The National Male Survivor Helpline

A Literature Review of the Health Seeking Behaviours and Needs of Male Survivors of Sexual Violence

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The World Health Organization recognizes child sexual abuse (CSA) as a leading, preventable contributor to the global burden of disease (Krug et al., 2002). Global estimates of male CSA vary due to reporting and methodological issues, with a meta-analysis of global CSA studies reporting estimates between 3% to 17% for boys (Barth et al., 2013) whilst Finkelhor et al., (2014) estimate one in six to 10 boys are sexually abused before the age of 18. Hence, CSA remains an enduring global public health issue.

Given the isolation that many individuals and families experience when facing the crisis of sexual abuse, confidential helpline services remain a potentially fruitful component of a comprehensive public health approach to addressing CSA and male trauma. Helplines are a significant phenomenon in the mixed economy of health and social care (Coveney et al., 2012). In order to understand the need for and use of the specialist National Male Survivor helpline (NMSH) for male survivors of sexual abuse and rape it is important to understand the impact of sexual violence on male victims, the role of gender norms and society's views on masculinity and the communication preferences for male survivors. Understanding these issues enables services to understand the barriers and enabling factors for males to access support. Having worked with male survivors for 25 years Safeline has a wealth of experience is this area and the Helpline team are a highly skilled team of professionals and have worked with callers of all genders, ages, sexualities, cultures and ethnicities across England and Wales. Safeline's commitment to male survivors was evident by being the first multi service organisation to earn the Male Survivor Partnership Accreditation status earlier this year (2019).

Impact of child sexual abuse (CSA)

How CSA is experienced, understood and processed can be affected by the age of the child, the nature of the sexual abuse, the child's relationship with the abuser and the quality of other interpersonal relationships (Sanderson, 2006). "Children who have experienced sexual abuse may learn and internalize beliefs that they are not good, not worthy of respect and the world is not safe" (Reese-Weber and Smith, 2011, p.1986). The effects of CSA on the adult are wide ranging and include increased psychiatric outcomes, behavioural problems, adult maladjustment, inter-personal difficulties, victim-perpetrator cycle, somatic conditions and neurobiological maturation (e.g. Paras et al., 2009; Zilberstein, 2014a). Table 1 outlines some of the major psychological manifestations of CSA which include self-harming behaviours, affect regulation, inter-personal difficulties and feelings of guilt and shame. Effects of CSA on the body (somatic conditions) include metabolic and neurological disorders (Leserman et al., 1998) such as nonspecific chronic pain, fibromyalgia, functional gastrointestinal disorders and psychogenic seizures (Paras et al., (2009).

Research is now beginning to focus on understanding how CSA affects the adult. For example, the 'traumagenic dynamics model' of CSA (Finkelhor and Browne 1985) in which sexualisation, powerlessness, stigmatisation and betrayal are identified as the core of psychological harm.

Table 1. The psychological impacts of CSA. Relevant publications are in parentheses

Psychological Manifestations of CSA			
Insomia/nightmares (Steine et al., 2012)	Substance abuse (Maniglio, 2011a; Draucker and Mazurczyk, 2013)	Self-esteem (Reese-Weber and Smith, 2011; Fergusson et al., 2013)	Guilt/shame (Chouliara et al., 2014)
Sexual dysfunction (Briere and Elliot, 1994)	Sexual risk behaviours (Tsutsumi et al., 2012; Draucker and Mazurczyk, 2013)	Ability to trust self/others (Sanderson, 2006)	Fear/anxiety (Fergusson et al., 2013)
Panic attacks (Goodwin et al., 2005)	Self-injury (Lang and Sharma-Patel, 2011)	Powerlessness (Finkelhor and Brown, 1985)	Anger (Gupta et al, 2011)
Memory loss (Elliot and Briere, 1995)	Attempted suicide (Maniglio, 2011b; Fergusson et al., 2013)	Altered sense of self (Briere and Elliot, 1994)	Aggression, hostility (van de Kolk, 1996)
Flashbacks (Briere, 2002)	Eating disorders (Dworkin et al., 2014)	Victimisation (Reese-Weber and Smith, 2011)	Depression (Fergusson et al., 2013
Dissociation (Knox, 2013)		Interpersonal difficulties (Briere and Elliot, 1994)	Affect regulation (Pearlman, 1998; Briere, 2002)
PTSD (Fergusson et al., 2013)			

Greenfield (2010) describes CSA is a life-course social determinant of adult physical and mental health with Fergusson et al., (2013) identifying further impacts on socioeconomic outcomes. Hence the effects of sexual trauma are wide ranging and can impact across all aspects of functioning. In order to better understand how to support male survivors we need to firstly understand male help seeking behaviours.

