How can Clinical Psychologists help to improve psychosocial interventions for male victim-survivors of Conflict-Related Sexual Violence?

Sujeena Navajeeva

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Clinical Psychology

May 2024

Abstract

This exploratory study aims to explore how psychosocial interventions for male (men and boys) victim-survivors of conflict-related sexual violence (CRSV) can be improved within the UK. This includes, but is not limited to, the National Health Services (NHS) and third-sector organisations. This study focuses on the ideas, theoretical frameworks and clinical practices utilised by Clinical Psychologists (CPs) and aims to identify key knowledge gaps. Twelve CPs were recruited and interviewed. Reflexive Thematic Analysis (TA) was used to explore the perceptions of CPs.

Results: The study identified four central themes: Theoretical and Clinical Frameworks, Critical Reflexivity, Knowledge, and Training Gaps, and Political and Ethical Considerations. These themes illustrate the complexity of addressing and navigating CRSV with their male clients. Critical reflexivity emerged as essential for CPs to understanding their biases and the broader social-political dynamics impacting their male clients and the systems that they operate within. Significant gaps in training and knowledge about CRSV against male victim-survivors were noted, indicating a crucial area for development. Finally, the constraints of systemic and institutional structures were noted by participants.

Discussion and implications: The study highlights the need for contextually aware psychosocial approaches and identifies significant gaps in training and practice, urging a shift towards liberation and human rights-based, politically reflexive psychosocial interventions, and pedagogy.

Table of Contents

1. INTRODUCTION

Over the last 30 years, since the genocides in Rwanda and Bosnia and Herzegovina, global research into sexual violence against women and girls in armed conflicts has led to some progress in the developments of psychosocial interventions to support victim-survivors of sexual violence (Kamali et al., 2020). However, research to understand conflict-related sexual violence (CRSV) against men remains limited and is an area that is rife with misconceptions and myths, hindering access and provision of care for male survivors of sexual violence (Turchik and Edwards, 2012). Male victim-survivors of CRSV continue to experience severe psychological consequences in the countries they seek refuge in, such as suicidal behaviour, sleep disturbances, memory loss and depression, long after they are removed from the conflict (Apperley, 2015; Kivlahan et al., 2024), thus scholars have repeatedly called for more research in this field to provide appropriate services for male survivors (Broban et al., 2020; Chynoweth et al., 2017). This qualitative study aimed to explore how psychosocial interventions for male-victim survivors of CRSV can be improved within UK mental health services.

A narrative review examining and critiquing available literature on both CRSV against males and psychosocial interventions offered to male victim-survivors of CRSV in the UK, is provided. A narrative review was intentionally chosen as it allows an interpretative lens to be adopted which is especially helpful in exploring under-researched fields as it draws upon a diverse range of studies, theories and models for synthesis and interpretation to provide *novel* insights (Sukhera, 2022). The following narrative review on CRSV was conducted across psychological literature and interdisciplinary databases. Grey literature including reports from non-profit organisations, books and non-English texts, infographics, videos circulated on social media by male victim-survivors of CRSV, was also used to comprehensively analyse data, case-studies, and unpublished insights, given the limited research on male victim-survivors. Cross-verifying information with these sources also enhanced the research's credibility.

The narrative review will firstly discuss why the United Nations (UN) definition of CRSV was adopted in this thesis. This will then be followed by the exploration of key

dimensions (profile of the perpetrator, profile of the victim, and the climate of impunity) in the UN definition of CRSV and how it relates to male-victim survivors of CRSV. Understanding the migration journey of male survivors of CRSV from home countries to host countries will be discussed followed by an analysis of current services available for males affected by CRSV in the UK, to help identify themes and research gaps with hopes of establishing a theoretical framework and two focused research question.

1.1. Conflict Related Sexual Violence

Adopting the UN definition as a foundational point is beneficial because it provides a standardised framework as the UN is globally recognised. According to the UN the term of CRSV is an umbrella term that:

> Refers to rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage and any other form of sexual violence of comparable gravity perpetrated against women, men, girls, or boys that is directly or indirectly linked to a conflict. That link may be evident in the ***profile of the perpetrator***, who is often affiliated with a State or non-State armed group, which includes terrorist entities; the ***profile of the victim***, who is frequently an actual or perceived member of a political, ethnic or religious minority group or targeted on the basis of actual or perceived sexual orientation or gender identity; the ***climate of impunity***, which is generally associated with State collapse, cross-border consequences such as displacement or trafficking, and/or violations of a ceasefire agreement. The term also encompasses trafficking in persons for the purpose of sexual violence or exploitation, when committed in situations of conflict. (United Nations, 2020, p. 5).

1.1.1. Critique

The UN definition of CRSV, while comprehensive, does not fully encapsulate the profound depth, aetiology, scope, and impact of sexual violence. This is particularly evident in contexts like Palestine, where the situation is not defined by armed conflict, but state-violence, militarisation, land occupation, and settler-colonialism. The UN definition falls short in capturing the complexities that transcend geographical boundaries, and a social constructionist perspective, recognising how our perceptions, beliefs, and language surrounding 'conflict,' and 'sexual violence' are influenced by social, political, and colonial contexts. Chynoweth et al., (2020, p. 3) suggest that CRSV includes situations that have a 'direct or indirect nexus with the conflict or political strife, that is, a temporal, geographical, and/or causal link.'

Diego Garcia, a secluded atoll in the British Indian Ocean Territory, serves as a poignant example. Formed through the brutal massacre of its indigenous population, Diego Garcia was the last known colony created by the British Government. It relies on the construction of isolation and obscurity and is strategically used as a military base ('a black site') by the Axis of Imperialism (America, Britain) (Motluk 2024). There have been reports of detention, sexual violence, and torture against detainees, such as Eelam Tamils awaiting asylum in the UK, including sexual violence against young boys, highlighting UK's active participation (Cuddy; Tamil Guardian, 2024).

Furthermore, this perspective expands CRSV's scope to include settings like UK detention centres, where systematic targeting of individuals from conflict areas occurs. It recognises CRSV's reach beyond immediate zones of military conflict, affecting diaspora and those in non-war countries. In the UK, certain state structures and policies are deliberately violent, inflicting harm on racially minoritised people, and thus for this thesis I will be suggesting an expanded definition of CRSV to include such state-sponsored and institutional violence.

The thesis recognises the UN definition of CRSV as a global, standardised framework for understanding the broad nature of sexual violence linked to conflict. The understanding of what constitutes CRSV has undergone significant evolution,

reflecting shifts in geopolitical and multidisciplinary perspectives. The UN definition places emphasises on acts such as ‘rape, forced prostitution and forced pregnancy,’ which are predominately framed around female experiences. Masculinity theory is introduced as a complementary perspective that can enrich the understanding of CRSV beyond the UN framework (see section 1.3.2.). Masculinity theories is used to highlight and address the gaps in the existing framework, particularly surrounding how expectations and norms around masculinity can obscure the experiences of male victim-survivors of CRSV.

1.1.2. Victim-survivor

Although there is not a universal or correct use of language to capture the experiences of those who experienced sexual violence, the terminology "victims/survivors" will be used interchangeably throughout this paper to refer to people subjected to sexual violence; the use of victim-survivors is to try to encapsulate the spectrum of self-perceived positionalities men who experienced CRSV resonate with (Pollino, 2021; Anderson, 2007).

1.2. Profile of the perpetrator

1.2.1. Profile

Contrary to the myth that CRSV is mainly perpetrated by male, undisciplined, and ‘barbaric rebels’ (Cohen et al., 2013; Wood 2014), conflict documentation shows that CRSV is more often committed by state forces than resistance groups. Researchers find this puzzling because states typically have better training and resources, factors known to reduce CRSV (Leiby, 2009; Cohen, 2013). Cohen and Nordås (2015) found that militias that recruit children are prone to higher CRSV levels, linking child recruitment to proxy factors like abduction and low cohesion, indicating the use of sexual violence for fostering group cohesion. Surprisingly, state-trained militias also show increased CRSV, challenging the notion that military training ensures discipline and restraint. Gang rape can serve as a method of socialisation, conveying norms of masculinity, virility, and loyalty between state and pro-state fighters (Cohen, 2017).

The Syrian Revolution illustrates this trend, where state-security forces and pro-government militias, such as the Syrian Arab Armed forces and the Shabbiha militia, delegated sexual violence to such an extent that it became the primary reason cited by many civilians for fleeing their homes (chaoLieth, 2017). These state actors were more likely to use sexual violence for various reasons compared to resistance groups opposing the Bashar al-Assad regime, such as the Free Syrian Army. Pro-state militia allowed the regime to enact violence covertly as they 'can slaughter under the radar while giving the regime a thin veil of deniability' (p.7). Furthermore, Skjelsbæk (2001) notes that defining CRSV to solely mean 'that perpetrated by male soldiers,' fails to acknowledge the variation of perpetrators, and systems behind CRSV.

1.2.2. Abu Ghraib: Women as perpetrators?

Abu Ghraib, a prison complex in the Al Anbar Governorate of Iraq, gained notoriety during the American-led invasion of Iraq over 'alleged weapons of mass destruction.' Photographic evidence exposed American military personnel sexually humiliating and torturing political prisoners (Titunik, 2009). The dehumanising treatment at Abu Ghraib included detainees being stripped, blindfolded, and subjected to sexual humiliation, such as being urinated on. Detainees were also forced to form human pyramids and crawl on the floor while leashed like dogs. Many held, including a 15-year-old Iraqi boy kept in solitary confinement in a wooden crate and sexually abused, at Abu Ghraib had no ties to the insurgency and were randomly picked up in raids (Webster, 2005).

Many Western feminists (Engle et al., 2004) endorsed the Global War on Terror (GWOT) based on imperialist beliefs, framing it as a means of 'saving' and 'liberating' Muslim women in the Middle East from the oppression of Islamic fundamentalism (Ahmed, 2012). However, when American female soldiers were implicated in sexual violence at Abu Ghraib, it contradicted these narratives. Western media depicted them as 'intimidated' and acting on the orders of a male superior. This portrayal reduces white femininity to a subordinate role and in need of saving, while enforcing racial superiority, undermining the agency, complicity, and autonomy of those involved in Abu Ghraib (Gronnvoll, 2008; Fallwell & Williams, 2016). Bond

(2013), argued that media and academia cast the female soldiers in traditional 'virgin/whore/mother' roles, emphasising their youthful and fragile appearance (blond hair), which evokes feelings of innocence, fragility, and vulnerability to fit the ‘damsels-in-distress’ trope, which portrays white women as inherently non-violent (Tucker & Triantafyllos, 2008). Distress is often centred on white women, which detracts from the racialised male’s lived experiences of sexual violence (Michael & Schulz, 2019).

Photographs were weaponised for control and identity in Abu Ghraib, instilling fear in Iraqi males about their potential exposure. The images graphically defied gender norms, heterosexuality, and race, as we were presented with white women sexually degrading, abusing, and forcing racialised men to engage in stimulated sex acts and assert dominance. These pictures of women instigating and carrying out sexual abuse caused cognitive dissonance within the westernised mind, as it played on essentialist ideas of women being inherently compassionate and being exclusively tied to victimhood (Bond, 2013). This also contested the orientalist notion of white women being ‘captive in Muslim lands’, complicating narratives around victimhood and aggression (Boutahar, 2013).

Abu Ghraib as a case adds to the growing acknowledgment of women, as active participators, activators, and instigators of CRSV, shifting from the dichotomous assigning of innocence to women and aggression to men. This acknowledgment of female agency deepens the understanding of women as whole participants in society, including their capacity to be perpetrators of CRSV.

1.2.3. Western Peacekeepers

The UN’s distinction between sexual exploitation by peacekeepers and CRSV, has been scrutinised following incidents like the exploitation of minors in the Democratic Republic of the Congo (DRC) by French UN personnel which came to light (Nordås & Rustad, 2013).

One account from a Congolese woman whereby she states, ‘two [UN] soldiers came up to me and told me that if I refuse to sleep with them, they will kill me. They beat

me and ripped my clothes. One of the [UN] soldiers raped me' (Human Rights Watch, 2009).

This challenges the peacekeepers' protector role, recognising their role as potential perpetrators of CRSV (Dorussen, 2022), undermining the 'do no harm' principle (UNHCR, 2019). Peacekeeping missions may inadvertently sustain harmful economic ecosystems and social structures, encouraging survival sex and prostitution (Olsson et al., 2020; Wheeler, 2020). The UN's strategy of increasing proportion of female peacekeepers to combat CRSV (UN Security Council, 2009), may not rectify gender power imbalances, as women deployed are likely to internalise masculine-dominant norms of the institution (Karim & Beardsley, 2016; 2017).

1.3. Profile of the victim

Research has consistently shown that while men often face human rights violations in conflicts, CRSV disproportionately impacts women, highlighting a link between gender inequality and vulnerability to sexual violence (Kreft, 2018; Rubini et al., 2023; Horne, 2023). Historical reluctance to address CRSV, viewed as taboo, has hindered awareness and accountability (Leatherman, 2011). The simplistic view of CRSV as acts by men driven by sexual urges has been challenged, with a shift towards understanding CRSV as a tool of power and domination, employed to instill fear and control populations, as argued by Brownmiller (1975) in her seminal work on sexual violence as a 'weapon of war'. The Algerian revolution (1954-1962) highlighted how sexual violence was used not just for immediate harm but to disrupt societal structures and identities, with acts such as the rape of Algerian women by French colonial powers serving to assert racial superiority, subjugate the Algerian people and undermine national unity (Vince, 2010, 2016; De Beauvoir & Halimi, 1964). The genocides in Bosnia-Herzegovina and Rwanda marked a significant turn in CRSV research, bringing to light the systematic use of sexual violence against women and girls, as a deliberate genocide tactic, reinforcing gendered power structures (Nordås and Cohen, 2021; Stiglmayer et al., 1994; Sharlach 2000).

Evolving research challenges the assumption that CRSV inevitably occurs in conflict, showing that the occurrence, frequency, and purpose vary independently of the conflict's intensity or duration (Wood, 2009; Cohen, 2013; Lieby, 2009). Increased attention to CRSV in the West, particularly post-Bosnia, has been critiqued for its lack of intersectionality, focusing on shared identification with victims based on geographic and racial similarities, rather than a comprehensive understanding of the complex social, cultural, and political contexts of CRSV (Crawford, 2017; Davenport et al., 2019).

1.3.1 Men and boys – invisible victims?

Sexual violence against men and boys has been documented globally, including in conflict, settler-colonialism, warfare, and genocide (Sivakumaran, 2007; Madar, 2023). The violence transcends cultural and geographical boundaries and is not confined to any one region, occurring in both countries of origin and asylum (Chynoweth et al., 2020). CRSV against males was not explicitly recognised under international law until the 2013 UN Security Council Resolution 2106 (United Nations Security Council, 2013).

Sivakumaran (2007) argues that men globally experience sexual violence at a higher extent than previously theorised, especially in detention scenarios. Research has documented that men and boys globally are targeted for CRSV, but the global estimates and prevalence are currently unknown (Chynoweth et al., 2020) due to diverse regional prevalence and challenges with documentation. For example, a study re-examined 2,050 detention records and testimonies in Peru, using an updated conceptualisation of sexual violence against men that included non-penetrative acts. This broader method of analysis revealed significant discrepancies, increasing the initial estimates of male victim-survivors from 2% to 29%. It was also noted that male victim-survivors in Peru often veiled incidents of CRSV in indirect terms, such as using statements like 'I was humiliated or disgraced' (Tozzini, 2007). This highlights the challenges in collecting CRSV data and indicates that clinicians, scholars, and policymakers might possess a limited understanding, often constrained by underreporting by investigators and narrow legal frameworks, of how men experience CRSV in contexts of state violence (Lieby, 2020).

Regional insights into male CRSV victimisation demonstrate varied prevalence rates. In Kashmir, one of the world's most densely militarised areas, males reported higher incidents of CRSV than women due to frequent detentions and exposure to violence under counter-insurgency measures. 17% of Kashmiri men in comparison to 5.4% of women experienced 'violation of modesty,' associated with strip-searching.

Furthermore, 77% of 270 Kashmiri men reported experiences of torture and hinted at 'violations of modesty' during detention. The study's authors argued that this term was used to describe instances of sexual violence due to the shame associated with explicitly mentioning sexual violence (de Jong, Ford, et al., 2008). In the DRC, since the onset of the first civil war in 1994, 23.6% of men reported experienced CRSV. Of these, 64.5% faced rape (Johnson, 2010). In contrast, in twelve districts in Ivory Coast, a lower percentage (2.2%) reported CRSV during the conflicts in the 2000s (Hossain et al., 2014).

Common sites of reported CRSV include border crossings, roadsides, in incarceration contexts (detention centres and prisons), and military conscription settings (Chynoweth et al., 2020; Hogg & Buckinx, 2023). Frequently reported forms of CRSV in these settings were genital injury, forced witnessing of sexual acts, and rape. Boys, particularly those internally displaced or unaccompanied asylum-seekers in Europe, face increased vulnerability to sexual exploitation and assault due to acculturation challenges, uncertain migration status, inadequate housing, and high exposure to potential perpetrators (Chak, 2018; Moss et al., 2023).

Intersectionality framework (Crenshaw, 1989) can be applied to male survivors of CRSV. Intersectional approaches explore how different forms of oppression and privilege intersect to shape individual experiences, and thus explore how various facets of identity (sexuality, gender orientation, race, class, and religion) may increase their risk of sexual persecution. Structural obstacles, shaped by prevailing notions of masculinity and heteronormativity, have obscured the visibility of males' experiences as victim-survivors in research, policy, and activism. Gorris argued that the female-focused approach to discourses around CRSV created the 'existing serious dichotomy between visible and invisible victims,' contributing to structural

discrimination (2015 p. 412) and thus a gender-inclusive perspective in understanding CRSV against men is crucial. The following section will explore themes using theoretical frameworks specific to male victim-survivors of CRSV.

1.3.2. Masculinity

Masculinity theories offer a nuanced lens to understand the experiences of male victim-survivors of CRSV, highlighting that masculinity is not a fixed biological trait but socially constructed through dynamics in politics, society, economics, and culture, resulting in multi-faceted forms such as ‘militarised masculinity,’ and ‘hypermasculinity’ (Connell, 2005). Hegemonic masculinity, denotes society’s accepted dominant configuration of masculinity, idealises traits such as valour, stoicism, and heterosexuality, sustaining male dominance in patriarchal societies (Connell & Messerschmidt, 2005). Male victim-survivors of CRSV often grapple with diminished power and perceived emasculation, challenging socially constructed norms of hegemonic masculinity. Deviating from heteronormative masculinity standards often lead to perceptions of not being a 'real man’, creating a dichotomy of ‘masculinity’ and ‘victimhood’ (Sivakumaran 2007, p. 270). The fear of reduced masculinity within family and community systems can drive males into silence and isolation, eroding the social fabric in communities that uphold traditional masculinity where men are expected to be protectors, warriors, and providers. Non-violated bodies retain their status as able-bodied, virile, and powerful, whereas men that experience CRSV are othered and rendered as invisible, challenging their status within their communities as noted in Sudan (Olaluwoye et al., 2023).

1.3.3. Collective Emasculation

Eichert (2018) discusses how CRSV against men serves as a tool of communication by perpetrators to dismantle the community collectiveness. CRSV against males symbolises a community's vulnerability and aims to warn, threaten, and humiliate, highlighting disempowerment when men are unable to prevent such violations. This message can be explicit, demonstrated through graphic evidence like photographs or mutilated bodies, or implicit, with survivors bearing psychological scars that silently testify to their ordeal, thereby spreading fear and humiliation within the community.

