodology was welcomed by participants and noted as an "empowering experience". -Apart from a mention on ethical approval and consideration of anonymity, there was not further discussion on ethics (safeguarding, signposting) -No mention on member checking. -No mention on reflection. -No information about how interrater disagreements were resolved.
Ending the stigma of male domestic violence and abuse victims: A mixed-methods study. Ambrozewicz et al. (2024)	To explore qualitative perceptions of male DVA victims between men who did and did not identify as being a victim of DVA	Mixed Methods	Purposive sampling from study 1 n=10 (5 participants experienced IPV and 5 did not have such experiences) Age range = 24 - 38	Semi-structured interviews	Comparative deductive thematic analysis (Hammond et al. 2023)	Qualitative findings demonstrate lack of awareness of IPV among male survivors of IPV, feelings of isolation and left to deal with trauma alone due to perceived bias of	+The use of qualitative and quantitative methods strengthened the trustworthiness of the data. -Brief mention to ethical approval but no further discussion on ethics.

UK	(study 2/qualitative part)					services. Mistrust towards the criminal justice system was also found. Few positive help-seeking experiences were noted in addition to the need and desire for public awareness.	-Small number of participants with experiences of IPV (n=5). -No explicit demographic data about the participants of the qualitative study except age range. -No information about how themes were generated. -No mention on member checking. -No mention on issues of reflexivity.
The Impact of Masculine Ideologies on Heterosexual Men's Experiences of Intimate Partner Violence: A Qualitative Exploration. Hogan et al. (2024) UK	To explore the impact of masculinity on men's sense of themselves and their relationship as well as their use of support networks for a group of British men.	Qualitative	Purposive and snowballing sampling. n=26. Age range=24–74 (M=47). White British =19 White Other = 5 British Pakistani=1 Black Afro-Caribbean =1 Employment status Unemployed =6 Full-time employment =15 Full-time student=1 Part-time student =1 Retired =3 Relationship status Single=14 In a relationship =7 Engaged=1 Married=4 Education:	Semi-structured interviews	Reflexive Thematic Analysis (Braun & Clarke, 2019; 2006)	Shame and embarrassment for not having met dominant gender expectations, shame and gender acted as barrier to help-seeking, positive help-seeking included empathy, validation and safe space to talk and express feelings and vulnerability.	+Highlights the impact of masculinity and gender identity on men's willingness to access support. +Large sample size. +Clear implications for practice offered. +Brief discussion on ethics. -Most participants were in full time employment limiting transferability to economically diverse survivors. -Majority of participants were White (n=24) British limiting transferability.

			No qualif. =2 GCSEs =1 Ordinary National =1 A Level =3 NVQ =3 City and Guilds =2 Level 4 Certificate =1 Undergrad. Degree =7 Postgrad. Qualif. =5 Prefer not to answer =1				
Exploring Help Seeking Experiences of Male Victims of Female Perpetrators of IPV. Machado et al. (2017) Portugal	To explore the experiences of Portuguese men who had sought help for their IPV victimization.	Qualitative	Purposive sampling n=10, Age range= 35-75 (M = 51.6, SD = 13.84). Employment status: Employed=6, Retired=4.	Semi-structured interviews	Thematic Analysis (Braun & Clarke, 2006)	Participants when seeking formal help for their IPV victimization, suffered secondary victimization due to gender stereotypes by the services. Those who had positive experiences this was due to being believed, understood and being offered practical help.	+1st qualitative study in Portugal exploring the experiences and the help-seeking process of male survivors. +A pilot interview was conducted. +Detailed information on the semi-structured interviews +Clear easy to follow research process. +An independent researcher analysed 50% of the interviews. -Unclear information about the educational background of participants -No mention on ethical approval and no discussion on ethics especially in regard to the fact that researchers recruited from IPV support organisations. -No mention on member checking. -No mention on reflexivity

(Un)Acknowledgment of Men as Victims of Intimate Partner Violence. Machado et al. (2023) Portugal	To explore the mechanisms and processes that lead to the victimhood acknowledgment of male victims of IPV	Qualitative	Purposive sampling n=10, Age range= 35-75 (M = 51.6, SD = 13.84). Employment status: Employed=6, Retired=4.	Semi-structured interviews	Thematic Analysis (Braun & Clarke, 2006)	Social stigma, and shame were the main difficulties. Findings demonstrate participants wanted to access information about IPV and reported that they want changes in the support systems (i.e. social services). Being heard and being understood was pivotal.	Same as above as it is the same research project.
'It's deemed unmanly': men's experiences of intimate partner violence (IPV). Morgan & Welles, (2016) UK	To explore how victims make sense of their experiences.	Qualitative IPA	Purposive sampling, n=7 Range of relationship length: 3-13 years, Range of time since relationship ended: 8 months to 14 years	Semi-structured interviews (telephone interviews)	IPA	The study described how societal gender perceptions about IPV shaped participants' help-seeking experiences.	+Brief discussion on ethics and ethical approval. +Involvement of independent researchers in the analysis. +Transparent and rigorous data analysis process. -Broad study aim. -No demographic data provided (apart from the length of the abusive relationship and time since relationship ended). -No mention on member checking.
Men's Experiences of the Criminal Justice System Following Female Perpetrated	To explore men's experience of the UK Criminal Justice System	Qualitative IPA	Purposive and snowballing sampling. N=6, Age range 40-65	Un-structured approach (Smith et al. 2009)	IPA	Highlights that the negative psychological impact of IPV was	+Highlights the psychological impact of IPV and the importance

Intimate Partner Violence. McCarrick et al. (2016) UK	(CJS) following female-perpetrated intimate partner violence (IPV)	perpetuated when professionals did not believe men survivors of IPV. In contrast, when survivors felt believed and heard this provided a sense of psychological strength.	of accessibility of support. +Provides a clear rationale for the methodology chosen. +Triangulation of data with a second researcher. -No mention on ethical approval. -No mention on reflexivity and positionality of researchers. -No mention on member checking.

1.9.4 Quality assessment tool

The Critical Appraisal Programme Tool (CASP) qualitative tool checklist was used for the quality assessment of this review (CASP, 2018). The CASP tool includes ten criteria which each study is assessed against. The CASP was used as it is considered the most commonly used tool for quality assessment in qualitative health and social-care qualitative evidence syntheses, and it is viewed as appropriate for novice researchers (Long et al., 2020). Futhermore, it is widely endorsed by Cochrane Reviews as a trusted framework for critical appraisal (Long, et al., 2020).The selection of an appropriate critical appraisal tool is crucial to ensure a systematic, transparent and reliable evaluation of the available research evidence.

Following a lenghty exploration of other SLRs within the subject area of the experiences of male survivors of IPV, the CASP tool has been used previously in the literature. For instance, Huntley et al., (2019) in their SLR about the help-seeking behaviours of male survivors of IPV selected CASP as their quality assessment tool. One of the strenghts of CASP is its accessibility, which makes it suitable for researchers who are new to research appraisal and SLRs (Long et al., 2020). Additionally, CASP is valuable for assessing the methodological quality of research and it is aligned to core qualitative concerns such as rigour ensuring the study design, sampling and data collection methods are appropriate (CASP, 2018; Long et al., 2020).

Furtherore, CASP is good fit for purely qualitative research; this aligned with the context of the present SLR as the vast majority of studies investigating the help-seeking experiences of male survivors of IPV are qualitative. However, CASP is not without limitations. Firstly, there is limited and not detailed guidance on how to weigh CASP's criteria and how to judge "enough rigour" which may lead to lower agreement among reviewers. In contrast, the Joanna Briggs Institute (JBI) critical appraisal tool (JBI, 2017) offers more granularity and methodological clarity, which supports higher consistency among reviewers (Moola et al., 2017; Hannes et al., 2010). A major weakness of the CASP is that it does not directly assess the theoretical framework informing the study. There is no consideration of how the epistemological/ontological position of the researcher(s) affected the methodology and the data interpretations. On the contrary, the JIB considers and assesses the philosophical assumptions of the study and their alignment (or not) with research methodology and interpretation (JBI, 2017; Hannes et al., 2020). Given the importance of epistemology/ontology to the research, it is acknowledged that this is a major limitation of the CASP.

An additional weakness of CASP is that it does not assess in detail the extent to which researcher's interpretations are influenced by bias thus limiting the ability to determine their credibility (Hannes et al., 2020). In contrast, the JBI assesses directly the influence of researcher bias. For instance, the JBI explicitly assesses researcher's reflexivity, representation of participants' voices, the influence of bias and whether conclusions are supported by data (Moola et al., 2017; Hannes et al., 2020). Therefore, it is acknowledged that the JBI may be more effective than CASP in evaluating the trustworthiness and dependability of the interpretations of research.

The JBI tool is aligned with a meta-aggregative approach that aims to systematically extract, classify and synthesise qualitative findings (Lockwood et al., 2015; Moola et al., 2017); this process includes grading findings and allowing for an aggregation of evidence that underlines the trustworthiness of interpretations (Lockwood et al., 2015). Despite JBI's strengths outlined above, the CASP tool was deemed more appropriate for this review. The primary aim was to assess methodological quality and identify common themes across the included studies in regard to what counts as a positive help-seeking experience for male survivors of IPV rather than to conduct a graded meta-aggregation of findings. Additionally, using CASP as an appraisal tool aligns with established practices in the literature of IPV against men, making comparisons with previous reviews easier and more meaningful. Nevertheless, in evaluating SLRs, reviewers are encouraged to take into consideration the strengths and weaknesses of the critical appraisal tools applied.

1.9.5 Quality assessment

To enhance the review's rigour, the same researcher who was involved in screening 30% of the titles and the abstracts, reviewed 30% of the identified papers (n=6). There were no disagreements between the second reviewer and me.

During the process of the review, I reflected on my positionality as White, female researcher who never experienced IPV to support me maintain the trustworthiness of this review (Amin et al., 2020). Also, given that I was not merely observing a phenomenon but shaped it through my interpretations, it was an ethical quest to remain aware of my mental experience while conducting all methodological forms of research (Mortari, 2015). This was done through keeping a reflective diary, reflection with the second reviewer and discussion/reflection of the process and the findings with experts by experience (EbEs) (30/01/25 and 06/02/25). The overall quality of the papers is discussed in the next section. The ratings on the quality of the papers are shown in Table 3 below.

Table 3

Critical appraisal of included studies

Criteria Yes= criteria met No=criteria not met Cannot tell	1)Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
Ambrozewicz et al. (2024)	YES	YES	YES	YES	YES	NO	YES	NO	YES	Highlights the need for gender sensitive support and training of service provides including criminal justice services
Bates (2020)	YES	YES	YES	YES	YES	NO	YES	YES	YES	Highlights how societal perceptions affect men's survivors help-seeking behaviour and

										the importance of knowledge & understanding the for positive help-seeking experiences
Carthy et al. (2023)	YES	YES	YES	YES	Cannot tell	NO	YES	YES	YES	Highlights that services were not equipped to support men survivors of IPV due to gender bias and underscores the importance of informal help-seeking for men survivors. Adds on the literature by exploring the experiences of midlife survivors which are generally absent from the literature.
Dixon et al. (2022)	YES	YES	YES	YES	YES	NO	YES	YES	YES	Includes a large, international sample from 4 Western countries and highlights the importance

										men place in 1) having a safe place to discuss and share experiences of IPV and 2) promoting knowledge about men's IPV victimisation for positive help-seeking experiences
Gueta & Shlichove (2022)	YES	YES	YES	YES	YES	YES	YES	YES	YES	Highlights that help-seeking process by men survivors of IPV is a complex process, shaped by the interaction of factors such as lack of awareness of help-seeking needs, help-seeking expectations, and actual help-seeking attempts.
Hogan et al. (2021)	YES	YES	YES	YES	YES	YES	YES	YES	YES	A valuable contribution to the

										literature on help-seeking experiences of men survivors with equal focus on positive experiences
Hogan et al. (2024)	YES	YES	YES	YES	YES	NO	YES	YES	YES	Highlights the role and impact of masculinity and gender identity on men's willingness to access support for IPV victimisation
Lokithasan et al. (2024)	YES	YES	YES	YES	YES	YES	YES	YES	YES	Contributes to the diversity of the literature as it explores recovery outside Westernised contexts. Highlights the importance of support from informal networks
Lysova et al. (2020)	YES	YES	YES	YES	YES	NO	YES	YES	YES	It provides infights into the experiences of men

										survivors of IPV within the criminal justice systems across 4 countries
Machado et al. (2017)	YES	YES	YES	YES	YES	NO	Cannot tell	YES	YES	The 1st qualitative study exploring men's help-seeking experiences for IPV in Portugal. It highlights the negative psychological impact of help-seeking on men survivors of IPV
Machado et al. (2023)	YES	YES	YES	YES	YES	NO	Cannot tell	YES	YES	Underscores the need of access to information and education on IPV and the needs for changes in the support systems (i.e.

										social services) for men survivors of IPV
McCarrick et al. (2016)	YES	YES	YES	YES	YES	NO	NO	YES	YES	Demonstrated the importance of appropriate support for psychological wellbeing and empowerment
Morgan & Welles, (2016)	YES	YES	YES	YES	YES	YES	YES	YES	YES	Underscores how societal gender role constructions interplay when help-seeking experiences of men survivors of IPV
Mwayuli et al. (2019)	YES	YES	YES	YES	YES	NO	YES	NO	YES	Provides important insights from Kenya, adding to the diversity of experiences and perceptions.

Park et al. (2021)	YES	YES	YES	YES	YES	NO	YES	YES	YES	Offers novel insights of men survivors of IPV who are not married/not having children. Adds on the diversity of literature as it provides insights from South Korea
Simon, & Wallace (2018)	YES	YES	YES	YES	YES	NO	YES	YES	YES	Focuses on the interplay among individual, organizational and cultural factors that facilitate or prevent the disclosure of male survivors of their victimization during the help seeking process in China
Taylor et al. (2022)	YES	YES	YES	YES	YES	NO	Cannot tell	YES	YES	Highlights participants'

										discrimination by support services
Walker et al. (2020)	YES	YES	YES	YES	YES	NO	YES	YES	YES	Highlights men's secondary victimisation by services. One of the few studies that consulted EbEs for the terminology applied in the study.
Wallace et al. (2019)	YES	YES	YES	YES	Cannot tell	YES	NO	YES	YES	Among the few studies that focused on the needs of men survivors of IPV

1.9.6 Quality evaluation of the studies.

Overall, the studies included were well conducted achieving moderate to high quality ratings. All studies included in this review had clearly stated the research aims which was helpful in assessing the choices regarding methodology. The methodological decisions were appropriate for all studies based on the research aims and the qualitative and mixed methods methodologies (i.e. Ambrozewicz et al., 2024) were appropriate.

Eleven studies applied purposive sampling within domestic violence services and through online advertisements, followed by studies that combined purposive and snowballing sampling, and studies that combined purposive, snowballing and convenience sampling. Others applied snowballing sampling only (Walker et al., 2020). These sampling methods are appropriate for qualitative methodologies and align with the recruitment of homogenous groups of participants. However, this limits the transferability of findings to participants who self-identify as a survivor of IPV and have actively sought help either formally or informally. However, in most studies the researchers acknowledge the limitations of these recruitment methods as well as the limitations in transferability of their findings (e.g., Bates, 2020; Carthy et al., 2023; Gueta & Shlichove, 2022; Hogan et al., 2021; Lokithasan et al., 2024; McCarrick et al., 2016; Park et al., 2021; Taylor et al., 2022; Walker et al., 2020; Wallace et al., 2019). It is important to note here that two studies omitted to acknowledge the limitations of their studies in general (Lysova et al., 2020; Simon & Wallace, 2018)

Bates (2020), Taylor et al., (2022) and Walker et al., (2020) applied anonymous, online qualitative surveys aiming to recruit a more heterogeneous group of participants, i.e. non-help seeking participants. Indeed, the researchers managed to recruit non-help seeking samples which is important given that the literature relies heavily on help-seeking samples

(Bates, 2020). This is important because we know from the literature that due to societal perceptions about IPV, a considerable number of men are not aware that they are experiencing IPV (Gueta & Shlichove, 2022; Park et al., 2021; Walker et al., 2020). In most studies that reported the mean age of their participants, this falls within the 40s (e.g., Bates, 2020; Dixon et al., 2022; Hogan et al., 2021; Lysova et al., 2020; Taylor et al., 2022; Walker et al., 2020) and most studies recruited male survivors who might have been married with, or had children with the perpetrator in the past. In contrast, Park et al., (2021) in South Korea recruited younger participants, aged 21-32, applying the criterion that participants have not been married and had not had children with the alleged perpetrator. This offers novel insights as research with this group of participants is sparse.

It should be noted that the findings of the studies regarding positive experiences of help-seeking are mostly descriptive; there was more in-depth exploration of negative help-seeking experiences. The only exception to this was the study conducted by Hogan et al., (2021). Only five studies considered the relationship between the researcher and participants (Gueta & Shlichove, 2022; Hogan et al., 2021; Lokithasan et al., 2024; Morgan & Welles, 2016; Wallace et al., 2019). This is an important omission given the importance of reflection and researcher positionality for dependability in qualitative research. Also, from all the studies included, in one research project (published in two papers) the researchers conducted pilot interviews enhancing the dependability of the findings (i.e. Machado et al., 2017; Machado et al., 2023). There were difficulties assessing the credibility of the findings of two studies due to the unclear analytical processes (Ambrozewicz et al., 2024; Mwayuli et al., 2019). In four studies independent reviewers were involved in coding and data analysis thus, strengthening dependability and credibility (Machado et al., 2017; Machado et al., 2023; Morgan & Welles, 2016; Walker et al., 2020). Only four studies conducted member checking (Gueta &

Shlichove, 2022; Lokithasan et al., 2024; Park et al., 2021; Simon & Wallace, 2018) which enhanced the credibility of the findings.

Most studies reported gaining ethical approval for the research, except for Machado et al., (2017), Machado et al., (2023), McCarrick et al., (2016), Taylor et al., (2022); this is a significant weakness in these studies. In total, most studies have not adequately discussed ethics about confidentiality, safety, debriefing and signposting to services (Ambrozewicz et al., 2024; Bates, 2020; Dixon et al., 2022; Lysova et al., 2020; Machado et al., 2017; Machado et al., 2023; Taylor et al., 2022; Walker et al., 2020; Wallace et al., 2019). For example, in one study (Wallace et al., 2019) the researchers recruited participants from IPV services and conducted the interviews with participants on site; however, there is no discussion on how the ethical considerations of recruiting and interviewing on site were addressed. These are important weaknesses in research in general and particularly when recruiting vulnerable populations (Smyth & Williamson, 2004). Lastly, all studies provided clear statements of findings that aligned with the research aims and in all studies the findings were considered and discussed in the context of the wider literature. Also, it is viewed important to note here that only one study consulted EbEs with the goal to inform the terminology applied to the study (Walker et al., 2020). No other study included in this review consulted or involved EbEs; the experiential knowledge of IPV would have provided relevance and sensitivity to the studies reviewed (Happell & Roper, 2007). Similarly, involvement of EbEs would have enhanced the credibility of the findings. Importantly, it could have potentially provided a deeper understanding of participants' experiences and needs within their contexts.

1.9.7 Rationale for choosing thematic analysis to synthesize the data

The synthesis of findings was conducted by applying thematic analysis (TA) following the guidelines suggested by Braun and Clarke (2006). It is acknowledged that thematic synthesis (TS) is a widely used method applied in qualitative systematic reviews as it provides a structured, transparent and systematic way of integrating findings across studies (Thomas & Harden, 2008). The rationale for choosing TA over and above TS is discussed below.

TA analysis was chosen as the aim was not only to aggregate the findings across studies but also to explore what counts as positive help-experience for male survivors of IPV (Braun & Clarke, 2006; Nowell et al., 2017). In contrast, TS is considered more appropriate when the goal is to aggregate the findings and it is suitable to inform policy and practice. Although informing practice was partly the aim of this SLR, an additional aim was to gain a conceptual understanding of the phenomenon under study. According to the literature, TA is appropriate when seeking conceptual understanding and not only practical recommendations (Nowell et al., 2017).

TA foregrounds researcher reflexivity and interpretive depth; the aim of this SLR was to conduct a context-sensitive account of what counts as a positive help-seeking experience for male survivors of IPV (Clarke & Braun, 2017). TA prioritises depth, context, and interpretive richness over aggregation enabling context to be retained and analysed reflexively rather than potentially flattened in the most aggregative process of TS (Braun & Clarke, 2006; Thomas & Harden, 2008). The process and the experiences of help-seeking for male survivors of IPV are influenced by emotional, relational, systemic and contextual factors (e.g., gender norms, culture, availability of services, intersectionalities, stigma, among others). TA allows for retaining contextual detail and thus noticing contradictions and similarities within and among studies rather than collapsing them into descriptive clusters (Thomas & Harden, 2008).

Indeed, the literature exploring the help-seeking experiences of male survivors of IPV underscores that there is a need to attend to contextual complexity (Taylor et al., 2022) which was especially relevant to our review given the different countries and contexts where the included studies were conducted. The included studies of this SLR were highly heterogeneous encompassing different populations, contexts and research questions. For instance, the study by Morgan and Wells (2016) in the UK investigated how male survivors of IPV make sense of their experiences of victimisation. Alternatively, the study, conducted by Lokithasan et al., (2024) in Malaysia explored how male survivors experience their personal recovery from IPV. TA in that case allowed for greater flexibility in interpreting meaning across differentt contexts while TS requires more homogenity across studies and it is better suited when included studies investigate similar research questions (Thomas & Harden, 2008).

Furthermore, due to TA's suitability for underexplored topics (Braun & Clarke, 2006), it was considered more suitable to support the identification of novel patterns without being constrained by more rigid synthesis frameworks limiting the risk of overgeneralisation (Barnett-Page & Thomas, 2009). Therefore, although TS prioritises reproducibility and comparability, TA was chosen as a more appropriate method to synthesise the findings of this SLR. The strengths and limitations of each approach are summarised in Table 4 below.

Table 4

The strengths and limitations of thematic analysis and thematic synthesis

Approach	Strenghts	Limitations
Thematic Analysis (TA)	1. Flexible across epistemologies	

	2. Emphasises in-depth, interpretative insights 3. Captures nuance, similarities and contradictions and context beyond aggregation 4. Well suited when the goal is to explore an underesearched topic 5. Allows exploration of diverse/minority views	1. Less focused on systematic comparability 2. Time intensive due to deeper engagement with the data 3. Increased potential for researcher's bias if the researcher is not reflexive 4. Less reproducible compared to TS
Thematic Synthesis (TS)	1. Structured, transparent and systematic (e.g., Thomas & Harden, 2008) 2. Facilitates broader generalisations across studies 3. Enhanced rigor and reproducibility 4. Appropriate for reviews producing policy/practice recommendations	1. Risk of missing context/ oversimplification of experiences 2. Emphasis upon consensus over nuance or difference 3. More aggregative than exploratory/risk of flattening diverse views/experiences

1.9.8 Synthesis of findings from selected studies.

Following reading of the studies included in this review, specific findings on positive help-seeking experiences of male survivors of IPV were reviewed and analysed. The NVIVO software was used for coding and analysis. I underlined extracts of interest and coded them on a semantic level focusing on what participants are saying overtly rather than a latent level (Braun & Clarke, 2006). Major themes and sub-themes were generated from the coding groups linking the data together and linking back to the research question. It is important to note that the "themes" and the "subthemes" were based not only on the criterion of frequency but also of saliency regarding answering the research question and illuminating aspects of the phenomenon under study (Braun & Clarke, 2006). Stated otherwise, "subthemes" were ignored if they were not supported by a minimum of four papers and if they did not provide or illuminate aspects that were pertinent to this study. I acknowledge that these decisions are subjective and arbitrary and therefore the researcher's influence on the analysis is recognised (Braun & Clarke, 2006). Three major themes were constructed: 1) positive help-seeking, 2) support from social networks and 3) need for changes. Seven subthemes were generated as demonstrated in Table 5.