Help seeking behaviours

Help-seeking behaviours involve asking for help, relying on others, admitting the presence of a problem and the emotional expression of a problem. Stigma is one of the largest barriers to men's decisions to seek psychological help and engage in help seeking behaviours (Cole and Ingram, 2019). Self-stigma is the belief that one is inadequate or weak if he wants to seek professional help with men engaging in more self-stigma than women (Hammer and Vogel, 2010). This self-stigma predicts unwillingness to seek support and internalization of

stigmatizing beliefs becomes more pronounced for men during times of distress when emotional support services are most critical (Vogel et al., 2011). Being confronted with psychological distress and the need for help-seeking becomes a self-perceived threat to masculinity (Schaub & Williams, 2007). Accordingly, 'men may feel a sense of failure due to a perceived inability to solve one's own problems, a fear of losing autonomy, or a fear of being perceived as weak' (Cole and Ingram, 2019, p.2). Hence a decision to seek help may be perceived as a last resort (Gough, 2016). Males are often born into societies with numerous gender socialized beliefs, such as thinking that it is not appropriate to discuss their feelings openly and that being emotional is not masculine (Sierra Hernandez et al., 2014). The degree to which men endorse masculine ideology likely influences the degree to which men experience self-stigma of help seeking (Hammer & Vogel, 2010).

Unmanaged shame in men has been associated with social isolation, emotional disconnectedness, stress, low self-regard, and resistance to building a therapeutic relationship (Gordon, 2018). In the article "Men, Shame, and Psychotherapy," Osherson and Krugman (1990) suggested that men are more vulnerable to shame, since shame is a key psychological motivator for boys and men, which has a powerful influence on masculine identity development. Masculinity can be defined as the possession of culturally informed social-role behaviours that are deemed necessary characteristics of being male such as being strong, tough, stoic, autonomous and able to cope (American Psychological Association, 2018). Stigma also appears to impact the types of issues that men seek help for being less likely to seek help for problems believed to be stigmatizing, uncommon, or reflective of their self-worth (Magovcevic and Addis, 2005). In this regard, seeking help for sexual abuse or rape (for which society has traditionally considered a feminine issue), for struggling to cope with the aftermath and for thinking they were to blame for not stopping the assault carries a high level of self-stigma, guilt and shame for male survivors. This extremely difficult and challenging situation leaves males believing they must be weak, unable to cope and emasculated.

Aspects of help-seeking (e.g., relying on others, asking for help, admitting to having problems, and emotional expression) may conflict with societal messages that men receive about the importance of self-reliance, toughness, and emotional containment (Cole and Ingram, 2019). 'Gender role conflict' (GRC) as described by O'Neil (2015), occurs when a male's socialized gender norms inhibit actions or behaviours (e.g., help-seeking) or lead them to feel negatively for doing so (e.g., "Real men don't get depressed"). For instance, men experiencing higher GRC may avoid disclosure of personal information and emotions whereas men with lower GRC are more likely to self-disclose (Pederson and Vogel, 2007). Male sexual assault and rape challenges every gender norm being the ultimate taboo that induces extreme GRC. Male sexual violence greatly impacts upon GRC and self-stigma preventing men from disclosing distress within significant interpersonal relationships which likely deprives them of important dialogues that may provide emotional support and normalize professional help-seeking behaviours by reducing stigma (Cole and Ingram, 2019).