Sexual violence embodies broader political contexts, intersecting with race and colonial dynamics. CRSV against men is symbolic of systematic destruction and domination of the national, racial, religious, or ethnic community that is being persecuted. For an example, in the context of Iraq, where white supremacy is heavily interlinked, state actors reassert colonial, regional and racial dominance using sexual violence against non-white male bodies and thus devaluing political legitimacy of the Iraqis (Puar, 2004). Hegemonic masculinity and heteronormativity are closely intertwined and considered a symbol of power, as globally heterosexuality is privileged and 'oppression positions homosexual masculinities at the bottom of a gender hierarchy among men,' (Connell (1995, p. 78). Forcing men to rape other men or be sodomised serves as an act to strip away the heteronormative (powerful) status, as the perpetrator retains the heteronormative power (Sivakumaran, 2005). This process not only impacts individuals but aims to weaken, fragment, and feminise the collective social fabric and to masculinise and thus to empower the oppressor (Vojdik, 2013).

1.3.4. Dehumanisation

Dehumanisation is a critical precursor to facilitating systemic oppression, and CRSV. It involves perceiving and treating persecuted groups as less than human by attributing animalistic or mechanistic qualities to them, stripping them of their humanity, identity, and dignity. This psychological mechanism is often employed to justify discrimination, violence, and mistreatment, reducing empathy and moral concern for those dehumanised (Haslam & Loughnan, 2014). Specifically, the dehumanisation of racialised men has been crucial in justifying, facilitating, and maintaining systems of oppression (Fanon, 1963).

Mechanistic dehumanisation, allows perpetrators to detach emotionally when committing CRSV, using it as a tool to dominate and humiliate both the victim and their community, with the victim's suffering being secondary to political aims. One example of this, is the phenomenon of engaging in taboo acts such as forcing men to 'rape by proxy' such as incestuous rape with close relatives, animals and engaging in 'mattress rape,' which is when perpetrators force men to act as a mattress whilst

their wives, sisters, daughters, or mothers are being raped on top of them (Leatherman, 2011).

1.4. Climate of impunity

CRSV remains prevalent, often met with impunity, due to inadequate legal systems, the protection of imperialist states and institutions, and cultural norms (United Nations, 2023b). This political climate of impunity often denies justice and perpetuates ongoing violence, impeding peace efforts. It is a tool that uniquely targets marginalised groups in conflicts, used strategically to intimidate based on ethnicity, religion, or political affiliation, distinguishing it from other forms of sexual violence. States may feel immune to legal repercussions or consequences like economic sanctions when violating human rights. State actors might be less concerned about international repercussions due to powerful allies and a lack of global accountability.

For an example, Sri Lanka's torture industry continues unabated and with impunity into the post-conflict era (International Truth and Justice Project, 2016). CRSV against Tamil males remains a systematic policy, reflecting a broader machinery of repression (Sooka & Harrison, 2021). People for Equality and Relief in Lanka (PEARL) highlights that those affected by CRSV, rarely, if ever attain justice, hindered by state protection of security forces, governments' utilisation of scare tactics, judicial delays, corruption, and the deflection of accountability by labelling accusations as terrorism-related, all of which aim to maintain impunity (2022). Despite evidence presented to the International Criminal Court (ICC) by the Tamil diaspora, UN bodies and human rights organisations, neither the Sri Lankan state nor its state actors have faced accountability (Medawatte et al., 2022).

This perception of impunity can embolden state-actors to commit CRSV. Conversely, resistance groups, aiming to alter the geopolitical status-quo, often avoid CRSV to maintain civilian and international support (Lieth, 2017; Dugard, 2023). For example, some resistance groups, committed to gender-inclusive ideals, show restraint in CRSV to uphold their values and bolster support, contrasting with state actors who might commit such acts under a sense of impunity (Asal et al., 2013; Re, 2015). In

conflicts marked by widespread violence including CRSV against civilians by one side, the opposing side may show restraint to assert moral superiority. Kurdish and Tamil civilians, for instance, joined the resistance groups, after facing CRSV from oppressive regimes, resisting the prevailing culture of impunity (Bloom 2005).

Israel will be used as a case study to exemplify how the climate of impunity is perpetuated and sustained. It should be noted that the colonisation of Palestine is often presented as a 'conflict,' thought this can be criticised as propaganda. This term has seen to be weaponised as it obscures the asymmetry of power between Palestinians under occupation since the Nakba in 1948 and Israel, a settler-colonial state with significant military capacity and economic backing from the West. Thus, the term 'conflict,' can serve the interest of imperial and colonial states. By framing a situation as a 'conflict,' imperial powers can frame their 'intervention' as a necessity or beneficial, under the guise of creating stability, peace, and civilisation (Erakat, 2019).

1.4.1. Israel's impunity

Israel has global impunity from peremptory norms including against sexual violence against men and boys (Dugard, 2023). Israel brands itself as the 'only democracy in the Middle East,' using pink-washing and feminism (promoting gender and sexual equality to appear democratic, whilst committing human rights violations) to garner international support, leading to a climate of impunity (Medien, 2021). Puar describes this strategy as 'arguably the most potent aphrodisiac of liberalism' (2015, p.1).

Israel, described as the 'greatest benefactor of homonationalism' (Puar 2015, p. 8), uses women's and queer rights to further nationalist and xenophobic agendas. Puar (2011, 2017) critiques how these justice-based movements are weaponised to justify virulent violence, under the guise of modernity and progressiveness, influencing perceptions of victimhood. This mirrors the GWOT, whereby women's rights were repeatedly used to propagate imperialist-led violence (Al-Ali, 2016), demonstrating how Western imperialist powers often co-opt rhetoric around women's and queer rights and liberation for geopolitical agendas.

The ubiquity of Hasbara's (the Israeli propaganda arm) claims, contrasts with the detailed reports of Israeli violations, by international human rights organisations and by their own state-actors on social media (United Nations, 2024). It could be argued that Israel, exploited the Hasbara-led narrative of 'rape by Hamas,' to garner international support, particularly from feminist spaces to justify the genocide in Gaza. Angela Davis's quote 'the fraudulent rape charge stands out as one of the most formidable artifices invented by racism,' (1981, p. 40) can be applied to claims of mass rape on October 7th, 2023. 'Sex exceptionalism' refers to a concept whereby sexual violence is seen as uniquely horrific or exceptional, in comparison to other forms of violence, particularly in the context of conflict, human rights and international law (Engle, 2020). Engle (2020) suggests that sex exceptionalism is often leveraged to justify militarised and disproportionate responses (i.e., ethnic cleansing, collective punishment, starvation, and use of white phosphorous). Sex exceptionalism reinforces the notion of Israeli exceptionalism, by framing the end of genocide in Gaza as endorsing and supporting a regime that violates women's rights.

1.4.2. Palestinian men and boys

Edward Said's framework 'Orientalism,' (1978) critiques western perceptions of Arab men. He highlights that Arab men are portrayed as sexually deviant, rapacious terrorists. It is part of a broader discourse of depicting the East (Orient), as eroticised, exotic, repressed by religion, and morally inferior to the superior, rational, and civilised West (Occident). Said argued that these tropes are used to fuel colonial projects, by dehumanising and othering the colonised, to legitimise violence. Orientalist stereotypes vilify Palestinian males as territorial threats needing military control and labels them universally as terrorists, including the most vulnerable and youngest. This portrayal obscures the brutal realities of occupation, resistance, and the nuanced identities of Palestinian males (Said, 1978; 1979; 1981). Moreover, even when Palestinian males embody the spirit of Prophetic masculinity, characterised by steadfastness, perseverance, and justice, these qualities are often rendered as criminal by those that hold power. Acts of resistance, which are rooted in the spirit of Prophetic masculinity, are frequently perceived by occupying forces

and dominant western narratives as acts of extremism or terrorism (El-Haj-Ibrahim, 2023).

Wood has repeatedly argued in her widely cited research that the systematic use of CRSV is exempt from Israel's military toolbox (2009; 2010). She stated, ‘in the Israeli–Palestinian conflict, also an ethnic conflict characterised by the increasing separation of ethnically defined populations, sexual violence appears to be extremely limited,’ (Wood 2006, p. 314). However, Weishut (2015) highlighted that Palestinians, including males often endure sexual violence in less visible, unregulated spaces, like prisons and military courtrooms making evidence and testimonies easier to erase. Despite sharing their testimonies on platforms like Tik-Tok, Palestinian voices are digitally suppressed by powerful Israeli lobbies and cyber surveillance (Tartir et al., 2024). Testimonies in Arabic, often remain unheard in Western discourse. Ramzi Al-Abbasi who was released from Negev Prison testified that the State of Israel was subjecting Palestinian males to deplorable states. He described Negev prison resembling a ‘living graveyard,’ where men are left ‘broken,’ from being ‘hit brutally and sexually harassed, even to the extent of rape (Middle East Monitor, 2023).

The modus operandi of Israel’s incarceration system in the West Bank, is such that every Palestinian family has at least one detained political prisoner. The majority are teenage boys and young men, charged with incitement of resisting the occupation by affiliating with the resistance or throwing stones and firebombs at Israeli forces. This has intensified since October 7th, 2023, and males and boys are subjugated to extreme violence including sexual torture. The enduring impact of sexual violence is exacerbated by unfair military trials, with children being subjected to trials in military courts (Nasir-Addameer, 2024).

Edward Said’s pivotal question ‘who has the permission to narrate?’ resonates to the idea of victimhood. Mohammed El-Kurd argued that for Palestinians to be heard, they need to fit the ‘perfect victim’ prerequisite: ‘docile,’ ‘defanged,’ ‘non-violent’ and palatably Western in demeanour, ‘an ethnocentric requirement for sympathy and solidarity’ (2023, p.3). The narrative of the 'perfect victim' is intrinsically linked to a broader culture of impunity for Israel. It shapes the discourse in a way that often

delegitimises Palestinian resistance and liberation. When the international community expects Palestinians to conform to this narrow archetype for empathy, it inadvertently reinforces a status-quo where Israeli actions, regardless of their impact on human rights, face minimal scrutiny or consequences, further emboldening their continued perpetuation of violent practices.

1.5. ‘Refugee crisis’

During the 2015-2016 'Refugee Crisis,' over 1.8 million people sought refuge, predominantly from Syria, as CRSV, torture, and chemical warfare were used as tools of suppression by Bashar al-Assad’s regime (Frontex, 2016; Jabbour et al., 2021). The ‘crisis,’ sparked varied interpretations across Europe; the United Kingdom’s (UK) response to the ‘crisis’, was shaped by the growing momentum towards its decision to exit the European Union (EU), culminating in the Brexit referendum in the summer of 2016, which emphasised policies of border control and national security (Keating, 2021).

The term ‘European refugee crisis’ entered widespread use in April 2015 sparked by the sinking of five boats, carrying almost 2000 people, mostly men (BBC, 2015). It is a term that implies Europe is under siege and constant threat, ignoring Europe’s active role in conflict, through military or diplomatic actions (Dhaliwal & Forkert, 2015). Metaphors like ‘flooded by them’ and ‘plagues’ perpetuates a distorted understanding of the nuanced complexity for asylum-seeking (Pruitt, 2019). Such language reflects an imperial discourse, which emerges from and sustains the perspectives, values, and power structures of European imperialism and colonialism by prioritising European concerns and portraying refugees as a monolithic threat.

This discourse often fails to consider racialised people’s vulnerabilities to violence and insidiously suggests they are unworthy of refuge, ignoring their need for safety and protection. It also minimises the historical and ongoing role that Europe plays in creating conditions, such as military interventions, economic policies, or the ousting of progressive leaders (Baerwaldt 2018). Hagopian et al. (2013) used the example of Iraqis to highlight that when Iraqis were displaced and migrated out of Iraq,

Europeans did not consider the context of the Iraq war, which left half a million Iraqi people dead and millions more externally displaced by joint Western forces.

It should be noted that the UK attracts asylum-seekers, attributed to its English language, historical and political ties globally from the colonial era. There is a dominant narrative the UK offers a sense of continuation, familiarity, and established communities. It is also perceived as a bastion of economic and political stability (Crawley & Hagen-Zanker, 2019).

1.6. Migration stages

Asylum-seekers coming to the UK face a myriad of traumatic experiences and human rights violations that can have a longitudinal impact on their health (Abdelhamid et al., 2022; Ba & Bhopal, 2017). Research globally illustrates how 'trauma' is associated with each one of the three phases of migration: pre-migration, migration, and post-migration, which can have a detrimental impact on their mental health (Ventriglio, 2022). Male asylum-seekers face ongoing multi-faceted hardships, including vulnerability to CRSV in their country of origin, during perilous journeys to safety and in host countries (Gray & Franck, 2019). Recognising this, the following section will explore how CRSV is present throughout the refugee journey.

1.6.1. Pre-migration

Pre-migration trauma encompasses serious human rights abuses, including political repression, sexual torture, forced disappearances and ethnic cleansing (Sigvardsdotter et al., 2016). CRSV is widespread in regions with heightened state-violence (Medien, 2021; Binaifer Nowrojee, 1996). Furthermore, children are often conscripted as soldiers such as in Uganda (Vindevogel et al., 2011); whilst countries like Eritrea practice forced conscription due to structural militarisation, boys are kidnapped and forced to join militia groups without pay and subjected to sexual violence (Hirt, 2010). Cycles of economic, cultural, and social instability from repeated displacement exacerbates the issue of CRSV (Braithwaite et al., 2018). Reasons for fleeing include persecution, human rights violations, CRSV, and detention (Freedom From Torture, 2022a).

1.6.2. Migration

The distressing and perilous process of seeking asylum in a host country can span over years (Crawley & Skleparis, 2017). Men and boys, particularly unaccompanied minors rely on human smugglers for transit, making then vulnerable to structural violence, CRSV, and enslavement (Tinti, 2018). In France, enroute to the UK, asylum-seekers, mostly males, face excessive use of violence (tear gas and chemical sprays) by riot police (Cautain, 2023). Due to a lack of safe and legal routes, people often must use ‘irregular’ and dangerous routes through multiple countries and the Mediterranean Sea that significantly increase the risk of harm and death (Giuffrida, 2023). The tragic incident of the 'floating coffin,' where a vessel from Libya which reportedly sank with about 500 people presumed dead, highlights the extreme risks asylum-seekers face after fleeing persecution (Smith & Henley, 2023). Unaccompanied boys, without family and community support systems are particularly vulnerable to sexual exploitation, ‘invisibility’ and marginalisation throughout the asylum process, leading to significant long-term psychological effects compared to non-refugee populations (Theisen-Womersley, 2021).

1.6.3. Post-Migration in the UK

The UK’s Illegal Migration Act of 2023 seeks to detain, remove, and prevent individuals from arriving in the UK ‘illegally,’ via ‘small boat crossings,’ to countries of origin or to a third country such as Rwanda (Home Office, 2023). The UN and human rights bodies have scrutinised the Act, as it eliminates safeguarding procedures against sexual trafficking and modern slavery. They argue that the risk of collective expulsions contravenes international law and criminalises a group that are already in vulnerable and precarious situations (United Nations, 2023a).

Article 31 of the 1951 Refugee Convention (UNHCR, 1951) recognises the complexity and difficulties faced by people fleeing life-threatening situations, allowing for irregular entry into host countries to seek asylum for protection without being penalised, recognising that safe and legal routes may not be accessible. Freedom From Torture notes that despite the UK’s key role in creating the Refugee Convention, it has enacted hostile policies to deter new arrivals (2022b).

Dehumanising language about refugees and asylum seekers such as ‘illegal,’ ‘criminals,’ ‘hurricanes,’ used by state-actors, acts as a dual mechanism: to strip asylum-seekers from their humanity and also legitimise the process of detention, torture, and offshoring, all while masking the absence of safe asylum pathways. This Act embodies a power dynamic, imbued with colonial rhetoric, to justify punitive practices (Ballentyne & Drury, 2023).

Upon arrival, many people face detention and torture. Male asylum-seekers in comparison to their female counterparts are more likely to be detained and face institutionalisation in UK, leading to iatrogenic psychological harm (Griffiths, 2015; Baumgartner et al., 2024). The UK’s asylum system, characterised by restrictive asylum policies and detention practices in immigration removal centres (IRC) has been criticised for psychological harm and inhumane conduct (Walsh & Ferazzoli, 2023). The UK’s detention process, unlike other European countries, has no time limit, with reports of durations ranging from months to years (Freedom From Torture, 2022a). Detainees, including victim-survivors of CRSV have experienced inhumane conditions including sexual abuse, leading to cases of psychosis without any mental health care (Bosworth, 2021; Bancroft, 2023).

Sometimes asylum claims fail, resulting in destitution, with asylum-seekers having no recourse to public funds, services, and facing homelessness (Brown et al., 2022; Refugee Action, 2020). The UK often uses the threats of destitution to deter ‘unmeritorious applications,’ and force return to unsafe origins. Asylum-seekers are barred from work, and thus live below the poverty line (HM Government, 2023), increasing their vulnerability to sexual exploitation, trafficking, and abuse (Jobe, 2020). Despite many asylum-seekers applying for refugee status with concrete medico-legal evidence, they face extended delays and scepticism from the Home Office (Freedom From Torture, 2023). Systemic hostility towards immigration, overburdened officials, and inadequate case oversight contribute to this and are symptomatic of the wider political climate of the UK. A case of a Tamil man who endured torture and was rejected for asylum under the premise of ‘self-infliction by proxy’ (orchestrating his own torture), suggests how systemic issues disproportionately impact male survivors (Freedom From Torture, 2023). Post-migration in the UK is captured by a statement from an asylum-seeker, ‘we left our

countries due to different problems, political or other, thinking that our situation would be improved but on the contrary, we found ourselves in a worse place' (The Jesuit Refugee Service UK 2018, p.18).

1.6.4. 'Slow violence'

Rob Nixon's concept of 'slow violence,' described as 'occurring gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all' (Nixon, 2011 p. 2), has been used to critique the gradual, often invisible adversities within the UK asylum system. Saunders and Al-Om (2022) describe how asylum-seekers are 'caught within its web' and forced to navigate the 'labyrinth' of the legality of the UK. Collyer and Shahani (2023), add that offshoring (practice of transferring asylum-seekers to third countries, to process their claims) and institutional racism, coupled with associated rejection and uncertainty, amplify levels of distress (Parker et al., 2023). This is supported by clinical research, which highlights that post-migratory stressors attributed to structural forms of violence (isolation, insecure immigration status and barriers to accessing healthcare), significantly worsen mental health distress (Morgan et al., 2017).

1.7. Psychological impact of Conflict Related Sexual Violence on male victim-survivors: UK context

Psychological symptomatology is part of a broader constellation of interconnected issues, including spiritual symptoms such as a loss of meaning or purpose, sexual symptoms like difficulties with intimacy, social symptoms such as isolation and interpersonal conflicts, and physical symptoms. Clinical Psychologists (CPs) in the UK are encountering a growing number of male refugees and asylum-seekers (RAS), a portion of whom are likely to have experienced some form of CRSV at various stages of their migration journey. The magnitude of its impacts is multisystemic, impacting the individual, family, and wider community. The psychological impact of CRSV on males have profound and lasting effects, both personally and socially, extending over periods of more than a decade from the initial abuse (All Survivors Project, 2019). Recent documentation reveals that Syrian men

have reported enduring symptoms and conditions for years following their experiences with CRSV, torture, and political imprisonment, even 13 years after the Syrian Revolution (Kivlahan et al., 2024).