Table 5

Major themes and subthemes from the meta-synthesis

Themes	Subthemes
Theme 1: Theme 1: Positive help-seeking experiences (Describes male survivors' positive experiences of seeking help and support for IPV)	a. Understanding of and spotting IPV signs . b. Being listened to and being believed . c. Validation . d. Being part of a support group
Theme 2: Support from social networks (Describes positive experiences from social networks)	a. Practical and emotional support
Theme 3: Need for changes (Describes participants' views regarding what needs to change to better support male survivors of IPV)	a. Increasing awareness of men's IPV victimization and educating the public b. Increasing visibility of services

1.9.8.1 Theme 1: positive help-seeking experiences.

This theme encompasses four subthemes: a) positive help-seeking, b) being listened to and being believed, c) validation, and d) being part of a support group. Those subthemes are discussed below.

1.9.8.1.1 Subtheme a: understanding of and spotting IPV signs.

In seven studies, (Bates, 2020; Gueta & Shlichove, 2022; Hogan, et al., 2021; Lysova et al., 2020; Machado et al., 2017; Simon & Wallace, 2018; Wallace et al., 2019), male survivors of IPV described understanding and recognition of IPV by professionals (police officers, mental health professionals, support workers, lawyers, among others) as a positive experience that shifted their thinking and helped them realise that they were experiencing IPV.

"*I didn't actually think I was a victim until it was pointed out to me [. . .] then when I looked back over 11 years of marriage, I realised I'd been a victim from day one* (P7)." (Wallace et al., 2019, p 252)

"*I consulted a psychologist, and it was good (...) It changed the way that I think and understand what was happening to me.* (B., 35 years)" (Machado et al., 2017, p 520)

Recognition of victimisation and alertness by professionals was described as instrumental in taking the decision to leave the relationship and promoted and encouraged further help-seeking for male survivors (Gueta & Shlichove, 2022; Hogan et al., 2021). This subtheme highlights male survivors' lack of awareness of signs of IPV which is documented in the literature (Hogan et al., 2021; Machado et al., 2023) and the need of training professionals in recognising, discussing and signposting male survivors of IPV (Morgan et al., 2014). The quote below highlights the importance of training and awareness of men IPV victimisation for frontline staff.

"*The pc's were young and had clearly received training. They knew something was wrong and said so, but she would not hear of any help and became angry and aggressive if it was even suggested*. (P33)" (Bates, 2020, p 502)

1.9.8.1.2 subtheme b: being listened to and being believed.

In six studies, (Ambrozewicz et al., 2024; Dixon et al., 2022; Hogan, et al., 2021; Machado et al., 2017; Machado et al., 2023; Wallace et al., 2019), being listened to and being believed was noted as a positive aspect of help-seeking that contributed towards participants' emotional health and empowerment. This subtheme links with the subtheme above in highlighting the importance of frontline professionals' training in spotting signs of men's IPV victimisation.

"*They heard me, they didn't judge me, they gave me support. Sometimes, only hearing what we have to say and having friendly words makes the difference*." (M., 36 years) (Machado et al., 2017, p 519)

"*Having one other person who believes you is significant, is important, and is a source of great strength*" (James). (Hogan et al., 2021, p 940)

CA2 Louis: "*you have to let men know that somewhere, somebody will believe them*" (Dixon et al., 2022, p 1328)

This aspect seems to be particularly important for male survivors of IPV. The lack of awareness that men can also be victims of IPV often results in men’s experiences being dismissed, devalued and even ignored (Bates, 2020). The literature demonstrates that often male survivors of IPV are not being believed (Dixon et al., 2020; Taylor et al., 2020) while fear of being accused of IPV perpetration is common (Huntley et al., 2019). In Hogan et al., (2021) study, apart from being listened to and being believed, participants highlighted that non-judgmental attitudes by counsellors and confidentiality were crucial components of positive help-seeking experiences.

1.9.8.1.3 Subtheme c: validation.

Validation was an additional component of help-seeking experiences that were described as positive by male survivors of IPV among six studies (Dixon et al., 2022; Hogan, et al., 2021; Lysova et al., 2020; McCarrick et al., 2016; Morgan & Welles, 2016; Taylor et al., 2022). Validation concerned confirmation of their victimisation by professionals and authority figures. The role of validation in reducing distress is established by the literature (Linehan, 1993) and according to some studies, contributed against feelings of isolation (e.g., Taylor et al., 2022).

“*It has been recently a huge relief and liberating to have had reassurance from professionals that actually I was the victim and not the perpetrator* (Participant 85, 47 years)” (Taylor et al., 2022, p 18433)

“*I think the figures are starting to show that more men are actually reporting domestic abuse. But it is the attitude you get. The last time, September when she did it on the doorstep and two police officers turned up, I was massively defensive with those police officers. And one of* *them just had to say to me, 'Look, I can tell from your body language you've got the shields up. I'm putting you down as the victim.' It was only when he said that to me that I relaxed. Because my expectation was that even though she was coming round to my flat and I was the one with the injured hand I would still be treated as the perpetrator."* (Lysova et al., 2020, p 1276)

Although most participants commented positively on validation, for one participant validation was not enough; they needed further support through signposting to services that offer ongoing support:

"*Yes, the police did arrive, they did take me seriously, they did follow up etcetera etcetera but there was no, you know, there was no, offer of on-going [support] to have a talk to the support line. They said what I had to do was call my lawyer up*. (Participant 5)" (Morgan & Welles, 2016, p 12).

1.9.8.1.4 Subtheme d: being part of a support group.

Among four studies, (Ambrozewicz et al., 2024; Dixon et al., 2022; Gueta & Shlichove, 2022; Hogan, et al., 2021), being part of a support group, was described as a positive help-seeking experience. Meeting with and/or sharing experiences with other men survivors who had similar experiences was an additional component of experiences that were described as positive by participants. It should be noted that the groups concerned therapeutic intervention groups, online peer support groups, or even research focus groups. Participants described valuing this because it helped with breaking isolation and shame, challenging gender norms around masculinity and victimisation (Hogan et al., 2021), feeling understood (Ambrozewicz et al., 2024; Dixon et al., 2022), they were offered practical support and socialisation (Gueta

& Shlichove, 2022).

"*I think it helped that we found each other so that we can talk to each other on a level of understanding*." (V2). (Ambrozewicz et al., 2024, p 4)

"*It's realising that you're not alone. That was the best thing about it, I'm not alone for God's sake, you know there are other guys that are suffering, I'm not the only weirdo here and that was the best part of it, there are other people*." (John, 74) (Hogan et al., 2021, p 940)

1.9.8.2 Theme 2: support from social networks.

Support from participants' social networks was the strongest theme among the studies reviewed. This theme encompasses one subtheme: a) practical and emotional support. This is discussed below.

1.9.8.2.1 Subtheme a: practical and emotional support.

In twelve studies, practical and/or emotional support from participants' social networks (parents, friends, siblings, in-laws, colleagues, neighbours) was identified as a subtheme under the umbrella of support from social networks (Ambrozewicz et al., 2024; Bates, 2020; Carthy et al., 2023; Gueta & Shlichove, 2022; Hoogan et al., 2021; Lokithasan et al., 2024; Machado et al., 2017; McCarrick et al., 2015; Mwayuli et al., 2019; Park et al., 2021; Taylor et al., 2022; Walker et al., 2020).

Practical support included but was not limited to receiving financial support, having a place to stay, and referral to services, among others. For example, in the study conducted by Carthy et al., 2023, p 10424) one participant commented: "*financial support of my family I managed to get a nice—well it was a 1-bedroom flat—but I set the bedroom up as the girls' nursery basically—and you know, without sounding dramatic: I escaped.*" Emotional support included being listened to, being validated and being believed and was an outlet for some participants. One participant in Taylor et al.,'s (2020, p 18433) stated: "*Yes, it was an outlet for me, to be able to talk to my mother and sister about her behavior. I received support from both.* (Participant 133, 59 years)".

It is worthy to note that among some studies, participants' positive help-seeking experiences concerned support only from their social networks (e.g., Mwayuli et al., 2019; Walker et al., 2020). Also, for some participants among studies, reaching out to their social networks was the only type of help-seeking participants engaged with (e.g., Bates, 2020; Carthy et al., 2023; Mwayuli et al., 2019; Park et al., 2021). According to the literature, a considerable number of male survivors of IPV do not share their IPV victimisation due to fear of responses and perceptions around masculinity and socially constructed gender roles. Despite the importance of sharing their IPV experiences with their social networks, informal support has its limitations. For example, according to one participant in Walker et al., (2020 p 219) study, "*They were supportive initially but became tired of hearing about the ongoing drama.* (P14)". This highlights the importance of accessible and visible services for male survivors of IPV.

1.9.8.3 Theme 3: need for changes.

This theme describes participants views about the changes that need to take place to better support male survivors of IPV. This theme encompasses two subthemes: a) increasing awareness of men's IPV victimisation and educating the public, and b) increasing visibility of services. Those subthemes are discussed below.

1.9.8.3.1 Subtheme a: increasing awareness of men's IPV victimisation and educating the public

Increasing awareness of male IPV victimisation and educating other men and the public was constructed as a subtheme among six studies included in this review (Ambrozewicz et al., 2024; Dixon et al., 2022; Hogan et al., 2021; Machado et al., 2023; McCarrick et al., 2015; Wallace et al., 2019).

"*Perhaps more dissemination, for example, on television. The disclosure that there is about women in the news, you only see IPV against women … The woman was killed by her partner. Then, it is also necessary to put in the news that the man was also murdered by his partner or the partner ordered someone to murder him. (...) I think this disclosure would have been more enlightening for the man. Men also watch television, it's not just women* (B., 35 years)". (Machado et al., 2023, p 258)

"*The biggest thing is a lack of advertisement, so like I was listening to talk sport which is predominantly listened to by men…there was a domestic violence ad about a female victim… it would have been the perfect opportunity to advertise directly to men and educate them on* abuse and the fact that men can be victims. (V4)." (Ambrozewicz et al., 2024, p 5).

There was a lot of emphasis on the need to increase awareness among participants to fight shame and social stigma and to support and educate other men to identify signs of IPV early on. For instance, one participant in Dixon et al.'s (2022, p 1328) study said: "*I think that the biggest . . . thing that could be of assistance here is awareness, so that other men realise this is not something that is an isolated event. . . I think you two (the researchers) are doing exactly what needs to be done . . . creating . . . awareness*."

1.9.8.3.2 Subtheme b: increasing visibility of services.

Among the studies reviewed, increasing visibility of IPV services for male survivors was constructed as the second subtheme among four studies (Ambrozewicz et al., 2024; Carthy et al., 2023; Mwayuli et al., 2019; Wallace et al., 2019). Several participants across these commented that they would not know where to report IPV and where to turn to for help. For example, one participant on Mwayli et al.,'s (2019, p 159) study, when asked about support services they commented: "*you know what we men do; you have no idea where to report*". This subtheme links with the previous subtheme in terms of the lack of public campaigns and advertisements of male victimisation of IPV.

"*I couldn't see anything for men, and then I thought: well, there's Women's Aid, is there no Men's Aid or something?. . . if there was more obvious help available at the time, I would have probably tried to seek it* (Participant 4)". (Carthy et al., 2023, p 10422).

"I didn't know what I was looking for, I didn't know where to go, I didn't know what I needed what I wanted, you are, you don't know what exists, you don't know how it exists (P1)." (Wallace et al., 2019, p 249).

1.9.9 Clinical implications.

Important clinical implications are being raised by this review. Several studies highlight the importance of frontline staff and psychological practitioners understanding of IPV and spotting its signs. As a result, this underscores the need for training and education of frontline staff and NHS professionals on IPV and male IPV victimisation. From an engagement perspective, clinical skills such listening skills and validation were identified as components of positive help-seeking experiences. Offering unconditional positive regard might be useful when working with traumatised populations and it has been linked with post-traumatic growth (Rogers, 1946; Flanagan et al., 2015). Those attributes are especially important given that we know from the literature that similarly with women, men are afraid to disclose experiences of IPV victimisation out of fear of not being believed. An additional burden to male IPV survivors is fear of being accused as a perpetrator (Huntley et al., 2019). Furthermore, some studies demonstrate that being part of a peer support group and sharing their experiences with other men who had similar experiences or socialising with men with similar experiences was perceived as a positive experience by participants due to breaking isolation, feelings of shame of victimisation and challenging gender norms around masculinity and victimisation. This is an important finding for planning for support and interventions. Lastly, although not a subtheme, it is worthy to note that one study in this review demonstrated the importance of confidentiality, trust and non-judgmental professional attitudes for men survivors of IPV (Hogan et al., 2021).

1.9.10 Future research recommendations.

There are important gaps identified in the literature. Most of the studies explored the barriers to help-seeking experiences and in most studies only a minority of participants reported positive help-seeking experiences. There were no studies exploring primarily and in-depth positive help-seeking experiences. Also, there were no studies investigating experiences of help-seeking specifically for psychological difficulties despite the negative impact of IPV on mental health. There is also a lack of research specifically on the experiences and the impact of participating in peer support groups and therapeutic interventions. Additionally, there is a lack of research on the help-seeking experiences of male survivors of IPV from the global majority. It is an imperative for further research to explore the help-seeking experiences of male survivors of IPV from the global majority and those with marginalised identities. Also, future explanatory research should aim to unpick the reasons of the chasm between identifying the vulnerabilities of male survivors of IPV and the lack of trauma informed, evidence-based interventions for male survivors of IPV. In depth research on the experiences of support from clinical psychologists and mental health professionals are also needed as well as research on the mental health and social support needs of male survivors of IPV.

1.9.11 Evaluation and conclusions.

To the best of the author's knowledge, this review is the first systematic literature review focusing solely on the components of positive help-seeking experiences for male survivors of IPV. A notable strength of the studies included was the holistic exploration of men's experiences on personal, interpersonal and wider systemic levels. It is clear from this review that men's experiences of help-seeking interplay with wider societal beliefs and attitudes around gender and gender roles. This review highlighted the importance of training on male IPV victimisation and professionals' understanding of and spotting the signs of men's IPV victimisation. For many participants this was pivotal in ending the relationship with the perpetrator, and for further help-seeking. Also, this review highlighted the importance male survivors of IPV give on validation, being listened to and being believed. Being part of a peer support group either as intervention or as a mode of socialisation was also identified as a positive experience for participants. The literature on survivors of alternative forms of interpersonal violence has established that connection with people with similar experiences through peer support groups is linked with normalization of experiences, psychological well-being, reduced self-stigma and shame and increased sense of empowerment (Konya et al., 2020). Increasing public awareness of men's IPV victimisation and visibility of support services for male survivors were the most dominant expressed needs of participants among the studies reviewed. Both public awareness and visibility of support services can help challenge social gender norms that prevent sharing such experiences and help-seeking for male survivors of IPV. It is worthy to note that despite being a vulnerable population, an alarming absence in the literature is the lack of any descriptions or mentions to evidence-based interventions or trauma informed models of care for male survivors of IPV.

A particular weakness of the studies is that the findings about positive help-seeking were in most cases brief and descriptive. There were no studies primarily aiming to investigate positive help-seeking experiences per se. Also, in all studies reviewed, most participants had negative help-seeking experiences and faced discrimination, disbelief and ridicule from professionals and on some occasions from their social circles. Additionally, in some studies, the methodology applied did not allow for follow up questions (i.e. Bates, 2020; Taylor et al., 2022; Walker et al., 2020). Further research is needed in this area to solidify satisfaction with help-seeking support and uncover the components of positive formal help-seeking experiences for male survivors of IPV. Such research could inform evidence-based practice and professionals' interactions with survivors. Also, another important weakness of this review is that most of the studies included were conducted in Western countries (e.g. UK, Australia, US) and have limited transferability to people of the global majority and minority groups, therefore caution is needed when interpreting the findings. However, this review includes studies conducted outside Western and westernised industrial countries such as Kenya (Mwayuli et al., 2019), Malaysia (Lokithasan et al., 2024), China (Simon &Wallace, 2018), South Korea (Park et al., 2021), and Israel (Gueta & Shlichove, 2022). Although beyond the scope of this review, it is worthy to mention that there were some striking similarities among the studies included, conducted either in International or Western countries: 1) the difficulty of men recognising abuse especially psychological violence (e.g., Gueta & Shlichove, 2022; Lysova et al., 2020; Mwayuli et al., 2019); 2) the reliance upon and the importance of positive support from social circles (e.g., Bates, 2020; Lokithasan et al., 2024; Park et al., 2021); and, 3) the negative, multi-faceted impact of IPV on participants' mental health (e.g., Bates, 2020; Gueta & Shlichove, 2022; Lokithasan et al., 2024).

CHAPTER 2: METHODS

2.1 Chapter Overview

This chapter presents and outlines the methodology used to address the research question guiding this study: “What are the mental health needs and priorities of male survivors of IPV”. The aims of this project were to explore and gain an understanding of the self-identified mental health needs and priorities of male survivors of IPV, to raise awareness of IPV against men and to inform therapeutic practice and support by providing insights into the perspectives of male survivors of IPV. In this chapter, I discuss the research design, its rationale and the research methods employed. I set out and address the ethical issues and the involvement of (EbEs). The concluding section outlines a quality appraisal of the current study.

2.2 Design

2.2.1 Qualitative methodology

The aim of this project was to explore and gain an understanding of the mental health needs and priorities of male survivors of IPV. Thus, a qualitative design was chosen (Olsen & Morgan, 2004). The goal of this study was not to gather generalizable facts, but to gain an in depth, experiential understanding of the mental health needs and priorities of male survivors of IPV in their own accounts. To address these aims, a qualitative research design was chosen (Willig, 2008). In addition, there was lack of qualitative studies exploring the self-identified mental health needs and priorities of male survivors of IPV (Randle & Graham, 2011; Hine at al., 2022). This study aimed to address this gap by exploring the views of male survivors of IPV.

Although also limited, most studies that researched the impact of IPV on male survivors' mental health are quantitative and cross-sectional (e.g., Hines, 2007; Hines & Douglas, 2011). Although this research is unequivocally important as it demonstrates prevalence rates and outcomes associated with IPV victimisation experiences, it does not adequately explain the complex nature of the mental health needs and priorities of men. It runs a risk of over-simplifying a complex phenomenon. Treating complex concepts such as mental health and violence solely as quantifiable variables, separated from the context, is useful in revealing the extent of the problem, but tells us little about the experiences and processes related to such concepts (Laskey et al., 2019). A rich understanding of the mental health needs and priorities of male survivors of IPV are vital for researchers and clinical psychologists to be able to adequately support men and design interventions that are informed by and relevant to service users (Heywood et al., 2019). Such research that incorporates male IPV survivors' engagement in the identification of themes related to their mental health needs is currently lacking.

According to the Seager & Barry (2022), there has been little initiative to design, deliver and research gender specific interventions for men. Due to shame and stigma surrounding men's vulnerability and patriarchal gender role expectations of "stoicism" from men, guidelines suggest that practitioner psychologists may need to think and act outside the box to reach out to men who need support (Seager & Barry, 2022). Yet, such initiatives for male survivors of IPV are currently missing. Drawing on the views of those with lived experience, is essential in offering meaningful and accessible services for male survivors of IPV. Finally, qualitative research can be a valuable to approach to engage under-represent groups in research. It can be an empowering experience, especially for participants who have had experiences of victimisation and abuse (Braun & Clarke, 2013) as they potentially have a more active role and more control about what they can share.

2. 3 Data Analysis

Reflexive thematic analysis (RTA) was chosen to analyse the data obtained (Braun & Clarke, 2020; 2012; 2006). RTA is an interpretive approach that supports the identification and analysis of patterns across a dataset (Braun & Clarke, 2012). This is in line with the focus of the current study which aimed to identify repeated patterns across the dataset regarding the mental health needs and priorities of male survivors of IPV. Additionally, the aim of this research was to inform clinical practice for clinical psychologists and mental health professionals working with male survivors of IPV. According to Braun and Clarke (2020), RTA is better suited to studies that aim to inform practice and service delivery (Braun & Clarke, 2020).

An additional reason behind choosing RTA was its flexibility and its compatibility with the epistemological framework adopted for this study, i.e. critical realism. According to Braun and Clarke (2006, p.81), TA is "characterised by theories such as critical realism" contextualised method that is placed between essentialism and constructionism. Although IPA (Smith et al., 2009) was considered, its focus on participants' biographies and unique characteristics made it less suitable for this study. IPA is theoretically bound and prioritises a detailed examination of individuals lived experiences and characteristics (Larkin et al., 2006). As such, IPA sample sizes are usually smaller (e.g., 5-8 participants). Rather, the goal of the study was to recruit a larger sample size (larger than *N*=10) to capture as much diversity as possible (Braun & Clarke, 2020). Narrative analysis was also considered but it was deemed unsuitable to the aims and the ontological position of this study. Narrative analysis focuses on how language is utilised and how individuals construct and tell their stories to enable meaning making out of their experiences (Riessman, 2008). Although important, this focus is not aligned with the current study.

Despite its advantages, there are limitations to RTA. One limitation lay on the flexibility of the approach. This means that there are many possible variants of thematic analysis; it is open to researchers' interpretations (Terry et al., 2017). On some occasions, the theoretical flexibility has been criticised for leading to inconsistencies between the researcher's theoretical approach and the actual analysis (e.g., Terry et al., 2017). An additional limitation of RTA is that, while it allows for reflexivity, it may not fully capture how gender for example is discussed in participants' accounts or how my sex and gender identity may have influenced the data collection process (e.g., Braun & Clarke, 2022a; Lazar, 2005).

2.4 Criteria for Participation, Sampling and Recruitment process

A purposive sampling strategy was applied (Patton, 2002). Participants were recruited through opportunity and snowballing sampling methods (through social media e.g., “X”). The success of using those sampling methods for male survivors of IPV is documented and supported by the literature (e.g., Bates & Hine, 2023; Bates, 2020). The choice of participants was directed by the criterion of relevance and adequacy of information to address the research question. These methods of sampling are consistent and appropriate when using RTA as they are rooted in qualitative paradigms that prioritise depth and richness over generalisability (Braun & Clarke, 2019).