How the National Male Survivor Helpline supports health-seeking behaviours

Males endorsing high conformity to masculine norms (e.g., power over others, dominance, and pursuit of status) are far less likely to talk to a mental health professional and more likely to engage in self-medicating behaviours (Cole and Ingram, 2019). This is crucial to

understand in order to promote and mange a service specifically for male survivors and at Safeline we recognise:

- perceptions that informal help-seeking is more confidential and less vulnerable than professional help-seeking (Johnson et al., 2012), a reason why the NMSH is seen and promoted as friendly, compassionate support that is confidential and men can 'drop in' and call on a day and time that works for them. In this regard it is purposefully not promoted as formal structured support as that would be applicable to professional counselling only.

- professional titles may also affect the decisions that men make about when and where to seek help (Brown & Chambers, 1986) and in some cases may act as a barrier to seeking help. Men may perceive that formal help-seeking approaches such as counselling are inherently "feminine" due to their emphasis on emotional expression and self-disclosure (Boespflug, 2005). As a result, men may be drawn to "masculinized" professional titles such as "executive coach" because coaching is associated with a more directive relationship than media portrayals of counselling (Boespflug, 2005). Similarly, the names of organizations that offer psychological support appear to influence the decision to seek help. Hence the term we use at Safeline for our NMSH staff is 'Helpline and Online Advisor' emphasising that men can ask for advice and information and there is no assumption in the title that they will have to talk about their emotions. This provides a sense of emotional safety and aids a sense of being in control of what is shared, crucial components to build trust in a service.

- perceptions that other men are engaging in health-seeking behaviours also increases the likelihood that males will engage in healthy behaviours (Mahalik et al., 2007); Seeing other men violate gender norms related to help-seeking improves utilization of mental health services (Vogel et al., 2008). Using the words 'National', 'Male' and 'Survivor' in the title of the NMSH clearly spells out who this service is for and being the support helpline for BBC TV and radio and ITV it is now a prominent and recognised service for male survivors across England and Wales. Consistent spikes in calls following high profile cases such as the footballers' disclosures in 2017 and the male rape storylines on Coronation Street and Hollyoaks in 2018 have been observed.

- men weigh up potential benefits and drawbacks to seeking support and must decide which is more important, getting relief or avoiding increased GRC and potential loss of status (Perlick & Manning, 2007). Hence, acceptance of treatment is associated with short-term struggles with GRC (e.g., discomfort with disclosure, shame, fear of dependence on the therapist, and fear of being perceived as weak by peers). Avoiding treatment will lead to continued psychological distress and ultimately a mental health crisis. In relation to this, many male survivors who contact the NMSH are at this point – the need to finally take control gives them permission to call and seek the support they need. Hence, as an organisation, it is important that we psychoeducate males to help normalise their reactions to coping with their abuse (such as mental health issues and self-harming behaviours) and the utilisation of emotional support when they experience these issues.

NMSH supporting the specific needs of Male Survivors and their family, friends and colleagues

The NMSH focuses on the needs of male survivors and offers an opportunity to obtain services or resources in a compassionate, safe, and anonymous environment, which addresses many of the barriers to help-seeking behaviour. Furthermore, the NMSH is also a resource for individuals who are concerned about a male they know but who are unaware of what to do or how to support a friend, family member or colleague. In this regard, the NMSH is an accessible instant place to call for those wanting to explore this and also to get support for their own wellbeing following a disclosure of male sexual violence.

- **Engaging with male survivors and raising awareness**

Attention needs to shift from solely addressing traditional views that men do not, and will not, seek help, to include a focus on increasing awareness of suitable support for men (Seidler et al., 2017). This is not to say that attempts to engage men in services should be abandoned, as this remains a pressing concern, rather we also need to consider how we might better engage male survivors who have taken the brave step to seek help.

The feeling of powerlessness felt by many survivors of abuse is a key aspect to be aware of when supporting survivors when, for example, a caller may mistrust others and expect to be victimised. "The resistance to change may be powerful due to the influence of existing representational models of relationships. In fact, the adult who was maltreated during childhood may feel less anxious when early childhood experiences, regardless of how negative, are re-created" (Cicchetti and Toth, 2009, p. 301). Therefore, the challenge to effective support lies in how best to engage an individual in the healing process. In this regard, person-centred therapy is an ideal approach as it is "a conscious renunciation and avoidance by the therapist of all control over, or decision-making for, the client", (Rogers, 1978, p14). A focus on person-centred care, through a purposefully collaborative client–clinician relationship, rather than more traditional clinician-led approaches, has been proposed as the model most capable of engaging men with services and catering to their diverse treatment needs.