The psychological impact of CRSV on males can encompass cognitive, emotional, and psychosomatic responses. These include symptoms aligned with PTSD, suicidal ideation, depression, and anxiety (Sivakumaran, 2007; Chynoweth et al., 2020). A systematic review found that feelings of shame, loss of power, humiliation and dishonour were prevalent for cisgender male survivors, as well as having flashbacks, intrusive thoughts, and nightmares. It was also found that males felt a sense of loss, grief, and hopelessness (Rubini et al., 2023). Health consequences for the individual can include genital mutilation, gastrointestinal issues, transmission of infections (HIV) and chronic pain and they are often interlinked with psychological impacts. Kivlahan et al. (2024) emphasised the enduring nature of both physical and mental health symptoms among Syrian men, who reported these issues were consistent across four distinct time periods.

The psychosexual and psychosocial effects of CRSV against men are interconnected (Onyango & Hampanda, 2011). CRSV does not exist in a vacuum, and it is deeply entrenched within broader socio-political and cultural contexts. It can profoundly impact males' relationships, sexuality, and sexual functioning, leading to unwanted questioning about identity and sexual orientation, which can destabilise roles they uphold (husband, father, friend and so on) (Touquet, 2018). CRSV strategically aims to disrupt victims' sexual identity and long-term relational capacities, essentially weaponising sexual violence to hinder procreative abilities and future intimate bonds (Zalewski et al., 2018; Sivakumaran, 2007). Many former British colonies continue to criminalise same-sex relations and do not recognise male victimhood, acting as a further deterrent for male survivors of CRSV who fear sodomy charges upon disclosure in countries of origin (Touquet, 2018). The narrow legal definition of CRSV permeates into psychological and medical support systems, meaning services are not set up to respond or monitor cases of CRSV against men in both countries of origin and the UK (All Survivors Project, 2019) resulting in a lack of medico-legal evidence (Palattiyil & Sidhva, 2015).

1.8. Policy frameworks and services for male victim-survivors of CRSV in the UK

1.8.1. Policy frameworks

The UK has engaged in the Preventing Sexual Violence in Conflict Initiative (PSVI) (UK Government, 2022), launched in 2012, to ensure healthcare and justice by using a 'survivor-centred approach' with a global action to end CRSV. With strategies focused on 'holding those responsible to account,' 'shattering the existing culture of impunity,' 'providing more comprehensive support to survivors' and 'tackling stigma' (Davis & Loft, 2023, p.16). Whilst the initiative is currently focusing on seven countries (Bosnia and Herzegovina, Colombia, DRC, Ethiopia, Iraq, Sudan, and Ukraine), its noted that a significant proportion of UK's bilateral aid going towards PSVI is directed towards preventing CRSV for women and girls (Davis & Loft, 2023, p. 25).

The introduction of the Murad Code by Nadia Murad (2021) a Yazidi survivor was launched in 2021 to safeguard the dignity and improve the experience of gathering information from survivors of systematic and CRSV. However, the focus on women and girls in PSVI's aid allocation raises concerns about the inclusivity of male victim-survivors of CRSV in these efforts (GOV UK, 2022). Javaid (2017) uses the framework of hegemonic masculinity to highlight that male victimisation is not seen as plausible within service, policy, and clinical practice and thus there is a high possibility that male victim-survivors of CRSV go under the radar and do not access therapy, justice, and collective healing.

1.8.2. Services

The UK lacks specific services for male victim-survivors of CRSV, however there are several support structures that could cater to their needs. In the UK, asylum-seekers with an active application and refugees can access the National Healthcare Services (NHS) without charge (NHS, 2024). For male victim-survivors of CRSV, this means that, despite the scarcity of tailored services, they can still obtain essential healthcare services including psychological support, providing a foundation for their recovery. Within the NHS, General Practitioners (GPs) serve as the initial point of

contact, responsible for referring individuals to specialists when necessary and coordinating their care (Naylor et al., 2020). GPs often refer patients to NHS Talking Therapies, formerly known as Improving Access to Psychological Therapies, a service reactively initiated after the 2008 financial crash. It provides short-term, cost-effective psychological treatments as recommended by the National Institute of Health and Care Excellence (NICE), for mild to moderate mental health issues (Oparina et al., 2024) and therefore may not be suitable for male victim-survivors of CRSV.

In the UK, specialist third sector services like The British Red Cross and The Refugee Therapy Centre, provide holistic support including medico-legal aid, housing provision and psychological support, serving as initial support hubs for male victim-survivors of CRSV. General services for men that have experienced sexual violence such as Survivors UK and Safeline, offer counselling therapy and survivor-led peer groups tailored to the challenges faced by men, however these organisations are not specifically tailored for men that have experienced CRSV and therefore there may be a gap in the provision of support for their experiences. Additionally, organisations like Freedom From Torture and The Helen Bamber foundation focus on torture and trauma, offer targeted support including male victim-survivors of CRSV. However, over a decade of austerity has led to persistent funding shortfalls for third sector organisations (Lowe & Rogers, 2017). Racialised victim-survivors who are not native English speakers are also less likely to seek support from these services (Javaid, 2017). Community-based CPs also work in settings like hotels or community centres where refugees and asylum-seekers may be housed, in which they may encounter male victim-survivors of CRSV.

1.8.3. Accessibility

David Cameron's government introduced the Vulnerable Persons Resettlement Scheme with a quota set to resettle 20,000 Syrian refugees. Only Syrians that were deemed as 'vulnerable,' such as female survivors of sexual violence were prioritised. Armbruster (2018), argues that selectivity in determining who is in need of 'legitimate' protection could be seen as 'rationing compassion.' This creates a hierarchy of worthiness and vulnerability that can extend to psychological services.

In accessing psychological services, male refugees are required to be classified as 'vulnerable' by healthcare providers, who act as state-actors aligning with current government policies. This is often based on criteria that include their health, legal and housing status. Turner (2019) critiques this practice for its failure to confront the systemic problems within humanitarian governance, which can perpetuate power imbalances and potentially lead to more control and racialised violence against these males. He argues for a more profound, decolonial critique that emphasises the autonomy and insights of refugees themselves. This approach advocates for dismantling existing power structures in humanitarian aid and shifting towards a model that narrows health inequity for refugees, ensuring their voices guide service access and interventions, thus promoting a more just and equitable health system. Turner (2019) further argued that what is necessary is a shift away from framing "vulnerability" as the main criterion for distributing resources to emphasise refugee autonomy.

Furthermore, navigating the UK health system is inextricably difficult due to intersections with race and socio-economic status. The experiences of racism and a pronounced sense of 'otherness' deter many from engaging in outdoor activities, further exacerbating health inequities (Fernando, 2017). Particularly for male refugees, these challenges contribute to a constrained lifestyle with limited opportunities for healthful practices, highlighting the intersection of migration status, financial constraints, and social discrimination in shaping health outcomes (Isaacs et al., 2020). 71% of Syrian men (of 106) reported that they had lacked awareness and knowledge of support services available, highlighting the inaccessibility and transparency of available services in the UK, 58.6% reported ‘embarrassment’ as a reason to not seek services, while others cited a lack of trust in the services and the physical distance from available resources as additional barriers (Kivlahan et al., 2024). Furthermore, there are instances where sexual violence has only been disclosed to the solicitor, even if the men have accessed therapy to help with recovery (Patel & Mahtani, 2004).

1.9. Clinical Psychology

1.9.1. Ethical principles

Nimisha Patel (2018) argues that principle of "do no harm" is central to the ethical practice of CPs. This ethos, derived from the Hippocratic Oath, requires CPs to both refrain from harmful actions and actively prevent harm, emphasising their dual responsibility towards individual clients and broader societal impacts, especially in sensitive contexts like working with refugees. Patel sees CPs as both rights-bearers and duty-bearers, and that they should work in line with British Psychological Society's (BPS) Code of Ethics and Conduct (2009), which is relevant across all interactions with refugees, asylum-seekers, and migrants (Patel et al., 2018). The principle to 'adopt human rights principles of inclusivity, non-discrimination, participation, and cultural and gender appropriateness in all aspects of psychological work' (Patel, 2018, p. 14), is essential when exploring how psychosocial interventions for male survivors of CRSV can be improved. It ensures that interventions are accessible and effective for all male victim-survivors, acknowledging the diverse backgrounds and needs within this demographic. This approach fosters a supportive environment that respects individual rights and dignities, essential for the healing and empowerment of survivors.

1.9.2. Human Rights-Based Approach

Patel (2019) argues that a 'Human Rights-Based Approach' (HRBA) is critical within Psychology at multiple levels (practice, research, advocacy, psychology training and pedagogy). It positions psychologists as 'practitioner-activists', by challenging traditional individualised psychological approaches which focus primarily on the psychological manifestations and consequences of rights violations. This stance transcends therapeutic infrastructures of individual therapy, advocating for systemic change and addressing the root causes of human suffering and adversity. By adopting a HRBA, Patel encourages CPs to challenge the status-quo and conditions that harm contribute to psychological distress. As practitioner-activists, it is imperative that CPs uphold dignity and human rights, by actively integrating survivors' voices, and collaborating with other stakeholders (such as legal and advocacy groups) to foster a multidisciplinary approach to justice, care, and

rehabilitation. This approach requires a reimagination of psychological infrastructures including training, practices, and theories to make sure human rights are a central tenet to psychological work when working with vulnerable survivors that have experienced human rights violations such as CRSV.

1.9.3. Whiteness in Clinical Psychology

Whiteness is a form or racial privilege, with psychological and social advantages, such as political power (Du Bois, 1903). According to Di Angelo (2021), whiteness permeates every aspect of society globally, shaping the production and reproduction of systemic, institutional rules, norms and discourses that privilege white people, whilst simultaneously operating oppressively towards racialised people. Whiteness often remains invisible by those it benefits yet remains a stark reality to those oppressed. It is important to note that, whiteness and white supremacist values are not solely perpetuated by white individuals, racialised people originating from the global majority can also uphold and be emboldened by these structures, however white individuals often serve as the primary agents of whiteness, embodying and propagating the system that privileges them. DiAngelo (2021) argues that one way in which progressive white liberals perpetuate racial harm is by romanticising and emulating racialised people. In the context of refugees and asylum-seekers and CPs, whiteness could maintain and sustain unequal power dynamics, and simplify the layered experiences into one-dimensional narratives of vulnerability or resilience. Psychology in the UK continues to be a profession which predominantly comprises white, middle class, cisgender women, and has been complicit in overt and covert racism, such as the Islamophobic Prevent duty (Wood & Patel, 2017; Ahsan, 2020). Nimisha Patel (2003) asserts that the foundations of psychology are deeply embedded in colonialism, eugenics, and empirical science and that whiteness in the field.

1.10. Psychosocial interventions

Although there is research acknowledging the widespread of CRSV against men and boys and its impact on mental health, there is limited and scarce evidence on effective psychosocial interventions (Kiss et al., 2020). Currently, there are no published studies specifically evaluating psychosocial interventions provided by CPs for male victim-survivors of CRSV in the UK. Thus, this section will draw upon a wider body of research on psychosocial interventions for refugees and asylum-seekers, which may include male CRSV victim-survivors who have not disclosed their experiences and interventions provided by an array of professionals (such as counsellors, spiritual healers, as well as CPs).

Psychosocial interventions aim to address complex psychological and social challenges faced by victim-survivors of CRSV, fostering healing and recovery, which can entail tailored psychological therapy, survivor-led support groups and psychosocial rehabilitation (Tribe et al., 2017). In the UK, there is an emphasis to provide evidence-based psychosocial interventions that are 'trauma-informed,' through the lens of a Post-Traumatic Stress Disorder diagnosis (PTSD) (BPS, 2016). The NICE guidelines for managing PTSD suggest that refugees and asylum-seekers are at heightened risk for PTSD and recommend screening for PTSD symptoms (NICE, 2005). CPs employ various modalities when working with refugees and asylum-seekers, with Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) being the predominant modality recommended as the initial treatment for PTSD (APA, 2017; NICE, 2005). The three-phase model of trauma treatment often employed by NHS Trauma Services includes: stabilisation, processing the trauma, and reintegration with community (Herman, 2015). During the second phase of processing trauma, CPs often draw upon ideas on imagery rescripting (Arntz et al., 2013). Narrative Exposure Therapy (NET) is another NICE recommended trauma-focused intervention for PTSD and co-morbid conditions for refugees and asylum-seekers that was allegedly developed in refugee camps and combat zones. It was intended to be an effective, brief, and culturally universal intervention for trauma survivors in conflict-related settings, drawing on theories from CBT, testimonial, and exposure therapy. The core concept behind NET is based on the memory processing of traumatic memories (Neuner et al., 2004; 2018). KidNET was also

developed for children and adolescents that have experienced trauma in conflict (Neuner et al., 2008).

Tribe et al. (2019) conducted a systematic review looking at psychosocial interventions for refugees and asylum-seekers; NET produced positive outcomes across the trauma spectrum and for refugees from various cultural backgrounds. Whilst NET was identified as the most empirically supported intervention for refugees, Tribe and colleagues highlighted the potential and theoretical biases of the synthesised findings, including 'researcher allegiance' which can influence various aspects of a research study, impacting the reliability and objectivity of research findings.

1.10.1. Critique of concepts

However, many have criticised the conceptualisation of PTSD from its origin to its current usage. Summerfield (2012) has questioned how effective therapeutic approaches aiming to reduce PTSD can be, when the premise of stability and safety is difficult with the ongoing threat for RAS. The invention of 'PTSD,' is linked to the military-industrial complex; it was significantly influenced by 'traumatic experiences' of military personnel in Vietnam War. The transformation into recognising US military personnel as traumatised victims rather than perpetrators was politically charged, as the diagnosis legitimised their 'victimhood,' gave them immunity from war crimes, and allowed for a pathway to disability benefits including financial compensation and specialised psycho-medical care based on the concept of PTSD (Summerfield, 2001).

The development was heavily influenced by psy-dysclipines and military personnel advocating for the recognition of traumatic war experiences in the 1980s, rather than clinical observations. This legacy continues to influence the conceptualisation, treatment, and funding of PTSD research, aligning it with military interests and priorities, and shaping the broader discourse on trauma and mental health within a militarised context. Thus, the psychiatric diagnosis of PTSD continues to be a tool to equate and legitimise trauma experienced by cogs in the Western military-industrial complex (Afuape, 2011; McHugh & Treisman, 2007). Furthermore, Galatzer-Levy & Bryant (2013) highlighted that the update to PTSD criteria in DSM-5, has made the

diagnosis less precise and more ambiguous, as there are now 636,120 different combinations of symptoms that can result in a PTSD diagnosis. This 'hidden heterogeneity' of western nosologies to classify nuanced human experiences into one overarching category, and thus can impact the quality of psychosocial interventions provided.

The theoretical frameworks surrounding PTSD have faced significant critique for its depoliticised approach and limited relevance to certain demographics. Dr Samah Jabr (2018), argues that 'PTSD' is a western and Eurocentric concept despite it being seen as a universal concept for traumatic experiences. She argued that '*PTSD better describes the experiences of an American soldier who goes to Iraq to bomb and go back to the safety of the United States. He's having nightmares and fears related to the battlefield and his fears are imaginary*.' She stated for people like Palestinians that are persecuted relentlessly including by the use of sexual torture, there is no '**post**,' because of the repetitive, ongoing, and enduring violence imposed by militarised occupation. She further stated that the use of the term 'PTSD,' is so that it is palatable to the West in the hope that the Palestinian experience is better understood. She further highlights that she isn't advocating for Complex-PTSD from the ICD-11 (C-PTSD), as a label either for colonised or oppressed people globally. In essence, aligning with ICD or DSM for categorising unimaginable experiences (CRSV), is challenging, both in terms of methodology and conceptualisation. These systems carry an implicit assumption that western psychiatric nosologies have universal applicability, which falls short when it comes to evaluating the complex and holistic rehabilitation outcomes for torture survivors. These individuals come from a wide array of backgrounds, each marked by distinct cultural, linguistic, political, and social nuances, and their experiences of torture and other human rights abuses vary greatly (Patel & Williams, 2022). Patel and Williams (2022) further argued that PTSD has become a 'brand, used as shorthand for extreme distress, following torture, and it is now the currency of researchers, funders, and rehabilitation services, and widely used in studies with torture survivors,' (p. 233). The use of decontextualised, reductionist labels overlook the complexity of 'trauma', which is not merely linear but intergenerational, collective, and colonial. This approach is compounded by the dominance of a biomedical model that pathologises individuals and locates the

problem within the individual, failing to account for broader political and social factors.

1.10.2. Critique of scientist-practitioner model

Early principles of psychology were informed by 19th Century scientific conceptual schemes, for an example by Werner Heisenberg's 'uncertainty principle' and Edward Lorenz's 'butterfly effect' (Davies & Gribbin, 2007). This influenced the early principles of psychology to understand the complexity, unpredictability, and systemic lens of human behaviour (Fernando, 2017). However, modern psychology has shifted to a paradigm distinct from flexibility and has attempted to use the 'scientist-practitioner model', grounded in a positivist approach. In an attempt to bolster the field's legitimacy as a 'hard-science,' the field aimed to enhance credibility, objectivity, rigour, empirical validation, prioritising scientific neutrality (Fernando, 2017).

Critics contend that the UK's NICE guidelines have established evidence hierarchies that prioritise methodologies such as randomised controlled trials (RCT), meta-analyses, and systematic reviews due to their economic feasibility and short-term effectiveness, which influences funding priorities and shapes policy recommendations. Consequently, these methodologies are prioritised over narrative or qualitative research methods, overlooking perspectives that cater to racialised people which might lead to more comprehensive policy development (Parkhurst & Abeysinghe, 2016). In line with the 'scientist-practitioner model,' RCT's are seen as 'gold standard' for assessing and improving treatment efficacy in psychology (Howick, 2011). There is a misconception that the efficacy of psychosocial interventions can only be validated through RCTs. However, RCTs often selectively 'cherry-pick,' participants that do not have compounding problems such as housing and legal instability. RCTs often require uniformity in participant selection and treatment delivery, which may not reflect the diverse realities of rehabilitation practice (diverse patient background, CP delivery and range of intervention methods) (Tribe & Morrissey, 2020). Furthermore, RCTs in PTSD research often focus on individuals that have experienced childhood sexual abuse in relatively stable

societies (i.e., Knipschild et al., 2024), which may not encompass the ongoing difficulties that male victim-survivors of CRSV face in the UK, as they are not a homogenous group and face a myriad of psychologically debilitating challenges in the UK.

Patel (2020) also highlighted various biases in clinical research rooted in positivist approaches, that could restrict the relevance of its outcomes to male victim-survivors of CRSV. This includes some clinicians having a ‘financial stake’ in a particular modality of therapy that they wish to ‘propagate,’ and assessment measures which may not demonstrate cultural validity. Most systematic reviews with refugee/torture survivors are in English, perpetuating an existing bias towards studies conducted, conceptualised, and designed using a Western framework by Western researchers, from the Global North, even when conducted on people from the Global majority. This also means that research isn’t driven by survivors themselves. Patel (2020) asked the question: ‘what kind of research is really needed, valued, by whom and in which context, for whom and to what end?’ Patel, argues that rehabilitation for survivors, is not solely about psychological interventions but an interdisciplinary set of protocols, that recognises recovery as a ‘human right to reparation’ for individuals and their wider systems (Patel & Williams, 2022, p.20).