The researcher set up a separate “X” account for advertisement of and recruitment to this study. The research flyer can be found in Appendix E. Also, four charitable IPV services for male survivors across the UK were emailed to request advertisement of the study through their social media accounts and websites. Those organisations contacted were provided with the study documents (participant information sheet, study recruitment poster, the protocol number and the researcher's contact details). Three organisations responded and advertised the study on their social media and/or their websites. I have not actively asked participants from which charity's social media/website heard about the study as it was decided that this would not add to the study while it may have brought participants in an awkward position. Some participants reported by themselves that they saw the study's poster and recruitment call on the social media accounts of those three charities while others reported that they heard about the study from researchers whom they follow on social media. In addition, the researcher contacted various colleagues through email, text messaging, and asked them to promote the study to their networks (snowballing technique). Potentially interested participants were invited to email the researcher to ask any questions or register their interest in participating in the study. Potential participants who emailed the researcher and stated their interest to take part in the study, were sent information about the study, its voluntary character, the study's information sheet and the consent form. Participants were asked to confirm whether they met the eligibility criteria before proceeding. Participants were asked to confirm that they met all inclusion criteria. Those participants who did not meet the inclusion criteria, or met the exclusion criteria were not able to take part in the study. Four participants who contacted the researcher expressing their interest to take part in the study were excluded due to not meeting the inclusion criteria. Among those individuals, three were excluded because they were residing outside the UK and one was excluded because they were not meeting the criterion of having at least six months length of time since last experiencing IPV. Detailed explanation behind the reason of exclusion was provided to all interested individuals. The inclusion and exclusion criteria are presented in Table 6 below

Table 6

Inclusion and exclusion criteria for participation in the study

Inclusion Criteria	Exclusion criteria
Participants must be 18+ years old	People will be excluded if they do not have the capacity to provide informed consent to participate in the study
Participants must have experienced IPV (such as physical, sexual, emotional, psychological, financial, or controlling behavior) from a female intimate partner	
Participants must no longer be living with and not intimately involved with the perpetrator for safety purposes	
Participants must be able to communicate in English and be based in the UK	
Participants must have access to the Internet and relevant equipment such as a smartphone or a laptop/computer	

Participants will have a minimum time length of 6 months since experiencing IPV to be able to take part in the interviews to protect them from re-traumatisation

Once participants confirmed that they met the inclusion criteria and consented to take part in the research, another email was sent to participants with attached information about support services available in case of distress, guidance about how to change their names on Microsoft Teams and use a pseudonym instead, reminder for participants to be in a safe and private space during the interview to avoid being overheard and use headphones if they wished, and additional reminder that the study runs in a voluntary basis. Participants were asked to indicate the date/time of the interview that would work for them. After that, a Microsoft Teams link was sent to participants.

On the day of the interview and prior to the interview, participants were provided with information about the study and its aims and were asked for verbal consent to participate in the study and for consent to record the interview. Participants were reminded about confidentiality and its breaches. They were reminded that the study is conducted on a voluntarily basis and that they had the right to not reply to any questions without having to provide explanations. They were also informed that they can withdraw from the study within two weeks from the day the interview was conducted. Participants were asked a few demographic questions before the interview started, and they were given the option to not reply to any of them if they felt uncomfortable. This information was stored in a secure and encrypted drive within the researcher's university account and the document was password protected.

The interviews were conducted remotely, lasting between 40-65 minutes. After the interview, the participants were debriefed and thanked for their participation. They were also sent an email thanking them for their time and information about support services was again provided. All recordings were transcribed verbatim by the principal researcher. All transcripts were double-checked for accuracy. After transcription and accuracy checks were completed, all audio files were permanently deleted. Transcripts were imported into NVivo 12 (QSR International Ltd, 2018) and analysed using RTA.

2.5 Data Collection

Semi-structured, interviews were selected as a data collection method. In total, I conducted eleven interviews with participants. The interviews ranged from approximately 41 to 64 minutes (M=52.4). The use of semi-structed interviews is common in qualitative research, and they are regarded to be suitable for obtaining an insider perspective (Denzin & Lincoln, 2005). The reason why semi-structured interviews were chosen is their flexibility in relation to allowing for unexpected issues to be raised by participants, whilst supporting the researcher to explore the aspects of the topic they originally aimed to explore (Braun & Clarke, 2013).

The choice of conducting the interviews remotely was based largely on the time and resource constraints of this specific project. The researcher aimed to recruit participants from across the UK and it was not deemed possible to travel to all potential locations participants are based. Additionally, face-to-face interviews may have put an additional barrier to participation for men, given the sensitivity of the topic under investigation and the shame surrounding male victimisation (Randle & Graham, 2011). Remote recruitment has been proven to work well for this population based on the available literature (e.g., Bates & Hines, 2023; Bates & Taylor, 2021).

Service user and carers involvement in research and in service design and delivery has been highlighted by the Department of Health (DoH) (2000). It is established that engaging individuals with lived and practice-based experience in research facilitates decolonisation of the research process (Gopal, 2021); also, it increases our understanding of service users experiences, improves research credibility, sensitivity and its relevance to stakeholders (Honey et al., 2020). To ensure the perspectives of male survivors and professionals working with them is reflected in this project, I engaged with EbEs who acted as volunteer research consultants. I recruited one volunteer EbE who is a professional providing support to men survivors of IPV and one volunteer research consultant who self-identified as a survivor of IPV from a female ex-partner. Please refer to Appendices (I & J) for the advertisement materials of these volunteering posts. The activities undertaken for both roles were to attend remote meetings (through Microsoft Teams platform) with the principal researcher to discuss the project aims, recruitment, process, interview questions, discuss findings and dissemination of findings. There was no requirement for the participating volunteers to attend all meetings or take part in all activities. The professional EbE took part in all meetings (four in total). As I struggled to recruit a survivor EbE, the survivor EbE joined the study at a later time; they took part in two meetings. The discussions with the survivor EbE focused on the aims of the study, research question, process and stage of study, reflections on SLR, and discussion of the interview guide. They did not take part and did not respond to the invitation to discuss the findings of the study and dissemination. Due to the time and resource constrains of this study, I acknowledge that EbEs did not have the active role I wished for in shaping all parts of the study. For instance, the aims of the project, the research question, the design and the recruitment methods were pre-established before recruiting the EbEs. However, their input was valuable in terms of their reflections regarding the accessibility of study’s materials, the process of taking part, their views regarding the interview guide and the relevance/meaningfulness of the study to them and their experiences. They shed light to aspects that I could not foresee such as the lack of joined services for men survivors and the anxiety this causes, the lack of visibility of services, the impact of lack of awareness of legal rights and lack of legal education among others. The EbEs received a participation payment of £15 per hour through bank transfer for completion of the activities described above. Payment was not made for any activities in which the participant did not participate. There was an agreement both EbEs signed about their involvement and payment (Appendix H).

2.6 Development of the Interview Topic Guide

I designed the interview topic guide (Appendix K) in consultation with the study supervisors to be open and flexible to allow participants to raise any concerns or topics that resonated with their views and experiences whilst, allowing me to explore aspects of the topic I originally aimed to explore (Braun & Clarke, 2013). I developed the draft interview guide based on the research question guiding the project whilst keeping in mind my knowledge of the literature on this topic. The goal was to align the guide with the research questions, the objectives, and the methodology of the study (Castillo-Montoya, 2016). The guide started with broad and easy to answer questions and became more focused in the following questions. I shared the draft interview guides with my supervisors and discussed whether it was easy to understand, relevant, open ended with enough prompts and eliciting in-depth responses (Rubin & Rubin, 2012). There was also a discussion around whether it was felt like a conversation while remaining on track. I asked my supervisors to check for leading questions. None were identified. There were no suggestions for changes during this stage. Since I wanted to ensure that those interview guides would be meaningful for participants, I shared the draft with the EbEs involved as volunteer, research consultants in this study. We reflected on the importance of keeping the interview guides as short as possible (Greenhalgh et al., 2020) and whether the guide is easy to follow, relevant and meaningful. The feedback received from both EbEs was good and both reported that the guide flows well and it is relevant and meaningful.

2.7 Reflexivity

Braun and Clarke (2013) highlight the importance of critical reflection upon the researcher's assumptions that shape the research process. As a White, heterosexual, married female, of middle-class background, who has not been in an abusive relationship and does not have any children I occupied multiple 'outsider' positions whilst sharing only few with some participants. My political ideology is also different from some participants; at least among those who brought up these beliefs with myself voluntarily during the interviews. Following the recommendation of Braun and Clarke (2013), I kept a reflexive journal throughout the research process. The reflexive journal provided a forum for me to record my thoughts, feelings, and assumptions surrounding the research topic, and to reflect upon my experiences of conducting the interviews, analysing the findings, and writing up this thesis (Etherington, 2004). It also served as an emotional outlet -in parallel with supervisors' debriefing - due to the sensitivity of the topic and the strong emotions associated with researching experiences of violence and trauma. An example of input to my reflexive journal following an interview is provided below.

"I was anxious today before the interview. I did not expect to start recruitment that soon and I certainly did not expect that expression of interest about my study from a "hard to reach" population. I found myself feeling uncomfortable and vulnerable asking questions about this topic. I was very aware of my different sex/gender, perhaps the first time I kept thinking about that. Is that guilt because the alleged perpetrator was a woman? Lots of psychological abuse in the past. I was quite moved, it felt many times that the participant wanted to tell me their story, what happened, how badly they were treated so I gave the space. I don't know what would happen with the following interviews, it felt like they really wanted to share what happened. I found myself thinking "oh I wish I could prevent you from experiencing abuse", I felt helplessness at times during the interview. Transference? Need to bring it to discussion with supervisors. I found myself keep remembering to myself that "you are here as a researcher, not as a practitioner" One of the things I decided today, I will give the space to participants to discuss the things that are important to them while following the guide. I certainly have not expected that they would want to share these experiences. My own stereotypes perhaps…"

2.8 Sample

Based on the time and resource restrictions of this project, the original aim was to recruit minimum of 10 male survivors/ participants. According to Braun and Clarke, (2021) the decision about the number of interviews to enable saturation in advance of data analysis is not in line with the values of RTA. The reason lies on the fact that meaning is generated through data interpretation, thus it is not possible to determine the total number of participants in advance. In this study, sampling stopped when there were no additional concepts observed at the data analysis stage; this was indicated by fewer higher frequency codes during coding.

Eleven participants within the age range of 40-70 years old were recruited. All participants apart from one self-identified as White apart from P11, who chose to reply to this question by "Other". All participants were residing in the UK at the time of interview. The demographic details of participants are presented in Table 7. All participants were employed in professional occupations apart from one participant who was retired and two who were unemployed. Due to the sensitivity of the topic studied, participants were given the option to decline to reply to the demographic questions asked. None of the participants declined.

Table 7

Participants' demographics

Participant	Age range	Race	Relationship status
P01	40-45	White	Single
P02	60-65	White	Single
P03	65-70	White	Single
P04	55-60	White	Single
P05	60-65	White	Single
P06	40-45	White	Single
P07	50-55	White	Single
P08	50-55	White	Single
P09	45-50	White	Single
P10	50-55	White	Single
P11	50-55	*Participant chose to reply to	Single

	this question by Other

2.9 Data Analysis Process

For the data analysis, I followed the six-step process proposed by Braun and Clarke (2021; 2019; 2006). The six-step process proposed by Braun and Clarke in 2006 remains relatively similar with the RTA refined in their later work; in their more recent work, they have slightly changed the names of the six phases (Braun & Clarke, 2021). Here, I apply the terminology used in their later work. During the first phase, interviews were listened and re-listened and transcribed by the principal researcher (Braun & Clarke, 2006). Following completion of transcription, I read all the interviews to familiarise myself with the entire body of data set highlighting in yellow extracts of interest. During the second stage named “coding the data”, I generated the initial codes from the transcripts using NVivo 12 software. It should be highlighted that I took an active role in the analysis by generating these codes (Braun & Clarke, 2021). I decided to code on a semantic level. The latent approach focuses more on ideologies and the underlying ideas within the dataset and tends to be associated with more constructionist approaches (Braun & Clarke, 2006). In contrast, my focus was on what the participants were overtly saying, given that this is an understudied topic.

I applied initial codes to the entire dataset. After coding all transcripts, I returned to each transcript and checked the relevance of the codes to the text. Not all sentences were coded in alignment with guidance by Braun and Clarke (2021); this decision was guided by the research question of this study. For example, descriptions about the alleged perpetrators’ childhood experiences were not coded as those aspects did not count for analytic interest/importance to this study. As a result, the codes I generated were influenced by the research question, by my critical realist stance, and by the literature I have read previously on the topic (Braun & Clarke, 2021). According to Braun and Clarke (2006, p14), “it is important to retain accounts that depart from the dominant story in the analysis”. I chose to do this to ensure that I did not omit a potential code if they appeared less common than another. This is evident in the next chapter where I include atypical data excerpts to ensure an accurate reflection of the data collected. During phase three, named “generating initial themes”, I had a long list of codes; I merged duplicate codes and collated similar codes. At this stage there were several codes that had apparent connections between them (e.g., “loneliness and losses” and “mental health difficulties”) but there were also codes that “did not seem to belong anywhere” (Braun & Clarke, 2006, p15). I struggled the most during this phase. I returned to re-reading the relevant sections in the interview transcripts and moved the codes across thematic groups to consider whether I should merge them with a thematic group or whether creating another group would be more appropriate (e.g., “massive awareness campaign”).

At phase four, now named “developing and reviewing themes” I checked potential themes against the coded data and the entire dataset. My goal during this phase was to determine that the themes tell a “convincing story of the data”, and one that answers the research question. In this phase, originally thought potential themes were discarded. This phase ended when I managed to create a provisional table grouping relevant themes and sub-themes. During the next phase, “refining, defining and naming themes”, I reviewed the names of the themes to ensure that they reflect the data, and they relate to the research question. At this phase, I realised that the names I provided to the themes were like “topic summaries” rather than “meaning-based interpretive stories” (Braun & Clarke, 2022, p2). For example, the first theme was initially named “impact of IPV” instead of “The many fragments of me-the toll of IPV”.

According to Braun and Clarke (2022), this is a common among data analyses approaches such as codebook TA or template analysis that focus on coding reliability and take measures to reduce researcher bias. Also, in these approaches the themes have been often conceivably developed before data analysis. This was not the case in this study. Also, in this study I aimed for the themes to represent interpretative stories that have a central idea that unifies them (Braun & Clarke, 2022). The final stage of Braun and Clarke’s (2021) RTA refers to the production and presentation of report. During the write-up of the analysis, I chose extracts from the transcripts to illustrate elements of the themes. It is important to note that the process of the data analysis was not linear as presented here. I went back and forth between the stages multiple times.

2.10 Ethical Considerations

The study was granted ethical approval by the University of Hertfordshire Health and Science Engineering and Technology; Protocol number: aLMS/PGR/UH/05627(1) (Appendix A). An amendment to remove my surname from the recruitment/promotion flyer was submitted and granted (Appendix B). I used the Code of Human Research Ethics to ensure the project adhered to the ethical guidelines (BPS, 2021).

2.10.1 Informed consent.

All participants had to consent to be able to take part in this study. The information sheet was sent to all participants via email upon expressing their interest in the project (Appendix C &

D). The information sheet outlined the purpose, aims and subject of the study. Also, it included information about what would be required of participants if they consented to participate, the risks and benefits, and how their data would be stored. All participants were invited to ask questions, and they were given a minimum of 24 hours to consider their participation in the study before consent was sought. Before each interview started it was emphasised to all participants that participation was on a voluntary basis and information about the study was given verbally to participants. Further verbal consent was sought both for participation in the study and to audio-record the interview.

2.10.2 Confidentiality.

In this study, confidentiality was maintained in accordance with the Data Protection Act (2018), the British Psychological Society's Code of Human Research Ethics (2021), and the General Data Protection Regulation 2016/679. Identifiable information was removed from interview transcripts and all participants were assigned a participant ID number (i.e. Participant 07). Data were stored in a secured and encrypted drive within the principal researcher's university account. Only the principal researcher and authorised researchers involved in the analysis had access to this data. Participants were informed that personal data will be retained for the minimum period necessary for the research, and after this period, all identifiable information will be securely deleted. Participants were informed about confidentiality and its breaches verbally and in written form (i.e. the information sheet and the consent form) (Appendices C and D).

2.10.3 Right to withdraw.

It was highlighted to all participants (both verbally and in written form) that they could withdraw from participating in this study and that withdrawing from the project would not negatively affect them in any way. Participants were informed that they can withdraw their data up to two weeks from the date the interview was conducted. This specific withdrawal date was established due to the character of the study. It was not deemed feasible to extract individual data once the qualitative analysis would start. None of the participants requested their data to be withdrawn. Participants were also informed that they have the right to terminate the interview without providing any reason and the right to not answer to any questions if they do not want to, without providing any reason.

2.10.4 Risk of harm.

Due to the sensitivity of the topic researched, it was anticipated that participants may experience psychological distress. Participants' wellbeing was at the centre of the research procedures. All participants were welcomed warmly and thanked for their time and willingness to participate. There were several practical measures taken to minimise distress and risk for participants. These included but were not limited to: 1) participants were not asked question about their victimisation experiences per se; 2) to protect participants from re-traumatisation, participants should have had a minimum time length of 6 months since experiencing IPV to be able to take part in the interviews; 3) to protect participants from harm, it has been decided that to be eligible, participants should no longer be living with and not intimately involved with the perpetrator; 4) participants were advised that they do not have to answer any questions, if they do not wish to, that they may take a break or terminate the interview at any time, and that declining to participate will not in any way affect them; 5) prior to the interview, participants were asked -if they wish- to change their names on MT and use a pseudonym instead so their real names won't appear in recordings. Guidance on how to do this was provided to participants (Appendix G); 6) information about local and national support organisations were sent to all participants (Appendix F); 7) debriefing took place after the interview with all participants (Appendix L).

2.10.5 Risk to the researcher.

Researchers who often engage in first-hand material of violence and abuse may experience secondary or vicarious trauma (Kaul et al., 2024). To mitigate for this, the researcher was offered support in the form of debriefing from the principal supervisor who is an experienced clinical psychologist and the secondary supervisor who has expertise in the topic of IPV against men. An additional measure was writing on the researcher's reflective journal without including any confidential or potentially identifiable information about participants.

2.11 Quality Appraisal of the Study

The CASP (2018) criteria used in the SLR were used to evaluate the quality of this study, as illustrated in Table 8 below.

Table 8

Evaluation of the study's quality

Criteria for Quality (**Y= Yes N= No, CT= Cannot tell)**	**Criteria**	**Evidence for meeting the CASP criteria**
Is there a clear statement of the aims of the research?	Y	The aims of this study have been stated clearly.
Is a qualitative methodology appropriate?	Y	Qualitative methodology was appropriate to explore and gain an in depth understanding of the topic studied.
Was the research design appropriate to address the aims of the research?	Y	A qualitative research design was appropriate to address the research question, and the research aims. It also addressed a gap identified in the literature.
Was the recruitment strategy appropriate to the aims of the research?	Y	The project applied purposive and snowball sampling.
Was the data collected in a way hat addressed the research issue?	Y	The data collection process is outlined in detail in the relevant section of this chapter. The interviews were conducted remotely through MT platform. SSIs were selected due to their flexibility to allow for unexpected issues to be raised,

		whilst supporting the researcher to explore the aspects of the topic they originally aimed to explore.
Has the relationship between the researcher and participants been adequately considered?	Y	I outlined my positionality and the epistemology in the introduction section. I had regular supervision, EbEs were engaged as consultants, and I kept a research diary with reflective notes/observations.
Have ethical issues been taken into consideration?	Y	The study was granted ethical approval by the University of Hertfordshire Health and Science Engineering and Technology; Protocol number: aLMS/PGR/UH/05627(1). Ethical issues are discussed in the ethics section of this chapter. An ethical amendment was made; this has been outlined in the appropriate section of the methodology and provided in the Appendix B.
Was the data analysis sufficiently rigorous?	Y	I followed a rigorous analysis process; the process has been presented with transparency in the analysis section. My active role as a researcher in data analysis has been highlighted.

Is there a clear statement of findings?	Y	I presented a table of the findings; a summary of the findings and I discussed the findings in regard the research question that guided this study in the last chapter.
How valuable is this research?	Y	This study addresses a gap in the literature by looking specifically at the self-identified mental health needs and priorities of male survivors of IPV. It offers important clinical implications for clinical psychologists, mental health professionals and service providers; suggestions future research are also provided.

CHAPTER 3: FINDINGS

3.1 Chapter Overview

In this chapter, I present and discuss the findings from the RTA. Four themes and eleven subthemes were identified from the interviews as shown in the thematic map (Figure 3) and Table 9 below. The themes and subthemes are discussed below, and verbatim extracts are provided from anonymised interview transcripts. Verbatim excerpts are presented in italics. Square brackets indicate inserted or omitted information, while ellipses indicate short pauses during speech. Excerpts were chosen based on representativeness of accounts, but atypical data excerpts are also presented to illuminate alternative perspectives of the topic discussed.

Figure 3

Thematic map of themes and subthemes

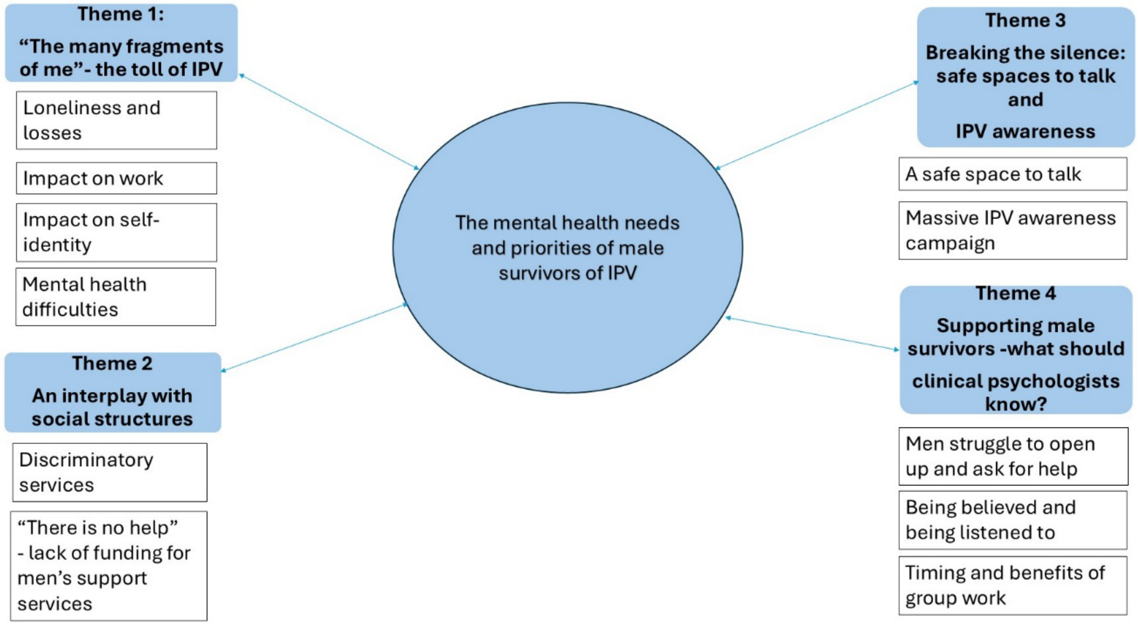


Table 9

Major themes and subthemes of the empirical study

Themes	Subthemes
Theme 1: "The many fragments of me" – the toll of IPV	1. Loneliness and losses 2. Impact on work 3. Impact on self-identity 4. Mental health difficulties
Theme 2: An interplay with social structures	1. Discriminatory services 2. "There is no help" -lack of funding for men's support services
Theme 3: Breaking the silence: safe spaces to talk and IPV awareness	1. A safe space to talk 2. Massive IPV awareness campaign
Theme 4: Supporting male survivors -what should clinical psychologists know?	1. Men struggle to open up and ask for help 2. Being believed and being listened to 3. Timing and benefits of group work

3.2 Themes and Subthemes

3.2.1 Theme 1: "the many fragments of me" – the toll of IPV.

This theme discusses the impact of IPV on participants. Within this theme, four subthemes were identified: a) loneliness and losses, b) impact on work, c) impact on identity and d) mental health difficulties. Each subtheme is discussed in turn.