The first step to person-centred care, in the case of men and mental health, is staff awareness of the tensions experienced by many men around emotional expression of vulnerability, and the simultaneous need to remain open to men's diverse patterns of emotional expression, to affirm other ways of being rather than reinforcing stereotypical interactions. In other words, the NMSH advisors read and adapt to the needs of each man, working within a continuum wherein some men may struggle to express emotions and others may not. The Safeline NMSH team are all trained to work in a person-centred way, to 'be' person-centred to enable the male caller to feel in control of what, when and how they disclose their abuse. The fundamental aspects of this approach are for each NMSH advisor to be empathic, non-judgmental and genuine in their relationship with each caller. This is echoed by Sanderson (2006, p. 117) who states, 'More than any other client group survivors of CSA need to experience sensitive and empathic listening and attunement'.

Seidler et al., (2017) suggest the best method for improving men's awareness of their issues is via the public health campaigns, which make getting men into mental health care their goal e.g., 'Real Men Real Depression' (Rochlen et al., 2005). Public health awareness raising of

the NMSH would put the service into mainstream support so males would be more likely to see it as an acceptable service to access that is specific for their unique needs

- **Case study: Tony**

To explore the effects of CSA and how a male survivor accessed and engaged with the NMSH I am going to introduce you to Tony, a male survivor of CSA who was a regular caller to the helpline (all details and names have been anonymised).

> *Tony described himself as a single 50y old white British male. The profile is the most common profile for males currently accessing the service. He accessed the service following a male rape storyline on a British soap and saw the NMSH helpline number advertised on the television. He was actioned into calling after breaking down at work and being signed off on sick leave. He was in crisis and felt suddenly confronted with the past he has up until now, managed to block out.*

Research indicates that men often embark on mental health treatment when suddenly in crisis and recognise they need to 'do' something (Seidler et al., 2017). Tony recognised that he couldn't go on like he was any longer and the need to take time off work and admit to himself he was not coping was at complete odds with his self-concept that as a man he 'should' be able to cope and not doing so left him feeling weak and emasculated. This compounded his feeling of shame and whilst acknowledging he needed help, he was not sure where to start. He saw the helpline number on the television and although wanting to get support was not ready to pick up the phone and call for several weeks. This is a pattern we have observed and it is common for males to call several weeks after being triggered by a media or social media event.

> *Tony's first words to the helpline were, 'I don't know who I am' (altered sense of self) but was aware he was a 'people pleaser'. However, being a pleaser was no longer making him happy and he was aware of his incongruence. Tentatively exploring Tony's phenomenological meaning of 'people pleaser' with the helpline advisor enabled him to identify its meaning of feeling safe, familiar and not thinking about what he wanted; Thinking about his needs was difficult as he experienced an external locus of evaluation. His self-concept had developed as someone whose own needs didn't matter and they could be a good person by pleasing others.*
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> *During the call Tony disclosed that he had been sexually abused by his uncle from the age of 6 for several years. Tony had never disclosed this before as he experienced deep shame associated with feeling 'weak and unmanly'.*

The impact of disclosure on the client can be overwhelming and re-traumatising (Farber et al., 2014) hence it is crucial that staff are mindful of their reactions and allow the caller to go at their own pace and to share only what they feel comfortable sharing. As trained professionals the helpline team are highly experienced in dealing with disclosures and are aware of the need to allow a survivor to have the time to talk in that first contact. Hence the first contact is not time-limited as we understand the courage it takes to talk for the first time and provide the time and space for each male to share their experience in a safe, empathic and non-judgmental environment. All further contacts are limited to 45 minutes once a week to enable repeat callers to be aware of the boundaries which in itself can aid a sense of safety helping to build

trust. Data from the NMSH clearly shows that our callers are very often repeat callers so it can be deduced that they trust the service and feel supported by the service.