1.10.3. Alternative concepts

Historically psychology and religion have been closely intertwined, as faith, soul and spirituality were central tenets in early conceptualisations of psychology (Hayes & Cowie, 2005). However, in wanting to be aligned with other scientific disciplines, psychology has developed within a paradigm distinct from that of religion (faith). Non-western psychosocial interventions such as body mapping (a therapeutic technique to explore traumatic memories, narratives, and sensations through visual representation) remains embedded in religion, spirituality, and philosophy; contrary to Western psychology, which strives for a 'scientific' approach and aligns with western and Eurocentric medical practices (Fernando, 2017). In clinical psychology programmes, there's often a noticeable gap when it comes to formulating religion and spirituality into psychosocial interventions. This lack of focused training can leave CPs not equipped, especially when they're working with people from states

where religion isn't just a personal belief, but a cornerstone of the entire societal structure, like in theocratic states or countries deeply influenced by religious norms (Jafari, 2016). For an example, on a longitudinal study looking at 106 displaced Syrian men that experienced CRSV, torture and detention since the Syrian Revolution; it was found that 70% of the men reported faith, spirituality, and religion as main sources of strength over a long period of time. Only 3% of the males found accessing formal psychological support services as a major source or recovery and strength. The authors highlighted the need for early intervention, accessible and appropriate services (Kivlahan et al.,2024).

For an example, clinicians in Palestine have incorporated Islamic concepts such as Sumud (meaning ‘steadfastness’ or ‘resilience’) and Ribat (meaning ‘guarding,’ or ‘defense’) to symbolise how non-violence resistance fosters strength, survival, and resilience despite the ongoing occupation (Jabr & Berger, 2023). Hammad and Tribe (2020) highlighted that Sumud is a core pillar of resilience, offering Palestinians a ‘meta-cognitive framework,’ for meaning making, navigating, and reacting to ongoing injustice, fostering a sense of purpose and meaning making. This is similar to the Rwandan concept of kwihangana, kwongera kubaho, and gukomeza ubuzima (which loosely translates as withstanding, living again and continuing life); Kwihangana means “to strengthen oneself, to forbid suffering from becoming overwhelming” (Zraly & Nyirazinyoye, 2010).

The layered and non-linear experiences faced by male victim-survivors of CRSV in the UK are deeply entrenched in social, political, religious, and cultural factors that may not be aligned with a positivist framework and these present modalities should integrate more holistic, context aware practices to acknowledge the unpredictability and complexity of these human experiences, particularly in the realm of CRSV, loss and displacement. Therefore, it is important CPs incorporate concepts familiar to clients, as coping mechanisms are crucial in mediating the relationship between distress and mental health among survivors of conflict (Thabet et al., 2014).

1.11. Justification for current study

Recent initiatives have focused on improving psychological support and service provision for male sexual assault survivors in the UK (Lowe and Rogers, 2017). However, research, interventions and services for those male victim-survivors that have experienced ‘wartime rape’ (CRSV) remain notably limited (Lowe, 2018, p.181). This oversight extends to the challenges faced by racialised male refugees and asylum-seekers, who are stigmatised and may not be recognised as victim-survivors due to their lack of racial and geographical proximity (The British Psychological Society, 2023). This results to selective and conditional protection from the UK, which can prevent clinicians from recognising these individuals as victim-survivors, even when incidents are formally reported. As a result, oppressive practices are sustained and perpetuated, and their access to psychological support is hindered (Brouwer et al. 2017; Onyango & Hampanda, 2011). There is a critical gap in research exploring the perspectives of CPs working with male victim-survivors in the UK. By focusing on CPs, this study aimed to bridge the gap between theory and practice when delivering psychosocial interventions for male victim-survivors of CRSV. It examined the complexities and limitations of existing psychosocial interventions and sought to address how the context of structural violence in the UK asylum system, impacts the delivery of psychosocial interventions for male victim-survivors of CRSV. This study aims to address this by exploring the ideas, theories and frameworks CPs use and the key knowledge gaps they identify that need to be addressed to enhance psychosocial interventions for these victim-survivors. The insights of the study could lead to improved therapeutic practices, service delivery, and inform policymaking, potentially transforming the scope and quality of mental health services in the UK for racialised victim-survivors of CRSV.

1.12. Research Aims and questions

Currently, there is no published research exploring the perceptions of clinical psychologists in the UK who support male victim-survivors of CRSV. This exploratory research aim to start narrowing this gap.

> What ideas, theories and frameworks do clinical psychologists draw on in relation to their work with male victim-survivors of CRSV and what informs these (in relation their experiences, training, and education)?
>
> What are the key knowledge gaps that need to be addressed to improve the design and implementation of psychosocial interventions for male survivors of CRSV in the UK?

2. METHODOLOGY

In this chapter, the methodology of the research is described, beginning with epistemological position, followed by the rationale for choosing thematic analysis (TA), procedure, ethical considerations and finally the step-by-step phases of TA.

2.1. Epistemological position

Parker (2005) emphasises the importance of researchers reflecting on their ontological, ethical, and political commitments to identify their epistemological position. Critical realism informed my approach to the data. Pilgrim (2020) argued that: ontological realism, epistemological relativism, and judgmental rationality are the ‘holy trinity of critical realist premises’ (p.17). Ontological realism emphasises that there is a reality independent of the theories and our perceptions of it. In the context of male victim-survivors of CRSV, ontological realism acknowledges that male victim-survivors of CRSV experience real events and mechanisms that shape their lives, irrespective of how these experiences are understood. Thus, the data collated through interviews with CPs is assumed to reflect real experiences that exist independently of my own conceptualisation. Epistemological relativism is important to understand the multiple perspectives in understanding how CPs can improve

psychosocial interventions for male victim-survivors of CRSV. Epistemological relativism suggests that our understanding of reality is partial and shaped by and contingent of our socio-political, cultural, historical, economic, and lived experiences and thus impacts how we construe it. With regards to this study, epistemological relativism means acknowledging that the interpretations of data concerning male victim-survivors and the effectiveness of psychosocial interventions by CPs are influenced by the researcher's and participants' backgrounds, beliefs, and contexts. Judgemental rationality helps to bridge the gap between the recognition of multiple interpretations (epistemological relativism) and the need to make rational interpretations that are valid and reliable. Judgemental rationality was used to assess the multiple perspectives of CPs, to identify those that most accurately reflect the effectiveness of psychosocial interventions for male victim-survivors by CPs. A critical realist epistemological position infers that our understanding of data may not explicitly reveal the political, historical, institutional, and cultural impacts informing these experiences and practices of CPs (Harper, 2011). In the context of male victim-survivors of CRSV, a critical realist approach might suggest that, in order to explore the effectiveness of psychosocial interventions implemented by CPs, research needs to move beyond modalities to include the broader social, economic, and political climate. This perspective recognises that factors like hegemonic masculinity, perceptions of victimhood, and the socio-political context for refugees and asylum-seekers can impact the effectiveness of psychosocial interventions. A critical realist position further acknowledges that CPs, whilst operating within larger organisational structures (i.e., BPS), can still exercise agency. This dual approach provides insight into how CPs navigate systemic, institutional, and political constraints, whilst improving psychosocial interventions for male victim-survivors of CRSV (Price, 2014).

A critical realist approach can explore how healthcare infrastructure, clinical psychology training and societal influences shape psychosocial interventions for male victim-survivors, emphasising the need for multi-layered improvements from individual clinical practice to policy reformation. Thus, the critical-realist approach aligns with the exploratory nature of this study, enabling a comprehensive examination of factors that influence effectiveness and implementation of psychosocial interventions for male victim-survivors of CRSV. It facilitates

exploration of contextual, structural, and political influences on intervention delivery, recognising the role of underlying social determinants in the UK context.

2.2. Rationale for choice of a Qualitative Method

Harper (2013) noted that qualitative methods such as employing individual interviews allow for the exploration of people's views and experiences shaped by sociocultural including political environments. This makes a qualitative approach ideal for the focus of this research to examine how CPs engage with male victim-survivors of CRSV and how these experiences inform psychosocial interventions. Qualitative methodology moves beyond surface analysis to elicit insights into biases, factors, and knowledge gaps that could inform improvements to psychosocial interventions (Nowell et al., 2017).

Davies and True (2015) argue that research on CRSV lacks contextual understanding and depth; a notable gap that this study aims to fill using qualitative methodology to avoid predetermined ideas, assumptions, and concepts about gender and conflict. This approach allows richer interpretation and insight cultivation (Braun & Clarke, 2006). By opting for a qualitative methodology, this study aims to capture the complexity of CP's practice within the broader professional, educational, and political contexts, allowing for a contextualised exploration that contributes to a deeper understanding of the field (Creswell & Creswell, 2017).

Whilst the existing literature on CRSV predominantly uses a critical feminist lens, focusing on women and girls, there has been a growing recognition to not neglect the experiences of men and boys. This research acknowledges the feminist framework's importance while extending its scope to include experiences of men and boys, particularly racialised men affected by conflict. By implementing an intersectional feminist lens, this study aims to understand how gendered power and social structures impact male victim-survivors of CRSV, enhancing our understanding of how CPs can improve psychosocial interventions for this demographic.

2.3. Thematic Analysis

Qualitative research approaches are complex and can vary greatly (Holloway & Todres, 2003). Reflexive Thematic Analysis (TA) was chosen for its alignment with the exploratory nature of the study, compatibility with chosen epistemological stance, and capacity to foster reflexive thinking. Reflexive TA, provides a flexible framework for identifying, analysing, and reporting patterns (themes) from transcribed data (Braun and Clarke, 2006). It is distinctively reflexive rather than theory-agnostic, encapsulating broader theoretical concepts about improving psychosocial interventions for male victim-survivors by CPs, allowing for a nuanced analysis shaped by the researcher's theoretical insights.

Joffe (2012) highlights that TA is a constructionist method emphasising how language and societal constructs shape experiences and perceptions. The constructionist lens allows the exploration of constructs like gender, orientalism, and sex exceptionalism in shaping clinical psychology practices for male victim-survivors of CRSV. As such, TA is a framework that "works both to reflect reality and to unpick or unravel the surface of 'reality'" (Braun & Clarke, 2006 p.81). TA is applied at both the semantic (observable) and latent (interpretative) level, to analyse explicit content and implicit meanings within the data. Critical realism highlights the existence of both observable (manifest) and underlying (latent) structures in social phenomena (Bhaskar, 1975).

Implementing a flexible TA approach, this study will implement both inductive and deductive analyses to improve psychosocial interventions provided by CPs for male victim-survivors in the UK. Deductive analysis will be informed by existing psychological theoretical underpinnings, while the inductive analysis will involve the generation of themes and patterns discerned from the CP's experiences. This dual approach of actively seeking novel ideas and concepts will mitigate the chance of "reinventing the wheel" (Joffe, 2012, p.210) and shape the future of psychosocial interventions for male victim-survivors of CRSV.

2.4. Reflexive Thematic Analysis

Adopting a reflexive TA approach within a critical realist framework acknowledges the inherent subjectivity of the researcher's perspective, viewing it as one of many possible interpretations of the data (Braun and Clarke, 2020). Braun and Clarke (2019, p. 594) argued that researchers play an 'active role in knowledge production.' Medico and Santiago-Delefosse (2014), emphasise that researchers are influenced by their political, socio-cultural, and emotional connectedness. In line with this, I have critically reflected on my positionality, biases, and personal experiences to transparently inform the rationale behind the research.

My background as a daughter of Tamil refugees from East London, shaped by anti-colonial and Marxist-Leninist values continues to deepen my understanding of state-violence and marginalisation in the UK. My doctoral training covering topics on human rights, liberation psychology and social constructionism profoundly shapes my thinking and perceptions, influencing how I approach therapeutic work with male victim-survivors. Furthermore, my placement at a third sector organisation supporting survivors of torture has provided me with direct exposure to and personal understanding of the experiences faced by racialised male victim-survivors of state-sanctioned detainment and CRSV, mostly from Muslim and Middle Eastern backgrounds. This has given me insight into how whiteness, power, and privilege interplays within the design and implementation of psychosocial interventions within the UK.

During my visits to Vavuniya (Tamil area) and Ramallah and Nablus (Palestine), I was confronted with the pervasive impacts of imperialism, which continually prompts me to reflect on injustice globally. I gained insights into how resistance, community bonds, and steadfastness persists amidst oppression. Specifically, I reflected on fatherhood, recognising it as a gendered, communal, and political role heavily impacted by state violence (occupation, forced disappearances, torture and displacement). These insights resonate with Ghassan Kanafani's quote 'imperialism has laid its body over the world, the head in Eastern Asia, the heart in the Middle East, its arteries reaching Africa and Latin America. Wherever you strike it, you damage it' (1969).

Post-doctorate, I aim to become a documentarian to spotlight the realities of male victim-survivors of CRSV globally, promoting sustained awareness and advocacy, in line with critical realism. Although I am not a male victim-survivor of CRSV nor have I sought asylum in UK, my connections to those impacted deepen my empathy for racialised males leaving turbulent circumstances and encountering perilous journeys for a 'better life' in the UK, only to encounter ongoing state violence here. This drives my goal to advance psychosocial support upholds the human rights and dignity of these victim-survivors.

2.5. Procedure

2.5.1. Inclusion criteria

The inclusion criteria are as follows:

- Professional role: CPs registered with the Health and Care Professions Council (HCPC).
- Experience: Participants with direct experience working with male victim-survivors of CRSV
- Location: CPs must be actively practicing in the UK, aligning with the relevance to the national healthcare infrastructure and policies.

2.5.2. Exclusion criteria

The study excludes CPs not currently practicing or engaged in the profession in the UK (e.g., on sabbatical), and non-CPs working with male victim-survivors of CRSV. Additionally, CPs who solely work with female victim-survivors are also excluded to maintain a focus on experienced CPs actively involved in the providing psychosocial interventions for male victim-survivors of CRSV in the UK.

2.5.3. Participants and recruitment

Twelve CPs working in the UK participated in this research study: three men and nine women. Regarding ethnicity, six of the women self-identified as White British. To reduce the possibility of identification, ethnicities of non-white participants have been omitted. All participants were qualified CPs with experience of providing psychosocial interventions for male victim-survivors of CRSV. The CPs recruited work in a range of clinical settings including the: NHS, third sector organisations, and community initiatives aimed at supporting Muslim and racially marginalised communities impacted by state-violence. All CPs, apart from one, primarily work in London, some also are involved in international projects such as in Gaza. Their practices and approaches vary, including community-led psychology, abolitionist, and human-rights frameworks, alongside evidence-based modalities like Trauma-Focused CBT and NET. The average years of experience across the specified roles was 12 years. The experience ranged from a minimum of two years to a maximum of 32 years as a qualified CP working with this refugees and asylum-seekers, many who have seen a high proportion of male (men, boys and people that have transitioned to men) victim-survivors of CRSV. Nine of the participants stated that they see a high proportion of male victim-survivors of CRSV in their clinical practice.

The interview schedule was created through consultations with researcher's Director of Studies (DoS), a Tamil male victim-survivor of CRSV, and a human rights lawyer who has conducted field research in Sri Lanka, UK, and Canada. Their insights informed the interview schedule, though they did not participate in the study itself. The interview schedule consisted of one question to warm the context, three questions associated with 'Ideas, Theories, and Frameworks,' three questions on 'Training and Education,' and three questions on 'Key Knowledge Gaps' (see Appendix A). These questions were developed in line with the research aims, existing literature and the exploratory nature of the study.

The recruitment strategy involved posting the flyer (see Appendix B) for the study on social media platforms (i.e. X and LinkedIn) for outreach, alongside reaching out to professional networks and specialised UK-based services in refugee mental health, men's psychosexual health and human rights organisations such as Freedom From

Torture (FFT) and Abuse Never Becomes Us (ANBU). FFT, in which I am undertaking my third-year clinical placement served as a primary recruitment source, which led to 'snowballing' of further participant recruitment. Snowballing sampling method involves existing participants recruiting further participants from their networks, to grow the sample size (Goodman, 1961). Potential participants were also found from a WhatsApp support group for UK based CPs working with refugees. Potential participants were reached out to or responded via email to express their interest in the study. Interested participants were forwarded the Participant Information Sheet via email (see Appendix C) and invited to contact me with queries. Common queries from participants included clarifying the definition of CRSV and whether their experience in this area was sufficient to take part in the study. Interviews were scheduled via email and conducted over Microsoft Teams, ranging from 45 minutes to 86 minutes, providing flexibility for the participants.

2.6. Data collection

2.6.1. Interview Process

Prior to the interview commencing, participants who agreed to take part in the study were given a consent form to complete via email (see Appendix D), emphasising the right to withdraw from the study, regardless of reason. Each participant signed the consent form before the start of the interview and sent it back via email. Confidentiality was outlined in the consent form, and informed consent was discussed prior to the interview commencing.

One-on-one semi structured interviews were conducted on Microsoft Teams, promoting a two-way conversation with scope for clarification and flexibility. This format enabled participants to explore more sensitive concepts and ideas pertaining to working with male victim-survivors of CRSV in the UK. The aim was to enable participants to express ideas flexibly, resulting in more comprehensive and nuanced data. A debrief occurred after the interview to address queries, and reflections.

2.7. Ethical Considerations

2.7.1. Confidentiality

To maintain anonymity, participants were given a pre-assigned code such as ‘CRSVF9’ and identifiable information was minimised in the transcription process, conducted three weeks post-interview. This period allowed participants to opt out and withdraw their data, though none did. Audio and video recordings of the interviews were securely deleted after verbatim transcription. Data is stored on UEL’s OneDrive, under the oversight of the Director of Studies (DoS), ensuring secure handling of the transcripts and any personal information. Post thesis and viva voce, data will be transferred to the DoS and retained for 3 years prior to secure deletion. To ensure the anonymity of participants was maintained, anonymised transcripts were to be exclusively accessed by researcher, DoS, internal and external examiners, maintaining strict confidentiality unless disclosure was necessary to prevent harm.

2.7.2. Ethical approval

The University of East London Research Ethics Committee (School of Psychology) granted ethical approval for the research, with a minor amendment to clarify the advert and Participation Information Sheet (PIS) whether ‘CRSV’ referred exclusively to ‘war situations or to conflicts within relationships’ (See Appendix E). Amendments to clarify the definition of CRSV were discussed with DoS and corrected. Data collated has been electronically stored in line with Article 89 (2) research exemptions of GDPR 2018.

2.8. Data Analysis

This section details the use of the 15-Point Checklist of Criteria for Good Thematic Analysis Process in line with Braun and Clark (2006, p37). NVivo was used to code the interviews, an example of coding is provided (see Appendix F). Despite being presented in a linear manner, the process was iterative, with stages re-examined with DoS.

2.8.1. Transcription

Interviews were audio and video-recorded with participant consent; content was transcribed verbatim by Microsoft Teams. However, transcripts were thoroughly reviewed against the recordings to ensure accuracy. Any identifiable material (name, locations, information about clients when used as examples) in the transcripts were anonymised by deleting or censoring. By meticulously checking the transcripts, I was able to fully immerse myself with the data and to begin analysing its meaning. Braun and Clarke (2006, p. 88) highlight transcripts for TA need to be 'rigorous and thorough orthographic transcripts,' capturing the essence of the original verbal account. Thus, in my transcripts, I included non-verbal cues such as pauses, word-emphasises, and emotional responses such as expletives. The transcripts also noted instances of sarcasm to fully grasp participants' expressions and nuances. Re-reading completed transcripts alongside the original audio recording allowed for further clarity, familiarisation, and precision (Braun & Clarke, 2012).