3.2.1.1 Subtheme 1: loneliness and losses.

Participants commented on the losses and loneliness due to leaving the abusive relationship and because of experiencing IPV. For example, according to P09, due to a lack of understanding from his family and not wanting to burden his friends with his IPV experiences he reported: "*You feel really lonely, you know, I've, I've not thought about killing myself. But I understand why people might end up there."*

P07 commented that although "*it's a healthy thing to leave the abusive relationship*", there are still losses such as no longer being a family unit and significant changes that follow the separation from the abuser (e.g., contact with children). In addition to the losses that accompany that decision, P07 commented on the anxiety of not knowing what the future will look like.

"*… the thing about the loneliness as well, it's kind of loneliness, but, actually, I think it's probably more loss. It's a bit like a bereavement because and you know, whilst it's a healthy thing to come out of an abusive relationship of course, there are still things that you are losing by doing that you know? So, until that point, we were a family unit, you know, husband, wife, three children. And you are putting a stop to that. And so, life changes* *significantly from that point forward. And so, the loneliness that I felt is more about a sense of loss and not knowing what the future is gonna look like. I think it's more about that, not knowing what's gonna happen next and that the anxiety that brings*” P07

P04 also commented on the grief of losing his wife and his children who turned against him in the afterwards of separation.

“*And so, during that time, it wasn't only the pain of the abuse and the grief of losing my wife, it’s the afterwards of even the children were turning against me as well*.” P04

Participant P10 commented that he lost everything in the process (i.e. his career, savings, house, and his friends) and highlighted that he is restarting his life now. He discussed that he does not have any desire to save up again for a house, and he commented that if he gets a terminal illness due to his inability to work and lack of savings in addition to lack of support due to loneliness that would be the end for him.

“*I've lost everything in the process. I'm literally restarting life at [age of participant]. I'm at the fact that if I, you know, if I got terminal illness or if I got ill, that's it! […] She took every possession I had, so I've had to restart life. I've got no, no inclination to save up for a house or anything*.” P10

“*So, when we split up, I lost all my friends in 20 years, so I was very lonely for quite a while, for about two or three years*.” P05

P08 highlighted the loss of time spent with his child as an outcome of separation with the perpetrator and because of how the family court system functions.

"*Yeah, it's absolutely unbelievable what's going on and it's like, this is your thing, right? You've got more contact with my own* [child] *than I have. What the hell? […]. The local shopkeeper has got more contact with my* [child] *than I have. This is insane!*" P08

Similarly, P11 linked the experiences and the impact of IPV with male suicide rates however, commented on isolation and not loneliness. According to P11, because of his age and financial stability he had the opportunity to search and read about IPV against men and inform himself. In contrast, male survivors who do not have those privileges feel isolated.

"*So, somebody who is, I don't know, less life experience, and yeah, less kind of knowledge, how do they go? I think they would be very isolated. And I'm not surprised that male suicide rates are higher. Yeah, that that how serious this is I guess*." P11

It is worthy to note all participants reported being single at the time of the interview. Apart from being reflected in the accounts of participants included in this subtheme, loneliness was further suggested by the fact that most participants highlighted their need to have someone to talk to, the need to be listened to, and their desire to meet and socialise with other men survivors of IPV. Those subthemes are linked with this subtheme, and they are presented and discussed later in this chapter. Feelings of loneliness are being intensified when social institutions (e.g., police, social services) designed to provide support, fail survivors. This links with the following theme named “an interplay with social structures”.

3.2.1.2 Subtheme 2: impact on work.

Participants discussed the negative impact of IPV on their work. The impact on work reported concerned difficulties with concentration and focus, low self-esteem, losing a job or a career, and being suspended for a period due to false allegations. This finding highlights the complexity of IPV and its multilayered impact on survivors and on the social systems around survivors. P01 and P05 commented on the impact of IPV on their work due to their inability to concentrate and communicate with others which may have impacted upon their productivity.

“*[…] and my work was a bit of an outlet, but even at work, my work suffered, and my colleague realised how unwell I was, you know, physically and kind of mentally. I wasn't this focused*.” P01

“*But at work I've been really stressed out and really anxious because I found it really hard to communicate with and be around people*.” P05

According to P06, IPV cost him his career which was due to his own and his ex-partner behaviour.

“*Yeah. I mean so. So, I lost my career. I was studying [subject] in [name of city], so obviously you know, it was partly me, partly her. But as a consequence of mine and her behaviour, I lost my career as a [job title]*” P06

For P07, the impact of his experiences at work was related to his confidence and self-esteem which has been noticed and raised by his boss.

"*I started to work for a new boss and this new boss had a meeting with me once and I had a discussion with about my personal confidence and saying you do, you're really good at your work, but you don't come across as very confident and that sort of made me realise that I'd obviously lost a lot of my personal confidence and self-esteem. And so, that was probably most noticeable*" P07

P09, apart from the impact of IPV on his work, commented on the impact on people around him, such as his parents as well as additional social institutions such as schools.

"*Yeah. So, her behaviour has impacted everybody else around the family at my parents, my, my, my parents worried they came and helped me for a while. She's created chaos with schools, you know. Yeah, it's, you know, anyway it just impacts so many people."* P09

3.2.1.3 Subtheme 3: impact on identity.

Participants commented on the impact of IPV on their identity and self-perception. Participants' accounts highlight the devastating impact of the loss of or reformulation of self-identity due to IPV. According to P04, within the context of IPV, a person completely loses who they are, as what they are is being devaluated and shamed; at the end according to P04, this person becomes a shadow of themselves. P07 used the exact same expression to describe how they felt in terms of their identity within the abusive relationship as they reported that they were unable to pursue the things they enjoyed and loved within the relationship with the alleged perpetrator.

"Because the person that I was with, she just tore me to shreds. I needed to regain a sense of myself. […]. You completely lose, exactly, you completely loose who you are for various reasons. I know how they do it, it's bit by bit by bit by bit by bit and then when you do start regaining yourself, they crush, they try to, they try to shame you and crush that down so that when you start trying to be yourself like as a [creative profession] *whatever would seem not great, you know. Oh being a* [creative profession/job title], *it's not a good thing, type of thing. But yeah, that's who I am, I am a creative person. So that becomes, I couldn't be myself. So, not only about regaining, trying to regain a sense of self, but you change and become something different to what you were. You become a shadow of yourself."* P04

"*[…] I think I think the biggest thing is reclaiming those sorts of things that I was passionate about before the relationship. So, one of the things about being in a controlling relationship is that I couldn't pursue the things that I held dear. […]. So, I realised now looking back is that I was a shadow of myself in the relationship*." P07

P09 commented that questioning your experiences and your sanity is even worse than losing self-confidence and sense of self-identity.

"It's horrific. It's degrading. It's basic extreme boogying, and I think there is it. You lose self-confidence, you lose self-identity. But almost worse than that, if the perpetrator is in denial,

you start questioning your own sanity. You start to question whether or not what you've experienced, what your experience is, is real or not, and towards the end I became desensitised to it.” P09

This is in line with P01’s statement according to which “*You kind of always questioning yourself, whether you feel stupid that you let yourself, this would probably go for males and females, if you're in this sort of a relationship where you're trauma bonded to a person, you love them even though you know that they were a bad person.”*

Participants’ accounts reflect the journey through the erosion of their self-identities to a process of rebuilding themselves. For example, P04 reported “*She used to like me to not shave. I also became quite scruffy at let myself go, you know, but to cope, I would try to regain a sense of myself, and I would shave*”. While according to P07 “*I'm much more, hm, less tolerant of things that are harmful to me, if that makes sense. So, in some ways I'm better than I was in some respects*”

3.2.1.4 Subtheme 4: mental health difficulties.

All participants described IPV as a traumatic experience in their lives. Participants reported that their mental health suffered because of IPV. Anxiety and depression were the most commonly reported difficulties together with sleeping difficulties and symptoms of PTSD such as flashbacks, nightmares, hypervigilance and hyper alertness. Two participants (P02 and P09) received an EMDR intervention for their PTSD difficulties in addition to counselling and CBT. Four participants reported that they initially coped by abusing substances such as alcohol and/or marijuana. It is worthy to mention that nine participants sought for and received psychological support for their mental health difficulties. Participants described psychological support as invaluable, useful and helpful.

P04's account describes how he experienced depression and low mood. After experiencing an emotional breakdown at work, he stayed out of work for three months.

"*Uh, I was very, very low at times. […]. I was incredibly tired. A lot of the times I felt I was trying to just struggle to get through. I had a breakdown at work, where I just, everything just stopped. I couldn't stop crying. I couldn't move. I couldn't! I didn't go into work for three months. I spent the time in bed for the most part*." P04

P01 described seeking psychological support and engaging in CBT for depression and anxiety because of experiencing IPV. According to his account, IPV was affecting him both physically and mentally.

"*So yeah, it was obviously really, really depressed and the anxiety started like, it was affecting me in every single way, you know, physically, mentally everything, really*." P01

P10 described his mental health difficulties as "paranoia" although the symptoms described were indicative of agoraphobia. However, due to the mental health stigma at his work and him being fearful of people at work finding out he accessed mental health support he did not receive psychological support from a qualified professional for his difficulties. Based on his account, his agoraphobia seems to be long lasting. It is important that P10 described still being "petrified" from his ex-wife despite having separated 3 years ago.

“*So yeah, but obviously a lot of paranoia, as I said out in public, in groups, you know, bought headphones just to cancel noise. I don't like being in groups. I am petrified of my ex-wife because she does not care what she does and what she does to other people. Because she's never been held to account for it*” P10

P09 described how he became hypervigilant during the abusive relationship due to looking out for signs of escalation of emotional outbursts and violent behaviour.

“*[…] and you know but then you're always, you always live in fear, and you become hypervigilant, right? It's the word I haven't used yet. You do become hypervigilant because you're looking out for the little behavioural traits where you will know that once that's happened, we're on an escalation path*.” P09

“[…] *there were lots of other, lesser allegations that I had to deal with because it seemed to be that I was guilty until proved innocent, not the other way around. Hmm, and that, yeah, that, nearly finished me off. I couldn't sleep. […]. I spent from the early beginning of 2012 till probably halfway through 2014 and I was not sleeping because if I went to sleep, you know when you wake up in the morning and it maybe takes 5 or 10 seconds for you, you know. And it's when everything hit me when I woke up. So, my body refused to let me sleep, or so my brain refused to let me sleep because of that*.” P02

“*So, I started, I managed my emotions with marijuana and alcohol. […]. But I was lonelier once I'd stopped because it was my best friend. It was my, my emotional support and so I'm still learning to deal with my emotions without alcohol*.” P05

The accounts presented here demonstrate the severe impact IPV had on participants' mental health and highlight the need for trauma informed models of support to male survivors. These findings underline the need for clinical psychologists and mental health professionals to be aware of the relationship between IPV and mental health problems, ensuring service users' safety and being able to identify and address these issues in treatment plans. The importance of training in IPV and awareness of its links with mental health for health professionals is further highlighted by what P02 shared when asked if there was anything that he would change about how the systems around male survivors of IPV work, what would that be. According to P02:

"[…]. And needs to be counsellors attached to GP surgeries, cause what people want is, they want somebody to talk to. They don't want drugs, they don't want to be medicated for suffering domestic violence you know, because they're again the number of people I've spoken to, they've been to their GP, they've been brave enough to explain what's been going on, and again you know you get put on the waiting list for psychology and you get off of antidepressants and you know, it's not necessarily what you want, is it, you know. Yeah."

P02 account underlines the limitations of the biomedical model; focusing solely on addressing the mental health symptoms and offering medication for symptoms associated with IPV is not particularly what all IPV survivors want.

3.2.2 Theme 2: an interplay with social structures.

This theme presents the problems participants experienced and/or identified when they sought support for IPV. The subthemes constructed are two: “discriminatory services”, “there is no help-lack of funding for men’s support services”. This theme, links with the previous theme as the impact of IPV is directly linked with the support available and the quality of support received. For participants, their experiences with support services contributed negatively to their mental health and perceptions of themselves in addition to the IPV experiences. For some, these experiences were even more traumatising than the actual IPV (e.g. P07). Each subtheme is discussed below in turn.

3.2.2.1 Subtheme 1: discriminatory services.

Participants reported that the support services are discriminatory against men (e.g., the police, social services and the criminal justice system). They appeared dissatisfied with the services, helpless and they reported being treated with disbelief and suspicion. There was a sense of perceived injustice in their accounts.

According to P02, being treated with disbelief and suspicion by a professional was disturbing. He then described an experience of his, when he reported to the police sexual violence victimisation by his ex-partner, and the police officers commented that he must have enjoyed it.

“*I'm, I'm a pacifist by nature and ideology. You know, I've never hit anybody, never mind a woman! And to suddenly be treated in this way by all these professionals was really very, very disturbing […] And I went along, and it was two female officers and one of them had this big sheaf of papers, and then she brought out a sheet, she said oh, it says here your wife used to handcuff you to the bed and squeeze your testicles well, you must have enjoyed it, or you’d reported it sooner. So, I just, I couldn't say anything after that. I just left and that set* *me back a bit and my flashbacks became a bit, whatever you want to call them, they became a bit more frequent*." P02

P07 reported that when he went to the police, they told him that because he is a man, he should be able to deal with IPV on his own. He commented that this is not justice for him and described it as inequality.

"*So, when I went to the police about my problem, the second time I went to the place there was there was a first time, but the second time I went to the police they told me that as a man I should be able to deal with it. There were used to helping women, so the police officer said to me we're used to helping vulnerable women, women, but as a man you should be able to deal with this yourself and they didn't wanna get involved. […]. It isn't, it isn't justice. Yeah, it's inequality*." P07

P09 commented on the differences of how a male perpetrator of IPV would be treated in contrast with a woman, i.e. his ex-wife. According to his account, although it has been proven that he is a survivor of IPV in court, he suffered multiple losses in contrast with his ex-wife, who has not faced the consequences a man would face if they were found to be an IPV perpetrator. For P09, this is not only sexism but double standards discrimination against middle class men.

"*Such was the severity of what had happened. So, so it's not just sexism, it's also without being political, it's two tiers if you're middle class. So, so you, you, probably know. I mean, there's the, the, if she'd have been a man, should have had to go on a domestic abuse* *perpetrators program before she had any contact with the children the first time we were in court, she did not have the kids overnight for six weeks, six months and she was just giving them three nights a week.*" P09

P10 discussed how he has been dismissed from his work because he is a man, although it was proven in court that his ex-wife was the perpetrator of IPV. According to P10, the consequence of that was that he lost his job.

"*How, how they've dismissed me as a male and they just accepted even my ex-wife said, even though the court since proved it.*" P10

"*Nobody listens. Nobody cares. Nobody takes you seriously. Because you're a man*." P02

The perception of injustice, discrimination and being unfairly treated by services may be linked with re-traumatisation and powerlessness and can worsen mental health outcomes.

"*And I think the way domestic violence services are, they're turning this into a gender war, it shouldn't be*." P11

3.2.2.2 Subtheme 2: "there is no help" - lack of funding for men's support services.

Participants in this study reported that there is no adequate help for male survivors of IPV. According to participants, the support services for male survivors of IPV receive limited funding, which is not adequate to offer meaningful support to survivors. Participants' accounts reflect a sense of helplessness and perceived injustice by drawing on comparisons with existing services for women. For instance, according to P08, "*And what I mean by that is no funding for men, monopolization of the funding by women services*". According to P02, "*There's no help. Uh, there's, there's still very, very little help.*" P10 and P09 referred to a UK helpline charity that supports men survivors of IPV and they highlighted that it is under resourced, and they can be contacted only during working hours.

"[…] *but the funding is not there. They don't get funded like Women's Aid or refuge, or anywhere like that. […]. There is no 24-hours support line for male victims of domestic abuse. You know, there's* [name of helpline charity], *but that's only if you can ring during the working day.*" P10

"*I think there's the* [name of the helpline charity] *[…]. So, they clearly are under resourced."* P09

P01 raised comparisons with the Women's Aid in terms of men survivors lack any unified support. He also underlined that an advice line is not the same as face-to-face support due to it being impersonal. Importantly, the advice line is tied up to Women's Aid and according to P01 men are afraid to contact them due to fears of their stories of victimisation being "twisted" and used against them.

"*When I went into Women's Aid, and I saw the setup that they had, and I'm like nothing like this exists for men. Nothing unified anyway. And the thing, the only thing that exists for men is something called the men's advice line. I don't know if you've ever heard that, but that's an advice line. It's, all it has is like a phone. It's not like an actual physical space you can go to,* *so it's impersonal, but it's also tied to Women's Aid. So, there's a lot of men that think I don't want to speak to that because things may be twisted around, and then I might end up being the subject of Women's Aid, and they're afraid, I totally understand that. […]. But you know what it's like in terms of getting funding for some things. These things, it's not, it's not easy*." P01

P11 described his journey of seeking support through various services including IPV services for men, his employer, and his GP. He reported that he struggled to find any kind of support apart from his counselling for which he is paying privately.

"*I've really struggled to find any support of any kind actually. So… yeah, yeah. I've been to… What do they call it? Occupational health. Occupational therapist through the GP. So, I'm thinking I've done everything I could proactively to share what's happening for me, but like I say yeah, wasn't, it wasn't really getting anywhere in terms of finding any support."* P11

3.2.3 Theme 3: breaking the silence: safe spaces to talk and IPV awareness.

This theme illustrates the main needs and priorities I identified from participants accounts. This theme encompasses two subthemes: a) a safe space to talk, and b) massive IPV awareness campaign.

3.2.3.1 Subtheme 1: A safe space to talk.

According to participants, a safe, contained space to talk about their experiences of IPV and its impact on them, is a male survivor's main need and should be a priority. For instance, P01 when asked about male survivors' main needs and priorities he responded: "*It's definitely talking, like a talking therapy having someone to speak to who will listen*." P01

P11 commented that while it is hard to speak on behalf of all men, a safe space to talk offered by professionals, fostering emotional wellbeing is the main need of men survivors. He noted that for those men who lack the financial resources to pay for counselling sessions weekly - like himself- such a space does not exist.

"*I think it's really hard to say for all speak on behalf of all men, but I think there's something about emotional well-being and support and giving men a safe space to talk through professional services. I just don't think that exists unless you seek it out yourself. And if you can't afford that, and I had a job, there are lots of people who just wouldn't be able to afford a counselling session every week*." P11

"*the first step in this is I think as we all know is getting the men to talk, you know, my wife is hitting me, my wife is being abusive, my wife is doing this to my children and you know, you can't, unless you know, because after if they do ask for help then that's great because they can speak to our psychologist and find out they're not alone and find out that, maybe find out ways of treating the wife. […]*" P03

P05, similarly with P01 and P11 placed the need to talk within the context of a therapeutic relationship; it is the therapeutic relationship that would allow men to talk and share IPV victimisation. P05 added the dimension of unconditional positive reward, a core concept of person-centred therapy as crucial because according to his view, men lack awareness of dealing with emotions.

"*The immediate need is relational, a therapeutic relationship. Someone who would listen to them. Relationship to allow them to talk and to provide just a huge amount of unconditional positive regard because they're like most men were emotionally stunted, we don't know how to deal with our emotions*." P05

Although it does not constitute a subtheme, it is important to note that some participants added that an additional need is guidance for survivors. Guidance according to participants' accounts concerned signposting to services, how to stay safe, how the legal system works, and legal aid. Thus, guidance may be personalised to each person's needs. This finding highlights the need for GPs and mental health professionals to be aware not only of IPV, but for third-party support services and multi-agency support.

"*OK. I, I well for me the most important thing would have been guidance, some sort of guidance around what to do, some support and help because you can't think straight. So, you need that sort of help for someone to help get help you get your ducks in a row, so there's that element and then some guidance around what you need to do next, and you know, how to stay safe, and so, I'd say those are the sort of the key things."* P07

However, in contrast with most participants, P06 reported that talking is not what he wants to do; instead, he reported that he prefers problem solving because this is what society expects from men within the capitalist system.

"*It's not true, you know, get a good job, earn some money, buy a house, find a decent woman, have a family. That the reality of what men are gonna be expected to do like within capital, right? That's what you're gonna be expected to do! Crying about stuff is and talking about stuff no, you need to act! Yeah, you need to act in the world like you know, we can talk about whether that's a good or a bad thing but that is the bottom line of what you will be expected as a guy."* P06

3.3.2.2 Subtheme 2: massive IPV awareness campaign.

Participants noted that the priority is to raise awareness of IPV against men among the public and among professionals to increase knowledge that IPV against men exists and to break the stigma. This links with the theme "an interplay with social structures", thus with men's experiences of being discriminated from services and their perception of injustice regarding lack of funding of services for male IPV survivors. It also links with participants' experiences of disbelief and devaluation of their experiences from services. For instance, according to P02, "*And then I think that needs to be a massive just awareness campaign… […]*".

P05 reported that there needs to be a public awareness campaign funded by the government for IPV, family violence and mental health to break the fear and the stigma of these topics.

"*Oh, get the government to put some money into a public, public awareness scheme. So, it's there on TV. I mean alongside there should be men's domestic violence, family, domestic violence. Well, men's mental health. if people were seeing adverts on the TV every couple of hours or once a night or something, over time it would normalise, it would bring it into a* *conversation, and once it's in conversation, fear is reduced, and it starts to be accepted to talk about it*." P05

P09 reported that if he had the money, he would be commissioning a public awareness campaign through TV. Also, he commented on the power of people's stories and advised the research to publicise their research so awareness of IPV against men is raised.

"*I actually thought if I had the money, I would commission somebody to do a something on the TV. Like you know, a one or two hours, maybe a 2-hour thing. Because the thing that everybody said when my family broke out, everyone said we thought you guys gotten really well and you know, you've got the perfect life, and I've had to expend note behind doors. […]. And just raising awareness so I think I think the press. Stop what you're doing great, publicise it, you know, that's another one, press. People's stories, right?*" P09

In addition, two participants underscored that there is also a need to increase visibility and promote existing services. Again, there is a comparison with IPV services for women, which according to P01, everybody knows. The perceived sense of injustice is evident and characterises all interviews. According to P01, increasing the visibility of existing services would make it easier for male survivors of IPV to approach these services and seek support.

"*Like I had to search for those things, I never knew. I never knew where they are. But Women's Aid is, like everybody knows. It's a well-known brand. There's nothing like that for men, so having something like that, this unified, ideally with government funding. […] but it would maybe make the process of men approach stuff a bit easier because they would know that there's this, right? If you have been abused well, this is the place you go to rather than* *having to Google search. You'd know who might help and how they operate and things like that*." P01

According to P06, although a public awareness campaign of IPV against men is needed and must be a priority, this is not enough. According to his views, there needs to be a cultural change in how men are perceived since according to his views, there is a negative societal perception of men and masculinity.

"*Yeah, I'll try, I'll try and resist being too provocative, I don't know. I certainly think, a more positive vision of what men are, you know, but that's like a profound, you know, that's a big work of propaganda or if that's the right word or cultural change. Cultural renewal. Yeah, like a sort of societal shift in the perception of men. But that's like, that's almost, I can't imagine it ever happening because it's kind of so profoundly, it is incredibly difficult. Like, it's unthinkable to think of that change in some ways, but I guess it's possible*." P06

The finding about raising IPV awareness against men highlights the need for clinical psychologists to be aware of the experiences of male IPV survivors including challenges of accessing help and support as those are crucial in informing therapeutic practice. This theme's subthemes convey a strong sense of isolation and powerlessness; the need for a safe space to talk, and the need to educate the public and break the stigma of IPV against men demonstrate feelings of isolation and marginalisation of experiences.

3.2.4 Theme 4: supporting male survivors -what should clinical psychologists know?

This theme illustrates participants accounts regarding what clinical psychologists should know when working with male survivors of IPV. This theme encompasses three subthemes: a) men’s struggle to open up and ask for help, b) being listened to and being believed, and c) timing and benefits of group work. Those are viewed important in informing interventions to support men survivors of IPV.