> *Tony was confused by the abuse but was always assured by his uncle that he was a 'good boy' and they were both 'enjoying it' and to survive his abuse he denied or distorted his experiences (Rogers 1951). However, Tony experienced further guilt and shame related to the fact he enjoyed the physical sensations of the abuse and developed a core belief of 'I enjoyed this so I must be bad'.*

During his calls with the NMSH the team engaged in psychoeducation and explored Tony's body's natural physiological reaction to touch and stimulation helping Tony to 'normalise' his experience and understand it was a sign his body was functioning appropriately. Accepting his natural physical response to the abuse helped Tony deal with his feelings of shame and guilt – recognising the perpetrator took advantage of his body's natural reaction and used it to silence him.

> *As a teenager, Tony began the risky sexual behaviour of 'cottaging'. Tony's introjected value 'I give sexual pleasure to men therefore I must like men' stayed with him until he began to realise that he never actually liked men but had unconsciously told himself that to be able to cope with the abuse from another male.*

Questioning sexual identity is a common issue for male survivors and an important area for them to explore when they feel ready to do so and again a key part of the psychoeducation that the NMSH team undertake with callers.

> *As a middle-aged man Tony felt like he was stuck as a teenager and struggled to know how to develop inter-personal relationships. To cope with his loneliness as a result of failed relationships, Tony turned to food for comfort and became very overweight leading to diabetes.*

Research has shown that "most children in western societies show a preference for a single attachment figure and that later relationships often match the level of security of that original bond", (Zilberstein, 2014b, p. 93). Hence, it is possible that Tony's CSA has affected his ability to form secure attachments as an adult but also the difficulty with trusting others and the sense of not feeling worthy of love, of being 'unlovable'. Tony's diabetes could be considered a somatic condition related to his CSA and was the reason he sought support from a GP. At no point did the GP ask about a possible history of abuse likely due to time restraints and a lack of awareness of the somatic manifestations of CSA. Ways of coping with the effects of CSA such as self-harming behaviours are crucial to normalise for survivors so they can stop punishing themselves for these behaviours and see them as a way of coping with intense emotional pain. This is a key role of the NMSH staff who, along with exploring these coping behaviours, can offer suggestions, if appropriate, for less harmful coping strategies.

- **Repeat callers to the NMSH – what do they tell us?**

The average number of repeat male callers to the service is 63% with 37% of new callers to the service on average each month. The impact on relationships is now well known for survivors of sexual abuse and leads to high levels of isolation and loneliness but the perception that frequent callers are lonely and contacting helplines for general support underestimates their needs. There is evidence that regular callers may have fewer social supports than other

callers, if never having been married is regarded as a proxy for this, but, as a group, they don't call without good reason. Regular callers to crisis services are more likely to be male and unmarried. Compared with non-frequent callers, regular callers are more likely to present with significant mental health problems and high levels of risk, including for suicide (Spittal et al., 2015). Hence, the benefits of talking to a trained NMSH professional in that moment of crisis cannot be underestimated not only to aid a sense of connection which is crucial for wellbeing but also to help alleviate the experience of crisis and to be heard and supported. This is also echoed by Coveney et al., (2012) who state that a potential impact of voluntary sector support services such as Samaritans lies in providing a sense of "connectedness" for callers as a means of deflecting or reducing impulses to suicide or self-harm. Regular callers often have complex problems and high levels of need, so the ability of helpline staff to weave their way through the complex issues and to 'hold' that person in their time of distress whilst maintaining an empathic non-judgmental stance can be extremely healing.