2.8.2. Generating initial codes

Initial coding was conducted using NVivo software, where interview transcripts were uploaded, organised, and coded for analysis (Dhakal, 2022). Segments of the data with key patterns, concepts or key phrases were highlighted, and assigned codes which became initial codes. A dual approach of deductive and inductive coding was used to generate the initial codes. Inductive coding involved drawing directly from the data without any predefined categories, and the deductive coding was theory-led, guided by existing knowledge from literature, clinical experiences, and research objectives (Boyatzis, 1998). The coding process involved iterative refinements to ensure validity, reliability, and accuracy, as the understanding of the data deepened. This methodological approach ensured comprehensive analysis, including identifying data contradictions, exceptions, and personal anecdotes (Braun & Clarke, 2012).

2.8.3. Generating Themes

Themes were generated using NVivo; initial codes were used to identify emerging patterns and reoccurring concepts within the dataset. Codes were categorised into potential themes, with their interrelations forming overarching themes (Braun &

Clarke, 2006). A visual table was used to cluster codes into broader themes. An initial thematic table facilitated the examination of code-theme relationships. Codes that were not aligning with initial themes were categorised as 'miscellaneous,' for a further review and clarification, ensuring a comprehensive and systematic thematic analysis (Braun and Clarke, 2006).

2.8.4. Theme Review

This phase encompasses two levels of 'reviewing and refining' the themes (Braun and Clarke, 2006, p.91).

The first level of reviewing themes was to identify each theme's coherence, ensuring it was reflective of the data essence and related to the overarching research question. It involved checking the entire data set within each theme to confirm it formed a consistent pattern and distinguishing it from other themes. It was imperative to guarantee that a substantial amount of data supported each theme (Braun and Clarke 2006). When reviewing the themes, internal homogeneity and external heterogeneity were taken into consideration, in accordance with Patton (1990). Sub-themes that lacked supporting data were either combined, discerned, or expanded into broader themes to ensure that each theme was robust and distinct. An initial thematic table was created once the themes were defined (see Appendix G).

The second level involved re-reading and assessing the validity of each theme, to see if was representative of the data set. Re-coding the data set was a crucial step, reflecting the 'ongoing organic process' (Braun and Clarke 2006, p.91). Themes were revised four times to capture the data's nuances. Braun and Clarke (2006, p.92) argued that the procedure of coding, creating, and revising themes can potentially become 'ad infinitum.' Therefore, once I had reviewed the 4th visual table, I concluded that further adjustments to the coding and thematic structure would not yield any substantial changes. The finalised themes encompassed the entirety of the collated data (Campbell et al., 2021).

2.8.5. Defining and Naming Themes

Braun and Clarke (2006, p. 92) highlighted that it was important to capture the 'essence' of the collated data. Thus, each theme was closely scrutinised to determine its significant and how it reflects the underlying data, ensuring relevance to the research questions (See Appendix H of themes and sub-themes).

2.8.6. Report

Selected extracts were integrated into an analytical narrative to encapsulate themes in connection with the research questions and literature.

3. RESULTS

3.1. Overview

A TA of the twelve-semi-structured interviews conducted with CPs working with male victim-survivors of CRSV resulted in four distinct themes that are central to understanding the complexities of improving psychosocial interventions. Each theme, along with its aligning sub-themes, is supported by excerpts from the interviews to enhance clarity and comprehension for the reader. Words, phrases, or punctuation that might obscure the intended meaning have been omitted, shown by an ellipsis. To maintain authenticity of the participants' voices while ensuring readability, clarifying, or substituting words have been added within square brackets. Additionally, to aid understanding, explanations derived from the broader context of each conversation are provided where the initial excerpts may prove challenging. This approach ensures that the results are both accessible and representative of the nuanced perspectives of the CPs.

3.2. Theoretical and clinical frameworks

The first theme highlights the foundational approaches that CPs employ as techniques, tools, models, and frameworks when working with male victim-survivors of CRSV. This overarching theme encapsulates the integration of varied psychological models and theories that are not only drawn from established

therapeutic practices but are also tailored to address the specific complexities associated with CRSV.

3.2.1. Use of Structured Therapeutic Models

This sub-theme explored the structured therapeutic models frequently utilised by CPs in their clinical practice with male victim-survivors of CRSV. CPs often highlighted the use of theoretical models such as Ehlers and Clark's (2000) cognitive model of PTSD in clinical settings in both the NHS and third sectors such as charities to inform their clinical work with male victim-survivors of CRSV. Some participants emphasised the effectiveness and necessity of evidence-based trauma-focused interventions such as NET, Eye Movement Desensitisation and Reprocessing (EMDR) and TF-CBT, for treating PTSD in male victim-survivors of CRSV. Five of the participants addressed memories such as rape through techniques that are used within the framework of Ehlers and Clark's (2000) cognitive model of PTSD like reliving, updating hotspots (revisiting distressing memories, to help process and reframe these memories), and imagery rescripting. Participants justified the use of such methods and techniques to help survivors reprocess their experiences, and to alleviate feelings of shame associated with the trauma. The excerpt below provides an example of a participant working with survivors who had been diagnosed with PTSD, benefitting from the use of TF-CBT techniques including psychoeducation and imagery rescripting, responsibility pie charts, and compassion-focused techniques to regain control over their narrative and to depersonalise CRSV.

> *'Within a CBT framework, either doing sort of reliving and updating hotspots, or we use quite a lot of imagery rescripting….Because it allows people the chance to do what they were prevented from doing at the time, fight back or tell people what they think of them, which I find very empowering… there's shame in those memories, then we'd be using sort of cognitive work around that to try and reduce the shame…. I'm afraid the science is very clear. The only way to get rid of PTSD is to go into the trauma memory…. non-trauma focused treatments do not work for PTSD, and I'm only talking about PTSD'* - Participant 4

> *'I think it's 86 or 84% of them get an erection. Yet, they do not want this sexual activity, but they're getting erections. Showing people that kind of statistic and teaching people is really helpful. Otherwise, they think, well, I had an erection. That must mean I was enjoying it, but 20% of people have an orgasm in forced sexual activity. They are not enjoying it. They do not want it'* – Participant 4

Some participants identified EMDR as a helpful alternative for male victim-survivors who were reluctant to speak openly about their experiences. Often participants, noted that a sense of safety and trust in the therapeutic setting was crucial for facilitating recovery.

> *'I have a preference to working with EMDR with any form of sexual violence because it doesn't require you to recount every single detail and it doesn't require you to find the words for everything. I think with sexual violence, that's a particularly difficult thing for men to talk about… But I think we have to think about the context and what's going to make it safe for men A) to disclose what they've been through and B) to then be in a position to work on it with you.'* – Participant 6

However, 10 participants drew from an integrative perspective combining various approaches and modalities to suit the clients' individual needs such as Tree of Life (Ncube, 2006) that may not be rooted in Eurocentric modalities, emphasising the importance of flexibility and sensitivity to the unique contexts in which the survivors operate.

> *'I try to hold in mind a social constructive or narrative perspective…. I don't think a one-size-fits all methodology or cutting and pasting the same treatments onto each client works'*– Participant 8

Many participants critiqued the practice of solely drawing from structured, evidence-based therapeutic modalities because they fail to contextualise and politicise the contexts in which male victim-survivors operate. This excerpt below highlights the prevalence of structured therapeutic models within clinical settings.

'In the services, I've often worked in, the models and frameworks that have often been pushed for and advocated for have often been models which prioritise trauma or memory processing…one way in which it [sexual violence] might impact someone is the way in which it impacts their memory, but that being one way and not the only way… I am trained in them [trauma-focused interventions] and have them as part of my toolkit, but the theoretical framework I think often drawn from, fall under the systemic psychotherapy framework. They might be models like CMM, liberation and narrative therapy when thinking about the wider socio-political context that clients exist within or have fled' – Participant 11

Participants offered a nuanced critique of trauma-focused therapies and the concept of trauma in clinical settings for male victim-survivors of CRSV. Participants discussed moving beyond traditional trauma frameworks to consider the socio-political contexts affecting survivors who have intersectional identities. They also emphasised the importance of seeing 'trauma' within a broader narrative and community to address ongoing vulnerabilities and injustices. Thus, strictly adhering to evidence-based and trauma-focused models was limiting.

'One of my challenges that I have with the experience of 'trauma' be it sexual violence or otherwise, is that the very notion of trauma… tends to localise the experience of violence in the past. So, something happened in the past. But now people are in total safety, right? (Sarcastic).. It's clearly not true today for any racialised minority… policies like the War on Terror, especially prisoners, continuously exposed to police raids even after having experienced sexual violence' – Participant 3

3.2.2. Cultural, Faith and Spiritual Integration

This sub-theme explored how CPs incorporate ideas around culture, faith, and spirituality into psychosocial interventions for male victim-survivors of CRSV. They examined the significance of using these elements in the therapeutic process, whilst

also addressing the challenges they face in integrating these aspects, particularly when they come from a different background from their clients. Participants discussed the importance of incorporating elements of culture, faith, and spirituality into psychosocial interventions to enhance their relevance and effectiveness for male victim-survivors of CRSV. Participants highlighted that meaning-making through culture, faith and spirituality plays a crucial role in how male-victim survivors of CRSV cope with, resist, and interpret poignant experiences, particularly in the context of surviving trials and tribulations. Interviewees highlighted that drawing on clients' religious and spiritual beliefs not only helped to construct a narrative that makes sense of their experiences but also imbued them with a sense of resilience.

> *'What has helped them during those difficult times to survive …whether in spirituality… legacy that they've taken on from people, teachings... I integrate faith into therapy. I've done that with clients who are Muslim using Sumud or Christian and we think about, the things that we're seeing in a psychological way, but also how does it come across in a spiritual way? What are those sayings? What are those things that carry them forward? What does faith do to them? How can they ground themselves with faith. How can they make sense of it? What's the bigger picture? That has helped a lot of people.'* – Participant 2

The majority of participants who had originated from White British backgrounds voiced uncertainties about effectively integrating faith and spirituality into therapy. Some acknowledged their own lack of personal experience with these tenets, which led them to question their ability to fully engage and connect with clients on spiritual matters.

> *'I don't know if I am always the best person to allow for that space...I always wonder.., like actually if someone was more religious and really kind of had that connection, would they be able to have these conversations a bit better?'* – Participant 10

A reccurring thread throughout all interviews was the importance of cultural literacy and humility. Participants highlighted recognition of their own limitations and the

need to actively learn about the cultural, historical, and linguistic backgrounds of their clients, using interpreters and readily available resources.

> *'I try to have cultural humility and be honest about my ignorance and what I don't know about and ask about that'* – Participant 1

> *'Their self-perception is informed by their culture, background, experiences, which are all very different to mine. I try and sort of approach it with cultural humility. I don't necessarily know how they perceive themselves, but it's this whole incumbent on me to try and understand…. And isn't sort loaded with loads of assumptions…interpreter is bringing their ability to help facilitate not only with language but with also understanding culture and things that I might miss'* – Participant 7

Participants' cultural humility enabled them to discuss sexual violence in culturally appropriate ways, encouraging clients and interpreters to guide the conversation on sensitive topics.

> '*They're [clients and interpreters] able to tell you….Well, in our culture, it's not OK to say XYZ or this is how you need to approach it [sex]'* - Participant 10

3.2.3. Issues of masculinity

This sub-theme explored the multi-facets of identity and the complex interplay of masculinity and victimhood that male victim-survivors of CRSV face. Participants explored concepts of masculinity, shame, and victimhood. Participants noted that addressing feelings of shame, disgust, and humiliation appeared to be easier to navigate with their non-male CRSV clients. They attributed this to the influence of global movements tackling gender-based sexual violence, awareness, and the pervasive belief that women inevitably experience CRSV. Participants noted that CRSV left an intrinsic impact on their sense of self and healing required ideas, theories, and frameworks beyond trauma-focused interventions.

> *‘Shame, masculinity, and the humiliation. The impact that it has on their sense of self, and their beliefs of themselves as a father, son, or a man…It can be really tough to kind of help clients get out of that… It almost becomes a part of their identity that is solidified and so crystallised…* - Participant 8

Participants utilised clients’ testimonies to shed light on their perspective on victimhood, shame, and masculinity. Some participants highlighted feelings of dishonour and permanent change expressed by survivors even after psychoeducation about how CRSV is a violation of international law and against human rights.

> *‘I remember him saying yes, but it is unforgivable, dishonourable, I have changed forever, and nothing will unchange that.’* – Participant 9

This sentiment was echoed by clients expressing that CRSV is not something a man should ever experience, and struggled with the societal norms of masculinity, feeling an intense burden of shame and a sense of personal failure for not preventing the assault. This often led them to not disclose to their family and social circle.

> *‘They [male clients] say something like ‘something a man shouldn't experience, something that is not honourable happened to me… I'm strong enough. Why didn't I stop it?’ I hear that a lot… They don't share anything with their family… They've never told anyone’* – Participant 2

Some participants spoke about the religious, spiritual, transcendental boundaries of exposure amplifying feelings of violation, and how that might not align with dominant Western-centric perspectives on sexual trauma and bodily experiences.

> *‘The element of Awrah [Islamic concept based on modesty] that's considered within Islamic traditions, of not showing your body off to people. He [client] felt that that [strip-searching] was a very explicit act of violence that was done to humiliate him by removing all his clothes constantly with no reason whatsoever. In the Western world, how would that be understood? We know that experiences of trauma are often like somewhere related to, actual bodily harm in some way, shape or form, or like full penetration, without fully*

recognising how people from racialised identities do have different boundaries according to different forms of ethics. It's [strip-searching] often instrumentalised as the weapons of violence by for example Israeli forces in Khan Younis' – Participant 3

Participants also drew upon ideas from writers such as Franz Fanon and Edward Said to highlight how racialised men are not seen as victim-survivors but as threats, which is cognisant of the broader societal narratives.

'*Orientalism permeates every single aspect of society: academia, therapeutic spaces, media. There is a bias image of Arab and Muslim men. I think about sexual violence. We never see them as victims. We always see them as the threat.'* – Participant 12

3.2.4. Community mobilisation and collective healing

This sub-theme explored how CPs emphasised the importance of community mobilisation and collective healing in addressing the systemic oppression male victim-survivors of CRSV face. Liberation practices and ideologies were noted by participants as a way of mobilising not only individuals but also communities that they originate from to overcome personal and systemic oppressions, playing a crucial role in collective healing and justice for communities impacted by conflict, state violence and intergenerational trauma. Participants highlighted how western ways of working with trauma, localise suffering and distress within the individual, without looking at how communities can mobilise, heal, and liberate themselves. Participants also cited how discourse around survivors can be one-dimensional, viewing them as vulnerable and helpless.

'It's a very Western way of thinking about how we respond to trauma…often still only presents like a single narrative, of them being vulnerable and completely neglects their resilience on their own. It completely neglects the ways in which healing can take place in communities, in which communities can heal each other and heal within themselves. I think that's really influenced my ideas of how trauma is understood, how violence is understood, how we make sense of it, how communities come together off the back of state

violence and war. And also, how they resist. [Spoke about a male client] We then spoke about the ways in which he's been able to reclaim his power. So we spoke about going to marches and demonstrations in the UK and for him that was a way of reclaiming his voice and resisting. So, whilst it doesn't mean he goes around telling everyone that he has experienced sexual violence, but it does mean that actually where they've [state-actors] told him to be silent, he's been able to open his mouth and speak against what's going on going on in Sri Lanka.' – Participant 11

'It [testimonies of survival and resistance] is certainly relevant for people here to document or testimony of their experiences here, for example in prisons, and be able to mobilise on that.' - Participant 3

Participants also highlighted how the loss of homeland is inextricably linked to collective healing.

'The enormity of loss. Like, how enormous the loss of home is and just how just crushing that can be for people. How the alienness and the unfamiliarity of a new country. How huge a job it is to even orientate that, let alone begin to think about integration…I think one of the really interesting thing is trying to help people recover from the loss of homeland, community and everything.. so, they can live life more fully, more creatively'– Participant 1

Participants cited that they sought research led by racialised communities to inform their thinking on collective harm done to the social fabric of communities. Participants more advanced in their career noted that they were involved in community-led projects thinking about systemic changes and healing.

'From the Tamil community; there was a paper from by XXX, that documented the experiences of CRSV. I've shared that with men in the past, to show like this is happening. It's collaborative research that me and the client can do together to look at the prevalence'– Participant 5

'Attached to a mosque and one's attached to a church and I trained people from the community' – Participant 12

3.3. Critical Reflexivity

This theme explored the role of critical reflexivity when clinically working with male victim-survivors of CRSV. Critical reflexivity is integral for CPs to ensure that psychosocial interventions delivered are ethically grounded and effectively tailored to male victim-survivors of CRSV. The process involves continuous reflexivity with regards to self, contexts, and systems that influence the therapeutic process and the experiences of the clients. It requires CPs to constantly question and reassess their own therapeutic practices, biases, and the broader institutional and societal structures within which they operate. As an iterative process, critical reflexivity helps develop a practice that aims to be responsive to the specific needs of male victim-survivors of CRSV.

3.3.1. Political Contextualisation

This sub-theme examined how the political and bureaucratic systems in the UK detrimentally impact the experiences of male victim-survivors of CRSV seeking asylum in the UK, and how this impacts the psychosocial interventions provided by CPs. The discrepancy between the perceived safety of the UK and the actual lived experiences of asylum-seekers, particularly around issues of sexual trauma, exploitation and violence were noted.

'There's this perception that UK is safe; I think that's why a lot of people risk their lives. Often there are very different narratives about England. They will have a better life here and won't experience any sexual violence or any other kind of trauma. But as we know, like in detention centres, a lot of people experience sexual violence.' – Participant 9

Participants often held critical views on how deeply entrenched and powerful British imperialist propaganda has influenced global perceptions of the UK. They argued that despite various political and systemic issues in the UK, including the risks of

further sexual violence in detention centres, centuries of British colonial propaganda and perverting the economies in the global majority had created an indelible image of the UK as a safe and desirable destination.

> *'Because of the imperialism, and of how unbelievably powerful England's propaganda is…The reality on the ground just does not translate it. It doesn't erode this propaganda that we have. I think it's because of the colonisation, as well as like the brute force, the killing and taking over like you know, full scale gutting countries and perverting their economies…. So, we're up against what? Like 400 years' worth of propaganda that's embedded all around the world and the Commonwealth in particular.'* – Participant 1

Participants also spoke about the political and bureaucratic context that their male clients faced. Some highlighted that client experiences of CRSV and intersectional identities are often scrutinised and discredited by the Home Office, highlighting the challenges for CPs to provide psychosocial interventions that validate clients' identities and stories.

> *'The political context is hugely impactful and … that sort of dynamic from the Home Office of having to prove. It's told people 'Ohh well, you don't look gay.' I know a lot of people who do share their experiences of sexual violence with the Home Office, and they're not being believed.'* – Participant 6

Bureaucratic challenges and inefficiencies were noted to contribute to ongoing distress for clients and participants noted the difficulty of trying to explain to clients that the Home Office is dysfunctional and systemically oppressive. Participants often noted how the bureaucratic asylum experience replicated pre-migration traumas they had experienced such as racial persecution.