3.2.4.1 Subtheme 1: men struggle to open up and ask for help.

Participants reported that men usually struggle to open up and ask for help. Participants’ explanations of men’s hesitation to disclose align with gender stereotypes and the socially constructed gender norms of men being stoic and self-reliant. It is worthy to note that this finding compliments and underscores men’s need to talk discussed above. Shame has also been noted as another reason. The ramifications of men struggling to disclose and to ask for help is that they will need long term therapeutic intervention and more time to build rapport. According to P02, it was not until he experienced flashbacks that he asked for help. P02 referred to the way men are brought up, i.e. to be stoic. He described getting men to ask for help as the first problem, and a major one.

“*Well, the first problem is actually getting people to ask for help. Because it took me well, it took me until I started having these flashbacks that I could not deal with, to ask for help. But I didn't like asking for help because again, if you're a man, you're sort of brought up you know, to be self-reliant, you don't need any help, you know man up, all that stuff. And it was* *quite difficult, sort of putting myself at somebody else's mercy in that way. So that's the first problem. Just getting men to ask for help*." P02

Apart from being private, P03 stated that the potential reasons why men are reluctant to disclose are embarrassment and fear of not being believed.

"*I, I suppose, like most men, I'm very private. And I don't let people in, and I don't like talking about, you know. I don't like sharing and information. [...] Just that the man will be probably reluctant to speak, he would feel ashamed, you know, to tell the story as it is because he will be embarrassed, and he will feel that he's maybe not getting believed*" P03

P09 referred to the "nature" of men as an explanation of struggling to open up, shame and perhaps not understanding what happened to them i.e. IPV. He stated that psychological support needs to be long term to be meaningful given the above characteristics.

"*Secondly, I think they're gonna find it much harder to open up and talk about stuff, but again, the nature of the man, but also, shame, but also maybe not understanding what's really happened to them. Uh, and I think it has to be long term. You know you can't just have one or two sessions, [...]*." P09

"*I worked in the* [name of organisation] *with patient groups. Men talk very differently about their experiences; they are much more hesitant to come forward and it takes a bit of time. So, I guess you need to give them more time to build up that rapport with you*." P11

This finding underscores the need of clinical psychologists to be aware of traditional gender role stereotypes that render victimisation and mental health problems difficult to assess. Additionally, although it does not constitute a subtheme, it is important to note that four participants added that men hide their IPV victimisation because of shame and embarrassment because this contradicts with the societal stereotypes of masculinity and due to beliefs that society will view the survivor as a failure. For example, according to P01: "*it's just that men hide it because they feel shamed, because it's not the way it's supposed to be, you're not meant to be psychologically or physically bullied by a woman that are seen as the weaker sex, which is nonsense, complete nonsense*".

3.2.4.2 Subtheme 2: being believed and being listened to.

Participants highlighted the importance of being believed and being listened to by professionals. For instance, P04 stated that: "*The very, very first thing is somebody hears them and actually believes them and they get it, they, like they see, they hear, they validate*". Most participants in the current study experienced disbelief by professionals when they sought support and/or devaluation and dismissal of their experiences. In addition, some participants reported having their stories twisted against them and them being falsely accused of IPV.

P01 referred to Women's Aid policy regarding believing women survivors and stated that men should be treated the same way. He later noted that a man who asks for help for IPV would have already been through disbelief.

"*And the other one is just listening to us, believing people. Hmm, Women's Aid make a big thing about, you know, we believe every woman. Well, we should have the same, you know. Hmm, and that's what you don't get. And when somebody has asked for help, just being as accepting and listen because I think nearly any man who actually gets as far as asking for help will have been through the whole disbelief thing and just to find somebody they can talk to, who isn't just questioning their every, you know, it hasn't happened, just been taken seriously*." P02

P10 reported that it took him 2 and a half years to report IPV to the police due to fear of being disbelieved and because he was going through family court to get contact with his child.

"I would say the first one is to actually be believed. I think it's the biggest thing. It's taken me 2 1/2 years to actually report to the police that my ex-wife repeatedly strangled me, punched me, scratched me, kicked me, bit me, all of that now is outside the times for reporting it. Because I wouldn't be believed, and because I was going through family court to try and get some contact, with my [child]*"* P10

According to P10 professionals should be aware not to reinforce their own biases and really listen to the person reporting the abuse. Interestingly, he added that professionals should be aware of the biases of male survivors about what happened and what IPV looks like. This aligns with participants' reporting that it took them a long time to understand that what they were going through was IPV as they have reportedly thought that IPV happens only to women.

"*I think, I think the most important thing for me is to try and push any kind of preconceptions out their minds and just really hear the person what they've experienced because a every situation is different. But, but I think particularly with male victims, maybe as well with female victims, we come uploaded with our preconceptions about what happened. And what we think is domestic violence, what it looks like, what it sounds like*."
P11

It is important to note that not being believed and invalidation of suffering can be re-traumatising. It might also constitute a secondary victimisation; survivors may experience this as a replication of the gaslighting survivors suffered by the alleged perpetrators.

3.2.4.3 Subtheme 3: timing and benefits of group work.

This subtheme illustrates participants' views towards group interventions. Participants commented on the benefits of being part of a group and reported that they would like to be part of a group. The main reason behind this was validation that their experiences are not unique, and they are not alone in their struggles. Additional reasons mentioned were learning from each other and supporting each other. This finding underscores the loneliness and isolation participants experience, which was discussed in theme one. However, it is important to note that participants reported that both one to one and group work have their place, and both options should be offered to male survivors of IPV depending on their needs (e.g., P01, P02). A number of participants reported that they would prefer a mixture of both one to one and group work.

"*… and then yeah, then a team, a group. So, you can hear other people's experience. So, you get reassurance as per that TV program that this happens to other people, you know, you are not alone*." P03

P02 reported that when he joined the support group, he thought it was only him who experienced IPV; he also stated that joining this support group saved his life.

"*[…] part of my therapy if you wanna call it that way, was that quite by accident I found a support group for male survivors quite near where I live. […]. There were these people, so I went and found them, and I was just amazed the first three times I went I didn't say a thing. I just listened because they're all the other people, I just thought it was me. I had no clue. We were all we all had similar stories as well. It was just incredible. […]. And that pretty much saved my life because I was a terrible state at the time*." P02

"*I think the one thing that would benefit from is you don't feel as though it's just you, going back to why you're doing this. You feel as though it's you look round at all your friends and your family and your connections, and you go shit, you know, I'm the only one this has happened to, and therefore there's no one, there's no one really you can talk to that's experienced this even now. I've got a friend who's divorced from an alcoholic. She's, she's the survivor, he's the alcoholic. I can sort of talk to her about stuff, but I lack some, going back to the group thing, I lack someone who's been through a similar experience*." P09

P11 stated that he would love to join a group for people affected by IPV to share experiences with each other and get support, but he never found one. He briefly mentioned a positive experience he had in an alternative group, which he described as fantastic due to the way the group members supported each other.

"*if I was going to a group like a group of people that have been affected by domestic violence. I would love to go to someone like that, but I've never found it. I think it would be really good to share experiences and get support from a group, and I've been through that with an organization [name of organisation] and it was a support group for people who have lived with someone with borderline personality disorder. That group was fantastic. Again, not specifically around domestic violence, but the way everyone supported each other. And there were a number of incidents around domestic violence within that*." P11

Participants' views on group work underline the need for interventions that "normalise" their experiences in terms of men being victims of IPV, tackle shame and isolation and promote a sense of secure belonging.

CHAPTER 4: DISCUSSION AND CONCLUSION

4.1 Chapter Overview

In this chapter, I discuss the findings of this study in relation to the research question. The findings are discussed within the context of the existing literature. The strengths and limitations of the study are addressed, as well as the clinical implications. Suggestions for future research and my final reflections are included.

4.2 Summary of Findings

The study explored the self-identified mental health needs and priorities of male survivors of IPV. The research question guiding this study was: “What are the mental health needs and priorities of men survivors of IPV?” Eleven participants were interviewed in this study, who experienced different forms of IPV, ranging from psychological to sexual and physical IPV. In all cases, the perpetrator was a female, ex-partner intimately involved with the participants. I applied RTA to analyse the data through which I generated four major themes and eleven subthemes. Together, these themes describe the mental health needs and the priorities of male survivors of IPV based on participants’ accounts and my understanding of the data. They highlight the impact of IPV on participants’ well-being, lives, identities, and their relationships. Their needs and the impact of IPV appear to interact with or be influenced by sociocultural and systemic factors. These themes and the subthemes also demonstrate that despite the development of research on male survivors of IPV and knowledge on the topic (Bates & Papamichail, 2022; Hogan 2016; Hogan et al., 2021), there is a need to increase awareness of IPV against men among professionals and the public.

Before proceeding, it is important to highlight that regarding participants' engagement with the process and the research questions, I was surprised by the interest in the study, participants' engagement and openness to discuss histories of vulnerability. This should be highlighted as I recruited participants remotely through social media and particularly "X" and through advertisement of the study by local charities supporting male survivors of IPV. The willingness to take part and the openness in discussing not only their mental health but also their IPV victimisation is in contrast with traditional gender role expectations of stoicism, emotional toughness and avoidance of sharing vulnerability and emotionality (White, 2009). In contrast, my thoughts and feelings during recruitment and the interviews were that participants really wanted to share their stories and their views. Additionally, nine out of eleven participants in this study sought or received mental health support from mental health professionals (e.g., mental health nurses, counsellors, clinical psychologists, trainee CBT therapists, among others). For those participants, mental health support has been described as helpful, useful and invaluable. This is in line with the findings of Tsui et al., (2010) according to whom such support was helpful and preferable by male survivors of IPV.

These findings are in line with a recent qualitative study in Canada highlighting that "the diverse ways the participants define their experiences and masculinities demonstrate a problem with boxing men's experiences" within a strict framework of hegemonic masculinity" (Brooks et al., 2020, p. 5407). Although several participants' accounts align with hegemonic masculinity ideals, others do not. These findings suggest that conceptualising male survivors' experiences of IPV, help-seeking and their needs solely within an exclusive framework of hegemonic masculinity might be limiting and inadequate to capture men's experiences in their totality.

4.3 Research question: What are the Mental Health needs and Priorities of Men Survivors of IPV?

The first major theme “The many fragments of me – the toll of IPV” conveys the impact of IPV on participants’ wellbeing, work and mental health. Additionally, it underscores the relevance of the trauma informed care framework to understand the experiences and needs of male survivors of IPV (e.g., Elliot et al., 2005; SAMHSA, 2014). Although I initially considered Maslow’s (1954) hierarchy of needs as a framework to understand participants’ needs, I decided against it because 1) it applies an hierarchical sequence of needs and this may not be applicable to all survivors whose needs appear to be more interrelated (Kenrick et al., 2010), 2) it does not take into consideration the role of crisis or trauma and non-linear healing, and 3) it fails to account for cultural variations in needs as it reflects the values of Westernised, individualistic societies (Hofstede, 1984).

In this study, participants’ need for safety was unmet (Maslow, 1987). Echoing the findings of female survivors, the impact of IPV on participants’ work, income, careers and studies was described as detrimental (Tilbrook et al., 2010). IPV posed a significant threat to the financial and housing security of participants and constituted a contributor of income and/or employment loss (Tilbrook et al., 2010). Some participants lost their houses, and they had to move to new homes. It is established by the literature that resource losses constitute a contributor to chronic distress and a significant inhibitor of recovery after separation from the IPV perpetrator (Crielaard et al., 2021; Paphitis et al., 2022). Trauma informed care places emotional and physical safety at the centre which is crucial for male survivors especially in the context of stigma and disbelief (Elliot et al., 2005). Additionally, participants in this study faced loneliness and isolation; participants’ needs for connection and belonging were unmet (Maslow, 1987). Humans’ need for social connection is fundamental for survival and wellbeing, and it has been established by research that loneliness is associated with distress and mental health difficulties such as anxiety, depression and PTSD (Dagan & Yager, 2019).

Also, they described significant losses such as their previous family unit, time spent with their children, and friendships. It is likely that loneliness and loss are key determinants and consequences of well-being (Ogbe et al., 2020). Anxiety and depressive symptoms may also be reactions to resource losses, uncertainty, and perceived threats, associated with the impact of IPV. A trauma-informed care perspective acknowledges that interpersonal trauma such as IPV can fundamentally disrupt a person's capacity to feel connection and belonging and to form trusting relationships (SAMHSA, 2014).

Rather than pathologizing the individual, it conceptualises loneliness and isolation as adaptive responses to interpersonal victimisation, betrayal, stigma and systemic marginalisation. Restoring relatedness and belonging through peer support, empowerment and cultural sensitivity are essential components of recovery (Herman, 1992). Furthermore, participants referred to the loss of or reformulation of self-identity due to IPV. This is a novel finding in the literature of IPV against men and it is in line with the literature of IPV against women (Hague et al., 2003). Also, participants discussed the knock-on effect of IPV on their self-confidence (Maslow, 1987; SAMHSA, 2014). Within a trauma-informed care framework, self-identity is viewed as relational and contextual; IPV and systemic invalidation of male survivors may erode personal agency and increase feelings of inadequacy. Restoration of safety, empowerment, agency and collaboration within a relational framework could address the adverse impact of IPV on identity and self-esteem (Fallot & Harris, 2009; Sweeney et al., 2016). An important way of combatting the impact on self-identity and the perceived sense of loss of self is agency and autonomy; both concepts partly inform trauma informed interventions and models of care (Sweeney & Taggart, 2018). Access to psychoeducation around abuse, IPV and healthy relationships, skills to manage contact with perpetrators and services, signposting to services and appropriate referrals can support a sense of agency and autonomy. Promotion of agency and autonomy has been found to constitute an important mechanism of interventions for women survivors of IPV (Paphitis et al., 2022).

Loneliness, social and resource losses, perception of loss of self-identity, lack of safety, are basic needs that were unmet for participants; it is likely that such deficits prolong and compound their traumatic experiences. Although it assumes a linear progression of recovery and misses the role of intersectionality, Herman's (1992) three-stage model of trauma-informed working, with stage one focusing on stabilisation could provide a basis for effective intervention with male survivors of IPV. Those aspects are of crucial importance for clinical psychologists and mental health professionals in informing engagement with and therapeutic interventions with male survivors of IPV. The findings of this explorative study are in consensus with the quantitative literature demonstrating the most common presentations among male survivors of IPV are anxiety, depression and PTSD as well as substance abuse (Hines & Douglas, 2010; Laskey et al., 2019) similarly with women survivors of IPV (Dixon et al., 2020).

The findings are in line with research indicating that both men and women with mental health problems, across all diagnoses, are more likely to have experienced IPV than the general population (Trevillion, et al., 2012). These findings underline the need for clinical psychologists and mental health professionals to be aware of the relationship between IPV and mental health problems. The combination of findings presented in theme one and discussed here shows the limitations of a sole symptom reduction focus in interventions for IPV survivors (Trevillion et al., 2014). Furthermore, -although not a subtheme on its own-, the dissatisfaction expressed by one participant for being offered medication for symptoms associated with IPV shows that this is not perhaps what all IPV survivors want. This is in line with the findings of a qualitative meta-synthesis exploring the healthcare experiences and expectations of mental health service users experiencing IPV with data from 140 female and 4 male mental health users (Trevillion, et al., 2014). Focusing solely on symptom reduction, risks pathologising survivors of IPV, missing survivors' context, and missing the complexity of needs and the emotional complexities involved in being abused by a loved one (e., raised by P01, P02, among others). The findings highlight the complexity of survivors' needs requiring trauma-informed, holistic care and IPV trained professionals. Also, they indicate that participants have basic needs unmet in addition to the mental health difficulties they experienced.

Participants talked about their experiences of navigating societal structures, experiencing discrimination, disbelief, invisibility and lack of adequate support (theme 2). These findings are in line with research evidence (e.g., Bates, 2020; Lysova et al., 2020). Participants' accounts imply that male survivors of IPV constitute a marginalised, often invisible group (Bates, 2020; Tsui, 2014). Their experiences with support services contributed negatively to their mental health and perceptions of themselves, in addition to the IPV experiences. This constitutes a crucial part of male survivors' experiences and informs their mental health needs (Bates, 2020; Morgan & Wells, 2016). The perception of injustice, discrimination and being unfairly treated by services may be linked with re-traumatisation and powerlessness and can worsen mental health outcomes (Bates, 2020; Walker et al., 2020). It is established by research that negative help seeking for survivors of IPV increases feelings of helplessness and powerlessness, increases social isolation (Morgan & Wells, 2016) and may lead to outcomes such as PTSD (Douglas & Hines, 2011), and anxiety and depression (Próspero, 2007).

For some participants, these experiences were even more traumatising than the actual IPV (e.g., P07). These findings are in line with the literature of IPV against men and constitute barriers to help-seeking (Bates, 2020; Dixon et al., 2020; Lysova et al., 2020; Taylor et al., 2022). It is worthy to note that participants' accounts echoed the findings reported not only by UK studies but from international studies in Portugal and Australia, among others (Machado et al., 2016; Walker et al., 2020). According to minority stress theory (Meyer, 2003), individuals belonging to marginalised or stigmatised groups can experience chronic stressors such as discrimination, disbelief and rejection, increasing the likelihood of mental health problems. These stressors can be external (e.g., discrimination from services, lack of support) or internal (e.g., stigma consciousness, shame, concealment, fear of disbelief).

Participants expressed a need to increase public awareness of IPV against men (subtheme 3b) to break the stigma, isolation and disbelief that underscores the emotional burden of marginalisation and highlights the interplay of mental health with societal structures. This finding is in line with the existing literature (Ambrozewicz et al., 2024; Dixon et al., 2022; Hogan et al., 2021; among others) and it links with participants' experiences of disbelief and devaluation of their experiences from services (Machado et al., 2016; Tsui, 2014). The need to increase visibility and promote existing services was also noted by two participants (Ambrozewicz et al., 2024; Carthy et al., 2023; Mwayuli et al., 2019; Wallace et al., 2019).

Applying intersectionality can further enhance the utility of MST in this context for clinical psychologists and mental health professionals (Crenshaw, 1989). By focusing solely on male survivors of IPV, social identity i.e. gender which equates with power and privilege in societal terms generally, we risk ignoring other aspects of individuals' identities and experiences of discrimination, missing or devaluing the impact of IPV and the impact of being discriminated against. Additionally, we risk simplifying experiences of oppression and privilege by thinking about them in dichotomous ways as those are inextricable (Black &

Stone, 2005). In addition, applying intersectionality can further enhance the utility of MST for LGBTQ+ survivors of IPV as well as IPV survivors from the global majority.

An additional mental health need raised by participants was a "safe space to talk" (subtheme 3a). This finding is novel and contradicts with the existing evidence supporting that male survivors of IPV prefer practical solutions instead of "talking" or emotional support (Roddy, 2015). Safe space to talk included unloading the burden of IPV and their victimisation to professionals and having the time and the space to articulate their experiences within the context of a therapeutic relationship. Some participants, in addition, commented on their need for guidance signposting to relevant services and guidance around practicalities e.g., the legal system among others. The accounts of participants convey a strong sense of isolation and highlight the need for multi-agency work for supporting survivors. They also underscore the need for GPs, clinical psychologists and mental health professionals to be aware not only of IPV, but for third-party support services and multi-agency support (Evans & Feder, 2016). However, it should be noted that the shortage of services may have negative implications for survivors' safety. For example, in Hogan et al.'s (2012) study, the counsellors working with male survivors reported that they were concerned about the lack of wider support available to men outside of counselling.

This finding contradicts hegemonic masculinity ideals that strip men of their vulnerability to psychological suffering and demonstrates that male survivors of IPV are not passive reproducers of socially prescribed gender role expectations. Instead, they can be active agents formatting their preferred version of masculinity (Brooks et al., 2020; Gueta & Shlichove, 2022). This agency demonstrates the part individuals may play in taking action, exerting power and acting towards the desired outcomes in their lives. Apart from the need to share their stories, participants' willingness to take part in this study was unanimously underpinned by a desire to bring about change. Also, most participants who took part in this study stated that they had done it to raise awareness of IPV against men and help others. This is in line with the study of Peel et al., (2006) which found that participants usually chose to take part in qualitative research out of a desire to help other people. Also, most participants reported that they already have taken action towards supporting other male survivors of IPV and raising awareness of IPV. This is in line with the epistemological framework adopted in the study that focuses on human agency (Archer, 2000)

It is worthy to note that nine out of eleven participants in this study have sought for and accessed mental health support by themselves (Tsui et al., 2010). It is likely that this study's topic and the professional role of the researcher (i.e. "trainee clinical psychologist") which was apparent on the study's recruitment flyer, attracted survivors who are positive towards psychological therapy and mental health interventions. Indicatively, P06 was the only participant in this study who reported that talking is not what he wants to do; instead, he stated that he prefers problem solving because according to his views, this is what society expects from men within the capitalist system (Roddy, 2015). This is in line with the findings of Hogan et al., (2021). However, this participant reported that he sought for and worked psychotherapeutically with a qualified professional to manage his distress. Nevertheless, the contradiction highlights that "one size does not fit all" and there is a need for tailored, individualised support.

Proceeding to the last theme named "supporting men survivors-what clinical psychologists should know", it communicates what participants reported that clinical psychologists should know when working with men survivors of IPV. Although this theme does not directly reply to the mental health needs of men survivors of IPV, it informs the research question indirectly and contains crucial and novel information about working with survivors in a therapeutic capacity. According to participants, it is important for clinical psychologists -and mental health professionals- to be aware that men usually struggle to open up and ask for help. The findings are in line with the literature of IPV against men that demonstrates that men tend to not seek help for problems that society views as non-normative for men (e.g., Machado et al., 2016) and the literature of men's mental health (Seager & Barry, 2022). Existing evidence shows that men are less likely than women to seek help for mental health problems (e.g., Seager & Barry, 2022; Hammer et al., 2013). This finding aligns with hegemonic masculinity and gender socialisation roles that portray men as self-reliant and stoic (Addis & Mahalik, 2003).

Although it did not constitute a subtheme, it is important to note that some participants also referred to shame as a reason that may inhibit men from sharing and asking for help; this is in consensus with the literature of IPV against women and men (Beck et al., 2011; Hogan, 2016). The shame was attributed to failing to live up to the gender role expectations of masculinity (Arnocky & Vaillancourt 2014; Huntley et al., 2019). Important ramifications of male survivors of IPV hesitation to open up for practitioners might be prompting more excessive in assessments when faced with brief responses (APA, 2018), awareness of potential concealment of victimisation, and longer therapeutic input. These findings call for practitioners to be mindful of potential stigma and shame around being perceived as "less masculine" or "a failure" (Arnocky & Vaillancourt 2014; Huntley et al., 2019). According to the literature, experiences of social stigma are linked with marginalisation (Link & Phelan, 2001). Another important implication is adopting trauma-informed, non-judgmental approach to address self-blame (Hogan et al., 2021).