The study by Apsler (1976) assumed that regular callers found crisis helplines helpful because they continued to call. This assumption was supported by Coveney *et al*., (2012) that measured regular caller's overall perception of helpfulness of the Samaritan's helpline. This study found that frequent callers gave an average score of eight out of ten for helpfulness. These survey findings are consistent with other studies in reporting a heavy use of services by regular callers, a high proportion of whom report having mental-health problems of chronic and ongoing nature. In addition, over half of the survey respondents had contacted Samaritans more than once. In line with other findings – and at variance with the stated aims and mission of the organization – this indicates that many callers value Samaritans as a source of ongoing support, rather than as a refuge in times of crisis

Hence telephone crisis helplines play a pivotal role in comprehensive suicide prevention systems. Each call to crisis helplines provides an opportunity to prevent suicide by facilitating the identification of, and response to, people experiencing imminent suicidal crisis. As the NMSH continues to grow and support more males the incidences of dealing with active suicides has risen year on year and the NMSH team have had many challenging calls. However, due to their skill and person-centred approach they have managed to lessen the feelings of being overwhelmed and believing that suicide is their only option for many men. These types of sensitive and yet intense conversations involve engaging effectively with the caller and for the caller to experience that they matter to at least one other human being cannot be underestimated. Again, the pace of the call, the tone of advisor's voice a well as the words spoken and not spoken are key for support.

- **Which support service do male survivors have a preference for?**

Providing different forms of communication for male survivors and those supporting them is important to enable them to get in touch with the National Male Survivor Helpline and Online Service via a medium that suits each individual. At inception in 2015 this service provided support via the telephone, text, instant messaging and email. It became evident by 2017 that male survivors rarely used instant messaging and a decision was made that year to close the service and focus on the other channels. This preference for calling and talking with a helpline advisor has not changed and as awareness of the male helpline grows the preference for talking over the phone has become highly significant. Independent research of Safeline's service data by Weare et al., (in press, 2019) on behalf of Male Survivors Partnership identified

that 95% of contact with the National Male Survivor Helpline and Online Service was via the telephone service. This data overwhelmingly shows that male survivors have a preference for seeking advice, information and support via talking to a trained professional over the phone. This is the first study that has identified this hugely significant finding that verifies the experience of the staff and data that Safeline has accrued since inception of the service. The need for telephone support is summed up by the latest feedback from a male caller to the NMSH:

"Wanted to talk to someone. Not everyone is computer literate!" (Oct 2019)

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- **Why males prefer to engage with support services via talking rather than text-based services**

In Pitfield's study of male survivors (2013) most of the participants spoke of finding talking 'beneficial and having someone available to listen to them seemed an important part of their recovery' (pp. 70) with good practice experienced as empathic responses with compassion and regard for the survivor. The pace of talking, tone of voice as well as the words are key elements of talking out loud that are experienced as healing by male survivors. The need to start feeling in control is crucial in the help seeking process as 'often disclosures were made at a point when participants perceived themselves to have lost control and 'broken down' (Ibid p.85).

Pitfield's study's findings indicate that participants benefited from talking therapy and had a desire to talk to someone about the rape but felt that formal services were not suitable for male survivors. This agrees with Johnson et al., (2012) report of males' perceptions that it is easier to talk to a more informal service. *This is exactly the void that the NMSH fills* – a welcoming , friendly, empathic dedicated service for men to talk with and get the advice and information that they need alongside the emotional support that does not require emotional disclosure from the caller but more importantly, that the NMSH advisor is attuned to the caller's needs and hence experienced as supportive.

Washington (1999) argued that therapeutic interventions delivered to men had little sensitivity towards their unique experience and that is why it is crucial to have a specific service such as the NMSH that clearly spells out who it is for, how they can access it and treats each caller as an individual. The participants in Pitfield's study expressed the importance of having someone listen to their story. However, 'taking support outside of mainstream organisations (such as the NHS) and relying on survivor networks can further silence men in that available help from the NHS was seen to have a normalising effect'. Hence the importance of the marketing and the language used around the NMSH is crucial to enable male survivors to recognise this is a *National service for them* and, as callers have accessed the service from all PCC areas, it is evident that awareness is there across England and Wales. The awareness and use of the service will only continue to grow as more services and survivors become aware of this specialist service specifically for males with instant access to an inclusive service 6 days a week.

The preference for talking over the phone is also reported for the UK Stop it Now helpline that reports that 56.9% of contacts were through the helpline with only 1.7% via web chat (Grant et al., 2019). The Samaritans report that those who had phoned or visited a branch tended to report higher levels of satisfaction with the length of response time than those who had used e-mail or text message (Coveney et al., 2012). A survey by Agilent Technologies (2005) identified that men preferred to talk more on their mobile phone than females who preferred to text – a very similar profile to survivors who use Safeline services.