> *'He actually decided to stop therapy himself. It was quite rational, really. He couldn't see any good reason why the Home Office wouldn't get in touch [despite the solicitor following up with a judicial review that was breached multiple times]… He was saying the uncertainty is what's killing him…In the therapist role you're trying to get across that the Home Office is totally*

dismantled like, I mean, a circus would be complimenting it. It's extremely dysfunctional obviously with fascist ministers… It's very hard to explain that to someone….. It literally makes people suicidal.' – Participant 1

3.3.2. Political reflexivity and power dynamics

This sub-theme examined how CPs engage in political reflexivity. Participants critically reflected on the ways in which political contexts, power dynamics and societal norms influenced psychosocial interventions, psychological institutions, and the frameworks that they utilise. It involved reflexivity in relation to socio-political issues such as how racialisation, colonisation and state violence operate and how racialised men that have experienced CRSV are vulnerable to continued state violence in the UK.

'Yeah, there's a total lack of reflexivity towards politics, of psychology and psychologists, which lends itself to how racism and racist policies perpetuate here in the global North through psychology. Discussions of racism are often very lacking, to the point that they are absolutely dismissive of how the process of racialisation operates, etcetera. I mean, it's one of those things where a lot of my thinking around politics and state violence, among other things, have just developed more organically through other sources, other communities, that informed my understanding. Even, organisations that do try to cater or pander to racialised minorities maybe, let's say, coming from the global South, replicate very sort of racist practices that perpetrate colonial ideologies. I think a big part of it comes to lack of reflexivity and sort of lack of that political agency to enact any difference here in terms of structures, in terms of institutions.' – Participant 3

Some participants characterised CRSV as a phenomenon that was bound to areas in the Middle East, South Asia, and Africa, however others linked the concept of conflict to state violence and the industrial military complex. They challenged the idea of CRSV being confined to a specific geographical region and extended the experience to the UK. Participants observed that forms of state violence such as

border policing, securitisation and surveillance impacts men that are racialised as Muslims noting the continuation of sexual violence through the policing system. This challenges the belief that CRSV is only prevalent in regions far from the UK, highlighting that such violence also occurs in the UK, a setting propagandised as safe.

> '*I see conflict more as a global phenomenon, that isn't bound by geography. If we think about how the War on Terror has instilled many different forms of policies, violence, and strategies that we know that they are central in experiences of CRSV, in Iraq, we saw American soldiers sexually violating Iraqi men and in Guantanamo Bay and I think it's in that spirit that we can also trace CRSV here to racialised Muslims in prison settings. Men experience various forms sexual violence or intimidation from prison staff, such as being continuously subjected to strip searches. So, you know in many cases where like a man was subjected to strip search every day for like months every day, they just keep coming in. Asking him to like, strip naked or in worst cases experiences, penetration. In acting certain uh forms of sexual violence directly towards the individuals, and not always in the same spirit of the War on Terror, which again is not only something we find abroad, like in Iraq (Abu Ghraib) and Guantanamo bay, strip searches in Khan Younis in Gaza by the Israeli forces but follow the same logic and continues here in the UK as well as it does in the US… But I think in terms of my own experience, umm, we can talk about border policing. We think about other forms, so security and constant surveillance among people who come from regions of conflict, that these experiences of violence can be maintained here*.' – Participant 3

Many participants critically assessed the limitations of psychological ideas, theories and frameworks used in NHS and third-sector settings, which are rooted in Western cultural contexts and may not effectively resonate with male victim-survivors of CRSV facing political turmoil, oppression, and dehumanisation. These ideas, theories, and frameworks may overlook the systemic and structural forces, positioning CPs as politically neutral. Many participants highlighted the importance of political literacy to navigate the dynamics of violence and displacement.

‘The power threat meaning framework .. falls short really, in lots of respects when working with this client group. ‘Tell me a little bit about what's happened to you.’ I guess I would take issue with that because we know what's happened to people that are …exploited, dominated, subjugated, dehumanised. I think this sort of stance is through a white colonial gaze as though you're neutral. So, the starting point I guess is kind of coming from a place of understanding and awareness about at least the country of origin and sharing that and making sure that you're clear, that you've done a little bit of work. What the timeline looks like for conflicts?’ – Participant 12

3.3.3. Personal reflexivity

This sub-theme explored how CPs engage in personal reflexivity. Personal reflexivity was demonstrated as CPs critically examined their own biases, beliefs, feelings, experiences, and cultural backgrounds, and considered how these factors influenced their practice. It allowed CPs to recognise and manage their own biases and preconceptions that might affect their therapeutic approach. All female participants acknowledged that their gender limited their understanding of the client’s perspective to an extent. They also noted that cultural and gender differences could add layers of discomfort to discussions surrounding sex. Participants that looked visibly younger also shared that their age was a barrier to men feeling comfortable with talking to them about CRSV.

‘I can't fully understand what it's like to share this [CRSV] with a woman or someone younger and because our culture is very different. I feel like there's something about a woman then asking a man about this and knowing that they feel uncomfortable. I've had a few of them comment on feeling like I'm their daughter or like the same age as their daughter ‘ – Participant 10

Participants from White British backgrounds reflected on whiteness within Clinical Psychology. They reflected on the interconnectedness of how being white and female might influence the therapeutic interventions provided to racialised men. They felt that recognising these dynamics was crucial for delivering equitable care. Participants often linked this to safety and gaining trust within a therapeutic alliance.

'Hearing all these stories and realising what a kind of whitewash my life experience, my education, my psychology education has been. That made me really interested in geopolitics in conflicts…Therapies often are white, female dominated and I think a lot from intersectional and feminist perspectives. I don't know how much we think about masculinity, and I wonder how impactful that is. When we do talk about masculinity, we have to talk about kind of toxic masculinity… I don't feel like that's [masculinity] something that I've heard talked about much in trainings or and I wonder if there's a bias there because there's so many sort of women in the field that we're not thinking so much about masculinity. And yeah. You need to earn trust. You don't get to just have trust. It doesn't get bestowed on you.' – Participant 6

3.4. Knowledge and training gaps

This theme highlights the significant knowledge and training gaps identified, including in the education and preparation of CPs working with male victim-survivors of CRSV. This theme brings attention to the areas in which current clinical psychology training courses may not fully equip clinicians across the UK with the necessary skills and knowledge to address the challenges faced by this demographic.

3.4.1. Lack of specific training and awareness

This sub-theme addressed the lack of specific training and the need for specialised knowledge, regarding working with male victim-survivors of CRSV. It explored how existing training focuses on general trauma, or trauma specific to women, rather than the nuanced needs of male victim-survivors of CRSV. All participants stated that they have not received specific training on how to work with male victim-survivors of CRSV from the NHS or their organisations despite regularly working with this population group, but instead have received training more broadly focusing on trauma.

‘I don't think I've got any very specific training on that subject at all… it's either childhood sexual violence or abuse or it's quite female oriented.’ – Participant 6

‘None but generic trainings, which should encompass working with refugees, asylum-seekers and undocumented migrants, of whom there will be a large proportion who have survived sexual violence in conflict’ – Participant 8

Participants acknowledged the substantial investment in trauma-focused training and awareness but discussed a failure to address psychosocial impacts like a man’s sense of self, masculinity and personhood which transcended symptom management of nightmares and flashbacks.

‘There's lots of evidence, training and lots of research that talks about how we work with memory processing, nightmares, flashbacks and psychological distress, but there's very little that talks about actually the impact it has on your sense of self, personhood and your place in the world and how you kind of how you make sense of why this is happening and why it's happening to you and who it happened to and how it's happened to your community.’– Participant 1

‘We are trained on trauma-focused therapies. There was loads of money put into it, make sure everyone's trained on EMDR, NET and trauma-focused CBT, make sure there’s supervision group set up for each of those things. [spoke about importance of indigenous therapies and training from the Global South and how these aspects were not prioritised in their professional training requirements]. When I came to this job, it was a requirement that I was trained in at least one trauma focused therapy, but no one asked me am I trained in COURAGE or Tree of Life [therapeutic approaches based on indigenous knowledge systems] or something else?’ – Participant 10

‘I feel like I've been disappointed in some of the trainings I've gone. I feel like there's a whitewashing of experiences, and like something that happened

somewhere else, some other time rather than something that's happening here [state-violence]'– Participant 3

Participants highlighted the dichotomy in therapeutic practice between conceptual frameworks and therapeutical models used in therapy and evidence-based tools recommended by NICE guidelines. They noted that research and therapies that receive funding and validation are typically evidence-based but they often had to escape the confines of evidence-based research and practice to make sense of male victim-survivors of CRSV.

'I think actually there'll be a whole host of research and therapies that are neglected' – Participant 11

'Rightly or wrongly, I think I battle with this, doing the doctorate at a place that is CBT focused, structured and evidence-based. I think what happens is that I see it as a safety blanket [spoke up being more critical of Westernised therapies when working with this population group]' – Participant 10

Participants spoke about the significant gaps in the curriculum of the clinical doctorate course on which they studied. This included a lack of focus on culture, race, and political systems within the curriculum, although some noted improvements following high-profile social justice movements. Many felt that even basic essential topics were not covered, leading to a lack of preparedness to engage with the complexities of clients' experiences of oppression in both country of origin and the UK. Many also felt that current geopolitical issues like the genocide in Gaza were not incorporated in training, which are crucial for understanding and responding to the broader contexts impacting clients and preventing harm.

'Conflict was not covered enough. Working with male survivors of kind of sexual violence was not covered enough.' – Participant 6

'*After George Floyd, they've tried to be a bit more conscious of race in training.'* – Participant 2

'Our training requires a lot more political reflectivity and thinking about our political positioning.' – Participant 3

'Even the sort of very basic preliminary kind of stuff is still missing. Anti-racist practice. But even the basics seem to be missing… You know Gaza, come along every couple of years, and I mean now it's unprecedented, in terms of the genocide that is clearly upon us. And. Absolutely nothing. You know from our community of psychologists. But it's not just even just putting head in the sand. It's kind of actively blocking any discussion about what's actually going on… I'm not sure that we really do facilitate and encourage vigorous debate, discussion, whole range of different kind of perspectives in much of the training. So then how on Earth would we stand a chance of being able to position ourselves in a way that's actually useful.' – Participant 12

However, some people had positive experiences of training that has influenced the way they work with male victim-survivors from a range of geopolitical contexts.

'I think another massive influence is I went to UEL.. I think there was some influential psychologists that really shaped my understanding of human rights abuses and state violence and how we work and that perhaps gave me their permission to move away from Western ideas and models of having to work with 'trauma' and being a little bit more creative.' – Participant 11

3.4.2. Need for specialised knowledge for racialised men

This sub-theme explored the significant gaps in understanding the intersectional identities of male victim-survivors of CRSV, specifically in relation to race, identity, physical abilities, and sexual health. Participants noted that intersectionality was important for understanding how racialised male victim-survivors of CRSV manage sexual health impacts. They noted significant gaps in theory, research and knowledge focussed on the sexual health and functioning of male victim-survivors, in comparison to their female clients. This includes understanding the impact of CRSV on identity, relationships, and intimacy. Some participants questioned the impact of

acquiring specialised knowledge about racialised men, emphasising the challenge of navigating both liberal and illiberal forms of racism within the clinical psychology.

> *'I'm always curious about intersectionality, like how a man of a particular cultural, religious group, or socioeconomic status, who don't speak English as a first language, and who may have had different kind of education levels may be suffering from chronic physical health complications following their experiences of sexual violence. Like, how do these the intersectionality of their identity relate to their experience of distress, of mental health and what they need'* – Participant 8

> *'Chronic pain and bladder difficulties… A client of mine is particularly struggling since his wife came over from his home country and they've been separated, they've been a different country since the torture…There are some issues in the sexual relationship which made perfect sense given his experience. But I think we're often not talking or not thinking so much about sexual function with men as we are with women. It really challenges a lot of men's kind of sense of their own masculinity and their role as kind of husband. I've seen a lot of challenges come up where people have wanted to start a family and the sexual dysfunctions come. It's got in the way of obviously being able to start a family..I think that we need to be sort of having those conversations.'*- Participant 6

> *'The concerns haven't necessarily been about contamination [common theme amongst P5's female clients], and much more about emasculation. What it means about their sexuality. They feel like it might influence their sexuality, or how their sexuality is perceived. I think there isn't a lot of specific guidance maybe around that to my knowledge. As I said, for some men it can even go so far as for them to start doubting their own sexuality. Does this mean that I'm gay now that this has happened to me? Often, that's what they've been told by their abusers'* - Participant 5

> *'I will remain fragile forever and I won't be a good husband [participant quoting one of their male clients that has experienced CRSV in Sudan]'* – Participant 4

'So how does it [CRSV] impact their sexual functioning? How does it impact sexual pain? How does it impact their sexual identity, their self-image? How does it impact kind of sexual behaviours, but not just kind of sexual, but relationships, sex, intimacy? I think that's an area again that I think we probably don't know about enough and should do with this client group' – Participant 2

'It's a bit like Tarek Younis's distinction between liberal and illiberal forms of racism. Illiberal- we all knew about. That's the brick through your window, kind of racism. But liberal is always served up with a smile or with a concern – and that is what we have in this field.' – Participant 12

3.4.3. Advocating for survivor-led and co-produced psychosocial interventions

This sub-theme explored the necessity of implementing survivor perspectives and co-product into the design and implementation of psychosocial interventions for male victim-survivors of CRSV. Participants advocated for co-production and survivor-led initiatives as a way to improve psychosocial interventions at multiples stages of research, design, and intervention, ensuring that services are not only informed by clinical expertise but also by the nuanced understandings and expressed needs of survivors themselves. Participants highlighted the importance of developing ethical psychosocial interventions rather than adapting pre-existing interventions that were not made with population group in mind or was made through exploiting this population group.

'I would say that there's paucity of survivor-led research, development of services and intervention. We need to give them the opportunity to develop and inform services, including within the charitable sector, where I think a lot of those support services are' – Participant 5

'The gap can also be people with lived experience. So, I think that would really help... I think it's sometimes it's easier for a man who's actually been through it and is leading a group or like a buddy system or mentor. I think that would be really like powerful and I think that is a big gap that I see. Because even the COURAGE group that I did, I noticed that when a survivor had spoken, all of them just took that in much more than what the therapists were saying, like a few of them asked me, how can I get to that position? They have so many questions for this person and I think that would be like a really big thing.' – Participant 2

'Co-producing and co-developing interventions with the affected communities A) should be funded. And therapy should be developed and designed where they're needed with the people that need them in mind….. And B), I think there's a knowledge gap there about how to do it, how important it is and why it's important and how to kind of respectfully approach it… There's limits of the evidence-base that we currently have, who has actually been part of the participant pool for the therapies that have been currently developed. Yeah, I'm just thinking about the of the origins of these ideas and some have not been ethical like NET.'– Participant 9

3.5. Political and Ethical considerations

This theme explores how psychosocial interventions do not exist in a vacuum and are heavily influenced by broader policies such as the PREVENT duty, immigration law, criminal justice practice, and healthcare funding, which can all detrimentally harm individuals, impacting their mental health needs and appropriateness of psychosocial interventions.

3.5.1. Systemic and Institutional considerations

This sub-theme examined the ongoing systemic and institutional barriers that hinder equitable service provision for male victim-survivors of CRSV in the UK. Participants highlighted the broad consensus on the need for systemic changes, so services

were more equitable and accessible for male victim-survivors of CRSV. Many highlighted that refugees and asylum-seekers were not prioritised, which causes a systemic issue in service provision.

> '*Ensure that people have some sense of equity of services, and we don't have anything like that at the moment. This is a kind of client group that often are on the bottom of everybody's lists, certainly for accessing psychological services.'* – Participant 12

Participants highlighted that CPs fail to understand policies that specifically target racialised men such as GWOT policies and PREVENT duty in the UK which are structural system flaws that hinder collective and community healing and continues to perpetuate harm.

> '*I think psychologists generally have very little political education about, like the role that they might be playing. People tend to localise politics, culture, ethnicity, all these things as something that belongs to other people and not something that belongs to us or like where we can find this here. [A third sector organisation] for example, has to abide by the Prevent duty. Well, that's actually quite significant if we think about how, racialised minorities are securitised, but if we think about sort of the anger and different experiences that might develop from racialised minorities who experience sexual violence and now maybe they have a distrust of the state, they have deep experiences or feelings of hostility towards the state. Is this a gap or is this like an actual problem in the in the actual system, in the actual structure?.. So, I wouldn't even call that a gap. I would call that an actual direct hindrance.. If racialised minorities will experience sexual violence, especially with men, because it's different for them, particularly they're securitised differently to women. It's much bigger than people can really fully appreciate because it basically puts everything within like this logic of risk assessment. We're no longer really attending to the needs and understanding of the person, but we also have the stakeholders of national security that we have to abide by.'* – Participant 3

Participants shared insights on how oppressive structures and systems exacerbate distress for male victim-survivors of CRSV. Specifically, they identified the Home Office as an institution that fuels this injustice and distress.

> *'In refugee services within the NHS, where we have provided psychological and community support to RAS, many of whom have experienced state-sponsored violence and CRSV, and some of them have been unaccompanied minors. I have also worked in detention centres of IRCS [immigration removal centres] in the UK for a couple of years where healthcare was provided by an NHS provider. Not everybody but many of the clients you might come across have experienced that violence and haven't had their claims believed by the UK Home Office. Like from Afghanistan, Sri Lanka, Eritrea. Who have experienced great amounts of oppression and violence and sexual violence as a means of torturing, obtaining information as a means of coercion and control. I have seen first-hand the impact this has had not only on their mental health, but on their sense of self, their ability to form future relationships, their ability to settle in the UK and how this has been inadequately addressed by wider services, Home Office and the government or how little thought has gone into thinking about this'* - Participant 11

3.5.2. Navigating politics and ethics

This sub-theme explored the complex relationship between politics and ethics in the field of clinical psychology. Participants spoke about the interplay between politics and ethics, noting resistance to deviate from dominant western models and a reluctance to adopt politically informed initiatives in the clinical psychology profession. Many envisioned future psychological systems that proactively navigate politics and ethics through preventative measures to address injustices.

> *'They have no housing, no money or they experience racism every day. That somehow, they still have influence over their feelings and behaviour [sarcastic]. So, I think my position does influence that a bit where I don't take that it [trauma] as how it's taught. I try and understand the context of each person that*

I see, what they bring and how that also will come across in the intervention I deliver. Thinking about like power dynamics in terms of like government systems that we're in. I think about the Home Office and that power dynamic and how it is in the therapy …There needs to be a space for that, for that to be validated, for that to be discussed. Otherwise, we're kind of just playing into it when we ignore these things that might come out.' – Participant 2

'Always returning back to kind of the status quo and you know we don't need to go too far to think about what that actually means for racialised people.' – Participant 12

'Often what psychology ends up doing is that it reinforces the same power relations and structures of violence, among other things, psychologists are often very complicit, in reinforcing state structures. [Gave an example of prominent Israeli CP called Dan Bar-on who spoke about how psychologists in the Global North are one of the least critical professions due to their proximity to the state and military industry complex]. I think it's important to not see our profession as the answer, but as one way of informing how to support people…that has to be often, first of all, rooted in community'' – Participant 3

'I feel like there has been a real resistance to do anything different…I think there's a real lack of wanting to kind of step out of the status quo. It's kind of a single western way of understanding something. If it doesn't fit that one single narrative which has become quite dominant in the West. There's a real resistance to move away from it. And when something is kind of adopted and taken in, it's taken in a way that has to kind of fit the mould and fit the Western frame so. I would love for us to politicise our work. I think in many ways I think I think there are some organisations that try to do this, but I think that's it's often done off the back of communities and is co-opted. Not stepping out of the status quo of like, therapy being the main thing we do. [discussed housing, state violence, racism, legal issues at the organisation that they work in]. Your ability to recover from these things is going to be tied to your asylum case and your sense of safety in the UK. How you're able to kind of navigate within all those really complex structures, but it's always an adjunct. It's always an add

on, so the kind of political stuff we do is always secondary. And I think I would really love to see that political side of things being the main thing. So, psychologists being at the forefront of thinking about how we influence policies, how we push for change, how we write research papers and how we influence kind of the government guidelines of how people like this are supported.' – Participant 11

3.5.3. Human rights

This sub-theme examined the intersection between clinical psychology and human rights and explored the ethical obligations of CPs to uphold and advocate for human rights. Participants emphasised the importance of using a HRBA, noting the intersection between psychology and human rights. Some participants argued that since human rights are a universal concern, CPs have an ethical obligation to a uphold these standards in their practices, actively advocating for the protection and promotion of human rights.