Furthermore, participants highlighted the importance of being believed and being listened to. This finding aligns with the findings of the SLR regarding what made help-seeking a positive experience for male survivors of IPV (e.g., Dixon et al., 2022; Hogan et al., 2021). Additionally, some participants reported having their stories twisted against them and them being falsely accused of IPV which is a common fear among men survivors of IPV (Huntley et al., 2019). Supporting the findings of Bates (2020), participants in this study reported that their victimisation was trivialised, or they were disbelieved by professionals because they were men. The value of being believed and being listened to when talking about one's experiences in therapy is of particular importance for therapeutic rapport and effective intervention. Invalidation of suffering can be re-traumatising; it can increase shame and secrecy, and act as a barrier to help-seeking (Hogan, 2016) and recovery (Campbell, 2008). Also, there is evidence to suggest that disbelief can potentially exacerbate mental health difficulties (Campbell, 2008). According to Sarantakos (1999), counsellors, psychologists and social workers may develop negative attitudes towards male victims because practitioner training programmes on IPV do not refer to heterosexual men as possible victims of IPV. This finding underscores the need for training and increasing awareness of IPV against men among mental health professionals. Additionally, it highlights the continuing need for reflection on values, intersectionality and addressing personal biases and assumptions (BPS, 2019; Health Professions Council, 2009) about IPV and victimisation for mental health professionals.

The last aspect that may be helpful in informing practitioners' work with male survivors of IPV is participants' positive views towards group interventions. This is a novel finding in terms of participants' preferences about characteristics of therapeutic interventions for male survivors of IPV. Also, it aligns with the SLR finding showing that being part of a support group with other men survivors of IPV was a component of positive help-seeking experiences (Ambrozewicz et al., 2024; Dixon et al., 2022; Gueta & Shlichove, 2022; Hogan et al., 2021).

Although all participants commented that both one-to-one and group work have their place and they should be offered the choice of both based on individuals' preferences and needs, most participants were positive towards group work. Group-based interventions can provide men with validation that they are not alone in their experiences and struggles (Yalom & Leszcz, 2020). A qualitative study by Vickery (2022) on men who received group interventions for mental health support found that the most important mechanism for positive change for men with mental health difficulties was being amongst others with similar life experiences of distress. Being part of a group can reduce the stigma of IPV victimisation. Also, it can provide a space where participants learn from each other and challenge restrictive masculine norms (Hogan, 2016). This could subsequently reduce feelings of isolation and shame. According to the literature, being part of a group intervention with other male survivors of IPV, can support participants to increase their awareness of IPV against men and become more confident in sharing their experiences in a group context (Hogan et al., 2021; Garfield, 2010).

4.4 Strengths and Limitations

This appears to be the first study focusing on the self-identified mental health needs and priorities of male survivors of IPV in the UK. Also, it seems to be the first study in the UK directly consulting survivors in terms of what clinical psychologists should know about working with male survivors of IPV. Furthermore, as highlighted in the SLR, it seems to be the first study that involved EbEs as research consultants in multiple stages of the research process. The ontological contribution of this study is that it documents male survivors' views on their mental health and priorities. Male survivors of IPV within heterosexual relationships remain a marginalised social group despite developments in research (Huntley et al., 2019). Additionally, this study draws attention to and challenges monolithic conceptualisations of a person's needs and experiences only through a gender lens and thus, ignores intersectionality and other aspects of participants' identities. By saying this, I do not -by any means- wish to devaluate the unequivocally important role of gender in shaping individuals' experiences and chances in general and within the context of IPV. It is established by the literature that gender is indeed important in understanding men's experiences and in informing intervention (Seager & Barry, 2022). Also, this study's findings highlight the role of socially constructed gender roles in shaping participants' mental health and informing interventions. However, an important contribution of this study lies in showing the limitations of applying an exclusive framework of hegemonic masculinity to understand men's needs and experiences. Participants in this study exhibited emotionality, expressed the need for having access to safe spaces to talk, openly discussed needs and shared vulnerabilities. They sought mental health support, and they were open about it. This does not align with hegemonic masculinity standards.

Additionally, the findings highlight the need to incorporate training on IPV against men and increase mental health professionals' awareness of IPV against men, as well as the association of IPV with mental health. Lack of awareness and training in addition to men's hesitation to disclose and ask for help, and/or shame surrounding such experiences risks missing such experiences and focusing only on symptom reduction. Additionally, a lack of awareness may be linked to disbelief and suspicion towards male survivors, which may be re-traumatising and devaluating potentially leading to an increased severity of mental health difficulties and a longer time to recover.

Nevertheless, the study is subjected to several limitations. Despite some variability in the sample in terms of age, social class and geographical locations across the UK, the vast majority of participants were White British (*N*=10). This limits transferability to people of the global majority and minority groups, therefore caution is needed when interpreting the findings (Randle & Graham, 2011). Also, the study was potentially biased towards men with favourable views towards psychological interventions and psychological therapy. Men who may have more negative or neutral perspectives on psychological therapy, and/or who do not view their victimisation as IPV may potentially present with different views and needs (Taylor et al., 2022). The same applies to men who might fear the stigma of mental health and thus, are unwilling to disclose and share their views. Additionally, some participants in this study occupied middle-class professions. As noted by these participants, their socio-economic status enabled them to access private therapeutic support. Their experiences may not be transferable to other men who may not be able to afford private support. This contrast was apparent in the study. For instance, participants who had no access to such privileges had to wait 18 months to see a clinical psychologist to undertake therapy (e.g., P02). Furthermore, one of the recruitment criteria in this study was that participants needed to have access to the internet and to a smartphone, laptop or tablet to be able to take part in remotely conducted interviews. Although conducting the interviews remotely was effective for recruitment in line with the literature on the topic (Bates & Taylor, 2021), and it was imposed by the time and resources constrains of the project, it has certainly disadvantaged participants living in digital poverty who have no access to the above. This is a major limitation of the study, and it should be taken into consideration when interpreting the findings.

The critical realist framework allowed participants' views to be understood in thematic terms of their realities shaped by the cultural and social context. This is in the UK in 2024. Therefore, the findings of this study are historically, culturally and geographically specific. The contextual character of this study produced one interpretation of participants' accounts:

other researchers may produce alternative interpretations in different contexts. Regarding the role of my identity, I recognise that my sex and gender and my different cultural background from participants may have influenced their responses and what they were to share. Although I tried to remain aware of these by keeping a reflexive journal and by not expressing any personal viewpoints, I recognise that a social constructionist perspective would have probably elucidated these influences. Despite these limitations, this study offers some new insights into the mental health needs of male survivors of IPV and offers important aspects to inform therapeutic work with male survivors. In the next section, I discuss the implications of the findings and future research.

4.5 Clinical Implications

The findings of this study show that understanding of the impact of IPV within the context of support to male survivors, should be inclusive of the so-called "invisible impacts" of IPV and the needs of survivors. Loneliness, losses of relationships, impact on work, self-esteem and self-identity, helplessness, perceived sense of injustice and the shame described by participants are practical and emotional repercussions that are difficult to quantify and measure, but they could act as triggers for the mental health outcomes described, such as anxiety, depression and PTSD (Tarzia, 2021). A collaborative formulation with survivors would help to unpick those repercussions and would extend beyond focusing solely on mental health symptom reductions and towards a sound, therapeutic relationship that would provide the context and framework for healing from IPV and post-traumatic growth.

The findings support the integration of holistic, trauma-informed practice when working with male survivors of IPV. Such practice prioritises participants' safety, trustworthiness, agency, choice, empowerment, collaboration and focuses on how services may respond to minimise harm and risk of re-traumatisation (Elliott et al., 2005). Given their role within the NHS, clinical psychologists are in a good position to educate and promote professionals in trauma-informed care through psychoeducation, consultations, supervision and team formulation among others. Additionally, the multi-agency framework provided by the commissioning of NHS services allows the development of targeted interventions for male survivors of IPV. The NHS Long Term Plan (NHS England, 2019) and the Equality Act (2010) instruct that services address the needs of all protected groups by eliminating inequality and discrimination. However, the gap in interventions for male survivors of IPV remains. Clinical psychologists are well equipped to address the existing gap in services. Their skill set in assessment, development and implementation of interventions, and service audits among others, means that they can support commissioners in making evidence-based decisions that align with the Equality Act (2010) obligations and the ethics of inclusive care.

The participants in this study attributed their helplessness and negative experiences of support to a lack of public and professionals’ awareness of IPV against men and due to their gender. A gender inclusive approach and raising awareness and training in IPV against men is particularly needed (Taylor et al., 2022). Additionally, in trauma-informed practice, professionals are encouraged to approach individuals with the assumption that they may have a trauma history (“universal trauma precautions”). In doing so, they may reduce the risk of re-traumatisation and disempowerment. Based on the findings of this study, it is recommended that all mental health professionals ask all service users irrespective of their sex and gender about potential experiences of IPV during their initial assessment. This would invite service users to share such experiences when they feel safe enough within the therapeutic relationship. Safety is an important component of trauma-informed care;

participants in this study reported that male survivors need safe spaces to talk about their experiences.

Professionals must ensure that interactions with services users do not reproduce experiences of victimisation (e.g., disbelief, discrimination, devaluation of the importance of the experience). Safety can be established by confidentiality and being transparent about confidentiality and its breaches, setting clear expectations, and a non-judgmental approach (Hogan et al., 2021). These can support men to build rapport and address self-blame about the potential perceived failure to meet masculine expectations and social norms. Empowerment through validation of perceptions and experiences is recommended (Elliott et al., 2005). Participants in this study reported that male survivors of IPV need to be listened to and believed. Given the findings of this study regarding male survivors being treated with suspicion and disbelief, validation is of particular value (Bates, 2020; Hogan et al., 2021). Empowerment can also be promoted by facilitating group interventions and/or support networks to break isolation and loneliness and establish connections and thus resources for survivors. Additionally, increasing knowledge of IPV against men through psychoeducation about IPV and its dynamics, as well as the impact on victims, can be empowering for survivors as it supports survivors to “normalise” their experiences and the impact of IPV on them.

In line with the findings, choice should be given to participants regarding the type of intervention offered (one-to-one and/or group), the focus (emotional support and/or problem-solving focus) and regarding the therapist’s gender. Although the therapists’ gender did not constitute a theme in this study, as most participants reported that they would not care about the therapists’ gender, still some participants reported that they would prefer a woman (e.g., P11) while others reported they would prefer a man (e.g., P01). This is echoed by the literature; in some studies, several male survivors of IPV reported that they would prefer working with a male therapist while others reported that they would prefer a female therapist (Hogan, 2016; Robby, 2016). These findings highlight the need to offer this choice to survivors.

In line with the trauma-informed model of care, collaboration with male survivors of IPV and involvement of survivors in the design and delivery of services as co-producers would support the implementation of interventions that are relevant and meaningful to male survivors of IPV. Additionally, it would help raise awareness of IPV and break the stigma of such experiences. In this study, all participants reported that they took part in raising awareness and helping others. This is in line with the study conducted by Hogan et al., (2021). This indicates that male survivors of IPV, at least some, may be eager to be involved in such initiatives. Clinical psychologists who are trained in service user involvement are well suited to facilitate such initiatives.

Within a patriarchal culture, heterosexual men are privileged as the culture and the social structures encourage, promote and reward male power and dominance (e.g., Tolman et al., 2003). The findings of this study highlight the complexity of such social phenomena and illustrate the negative consequences of patriarchy on men who fail to adhere to and perform to the socially desirable notions of the construct of masculinity (Khan et al., 2008). At a societal level, male survivors of IPV are culturally invisible and marginalised. Systems created because of patriarchy and the need of protection towards the typical victims of patriarchy, disadvantage male survivors of IPV, as their experiences and claims are not being believed or taken seriously. These findings are particularly important for clinical psychology regarding its commitment to social justice, which emphasises working with individuals who have experienced social marginalisation and discrimination (BPS, 2017; Hailes et al., 2021).

Lastly, the findings underscore that professionals should critically reflect on the applicability of "hegemonic masculinity" ideals to all male survivors of IPV and apply intersectional lens, cultural humility and gender sensitivity. Within a trauma-informed model of care, professionals should acknowledge the intersecting identities and numerous ways in which people may experience oppression and discrimination and engage in critical reflection and cultural humility (Tervalon & Murray-Garcia, 1998). Reflection upon and realisation of the various social identities our clients and we have, can support clinical psychologists to avoid the inclination to view clients as a sole categorical identity and to overcome simplified categorical assessments of their clients that are not representative of the complexities of their everyday life experiences.

4.6 Implications for Future Research

As mentioned earlier, a limitation of this work is the lack of participants from the global majority, belonging to ethnic and religious minority groups. There is a need to explore those groups' experiences and needs, especially when considering minority stress theory and the potential impact of their double minority status (e.g., men who are victims of IPV and from an ethnic minority). The call for exploring these groups' experiences remains unfortunately unanswered, perhaps due to fears of stigma and shame (Randle & Graham, 2011). Additionally, future research should aim to explore the mental health needs and experiences of transgender people who are survivors of IPV and subsequently inform therapeutic work with them. Currently, their voices are absent from the literature. Another important limitation of this study is due to its design, is that it excluded people living in digital poverty. In line with many other studies on this topic, this study recruited remotely (e.g., Bates, 2020; Bates & Taylor, 2021; Carthy et al., 2023; Lysova et al., 2020; Taylor et al., 2022). Despite the usefulness of remote recruitment for this population (Bates & Taylor, 2021), it means that digitally illiterate or people living in digital poverty are excluded from research, and their needs remain unknown. Future research should strive to tackle these issues, expanding on the demographics of men survivors of IPV represented in research. There are also insights provided by this study that deserve further investigation and evaluation. For example, focusing solely on the impact of IPV on male survivors' identity and worldviews or focusing and exploring in depth their experiences of disclosure and support within the NHS. Finally, this study could be conducted using community participatory action research, a methodology currently absent from the literature of male survivors of IPV (Aldridge, 2015). Such a methodology, aligns with trauma informed models of care, empowers participants because it focuses on sharing power and working in equitable partnerships and encourages active, equitable collaboration among researchers and stakeholders (Goodman et al., 2017; Yuan et al., 2016).

4.7 Conclusion

IPV is a pervasive health and social problem that affects individuals and societies across the world. This project explored an under-researched area of IPV, specifically against heterosexual men. The aim of this study was to explore the mental health needs and priorities of male survivors of IPV and to inform interventions that aim to support them. The findings of this study show that male survivors need safe spaces to talk and reflect on their experiences of IPV, and they need to be validated. Safety, belonging, social and resource losses, perception of loss of self-identity, and self-actualisation are basic needs that were unmet for participants. Such deficits prolong and compound the traumatic experiences of IPV, and it is likely that they exacerbate mental health problems. In line with the existing literature, participants suffered negative mental health, such as anxiety, depression, and PTSD (Hines & Douglas, 2010; Laskey et al., 2019). This study has shown the negative impact of disbelief and adverse interactions with services and professionals, and how those interplay with mental health and sense of helplessness for survivors. There is a need to raise public and professional awareness of IPV against men and to incorporate trauma-informed principles across settings, to help meet the needs of male survivors of IPV. The findings invite clinical psychologists and mental health professionals to be responsive to male survivors of IPV unique needs and cultural context, offer safety, validation, empowerment, choice, and collaboration and apply an intersectional lens and cultural humility when working with this group. Fair and inclusive access to care should be guaranteed for all survivors of IPV irrespective of their protected characteristics.

4.8 Final Reflections

Having completed this project, I feel relief and gratitude. I feel gratitude for the participants of this study, whose views and experiences I had the privilege to listen to. I also feel gratitude for the research consultants whose dedication and interest moved me deeply. The process of this research has further strengthened the values I aim to take forward as a professional: critical reflection, inclusive access, cultural humility, involvement of service users as collaborators, and inspiration to continue engaging in research to inform clinical practice.

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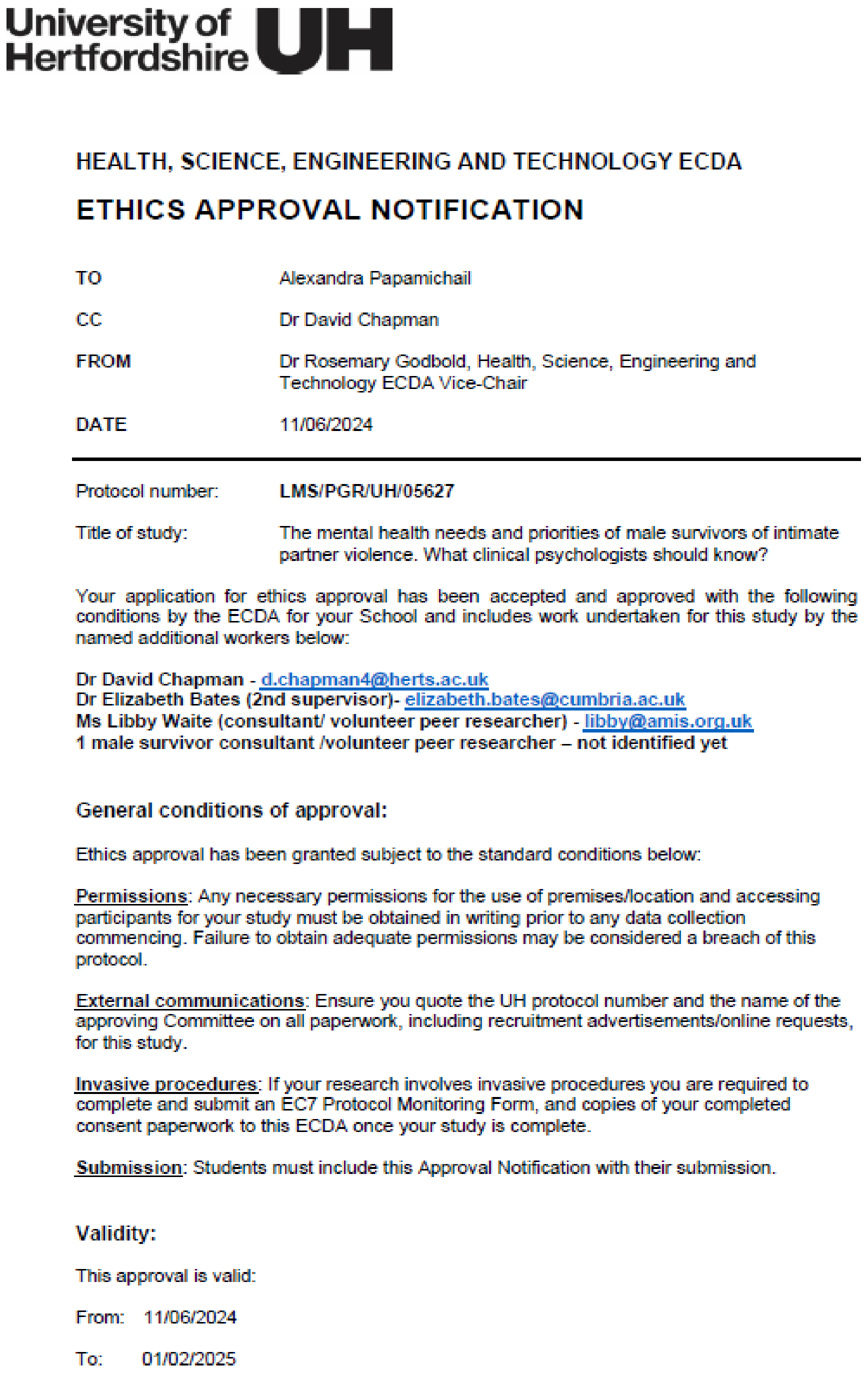
APPENDICES

Appendix A: Ethical Approval



University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Alexandra Papamichail
CC	Dr David Chapman
FROM	Dr Rosemary Godbold, Health, Science, Engineering and Technology ECDA Vice-Chair
DATE	11/06/2024

Protocol number: **LMS/PGR/UH/05627**

Title of study: The mental health needs and priorities of male survivors of intimate partner violence. What clinical psychologists should know?

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr David Chapman - d.chapman4@herts.ac.uk
Dr Elizabeth Bates (2nd supervisor)- elizabeth.bates@cumbria.ac.uk
Ms Libby Waite (consultant/ volunteer peer researcher) - libby@amis.org.uk
1 male survivor consultant /volunteer peer researcher – not identified yet

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

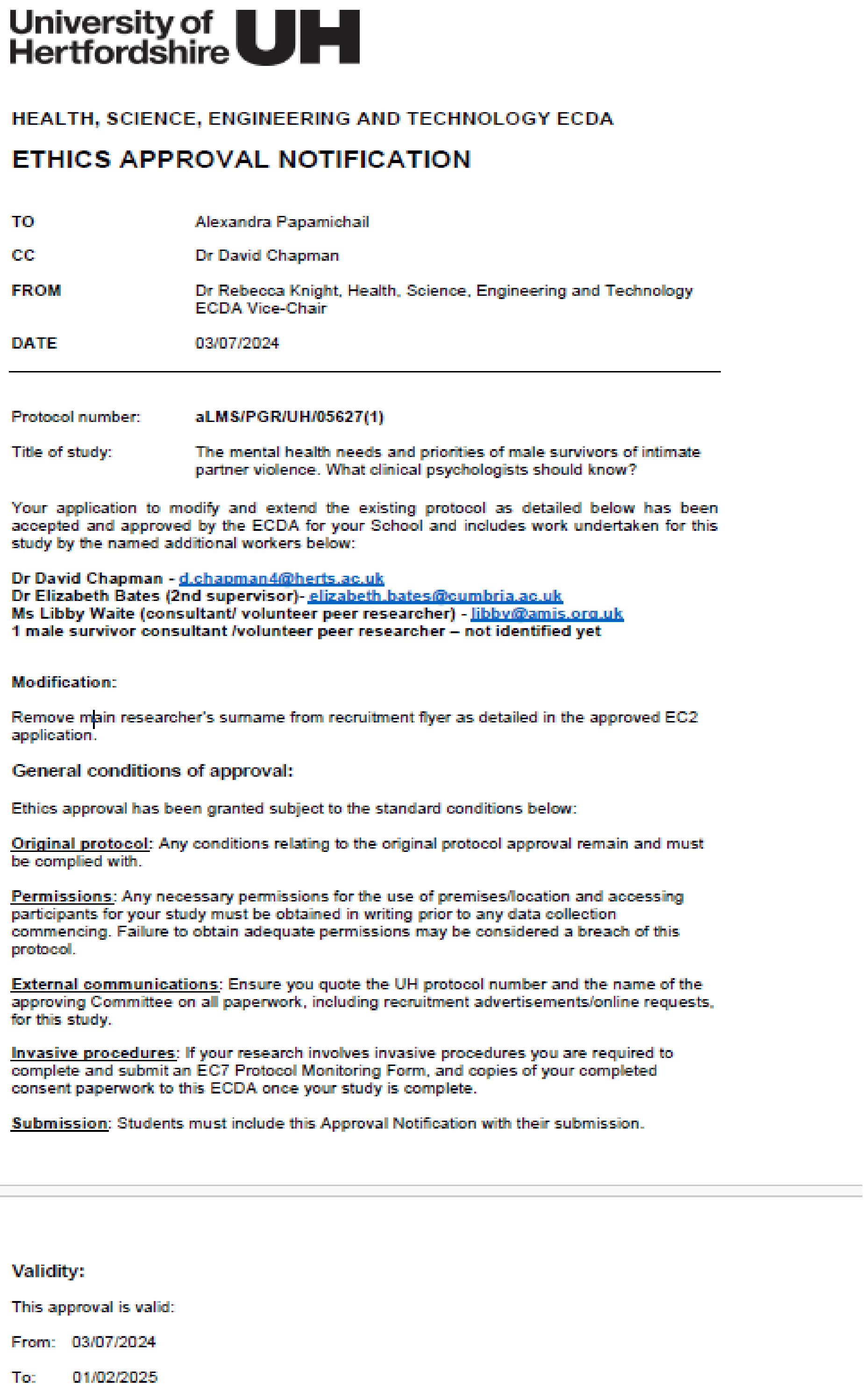
Validity:

This approval is valid:

From: 11/06/2024

To: 01/02/2025

Appendix B: Ethical Approval with Amendment to EC2 form



University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Alexandra Papamichail
CC	Dr David Chapman
FROM	Dr Rebecca Knight, Health, Science, Engineering and Technology ECDA Vice-Chair
DATE	03/07/2024

Protocol number:	**aLMS/PGR/UH/05627(1)**
Title of study:	The mental health needs and priorities of male survivors of intimate partner violence. What clinical psychologists should know?