Liddon et al., (2018) studied males seeking support for depression and the participants' desperation was revealed in the need for immediate, acute and specialised care rather than routine or appointment-based general services. For example, participants in their study reported, 'I can't remember who I phoned but I think it was maybe 911'. Numerous responses in their study showed that at a time of crisis a male just wanted to pick up the phone rather than communicate in other ways. They use the term 'genuine connection' and a central feature of genuine connection is a stated desire to be understood as a person and have one's illness validated within this context before embarking on a treatment regime. Having their healthcare practitioner genuinely understand them as a person, the complexity of their lives and their depression – being 'known'– were recurring features of this discourse: (pp. 356). Another key feature of this discourse is an articulated desire just to have someone listen.

An aspect of the genuine connection discourse articulated how the men did not want to take a subordinate, deferential position as a patient. Rather, men talked of a desire for a collaborative partnership with their healthcare provider in which they felt connected, understood, listened to and validated – again the principals of the person-centred approach that we work with at Safeline.

Nimbi et al., (2018) asked the question, 'Are helplines still effective in the social media era?' Although their service supporting callers with sexual issues registered a decrease of calls after the introduction of social media, in the last five years a new increase of calls and a switch in call focus has been shown. They suggest the increase of users in recent years could imply that the accessibility to sexual information is not enough to answer the users' requests, but they seem to need a direct contact with a person. It may be the possibility to explore the emotional and psychological weight of the users' concerns over the phone guided by a trained specialist that is the essential element. Men more often than women called the service for information, for reassurance about "normality" and paraphilias - themes which deal with male gender identities and share similarities with males calling the NMSH. With the advent of information available online now the authors suggest that males call the helpline for emotional support as the requests for information have decreased. The authors conclude that social media plays a very important role in communication and in the health-care process but at the same time, data and clinical practice seems to suggest that current technologies, although very useful in sharing information, cannot completely replace the importance of vocal communication via the telephone. A trained professional who can help the caller explore what they need in a live phone conversation seems crucial for male callers. Nimbi et al., (2018) conclude that Telephone support is still an important and effective resource to elicit requests that otherwise might remain hidden; therefore, it can be a useful link between health-care system and callers.

Published data on why males may prefer to talk about sexual abuse and rape over the phone is extremely scarce and the report by Weare et al., (2019, in press) is a key publication to

enhance our knowledge and understanding of how males access professional support. There is however, growing evidence of the effect of gender on the use and type of messages sent via text that may help explain why text-based support is not used by the vast majority of male survivors. Doring et al., (2005) and more recently Neda and Gheitury (2014) studied the differences in text messaging between females and males and results indicated that females are far more prolific users of messaging than males which is also a finding we observe at Safeline. As for the function of texting, texts produced by females were for the most part relational, involving an emotional language, males frequently employed messages for informative-transactional functions which were less wordy, more practical and in more authoritative language. In addition, males were more likely than females to employ their local dialect and forms considered less polite.

In this sense males just wanted to 'be themselves' and use their own way of talking via text and not conform to any preconceived ideas of what was acceptable. It's understandable for males to contact a professional service by text may add to their burden of worrying about the language to use and if they are not comfortable with emotional language and prefer informative messages then it would obviously not be a medium of choice to disclose extremely personal emotive experiences whilst also expecting the pressure to find the 'right' words to do so.

Moreover, findings from Doring et al., (2005) suggested that females value connection with others more, while males value status more through the process of gender role socialization, leading to gender preferential communication styles, differentiated as cooperative and competitive, respectively. In this respect, it is hypothesized that females tend to express support and affection in their messages more than males. Data from their study showed significant differences with males referring to their own feelings in only 6.9% of texts as opposed to females who shared in 21% of texts. Hence, recent studies reveal a great deal about the significantly different ways in which males and females communicate via text messages. Much like other social contexts where gender differences are realized and female and male identities are constructed via different uses of language and other semiotic means, texting may also be considered as a new social context with its own particular features. Hence individual differences in texting may be related to variables associated with gendered self-perceptions and traditional gender roles (Ogletree et al., 2014).