'I mean, psychologist think they shouldn't be political? This isn't politics. This is human rights. Human rights are not politics… That's against international law all around the world' – Participant 4

Participants also criticised the role CPs may play as state-actors in systems that infringe on human rights for racialised people. This includes CPs complicity with harmful political agendas, such as counter-terrorism measures.

'That relationship with PREVENT and psychologists have got their fingerprints all over PREVENT now you know, they've been complicit in that role of reporting people and that's a real concern.' – Participant 12

Participants also critiqued the lack of accountability for human rights violations, especially highlighting how racialised Muslim men are subject to security measures and policing in the UK. They also addressed the hypocrisy in colonial narratives

about where CRSV occurs, despite similar abuses in the UK being frequently overlooked, resulting in a failure to protect human rights universally.

> *'But look, even if there was a knowledge gap, what difference does it make if there are no systems of accountability for experiences of sexual violence that racialised Muslim men might go through in the security system, on the security apparatus or being strip searched. There are very little systems that take accountability for things like that. So maybe not a knowledge gap, but we definitely have an accountability gap. Which is kind of ironic because when I speak, especially with white liberal psychologists, they often to speak to how horrendous experiences of sexual violence is in like the global South right? They often think it's things that happen in 'barbaric' countries….but that can be found easily here as well. We see the way undocumented migrants are treated.'* – Participant 3

> *'They [perpetrators] would never be held accountable for what they did, they would never be tried. They would never be in prison, so I think that really shifts a lot of the conversations about injustice'* – Participant 8

Participants also spoke about how systemic disenfranchisement of victim-survivors was a direct violation of human rights, making people feel disempowered and suicidal.

> *'It's psychologically unsafe. The disempowerment as an asylum-seeker in England. No one needs to be a psychologist or a therapist to see the parallels between the disempowerment of abuse you've survived and the continuation. Clients talk about that explicitly. I worked with someone who hadn't gotten contact for a couple of months, and after I got back in touch with them it's because they've been going to train stations seriously thinking about killing themselves. Because of how personally victimised they felt by the Home Office'* – Participant 1

4. DISCUSSION

This chapter discusses the findings in relation to the study's main aim, research questions, and pre-existing literature. Critical appraisal of the study is then explored. Finally, the chapter considers the clinical, policy, and research implications of the findings. The research aim is to explore the perceptions of CPs in the UK who support male victim-survivors of CRSV to improve psychosocial interventions for this demographic. The collated 12 interviews resulted in rich data which can inform an understanding of how CPs can help to improve psychosocial interventions for male victim-survivors of CRSV.

4.1. Discussion of findings

4.1.1. Question 1: What ideas, theories and frameworks do clinical psychologists draw on in relation to their work with male victim-survivors of CRSV and what informs these (in relation their experiences, training, and education)?

4.1.1.1. Theoretical and clinical frameworks

The use of trauma-focused psychosocial interventions like NET, aligns with current literature on treatments for this population group (Neuner et al., 2018). Techniques, such as reliving experiences, updating hotspots and imagery rescripting which was noted by participants aligns with the current understanding of what is deemed effective trauma therapy (Steel et al., 2022). Participants in this study criticised the lack of consideration of broader socio-political contexts in the existing models and cited pressure to provide a conveyor-belt type of therapy under time constraints. Many participants highlighted that it took a long time to build a rapport with male victim-survivors, especially when it comes to disclosing sexual violence. Additionally, psychologisation reflects a broader trend in modernity, to reduce all human experience through a Eurocentric lens, framing them as intra-psychic experience (Younis, 2022). This critique aligns with literature that advocates for a more contextualised approach to the political, cultural, and social conditions, as well as how emotional distress is conceptualised and understood (Patel, 2020), which was echoed by participants.

In line with literature drawing from liberation psychology, participants deconstructed the element of 'post' in the diagnosis PTSD. They argued that this term does not accurately reflect the ongoing conditions of compounding epistemic violence that male victim-survivors of CRSV endure. The participants pointed out that the continuous challenges (e.g., Illegal Migration Act 2023) and systemic injustices (homelessness and exploitation) these individuals encounter mean their traumatic experiences are not confined to a past event but are ongoing. This perspective challenges traditional views of trauma and recovery, which often fail to consider the continuous and pervasive impact of structural violence that prevents genuine recovery and perpetuates suffering (Afuape & Hughes, 2015).

4.1.1.2. Integration of elements of culture, faith, and spirituality

Participants highlighted the crucial role of integrating culture, faith, and spirituality into psychosocial interventions, acknowledging their significance in the recovery process. This approach resonates with literature highlighting that recovery is often interlinked with cultural beliefs and practice, which can provide a framework for meaning-making and resilience in the face of adversity, sexual violence, and state-violence. For an example, when British-Pakistani Muslim man, Mozzam Begg was extrajudicially detained in Pakistan, and then Afghanistan, and then transferred to Cuba in Guantanamo Bay for three years without charges, Islam served as a form of resistance, providing alternative meaning-making schemas amidst torture. This highlights the intersection between faith, resistance, and incarceration during the GWOT (Quisay & Qureshi, 2024).

Western conceptualisations of CRSV often center around physical acts like penetrative rape, overlooking the spiritual, transcendental, and psychological realms of harm experienced by males from non-western cultures, with different conceptualisations of bodily and spiritual boundaries. For example, participants noted that in Islamic contexts, the concept of ‘Awrah’ pertains not just to modesty, but the sanctity of one’s bodily integrity. Violations of Awrah through enforced strip searching, sexual threats, humiliation and photographing are experienced not just as

physical intrusions but as profound desecrations of spiritual boundaries. This epistemic violence extends the physical act that impacts male victim-survivors' sense of self and spiritual well-being (Quisay & Qureshi, 2024). Such distinctions are critical in understanding the full scope of sexual violence on individuals coming from non-western backgrounds, where psychological and spiritual penetrations are equally as debilitating as the physical acts themselves.

The findings expose a gap in how comfortable CPs from white backgrounds are in navigating these elements effectively. One participant asked, 'how do I even go about that; to work with the aspects of religion?' Another said, 'even though I am not religious, I like to understand how people conceptualise things from their religious context.' This highlights the need for training in cultural, faith and spirituality, which is critical for working effectively in clinical settings with refugees and asylum-seekers (Khairat et al., 2023). A systematic review supports this need, noting that religion and spirituality are often neglected within existing training courses, although there is evidence of improvement in training efforts (Jafari, 2016).

4.1.1.3. Issues with masculinity

Participants in the study highlighted the profound impact of CRSV on identity, masculinity, heterosexuality and power, echoing findings from existing literature on intersectional masculinity and shame (Sivakumaran, 2007; Koos, 2018). The data revealed that the effects of CRSV extended beyond the individual to disrupt the social fabric of entire families and communities, which is a pattern found globally (Touquet, 2018; Féron, 2018; Meegaswatta, 2022). The stigma associated with CRSV against males is deeply entrenched, influences how men see themselves and exacerbates feelings of emasculation as noted by the participants.

When reflecting on issues with masculinity, participants discussed the implications of how victimhood is perceived and recognised, particularly in relation to racialised men who are often securitised, have precarious legal status and are viewed as threats rather than victims by the state. This perspective aligns with theories of orientalism, othering, and intersectionality (Said, 1978; 1981). These discussions around victimhood extended to the Israeli genocide against Palestinians, highlighted by the

participants as a current example of state-violence whereby the victimisation of men and boys from Muslim-majority areas, is systematically overlooked or denied. Participants pointed out these men are often not recognised as victims due to the dominant narrative and political agendas, which further complicates access and motivation to make use of psychosocial interventions provided by institutions that embody the state. Participants highlighted how the institutional failure from systems such as the British government and the BPS to recognise certain groups as victim-survivors, also inwardly impacts how male victim-survivors perceive themselves and their motivations to engage in therapy.

4.1.1.4. Community mobilisation and collective healing

Echoing Clark (2018), participants spoke about decentering trauma discourse to recognise the remarkable resilience of men who have survived tumultuous events. In exploring resilience and healing among male victim-survivors of CRSV, participants emphasised the value of grassroot, community and liberation perspectives that extended beyond individual therapeutic interventions and infrastructure. They highlighted the role of community solidarity, cultural identity, collective resistance to state oppression and collective action, which are central tenets of liberation psychology, in fostering recovery for survivors of CRSV (Afuape, 2011).

Many participants discussed using narrative therapy such as The Tree of Life (ToL), developed by Ncazelo Ncube in South Africa (2006), to facilitate collective healing. This post-modern approach utilises storytelling to explore ideas of life, resilience, and strength. It moves away from problem saturated stories and instead uses the metaphor of a tree to help people view their lives in terms of growth and interconnectedness. Particularly resonant in indigenous contexts, where the self is often seen as a collective concept shaped by community interactions, ToL regards people as experts on their own lives, validating their lived experiences (Ncube, 2006; Denborough, 2018). The ‘riverbank’ metaphor within ToL can be applied when working with male victim-survivors of CRSV in the UK. It suggests that it is important for people to get out onto the riverbank (stable and secure environment), before

asking them what it is like in the jaws of the crocodile (i.e. before recounting their trauma experience). The metaphor emphasises the importance of providing stability and safety to individuals before delving into their lived experiences. Given the challenges of the UK's asylum system, housing challenges and racism, it could be likened to a perilous river filled with obstacles and threats. Therefore, it is essential to ensure they reach a place of safety to avoid exacerbating their distress. Jacobs (2017) found that ToL was an effective way for unaccompanied young boys seeking asylum in Europe and easy to access for asylum-seekers with pre-conceived notions of traditional mental health services. In addition, Kaseke (2010) explores the power of collective disclosure of sexual violence in a community setting, using the metaphor of 'standing together on a riverbank,' to foster a collective healing approach.

4.1.1.5. Critical Reflexivity

A significant contribution of this research is highlighting the necessity of critical reflexivity and socio-political consciousness in the profession, particularly when working with working with male victim-survivors of CRSV. Critically reflecting on and evaluating the socio-economic and political contexts in which male victim-survivors operate is essential. Participants identified that the personal trauma experienced by victim-survivors does not operate in isolation from the political state violence that shapes their experiences. This connection was seen as essential in understanding the experiences of male victim-survivors of CRSV.

Participants in the study challenged the traditional conceptualisation of 'trauma' as confined to the past and outside of the sanctity of the UK, advocating for a perspective that acknowledges the impact of Western imperialism and state-violence. This approach, which centres the voices of the global majority (Jabr & Berger, 2023) recognises that victim-survivors of CRSV are not 'blank-slates' but individuals whose experiences are deeply embedded in complex political realities, suggesting that psychosocial intervention should reflect that.

4.1.1.6. Political Reflexivity

In discussing the role of political reflexivity within the context of psychosocial interventions for male victim-survivors of CRSV, participants recognised the

importance of the profound impact of political contexts. One example given was the PREVENT duty which is heavily tied to racism and Islamophobia. Participants spoke of their awareness that their clients were victims of imperial foreign policy. The systematic dehumanisation of men from the Global South through the language and conceptualisation of 'terrorism' in part sustains Western imperialist conflict, justifying its military engagements.

The securitisation of Muslims that the narrative of the GWOT allows, is deeply interconnected with racialised perceptions of threat, and has profound implications for how Muslim male refugees and asylum-seekers are perceived and treated in various contexts, including healthcare and legal systems. An important aspect to consider here is the corporate profit derived from portraying Muslims as the primary threat to national security. The majority of refugees and asylum-seekers in the UK are Muslim and are conceptualised as 'threats' and linked to terrorism and extremism, significantly influencing counterterrorism and asylum policies that impact this population, prioritising security over human rights and dignity (Abbas, 2019). Victim-survivors of CRSV fall subject to this in that despite being victims of brutal imperialist Western policy, rather than their experiences of injustice being heard and responded to, they are conflated as terror suspects and regarded as conditional citizens.

One way in which some CPs spoke of playing a complicit role in this aspect of the GWOT was their mandated participation in the PREVENT strategy. The PREVENT strategy, which is part of the UK's counter-terrorism measure, was introduced as a safeguarding and anti-radicalisation tool post 9/11 and 7/7 (Home Office, 2023b; Younis, 2019). Since 2015, the PREVENT strategy has mandated that public sectors including the NHS and third-sector charities comply with the duty, legally obliging CPs to participate in the national security measures through policing and monitoring (Home Office, 2023b). Prevent operates within a 'pre-criminal space' where no offences have yet been committed. Therefore, any evaluation of the potential for future risks or threat is inherently speculative (Holmwood & Aitlhadj, 2022; Goldberg et al., 2017).

The racialisation of Muslims heavily comes into play in the PREVENT apparatus as it pertains to racialised Arab men in the UK. Anyone who appears to be Muslim, e.g. looking phenotypically Muslim by having brown skin or a beard, or having an Arab name has the potential to be default coded as Muslim and therefore potential or 'future' terrorist. In his book '*Covering Islam: How the Media and the Experts Determine How We See the Rest of the World* (1981), Edward Said highlights how orientalist views of Islam contribute to the inherent association of Muslims, particularly Arab Muslim mean with labels such as 'terrorists,' 'security threats,' and 'criminals.' This allows the liberal western imagination's complacency when it comes to violence and brutalisation against racialised males. Prevent has been criticised for human rights violations and restricting civil liberties, and although presented as a 'colour-blind' prevention tool, it overwhelmingly discriminates against racialised Muslim communities (Qurashi, 2018; Manzoor-Khan, 202 2).

4.1.1.7. Personal reflexivity

Some participants highlighted how CPs are tools of the state, emphasising the need for them to reflect on their positionality, biases, and practices. These practices often sustain the status quo and structural powers within therapeutic relationships. This aligns with Parker's sentiment that psychology itself can act as a hegemonic force, as he believes 'psychology not only reproduces but also supports the social system that it pretends to help' (2007, p. 4). However, there is a growing recognition of the need for CPs to reflect critically on their backgrounds such as experiences with marginalisation and/or privilege (Ahsan, 2020).

Further emphasising the importance of personal reflexivity, Diniz De Figueiredo & Martinez (2019) emphasised that practitioners must understand their 'loci of enunciation,' to recognise the origins and biases in their knowledge acquisition and production. Without this, western psychology reinforces this notion that their knowledge is universally applicable and truthfully neutral. Rober and Seltzer (2010) highlight how current hegemonic psychological approaches and interventions could lead to a re-colonisation, when practitioners often unknowingly, impose their ideologies, like the concept of trauma or victimhood, without considering the client's perspectives. Participants highlighted that supervision and reflective practice aided

them to recognise that they are not apolitical or neutral, but bring their own histories, including intergenerational trauma or proximity to whiteness, into the therapeutic setting.

4.1.2. Question 2: What are the key knowledge gaps that need to be addressed to improve the design and implementation of psychosocial interventions for male survivors of CRSV in the UK?

4.1.2.1. Lack of specific training and awareness

Despite the funding and investment in trauma-focused interventions, participants felt that there remained a pronounced gap in addressing the psychosocial impacts on male victim-survivors' sense of self, and masculinity. Furthermore, participants highlighted that clinical psychology training programmes predominantly focused on individual and proximal factors rather than collective and distal factors in relation to CRSV. For example, participants stated that courses would focus on individual trauma symptoms such as flashbacks but neglect the broader contexts of conflict and human rights, meaning they felt insufficiently equipped to navigate the complexities of systems of oppression, and the compounding effects that arise from intersecting identities.

This is critical as research suggests that adopting an ecological approach to psychosocial interventions can improve therapeutic outcomes, whereby clinicians acknowledge the socio-political factors that contribute to the ongoing and sustained distress of refugees and asylum-seekers (Patel, 2019; 2020; Khairat et al., 2023). This echoes Kanceljak and Calia's (2023) perspective that overall, the field of psychology is predominantly shaped by its epistemic foundations, which are largely White, male, heteronormative, and able-bodied. This gap in training also reflects a broader trend in mainstream western psychological research, whereby there is a significant lag in acknowledging, reflecting, and exploring the Eurocentric underpinnings of mainstream psychological practices (Grosfoguel, 2007). Thus, enhancing the curriculum and further training of CPs to focus on culturally and geopolitically informed practices could significantly improve the efficacy of psychosocial interventions for male victim-survivors of CRSV.

4.1.2.2. Need for specialised knowledge for working with racialised men

Participants reported clients face challenges in their sexual functioning, complicating their positions within their communities. This aligns with research suggesting that the sexual health consequences of CRSV extend beyond the aftermath of violence (Sivakumaran, 2007; 2011). CRSV has enduring physical and psychological effects and strategically aims to disrupt sexual function and intimacy, impacting victims' sexual identity and long-term relationships (Zalewski et al., 2018). While systematic reviews often explore the psychosexual impact of childhood sexual abuse on sexual functioning, including male's experiences (Gewirtz-Meydan & Opuda, 2020), psychosexual research specifically addressing CRSV tends to focus predominantly on female survivors (Avery-Clark et al., 2019) or military personnel involved in conflicts (Clifford & McCauley, 2019) and thus more research needs to focus on the impacts in sexual functioning of male victim-survivors of CRSV.

Participants highlighted that racism and state violence impact the mental health outcomes of racialised men. Although clinical psychology training programmes have begun to incorporate some of these perspectives, particularly after the uprising of the Black Lives Matter movement after George Floyd's murder, recently qualified participants expressed while they could discuss these issues openly in their cohorts, they felt that these discussions were still insufficient. Participants also highlighted the various forms of racism in the clinical psychology profession. Building on Malcolm X's analogy about the danger of white liberals, likening them to foxes who smile before biting, Younis elaborates that liberals in the psychology profession 'lure in racialised minorities with a smile, offering support and encouragement, only to bite them later' (2022, p.31), highlighting that promise of support, only to perpetuate the same systemic biases. The subtlety of liberal racism is pernicious as it operates under the guise of neutrality, being apolitical and benevolent, and insidiously cloaked behind language such as equality and treating individuals all the same. Liberal forms of racism may acknowledge the systemic inequalities but fails to address them and may perpetuate stereotypes under the guise of positive attributes ('good immigrant') or see people through a single narrative of vulnerability or hopeless rather than seeing them as people who have power. Younis further argues that color-blindness overlooks the significance of racialisation in existing power dynamics and erases and

abstracts race to mere cultural differences. Such ‘colour-blindness’ from CPs contributes to a ‘white saviour’ complex (Kipling, 1899), positioning CPs complicit in perpetuating these subtle but harmful biases. The participants highlighted the importance of not only producing specialised knowledge about the experiences of racialised male victim-survivors but also critically examining and dismantling the liberal and illiberal racist structures within clinical psychology from psychosocial interventions to the broader policy frameworks.