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr David Chapman - d.chapman4@herts.ac.uk
Dr Elizabeth Bates (2nd supervisor)- elizabeth.bates@cumbria.ac.uk
Ms Libby Waite (consultant/ volunteer peer researcher) - libby@amis.org.uk
1 male survivor consultant /volunteer peer researcher – not identified yet

Modification:

Remove main researcher's surname from recruitment flyer as detailed in the approved EC2 application.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 03/07/2024

To: 01/02/2025

Appendix C: Participant Information Sheet

University of Hertfordshire UH Ethics Committee

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS (‘ETHICS COMMITTEE’)

PARTICIPANT INFORMATION SHEET

1 Title of study

The mental health needs and priorities of men survivors of intimate partner violence. What clinical psychologists should know?

2 Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether you wish to take part or not. The University’s regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link: https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs (after accessing this website, scroll down to Letter S where you will find the regulation). Thank you for reading this.

3 What is the purpose of this study?

This project aims to explore the mental health needs and priorities of men 18+ years who have experiences of controlling behaviour, abuse and/or violence from a woman in the context of an intimate, heterosexual relationship. We hope this will help to improve how support to men is provided in the future and to raise awareness of the issue of intimate partner violence against men as well as men's mental health and well-being needs. This research project is being conducted as part of the professional doctorate in clinical psychology (DClin). The data gathered for this project will be analysed and submitted for the thesis in clinical psychology for examination.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw without giving a reason. However, if you decide to withdraw from this study after the interview, you will need to notify the researcher within two weeks of the interview conduction. A decision to withdraw, or a decision not to take part at all, will not affect you in any way.

5 Are there any age or other restrictions that may prevent me from participating?

I am recruiting adult cis and/or trans people who self-identify as heterosexual men, aged 18 and over who have experienced abuse, controlling behaviour and/or violence from a woman in a context of an intimate relationship. To be eligible to take part in this study, you need to no longer be in an abusive, controlling and or violent relationship for a minimum length of at least 6 months for your own safety and due to distressing impact of such experiences. You also need to be able to communicate in English and have access to the Internet and to a smartphone/laptop/computer as the interview will be conducted remotely through Microsoft Teams.

6 How long will my part in the study take?

If you decide to take part in this study, you will be involved in it for one remote one-to-one interview with the researcher lasting approximately 60-90 minutes.

7 What will happen to me if I take part?

If you are interested in taking part in this study, please email the principal researcher (**ap22ads@herts.ac.uk**). I will email you back to provide information about the study and we may then arrange a phone call with you -if you want- to go through the study with you and answer any questions you may have.

Once you have consented to take part, you will be invited to take part to a 60-90 minutes, one-to-one, remote interview with myself. The interview will be conducted remotely through Microsoft Teams at a time and date that suits you.

Your interview will be audio-recorded. This is to ensure that I shall not forget anything that you have said, and I remember what we discussed during the interview. All interviews will be transcribed verbatim. Your recording will be saved securely on a password protected server. Once your interview has been transcribed, your recording will be permanently deleted. Your transcript will be stored (transcripts will be anonymised and potentially identifiable information will be removed from the transcript) securely on a password protected server. Your consent form will be kept until the end of the research project, and then securely and permanently destroyed.

8 What are the possible disadvantages, risks or side effects of taking part?

You are not going to be asked for details about specific experiences of controlling behaviour, abuse and/or violence from your ex-partner. However, some of the questions may bring up upsetting memories or feelings. It is recognised that reflecting on or discussing on your experiences could feel difficult at times. You can take your time answering and can choose not to answer to particular topics or questions I may ask you.

I am feeling distressed - what if I need some help or support?

There are external organisations which can provide information or support:

- If you need urgent support, please, contact your **GP**

- **ManKind Initiative (telephone: 01823 334 244/ Free phone: 0808 800 1170):** is a confidential helpline for male survivors of domestic abuse and domestic violence. Available Mondays-Friday from 10:00 am to 16:00 pm.

- **The Samaritans (telephone: 116 123)** is a helpline available 24 hours a day, 365 days a year. The service offers listening and support to anyone who is struggling to cope or is experiencing difficulties. https://www.samaritans.org/

- **SANE** is a UK mental health charity offering a range of services including **SANEline (telephone: 0300 304 7000)**, a national out-of-hours mental health helpline every day of the year (4pm-10pm). https://www.sane.org.uk/

- You can **text "SHOUT" to 85258** for free from all UK mobile networks. You'll then be connected to a volunteer for an anonymous conversation by text. https://giveusashout.org/

- **NHS urgent mental health helplines** – you can find your local NHS urgent mental health helpline at the following web address: https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

- **If there is an emergency, please contact 999**

9 What are the possible benefits of taking part?

Participation in this study may not have direct benefits to you right now. However, your participation will enable to gain a better understanding of the mental health and well-being needs and priorities of men survivors of controlling behaviour, abuse and/ or violence and how to best support them

10 How will my taking part in this study be kept confidential?

Your confidentiality is a top priority in this study. Your personal data will be held and processed in the strictest confidence, and in accordance with current data protection regulations. Confidentiality will be maintained for personal identifiable information in accordance with the Data Protection Act (2018), the British Psychological Society's Code of Human

Research Ethics (2021), and the General Data Protection Regulation 2016/679. Personal data including special category data obtained for the purposes of this research project is processed lawfully in the necessary performance of scientific or historical research or for statistical purposes carried out in the public interest. Processing of personal data including special category data is proportionate to the aims pursued, respects the essence of data protection, and provides suitable and specific measures to safeguard the rights and interests of the data subject in full compliance with the General Data Protection Regulation and the Data Protection Act 2018.

To ensure the security of your information, data will be stored in a secured and encrypted drive within the Principal Researcher's university account. Only the Lead Researcher and authorised researchers involved in analysis will have access to this data. Anonymity will be maintained by replacing any personally identifiable details with pseudonyms and/or codes. Your consent form, linking you to the study, will be stored separately from your data using a unique identifier. Data retention will be limited to the minimum period necessary for the research, and identifiable information will be securely deleted thereafter. Any information disclosed during the study will be used exclusively for research purposes and will not be shared with third parties.

11 **What will happen to the data collected within this study?**

- The data collected will be stored electronically, in a password-protected environment, until the award of the degree for which the work is undertaken, after which time it will be destroyed under secure conditions;

- The data will be anonymised prior to storage.

- The recording of the interview will be securely transmitted to a transcription company; a confidentiality agreement will be signed with the transcription company before. After transcription takes place, the researcher will remove all identifiable information from the transcripts. The transcripts will then be saved in a secure, password protected served at the University of Hertfordshire. Only myself and the 2 research supervisors will have access to the transcripts.

- The data will be analysed for research purposes, focusing on the study's objectives and research questions. Findings or conclusions drawn from the data will be presented in an aggregated, non-identifiable format to ensure anonymity.

- Personal data will be retained for the minimum period necessary for the research, and after this period, all identifiable information will be securely deleted. The results of the study may be disseminated through academic publications, presentations, or reports, with a commitment to maintaining the confidentiality of participants.

- If you choose to withdraw from the study, any data collected from you will be treated with the same level of confidentiality and included in the overall data analysis up to the point of withdrawal. You have the right to request the deletion of your data.

- All discussion during the interview will be anonymised and they will be kept confidential. The only exception to this is if it becomes clear that there is an immediate, current or future and/or serious risk of harm to you or someone else. In this occasion it is my professional responsibility to breach confidentiality and to signpost you to services that can provide you with information and offer support to you (e.g., 999). In more complex cases, I will seek support from my research team (named above). I will inform you if I need to do this. I will always seek for your consent to breach confidentiality and refer you to services that will support you. However, even if you don't consent and there is an immediate risk of serious harm to you or someone else, I still have a duty of care to breach confidentiality and signpost you to services in order to keep you safe.

13 Will the data be required for use in further studies?

The data <u>will not be used</u> in any further studies.

14 Who has reviewed this study?

This study has been reviewed by:

- **The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority**

The UH protocol number is **aLMS/PGR/UH/05627(1)**

15 Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me, in writing, by phone or by email: ap22ads@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and considering taking part in this study.

Appendix D: Participant Consent Form

Participant Consent Form

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS

(‘ETHICS COMMITTEE’)

FORM EC3

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[**please give your name here**, **in BLOCK CAPITALS**]*

……………………………………………………………………………………………………..…

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..……………………………………………………………………………………………………

hereby freely agree to take part in the study entitled **“The mental health needs and priorities of male survivors of intimate partner violence. What clinical psychologists should know?**

(UH Protocol number: **aLMS/PGR/UH/05627(1)**

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed and asked to renew my consent to participate in it.

2 I understand that participation is on a voluntary basis, and I have been assured that I may withdraw from the study without disadvantage or having to give a reason. I understand that I will have a two-week period following the interview during which I may request the removal or destruction of any associated data. After that period, it won’t be possible to remove my data from the study.

3 In giving my consent to participate in this study, I understand that voice/ audio recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been given information about the risks of my suffering harm or adverse effects and I agree to complete any required health screening questionnaire in advance of the study. I have been told about the aftercare and support that will be offered to me in the event of this happening, and I have been assured that all such aftercare or support would be provided at no cost to myself.

5 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

6 I agree to anonymised direct quotations from my interview being used in research reports and publications.

7 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

8. I understand that anonymity will be maintained and that it will not be possible to identify me in any research outputs. I understand that if the researcher suspects there is a risk of harm to myself or others, they will have to breach confidentiality and signpost me to relevant services. I understand that I will be informed about this.

9. I agree to take part in the above study.

Signature of participant…………………………………..…Date…………………………

Signature of (principal) investigator: Alexandra Papamichail

Date:

Name of (principal) investigator

ALEXANDRA PAPAMICHAIL

Appendix E: Research Flyer

University of Hertfordshire UH Ethics Committee

RESEARCH RECRUITMENT

We are recruiting men survivors of controlling behaviour, abuse and/or violence by a woman in the context of an intimate, heterosexual relationship. Participants will be cis and/or trans people who self-identify as heterosexual men.

Our aim is to explore and gain an understanding of the mental health needs & priorities of men survivors of intimate partner violence

If you are interested to take part, you will be invited to a remote, one-to-one interview with the researcher through Microsoft Teams

- Participants must be adults over the age of 18
- For safety purposes, you must no longer be living with and be intimately involved with the perpetrator
- For safety purposes, there should be a minimum time length of at least 6 months since experiencing controlling behaviour, abuse and/or violence
- Participants need to have access to the Internet and to a smartphone/laptop/computer
- Participants should be able to communicate in English and be based in the UK

Are you interested? Please, contact the researcher Alexia at ap22ads@herts.ac.uk

The study has gained ethical approval by the University of Hertfordshire Health, Science, Engineering and Technology ECDA. Protocol number: aLMS/PGR/UH/05627(1)

Appendix F: After Care Support and Emergency Services

Emergency and Support Services

- Samaritans, tel: 116 123, for free or email jo@samaritans.org
- Call 999
- Visit your GP or your local A&E service
- SANE is a UK mental health charity offering a range of services including SANEline (telephone: 0300 304 7000), a national out-of-hours mental health helpline every day of the year (4pm-10pm). https://www.sane.org.uk/
- You can text "SHOUT" to 85258 for free from all UK mobile networks. You'll then be connected to a volunteer for an anonymous conversation by text. https://giveusashout.org/
- NHS urgent mental health helplines – you can find your local NHS urgent mental health helpline at the following web address: https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

- ManKind Initiative, tel: 01823 334 244 (open Monday – Friday 10am to 4pm)
- Men's Advice Line, tel: 0808 801 0327
- Abused Men in Scotland, tel: 03300 949 395
- Men's Advisory Project, Northern Ireland, tel: 028 9024 1929
- CALM, tel: 0800 58 58 58

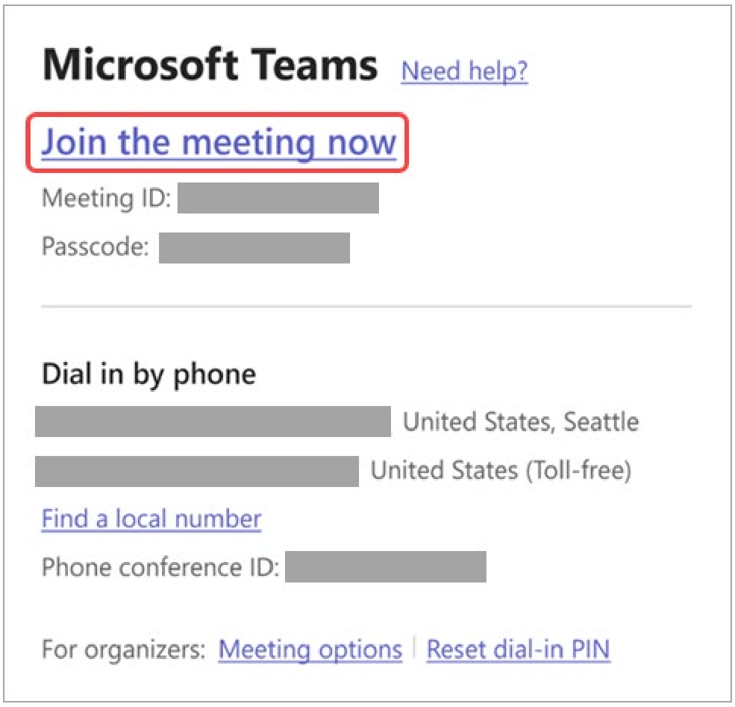
Appendix G: Guidance on how to join Microsoft Team’s link as a guest

Guidance on how to join Microsoft Team’s link as a Guest

You can join a Teams meeting anytime, from any device, whether or not you have a Teams account**. If you do not have an account or the MT app you do not have to download it. You can join by clicking on the link sent to you by email. If you have any difficulties, please contact the researcher.**

1. Go to the email invitation sent to you.

2. Scroll down until you see the link to the meeting. Shown below.



Microsoft Teams Need help?

Join the meeting now

Meeting ID: [redacted]

Passcode: [redacted]

Dial in by phone

[redacted] United States, Seattle

[redacted] United States (Toll-free)

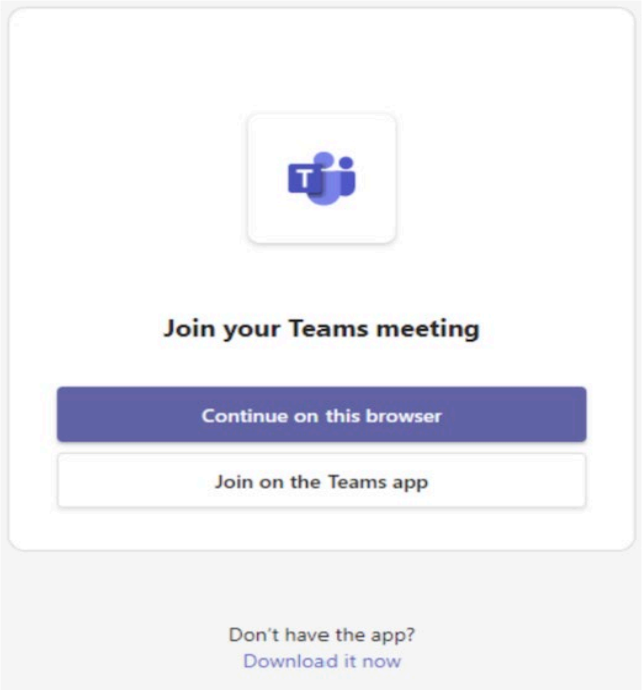
Find a local number

Phone conference ID: [redacted]

For organizers: Meeting options | Reset dial-in PIN

3) Right click on “**join meeting the now”.**

4) That'll open a web page, where you'll see two choices: **Continue on this browser** and **Join on the Teams app**. Click on **Continue on this browser.**



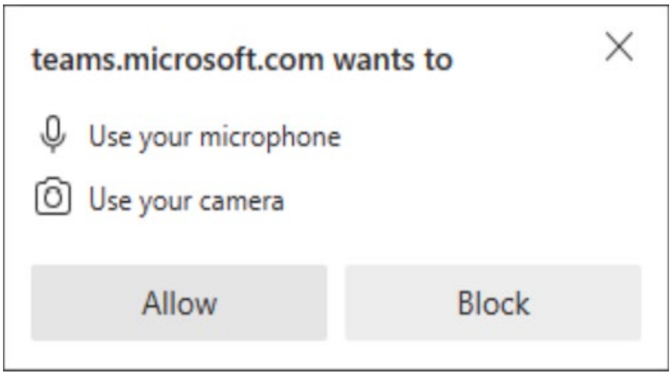
Join your Teams meeting

Continue on this browser

Join on the Teams app

Don't have the app?
Download it now

5) If you join the meeting on your browser, Microsoft Edge or Google Chrome both work. Your browser may ask if it's okay for Teams to use your mic and camera. Please, select **Allow** (you can always turn off your mic and/or video once you join the meeting).



teams.microsoft.com wants to

Use your microphone

Use your camera

Allow

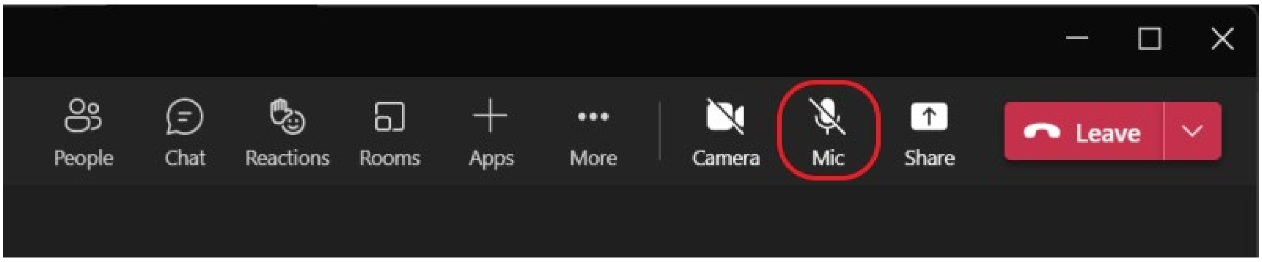
Block

6) The meeting Audio now appears. **You are now able to enter your preferred display name / pseudonym:** Type your preferred display name on **the box named: Type your name (at the top/centre of your screen)**. Please **Turn on computer audio and microphone** and if you wish **Choose your background and filters.**
7) When you're ready, select **Join now.**
8) You now entered the meeting lobby, please wait for the researcher in the meeting to admit you.

Options and preferences

1) **Mute or unmute during a meeting**

To turn on your mic during a meeting, select **Mic** 🎙 in meeting controls at the upper-right area of your screen. To turn off your mic, select **Mic** 🎙 again to mute yourself.



2) **To switch off your camera during a meeting**, select **Camera** in meeting controls at the upper-right area of your screen. You can switch off/on your camera by clicking on this icon.
3) Changing your **display name on Microsoft Teams**:

- If you already have an MT account, please watch this video on how to change your display name:

https://www.youtube.com/watch?v=dKjOuq8SBJQ&ab_channel=OfficeTutorials

- If you do not have an MT account and you want to join as a guest 1) click on the meeting link sent to your email, 2) select Continue on this browser link, 3) once done that, you can now enter your preferred named on the text box named Type your name.

4) End Meeting

1. On the meeting controls, click on the arrow next to **Leave**, click **End meeting**, then **End**.

2. You will be taken back to the Microsoft Teams screen.

Appendix H: Payment and involvement agreement form for EbEs

AGREEMENT FOR VOLUNTEERS & LAY MEMBERS INVOLVEMENT IN RESEARCH

Doctorate in Clinical Psychology research study:

Title: The mental health needs and priorities of male survivors of intimate partner violence. What clinical psychologists should know?

This research project is a study based at the University of Hertfordshire. The researcher is Alexandra Papamichail. The purpose of the study is to explore and understand the mental health needs and priorities of men survivors of intimate partner violence in the aftermath of abusive experiences.

Payment will be made to volunteers and lay members of the public for their participation in meetings and other research involvement activities. The project will finish on May 2025.

This form must be completed by the participating volunteer before payment can be made. Any queries concerning this Agreement should be referred to the relevant Head of Research Centre at the University of Hertfordshire

Between: The University of Hertfordshire

and

Name (The "Participating Volunteer")

Address

Tel No.

Email Address

ACTIVITY Volunteer for Doctorate in Clinical Psychology research study

The **Participating Volunteer** has agreed to assist the University by voluntarily taking part in the research **Activity**.

1. The Activity to be undertaken is described below and it is the Activity for which you have given your consent/agreement.

Attend meetings to discuss aims, recruitment, interview questions, discuss findings and how to share our results.

There will be no requirement for the participating volunteer to attend all meetings or take part in all activities.

CONFIRMATION OF ATTENDANCE

2. The Researcher will confirm the Participating Volunteer has attended the Activity outlined above.

PAYMENT

3. The Participating Volunteer will receive a participation payment of **£15ph** in the form of direct bank transfer for completion of the activities described above. Payment will not be made for any activities in which the Participant did not participate at all.

RELATIONSHIP BETWEEN THE UNIVERSITY AND THE PARTICIPATING VOLUNTEER

4. **The University does not regard the Participating Volunteer as an employee of the University nor as a worker, and the payment made to the Participating Volunteer for the participation is not made with respect to any employment relationship with the University.**
5. **The Participating Volunteer is advised that it is their personal responsibility to declare any payment for participation to HM Revenue & Customs under Self-Assessment, if that is appropriate to their personal circumstances. The University will not deduct income taxes from the payment.**

SIGNED FOR AND ON BEHALF OF THE UNIVERSITY

The signatory for the University confirms they have authority to enter into this agreement on behalf of the University e.g., Principal Investigator

SIGNED **Alexandra Papamichail**

PRINT NAME ALEXANDRA PAPAMICHAIL

Position at UH Trainee Clinical Psychologist

DATE

SIGNED BY THE PARTICIPATING VOLUNTEER

I acknowledge receipt of a copy of this agreement and accept its terms.

SIGNED ……………………………………………………………………………

PRINT NAME ……………………………………………………………………………

DATE ……………………………………………………………………………….

Appendix I: Advertisement for EbE

Advertisement for peer researcher- consultant Participating Volunteer – Peer Researcher Advertisement

As part of my research project for the Professional Doctorate in Clinical Psychology (DClin), I am recruiting one participant volunteer-peer researcher to assist and consult on the research project. The project aims to explore the mental health needs and priorities of male survivors of coercive control, abuse and/or violence from a female ex-partner. Peer research is conducted by people who have lived experience of the topic that is being researched. In this case that means that you will have experience of coercive control, abuse and/or violence from a female ex-partner in the context of a heterosexual, intimate relationship. You must be 18+ years old, have good command of English and have access to the Internet and relevant equipment such as a smartphone or a laptop/computer. For safety purposes you must no longer living with and not intimately involved with the perpetrator. You should have a minimum length of time of 6 months since experiencing abuse/violence from your ex-partner. This is only for safety and wellbeing purposes.