Holtzman et al., (2017) looked at emotional support during times of stress and whether text messaging could compete with in-person interactions. They showed that in-person support was associated with significantly higher positive affect compared to text messaging and greater satisfaction with the support. Social support has been identified as one of the most powerful predictors of well-being, particularly during times of stress and this study suggests that there may be costs to an increasing reliance on digital forms of communication, such as text messaging, to connect and exchange support with our social networks. The findings provide the strongest support for theories, which propose that in-person communication is more effective than digitally-mediated alternatives and suggests that there may be emotional costs to a reliance on digital forms of social communication during times of stress.

The current research by Holtzman et al., (2017) has important implications for support seeking in daily life. When facing an acutely stressful event, in-person support may result in greater emotional benefits than text messaging. This is also echoed by DeClerck and Holtzman (2018) whose study comparing text and talking showed that efforts to make amends through

digital communication may be less effective than in-person communication at fostering positive affect and bonding.

Due to not only practical constraints but the issues of masculinity and gender norms outlined above, male survivors may not always have the ability or desire to seek in-person support and in this regard identifies how crucial a telephone helpline is that is as close to in-person support as possible, is fully accessible, cost-effective and adheres to the person-centred principals that males report finding so important in their experience of support.

The role of the third sector in supporting male survivors

Aliraza (2017) in a review of the third sector working with male rape victims outlined four areas of concern and the response of the NMSH to these concerns is addressed. However, it is important to point out a key difference at Safeline is that due to the need for highly trained staff the NMSH does not currently use volunteers – all NMSH staff are salaried employees that have undertaken extensive and ongoing training and supervision to ensure they are providing the best support for the callers.

- Concern 1. The lack of choice of a voluntary agency practitioner (regarding gender) offered to victims
    - Safeline response 1. Callers to the NMSH have a choice of gender of staff and if the required gender of staff is not available we will provide a call back service. It is pointed out that out of the thousands of callers to the service we have only ever had one request by a male caller for a particular gender so in our experience this is not a risk to the service.
- Concern 2. Lack of gender-specific training in the third sector
    - Safeline response 2. All of our staff have gender specific training before working with males and ongoing continual professional development opportunities.
- Concern 3. The impact of limited resources and funding in the voluntary sector
    - Safeline response 3. Whilst this has improved in recent years the economic impact of not supporting male survivors would create a much larger burden on government finances (e.g. on the NHS, Police, social care, benefits) as the impact of abuse on male survivors is so wide ranging. In terms of statutory funding, the long term funding of the NMSH, already recognised nationally as the place a male survivor can access to gain the right advice and support, would enable the service to continue to support males as soon as they feel ready to talk, helping to limit the long term damage that keeping silent can do and enabling males to cope and recover.
- Concern 4. Prioritising male rape victims in the voluntary sector in terms of their age
    - Safeline response 4. The NMSH does not prioritise – we support men and boys of all ages and are fully inclusive.

Finally, comprehensive health economic data are urgently needed to estimate the public health costs of men's lack of service engagement, its impact on the community, and the changes required for future programs. Clinicians, researchers, and policy makers need to appreciate that men's mental health outcomes involve both getting more men to call the NMSH

and providing effective tailored gender-specific support. Failing to deliver a service tailored and responsive to men's diverse needs has, and will continue to, increase many men's feelings of alienation and shame regarding their sexual violence, further creating barriers to help seeking and heightening the potential for long term psychological, sociological, relational, financial, physical and emotional consequences (Primack et al., 2010). A person-centred framework, and treatment approaches adapting and embracing the diversity of men and masculinities to provide gender-sensitive and specific care, is critical. Even marginal reductions in men's rates of substance overuse and violence would result in lower public health and social costs.

The NMSH meets all the requirements outlined above by academics but maybe more importantly, based on usage and feedback, it meets the needs of the males who choose to access and engage with the service. This is a result of constantly reviewing the service such as which communication methods males prefer, when they need the service to be open and having a choice of staff of different genders to talk with. The NMSH is therefore an essential and necessary part of the male survivors' cope and recovery journey.

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