The activity to be undertaken for the role is to attend remote meetings (through Microsoft Teams) with the researcher and one professional peer researcher to discuss recruitment, construct interview questions, discuss findings and how to share our results. There will be no requirement for the participating volunteer to attend all meetings or take part in all activities. The Participating Volunteer will receive a participation payment of £15ph through bank transfer for completion of the activities described above. Payment will not be made for any activities in which the Participant did not participate at all. As only one participating volunteer-peer researcher is being recruited, the position will be closed as soon as it is filled.

Are you interested? If you have any questions, please contact the researcher Alexia at ap22ads@herts.ac.uk

Appendix J: Advertisement of EbE- professional

Participating Volunteer – Peer Researcher (Professional)

Advertisement

As part of my research project for the Professional Doctorate in Clinical Psychology (DClin), I am recruiting one participant volunteer-peer researcher to assist and consult on the research project. The project aims to explore the mental health needs and priorities of male survivors of coercive control, abuse and/or violence from a female ex-partner. Peer research is conducted by people who have lived experience of the topic that is being researched. In this case that means that you will have experience of providing direct support to male survivors of Intimate Partner Violence (at least 9 months). You must be 18+ years old, have good command of English and have access to the Internet and relevant equipment such as a smartphone or a laptop/computer. The activity to be undertaken for the role is to attend remote meetings (through Microsoft Teams) with the researcher and one peer researcher with past experiences of Intimate Partner Violence to discuss recruitment, construct interview questions, discuss findings and how to share our results. It is estimated that we will meet 3 to 5(maximum) times per year. There will be no requirement for the participating volunteer to attend all meetings or take part in all activities. The Participating Volunteer will receive a participation payment of £15ph through bank transfer for completion of the activities described above. Payment will not be made for any activities in which the Participant did not participate at all. As only one participating volunteer- peer researcher is being recruited, the position will be closed as soon as it is filled.

Are you interested? If you have any questions, please contact the researcher Alexia at ap22ads@herts.ac.uk

Appendix K: Topic Interview guide

Introduction

- Have you received any psychological support in the past or currently as a result of your experiences of abuse, control and/or violence?
- Your past: your mental health/ emotional well-being / quality of life before experiencing coercive control, abuse and/ or violence from your ex-partner

Main

- Could you please share what were your emotional/ mental health needs in the aftermath of abuse? (prompt your feelings? What were your thoughts? Bodily symptoms? Behaviours? Sleeping difficulties? Substances? Self-identity)
- What things were you doing more or less of because of this/these mental health/ emotional well-being difficulty/ies?
- When those difficulties started?
- What have you done to cope with those difficulties? What worked? What did not work? What kept those difficulties going?
- What do you consider are the most immediate needs of men survivors of IPV? (prompt: mental health, social needs, financial, social network, relational)
- What needs to be changed to make mental health services more accessible to men survivors of IPV (prompt visibility of services)?
- If you were asked to give advice/offer guidance to clinical psychologists working this client group, what would that be? What should clinical psychologists' priorities be when working with men survivors of IPV?
- According to your experience, what would the best possible therapeutic support to men survivors of IPV would look like?

Closing

- Is there anything you would like to change about how the systems around men survivors of IPV operate? Why? How?
- Is there anything we haven't talked about today that you would like to tell me?

Appendix L: Debrief following interview with male survivors of IPV

“Thank you for taking the time to take part in this research project. I would like to ask you how you found the interview questions? How have you found the participation process? Do you have any suggestions for improvement?

The research project aimed to explore the mental health needs and priorities of men survivors of intimate partner violence in the aftermath of such experiences. If you would like any further information about this research project, then please feel free to email "Alexandra Papamichail", (Principal researcher) on ap22ads@herts.ac.uk

Should wish to withdraw in the next 2 weeks, email the principal researcher within 2 weeks from today and they will remove the data from the study.

If any of the issues in this study were distressing and you feel you need additional support, please contact one of the organisations below for help” (after care support and emergency services document).

Appendix M: Candidate theme, sub-themes and extracts example

Potential theme	**Sub-themes**	**Examples of relevant extracts**
What clinical psychologists should know?	Men struggle to open up and ask for help	Because a lot of the time guys will hate sharing things and when you hate sharing things, you let someone else write the narrative and that's what happens a lot of time. Well, I mean that's a difficult one because you've put your, you know, because men don't ask for help. I've just said that when I was giving you that long overview and I never would have, I never thought of asking for help other than going to my sister. Well, the first problem is actually getting people to ask for help. Because it took me well, it took me until I started having these flashbacks that I could not deal with, to ask for help. But I didn't like asking for help because again, if you're a man, you're sort of brought up you know, to be self-reliant, you don't need any help, you know man up, all that stuff. And it was quite difficult, sort of putting myself at somebody else's mercy in that way. So that's the first problem. Just getting men to ask for help I, I suppose, like most men, I'm very private. And I don't let people in, and I don't like talking about, you know. I don't like sharing and information. Just that the man will be probably reluctant to speak, he would feel ashamed, you know, to tell the story as it is because he will be embarrassed, and he will feel that he's maybe not getting believed Secondly, I think they're gonna find it much harder to open up and talk about stuff, but again, the nature of the man, but also, shame, but also maybe not understanding what's really happened to them. Uh, and I think it has to

		be long term. You know you can't just have one or two sessions I worked in the [name of organisation] with patient groups. Men talk very differently about their experiences; they are much more hesitant to come forward and it takes a bit of time. So, I guess you need to give them more time to build up that rapport with you.
	Being believed and being listened to	The very, very first thing is somebody hears them and actually believes them and they get it, they, like they see, they hear, they validate And the other one is just listening to us, believing people. Hmm, Women's Aid make a big thing about, you know, we believe every woman. Well, we should have the same, you know. Hmm, and that's what you don't get. And when somebody has asked for help, just being as accepting and listen because I think nearly any man who actually gets as far as asking for help will have been through the whole disbelief thing and just to find somebody they can talk to, who isn't just questioning their every, you know, it hasn't happened, just been taken seriously It would be listening to these men and men getting reassurance So, men, men, need to be listened to until they're ready to hear their own bullshit [laughs]. Yeah. And to be validated you know, in a sense, I needed to be listened to, but only kind of in the broadest possible sense. Right? I would say the most important, the single most important thing for a man is that they are believed that there's compassion, that there's an acceptance that this does happen to men

		I would say the first one is to actually be believed. I think it's the biggest thing. It's taken me 2 1/2 years to actually report to the police that my ex-wife repeatedly strangled me, punched me, scratched me, kicked me, bit me, all of that now is outside the times for reporting it. Because I wouldn't be believed, and because I was going through family court to try and get some contact, with my [child]” I think, I think the most important thing for me is to try and push any kind of preconceptions out their minds and just really hear the person what they've experienced because a every situation is different. But, but I think particularly with male victims, maybe as well with female victims, we come uploaded with our preconceptions about what happened. And what we think is domestic violence, what it looks like, what it sounds like.
	Benefits of group work	Yeah, but the priority for men, I think, is somewhere they can speak to other people, where there's other men and where there’s trained professionals that aren't their family and friends. Especially for those who have been through something similar meeting other people with similar experiences is really important, because you can maybe see parallels. part of my therapy if you wanna call it that way, was that quite by accident I found a support group for male survivors quite near where I live. […]. There were these people, so I went and found them, and I was just amazed the first three times I went I didn't say a thing. I just listened because they're all the other people, I just thought it was me. I had no clue. We were all we all had similar stories as well. It was just incredible. […]. And

		that pretty much saved my life because I was a terrible state at the time. and then yeah, then a team, a group. So, you can hear other people's experience. So, you get reassurance as per that TV program that this happens to other people, you know, you are not alone. Guys, we have to, we got no choice and it wears us down and closes us up. So having groups, this is what we've set up now. Yes. OK, so for support after. Yeah. OK, I think group support is really helpful I think particularly for men because you know, I could imagine in a one-to-one situation, it can be quite intense and a little bit intimidating, whereas actually in a group situation, you could see how men could feed off each other and open up. So, I think the group will, it may depend on personalities, but I'm, I'm quite an extrovert so, I quite like the group So, so I think groups quite good because you can bounce off each other I think the one thing that would benefit from is you don't feel as though it's just you, going back to why you're doing this. You feel as though it's you look round at all your friends and your family and your connections, and you go shit, you know, I'm the only one this has happened to, and therefore there's no one, there's no one really you

		can talk to that's experienced this even now. I've got a friend who's divorced from an alcoholic. She's, she's the survivor, he's the alcoholic. I can sort of talk to her about stuff, but I lack some, going back to the group thing, I lack someone who's been through a similar experience. if I was going to a group like a group of people that have been affected by domestic violence. I would love to go to someone like that, but I've never found it. I think it would be really good to share experiences and get support from a group, and I've been through that with an organization [name of organisation] and it was a support group for people who have lived with someone with borderline personality disorder. That group was fantastic. Again, not specifically around domestic violence, but the way everyone supported each other. And there were a number of incidents around domestic violence within that.

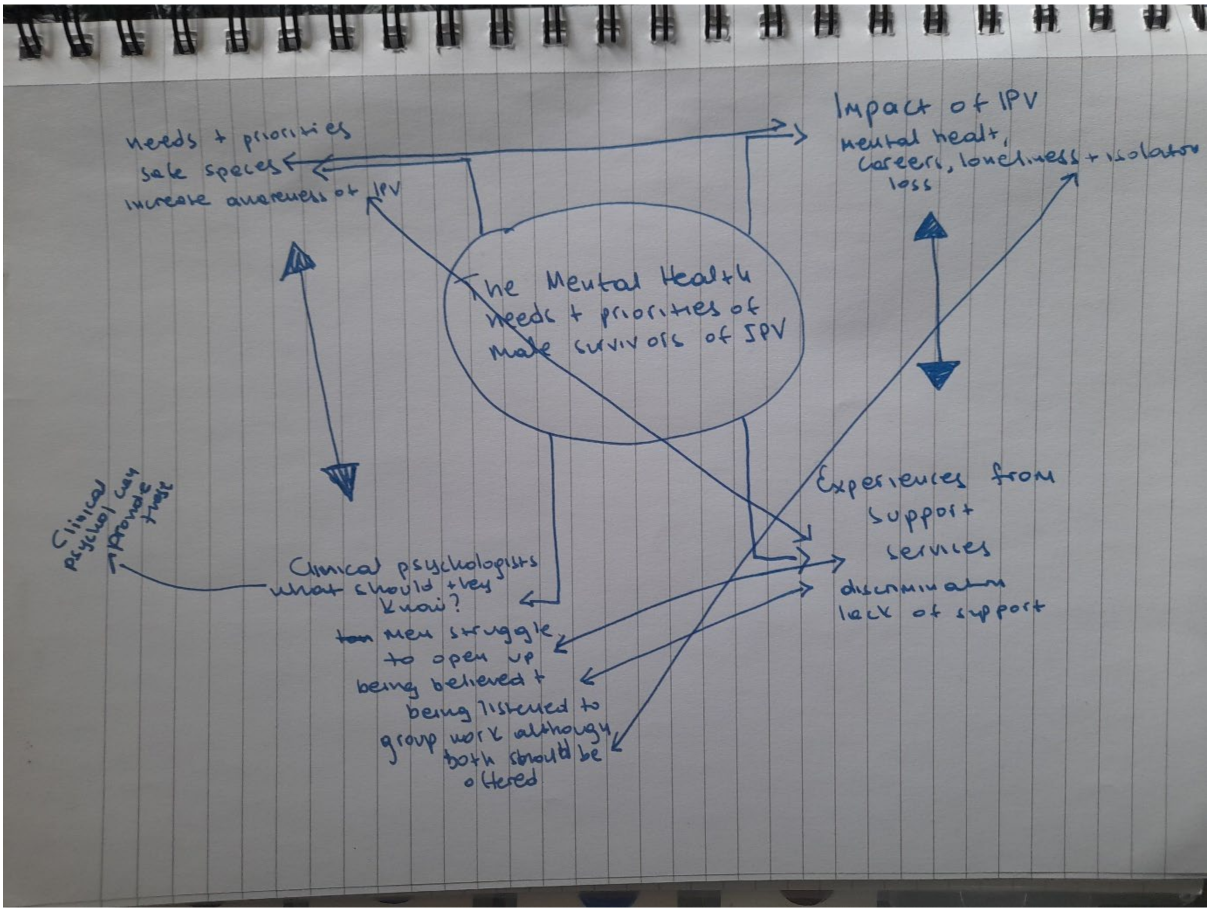
Potential theme	**Sub-themes**	**Examples of relevant extracts**
Needs and priorities	Safe space to talk	It's definitely talking, like a talking therapy having someone to speak to who will listen. I think it's really hard to say for all speak on behalf of all men, but I think there's something about emotional well-being and support and giving men a safe space to talk through professional services. I just don't think that exists unless you seek it out yourself. And if you can't afford that, and

		I had a job, there are lots of people who just wouldn't be able to afford a counselling session every week. But it's basically the, the biggest thing is just being able to talk to somebody who understands will have some strategies the first step in this is I think as we all know is getting the men to talk, you know, my wife is hitting me, my wife is being abusive, my wife is doing this to my children and you know, you can't, unless you know, because after if they do ask for help then that's great because they can speak to our psychologist and find out they're not alone and find out that, maybe find out ways of treating the wife The immediate need is relational, a therapeutic relationship. Someone who would listen to them. Relationship to allow them to talk and to provide just a huge amount of unconditional positive regard because they're like most men were emotionally stunted, we don't know how to deal with our emotions The therapy helped because it was somewhere I could go to, to actually talk about it. It was almost like I'm I can slice out a part of my attention which enabled me to just go right? How do you get, you know, prize in that information out of him making him realise that he's not the only one making him realise that unless he speaks about it, it's gonna perhaps torture them as it does with me for the rest of his life
	Massive IPV awareness campaign	And then I think that needs to be a massive just awareness campaign Oh, get the government to put some money into a public, public awareness scheme. So, it's there on TV. I mean alongside there should be men's domestic violence, family, domestic violence. Well, men's mental health. if people were seeing adverts on the TV every couple of hours or once a night or something, over time it would

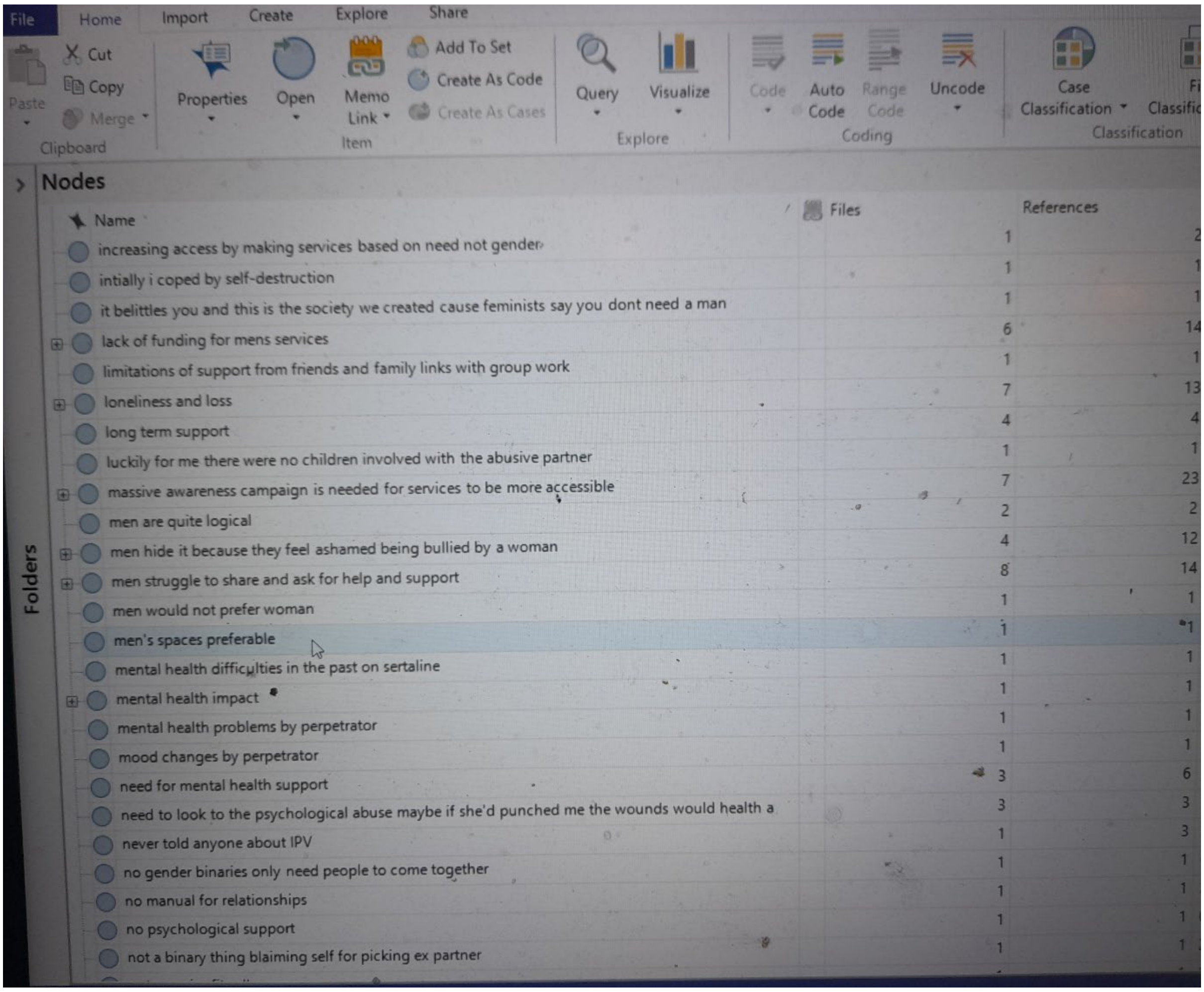
		normalise, it would bring it into a conversation, and once it's in conversation, fear is reduced, and it starts to be accepted to talk about it. So, public, public awareness campaign. And then if there are more people asking for it then. It might. It might start to happen. It needs money. Yeah, yeah, I guess I think maybe through the arts, like I don't know, have you seen gone girl, you know, gone girl, that film? Yeah, yeah! So, like, that's quite a good. That's extremely rare to see, like a female perpetrator! Kind of, you know, like seeing, you know, shown in that way, right? And she still gets away with it, right? That's the big, she gets away! She just comes back at the end and completely gets away with it! So, maybe the arts. Like maybe you need to see some, some like honest portrayals. And that helps to accept that this happens, you know, if it's sort of done metaphorically, you know. I guess a bit like, when you see a lot of mythology and stuff like that, and maybe we need to just go back to good art. But I think we can certainly get that in there, you know, just to make people aware because what most of the guys at that support group that I found back in [xxxx year] shared, they all shared the same thing: nobody believed them. And so, it's just making people aware that it's a thing other people need to realise what's going on and then other people sort of share their stories as well. […] There was an advert a couple of years ago with a man shouting at his girlfriend in the street. I think it was by [name of organisation]. Everyone jumped in and then, yeah, and, sorry then when you see it the other way around everyone just laughs, and that, that's just literally what it is. So, I think something like that that says you know, you know, we're half the victims. I actually thought if I had the money, I would commission somebody to do a something on the TV. Like you know, a one or two hours, maybe a 2-hour thing. Because the thing that everybody said when my

		family broke out, everyone said we thought you guys gotten really well and you know, you've got the perfect life, and I've had to expend note behind doors. […]. And just raising awareness so I think I think the press. Stop what you're doing great, publicise it, you know, that's another one, press. People's stories, right?

Appendix N: Preliminary thematic map



Appendix O: Examples of codes from NVivo



Nodes

Name	Files	References
increasing access by making services based on need not gender	1	2
intially i coped by self-destruction	1	1
it belittles you and this is the society we created cause feminists say you dont need a man	1	1
lack of funding for mens services	6	14
limitations of support from friends and family links with group work	1	1
loneliness and loss	7	13
long term support	4	4
luckily for me there were no children involved with the abusive partner	1	1
massive awareness campaign is needed for services to be more accessible	7	23
men are quite logical	2	2
men hide it because they feel ashamed being bullied by a woman	4	12
men struggle to share and ask for help and support	8	14
men would not prefer woman	1	1
men's spaces preferable	1	1
mental health difficulties in the past on sertaline	1	1
mental health impact	1	1
mental health problems by perpetrator	1	1
mood changes by perpetrator	1	1
need for mental health support	3	6
need to look to the psychological abuse maybe if she'd punched me the wounds would health a	3	3
never told anyone about IPV	1	3
no gender binaries only need people to come together	1	1
no manual for relationships	1	1
no psychological support	1	1
not a binary thing blaming self for picking ex partner	1	1

Appendix P: Examples of extracts from the reflection journal

After two interviews

-I felt uncomfortable today, stereotypes shared by participant “men are more logical than women”. It made me feel uncomfortable. It was towards the end. I felt bad with myself for not commenting on those stereotypes, I would, if not in a research context. I was annoyed. Kept reminding myself that I am here as a researcher, not to change anyone’s ideological views. Reflection with supervisor was very helpful we formulated these aspects together. I heard a lot of range, a lot of anger and sense of perceived injustice. I feel it is more a resources competition; this is what happening. It is lack of resources for social services in this capitalist society. I felt frustrated today and exhausted

-A tough day today, two interviews in three hours, it feels too much. I could see the pain and the hurt and this made me feel helplessness. I felt the urge to help and apologise for everything they have been through. Sense of injustice and justice not served is common with the interview conducted earlier. They shared about having lots of support from their family and friends, I am wondering how about people who don’t have such support. Or are not being believed. How painfully this must be.

Reflection after meeting with EbE

EbE meeting today- we went through the interview guide and explored areas I might have missed. I felt a bit stressed before receiving feedback. The feedback regarding the flow, the relevance and whether the interview guide is meaningful was good. Also, it was raised that the topic guide aligns with their experience, ethos and views. The research consultant asked me whether I included a question about disability status. I wondered then what it meant not to have attended to that – was this an oversight and why? I felt glad I was asked this question. I explained that I am asking as few as possible demographic questions and participants have the right to decline to answer to those. We discussed the impact of IPV on male survivors’ identity -struggling with who they have been before the abuse. We also discussed the mental health difficulties experienced by male survivors of IPV. Really useful insights offered. This meeting strengthened my decision to be more flexible, allow for silences to give space to the unexpected.

Last meeting with the EbE, it felt emotional. We went through data analysis and the themes and subthemes. It was more like a reflection on what I found rather than doing the analysis together. Another methodology would address that. We discussed whether the analysis tells a story that is coherent and meaningful. They offered additional perspectives, and this reminded me of “one size does not fit all”. I need to remember that when checking the chapters. We discussed next steps and dissemination.

Data Analysis

I enjoyed coding so much! The dataset seems rich, and the accounts seem powerful. There are parts I decided not to code- e.g., concerning types of victimisations experienced. Some participants really wanted to talk about these experiences. Double checking Braun & Clarke guidance was helpful.

I was thinking about the power that we have as the researchers. I enjoy coding the interviews especially for needs and mental health. This made me think of the risk of over-emphasising the data and codes that they speak to me and reminded to me the quote of Braun & Clarke about “findings not being found in the data”. I feel I need more time. This is a very thorough and exhausting process. The coding list is huge!

Searching for themes is daunting. I move between the original transcripts, coding in NVivo and the potential themes I wrote in paper. I was finally able to group my codes. I had to reduce them quantity. I needed to return back to my transcripts to check for patterns I might have missed. I cannot continue any more today. I need some space from the data and the analysis.

Going through Braun and Clarke again I realised that the names of my themes are descriptive -I need to go back and change that.