4.1.2.3. Advocating for survivor-led and co-produced psychosocial interventions

A major recommendation from the CPs was to adopt co-production and survivor-led initiatives, involving collaborative planning, development, implementation, and evaluation of interventions by CPs and male victim-survivors. In line with Needham and Carr (2009), some participants felt that survivor-led initiatives could influence service delivery, potentially reforming health services. Participants cited examples of co-production and survivor-led initiatives which they had co-led that were rooted in dignity, respect, and equity. However, experienced participants reflected on the dangers of a tokenistic and unethical approach, noting the potential exploitative nature of such initiatives.

Patel (2020, p.27) highlights the necessity of consistently adhering to human rights principles to minimise iatrogenic harm to survivors, families, and their communities. She calls for authentic participatory research to enhance rehabilitation services, reminding us that ‘torture survivors are not mere participants in an empirical experiment, but human beings subjected to gross human rights violations.’ Furthermore, Penny and Prescott noted that justice-based movements can be co-opted by powerful institutions and bodies aiming to ‘protect the status quo’ (2016, p.35), describing co-option as a strategy where powerful groups absorb or neutralise oppressed groups. They observe that while dominant groups might adopt certain elements of the oppressed group’s agenda, they typically dilute the ideas to the point that they are rendered ‘non-threatening and ineffective.’ In relation to CRSV, Dolan et al. (2024) argue that operationalising a survivor-led approach necessitates more radical and structural changes, which was echoed by participants about how to improve psychosocial interventions.

4.1.2.4. Systemic and institutional considerations

Cushman's perception that 'as a profession, therapy seems uncomfortable with grappling with how therapy practices are unintentionally political and how they unknowingly reinforce the status quo' (1996, p. 48) continues to be relevant as participants highlighted that as a profession there was a tendency to neglect the systemic and institutional structures such as immigration policies that further exacerbate distress. Patel and Mahtani (2004) argue the profession of CP adopted the scientist-practitioner model within a positivist framework, because clinical psychologists sought the credibility afforded by aligning the discipline with other science disciplines, requiring them to present themselves as neutral researchers and practitioners.

Participants often felt constrained by organisational policies and economic priorities, that operate under national regulations and limited funding for refugees and asylum-seekers, which they felt significantly restricted their ability to provide more creative, equitable, and sustainable support for male victim-survivors of CRSV. Some participants referred to liberation psychologist Ignacio Martín-Baró's approach to developing psychological therapy rooted in the experience of people that are subjugated and oppressed, rather than conforming to dominant perspectives. In line with, Martín-Baró who called for psychology to examine itself critically so that it could be a force for transformation rather than conformity, by developing 3 essential elements: a new epistemology, horizon, and praxis (Martín-Baró, 1996). Participants voiced that liberation psychology is the only ethical way to practice psychology, as it helps prevent systems from becoming highly exploitative and oppressive.

4.1.2.5. Navigating Politics and Ethics in therapy

Participants highlighted that CP occupies a universalist and apolitical position, but this purported illusion tends to fall apart when examined through the lens of the political conditions that shape practice. The fields' claim to universality overlooks how deeply it is influenced by the ideologies and power dynamics of modernity as highlighted by Younis (2022).

On a national scale, participants noted the role of power and the disempowerment male victim-survivors of CRSV endure in the UK. Participants were critical of psychology's emphasis on hedonistic focus, which often prioritises individual symptoms of mental health over addressing the structural violence, oppression, and wider systemic issues (e.g., social isolation, housing and state imposed worklessness). Participants spoke about the power that CPs have, and how they can utilise this to ethically support male victim-survivors. Just like how our clients show remarkable resistance, participants highlighted that CPs could showcase resistance by externalising psychological distress, deconstructing trauma, and critically examining their role, power, and influence at multiple levels of society. The notion that CPs should use their power ethically and responsibly, is in line with Afuape's understanding that: 'power cannot be removed, but can be linked to ethics, responsibility, and responsibility,' (2011, p. 186).

On a global scale, participants often referred to Palestine as a poignant example, giving examples of men and boys sharing recounts of being stripped naked in Khan Younis (Humaid, 2023). Participants also highlighted the political and unethical significance of psychological bodies (BPS) and organisations remaining silent or complicit, such as framing October 7th as equal harm and neglecting the 76 years of brutal occupation. They highlighted how academia in psychology, through discursive forces propagate perceptions and ideology, that are complicit in settler-colonial projects. Psychology can serve as an instrument perpetuating colonialism, shaping pedagogies, knowledge, and discourse to sustain and normalise harm, as it focuses too much on individualism, neutrality, and objectivism, which can obscure systemic issues and reinforce harmful structures (Bar-On, 2001).

4.1.2.6. Human rights

Participants emphasised the need for accountability systems and a justice-based approach, expressing concerns about the limited domestic and international avenues for male victim-survivors to access justice and reparation. As highlighted by participants, the inability to seek justice or reparation, with ongoing impunity can be seen 'as a continuing injury' (Patel, 2019, p.8). In line with Patel's HRBA (2008),

participants argued that CRSV including torture are inherently political acts and not a private act of violence. Participants argued that the role of CPs should extend beyond the therapy room, encompassing advocacy, policy changes that can improve the structural conditions impacting survivors. This involves advocating for systemic changes such as access to justice and reparations. By doing so, sexual violence is not sanitised, and enables a transformative vision of equality whereby there are implications for perpetrators and states that are accountable (Patel, 2008). This perspective fosters the recognition of survivors not just as victims, but also as agents of resistance, freedom, and transformative change.

Participants also highlighted that mental health systems are heavily bureaucratised and influenced by economic interests that often do not align with innovative and human rights-aligned solutions. This is in line with Fernando's parallel of psychiatry being heavily capitalised and co-opted, by the pharmaceutical industry. Similarly, distress has also become commodified and turned into a profit-driven industry (Fernando, 2014). CPs colluded with the 'biologisation of the mind,' which has led to a 'looping effect,' (Hacking, 2012). In line with participants' reflections, Fernando, highlighted that the western construct of psychological distress, emphasises individualised treatment (medication and therapies), focusing on altering biological states and beliefs, reflecting a broader issue within healthcare systems imbued with colonial legacy (2017).

4.2. Critical Review and Personal Reflections

4.2.1. Terminology

On reflection, the term 'conflict-related sexual violence,' may require consideration, not because it lacks validity, but because its interpretations can inadvertently contribute to racist discourses of 'othering.' This label confines CRSV to regions outside Western nations, obscuring its prevalence within the UK. Such framing fails to account for the domestic implications of colonial hegemonies, detention centres and policies related to securitisation and border policing (i.e. PREVENT) within the UK. The term 'conflict-related' inadequately captures the broader geopolitical and colonial influences that shape sexual violence, particularly those stemming from imperialist policies and agendas such as those noted in the GWOT. Routine

practices such strip-searching of racialised men in prison and detention centres, are not isolated abuses but directly informed by the policies, strategies, and rationale of the GWOT (Quisay & Qureshi, 2024). The term can obscure the systemic and pervasive nature of state-sanctioned violence both within and transcending traditional armed-conflict zones; highlight its entrenchment in both military and civilian institutions globally, due to what is seen as a threat by the colonial gaze.

Rather than abandoning the term CRSV, it is crucial to expand its interpretations to include these broader contexts. I propose that the term ‘state-sanctioned sexual violence,’ is a more inclusive and precise term that reflects the broader understanding of sexual violence that encompasses multitude of contexts such as global zones of armed conflict, imprisonment, systemic state violence and oppression. The term illuminates that sexual violence is implemented by state institutions, including in varied settings such as prisons, during policing, and as part of border control measures, directly linking it to governmental policies and actions. By broadening the scope of CRSV through this lens, we can more accurately address the complexities of sexual violence in both Western and non-Western contexts.

4.2.2. Tamil

The participants were aware of my Tamil identity, which may have influenced the dynamics and content of the interviews. My identity could have served as a catalyst for participants to discuss their experiences of working with Tamil male victim-survivors of CRSV. The application of reflexive TA was inherently influenced by my identity, not just methodologically. This approach allowed me to actively engage with the data, not just as a researcher, but as a member of the Tamil community, influencing the interviews, interpretations, and the themes.

Historically, I have been interested to see how CRSV is used to maintain control over the Tamils by fostering an environment of suppression and despotism, discouraging them from speaking out against the state. Males continue to be detained under the Government's Prevention of Terrorism Act of 1979, outside of ‘conflict areas’ in Colombo, including the fourth floor of the Criminal Investigation Department

headquarters. The term ‘fourth floor’ or ‘நான்காவது மாடி (Nāṉkāvatu māṭi) is a commonly used euphemism Tamils use to describe the systematic sexual violence without having to utter the words ‘sexual violence,’ as the acts that occur are so brutal that they resemble the ‘fourth floor to hell.’ This prompts me to consider other euphemisms used by racialised men who have experienced CRSV and what might be overlooked by CPs from different backgrounds.

Furthermore, the personal challenge of engaging with English-language literature on CRSV, dominated by perspectives that may not fully capture the nuances of local experiences or might inadvertently equate acts of resistance with terrorism, has been significant. For an example, the violent ethnic biblioclasm demonstrated by the burning of the Jaffna library in 1981, further dilutes the richness of available information, necessitating reliance on external and second-hand sources such as the diaspora, and grassroot community organisations (Tamil Guardian, 2021). These sources, often unpublished in mainstream academic outlets and primarily in non-English, highlight the erasure of marginalised voices even within their own communities.

My positionality also required a constant vigilance to avoid over-identification with the data, which could skew the analysis. Reflexive TA helped in mitigating these risks by compelling me to reflectively journal how my interpretations were shaped by personal experiences and biases which I discussed in supervision with DoS. This ongoing reflexivity was crucial in ensuring that the themes developed were not just reflective of my perspectives but were genuinely grounded in the participants' experiences. The reflective process was thus twofold: it involved an introspection of how my personal and clinical experiences working with male victim-survivors of CRSV influenced the research process and an examination of how this positioning might affect the authenticity of the themes identified.

4.3. Strengths

The study has some notable strengths, that could contribute to its dissemination and impact. Firstly, 12 participants were successfully recruited, which allowed for a solid foundation for data exploration. This allowed for effective unpacking of subtleties and nuances of CP's perspectives of working with male victim-survivors of CRSV in the UK, which is essential for improving and developing targeted psychosocial interventions. Secondly, consulting with members of the Tamil community that have experienced CRSV, ensures that the perspectives reflected in the research are rooted to a community that has been affected by CRSV, which enhances the relevance and applicability of the findings. Furthermore, this is an exploratory study and serves as foundational groundwork for developing training programmes, interventions, and future research, aligning with the identified gaps.

4.4. Limitations

Key limitations of the study capture the scope and biases of the study. Firstly, since the study focused on CPs rather than directly on male victim-survivors of CRSV, it may have missed critical insights, such as the quality of psychosocial interventions that they have received. The reliance on second-hand testimonies from their clients could also lead to a loss of authenticity in capturing the full meaning and nuances of their experiences. Secondly, the study utilised the 'snowballing' method to recruit participants, due to its practicality under time-constraints. However, this approach may have resulted in a sample that does not accurately represent the broader demographic of CPs. It might predominantly center the voices of those invested in improving psychosocial interventions for male victim-survivors of CRSV, who likely share similar views and employ similar psychosocial interventions due to overarching systemic pressures. Consequently, this sampling bias could skew towards more positive perceptions of funded psychosocial interventions. Furthermore, due to snowballing, the participants were primarily based in London, which presents with limitations regarding the generalisability across the UK, due to regional differences, exposure to racialised people, inequity, and resource availability across the UK. Future studies could employ stratified sampling techniques to ensure a more varied participant pool. Another limitation is that the heterogeneity of victim-survivors was not acknowledged. For an example, some males may not identify with the term

‘victim-survivor,’ as it misaligns their experiences of sexual violence in relation to their goals for liberation and political identity. Furthermore, even though some participants voluntarily discussed the effectiveness of the psychosocial interventions, there was not a question on the evaluation of the effectiveness of psychosocial interventions in the interview schedule, which means that there’s limited understanding of its longitudinal impact or potential harm.

4.5. Evaluating the quality of the study

The quality assessment framework outlined by Spencer et al., (2023) was then used to evaluate the study, focusing on three main principles: contribution, credibility, and rigour.

4.5.1. Contribution

The principle of contribution refers to the originality and value of a study’s findings and whether they advance knowledge, policy, and practice. Whilst the majority of the existing research on CRSV focuses on women and girls, this study offers novel insights into the experiences and needs of male victim-survivors and the psychosocial interventions that is provided to them. By setting the study within the context of existing knowledge, new areas for investigation were identified, and limitations of this current study were identified (see section 4.4.).

Although generalisability is commonly associated with quantitative research, Spencer et al. (2023) highlight the importance to consider the relevance and broader applicability of qualitative research findings beyond the CPs involved in the study. The participants in this study varied significantly, in terms of their length of clinical service, clinical settings, research interests, theoretical orientation, and preferred therapeutic modalities. This variation enhances the study's external validity and transferability, thereby increasing its potential to inform and improve knowledge and practice of psychosocial interventions within the clinical psychology field for male victim-survivors of CRSV.

4.5.2. Credibility

According to Spencer et al. (2023), credibility is a fundamental element of any robust research framework. For qualitative research to be credible, the research claims must be both defensible and plausible. To establish credibility, claims must be substantiated through 'well-founded and plausible arguments about the significance of the evidence generated' (p. 9). Spencer et al. (2023) further argue that methodological transparency and thorough documentation of the research is needed to achieve credibility. This transparency is exemplified in the results section of Chapter 3, where data excerpts are provided to illustrated how the analysis was derived from the raw data. Additionally, an example of the cluster table is also presented in the appendix (see Appendix G).

4.5.3. Rigour

Rigour in qualitative research refers to the precision and methodological validity with which the research was conducted. According to Spencer et al. (2023), rigour is conducted 'through systematic and transparent collection,' (p. 9). A detailed description and rationale of the research methodology can be found in Chapter 2, while the reasoning behind the study's aim and its justification can be found in sections 1.11 – 1.12. The research process was meticulously planned, considered, and documented in the Methodology section, with continuous consultation with the DoS at every stage of the research process. This consultation provided included feedback, guidance, and reflection on coding and theme generation, ensuring that the research maintained high standards of rigour. To further ensure methodological rigour, the research adhered strictly to established protocols for TA as provided by Braun and Clarke (2020). These protocols were systematically implemented, grounding the findings in a solid methodological framework, as documented in Chapter 2. Additionally, the researcher's positionality and influence were important to acknowledge to maintain rigour. Recognising how own potential biases, assumptions, influences, and relationship to CRSV might affect the study was an important aspect to the research. By being transparent about my positionality as a Tamil Sri Lankan clinician and researcher, I demonstrated reflexivity as explored in sections 2.4. and 4.2.2. This reflexive approach ensured that personal biases and

influences were critically examined and managed, thereby enhancing the overall rigour of the study.

4.6. Clinical and Research implications

Implications for research, clinical practice and policy at both micro and national level will be discussed. Recommendations are made based on the gaps identified as a result of the study, as well as broader issues within the field of clinical psychology.

4.6.1. Future research recommendations

The findings reveal the multiple gaps in the knowledge and a lack of confidence amongst CPs in the application of faith/culture/religious factors when working therapeutically with men who experienced CSRV. Thus, research in the field of CSRV among men is warranted. While some recommendations might align with broader research agendas, the following suggestions are particularly informed by the findings of this study:

1) Longitudinal research to determine the long-term efficacy and ethical safety of psychosocial interventions currently used in the UK, including examining outcomes for psychological wellbeing, improvement in perception of self, integration within community and sexual health.

2) Furthermore, there is a lack of research that integrates direct accounts from male victim-survivors about the effectiveness of psychosocial interventions that they have received. In addition, to thinking about effectiveness, further research can investigate the challenges and potential harm experienced by male victim-survivors when accessing psychosocial interventions delivered by CPs in the UK. This research would be crucial for evaluating the process and outcomes of psychosocial interventions, as well as improving access to services, and ensuring the appropriateness of current measures.

3) Furthermore, the importance of systemic and cultural factors may warrant further exploration of how social and political factors such as the Rwanda Bill, counter-terrorism policies, and global attitudes towards masculinity, impact

the mental health and recovery of male victim-survivors that have experienced CRSV.

4) Research into liberation practices and collective healing, such as narrative therapy, could provide valuable insights into culturally congruent practices that might be more appropriate and effective for racialised men from the global majority. This could lead to more funding being available to train CPs in these psychosocial modalities.

4.6.2. Clinical practice

Implications for clinical practice centre on increasing CPs understanding of harmful structures, mechanisms, and processes, such as whiteness and a lack of political reflexivity, and how they can actively work to dismantle these, instead of adhering to the status quo. This can be achieved through training, psychoeducation, and engaging in reflective spaces to understand biases, deconstructing whiteness in clinical and academic settings, and encouraging clinical research based on personal accounts of survivors to inform policy work at a macro level.

UK psychology training courses reflect a colonial and Eurocentric bias, suggesting that there is a need for diversifying curricula and redefining what constitutes as expertise, so the discipline can authentically uphold human rights beyond the individual therapeutic realm. It is crucial to incorporate pedagogy that is rooted in human rights-based principles (Kanceljak & Calia 2023; Farooq et al., 2023). This can also be done through political reflexivity by examining how structures perpetuate and sustain oppression and violence against male victim-survivors of CRSV. Additionally, the issue of political repression in academic spaces, exemplified by Israel's misinformation apparatus through academic institutions in the Global North as a key weapon in its arsenal (Wind, 2024), impairs the ability of CPs to bear witness, support and learn from research conducted from the global majority. To effectively, work with male victim-survivors of CRSV, it is crucial to counteract this censorship to maintain narrative and discourse ownership rooted in the lived experiences of impacted communities.

CPs are human rights defenders. Comprehensive training programmes specifically designed with male victim-survivors of CRSV in the UK in mind must be developed. They should focus on structural factors like racism, policing, and legal status. It's essential that CPs receive ongoing Continuing Professional Development (CPD) to develop psychosocial interventions which adopt a human rights approach, and which are ecological in nature, explicitly moving away from frameworks rooted in whiteness and neoliberalism.

4.6.3. Clinical Policy

The findings highlight the issue with using individualistic and disorder-specific approaches and psychosocial interventions such as NET for 'PTSD', and advocate for a more community-based approach, working towards tackling social injustice and dismantling systemic oppression in the UK. This echoes Franz Fanon's sociodiagnostic approach to mental health, in opposition to the current bio-psycho-social-spiritual approach that operates in mental health services. Fanon believed that one cannot understand psychological problems outside of the conditions of oppression that lead to them, and thus the central role of psychology practice, is to not only alleviate suffering, but to illuminate social structures and remedy them (Fanon, 1963; Fanon et al., 2018). In terms of clinical policy, this can be done by revisiting the stance of the psychological bodies such as the BPS and the NHS on neutrality, acknowledging the influence of political instability and displacement on mental health. The myth of neutrality is evident in the refusal to condemn Israel's actions, contrasted with the BPS's expression of solidarity with Ukraine. This inconsistency must be challenged so that the discipline of psychology is aligned with a HRBA.

CPs should adopt a dual role: while providing therapeutic care, they must also prioritise advocating for their clients' social, legal, and human rights. Organisations like CAGE International in the UK exemplify this approach that confront global state oppression driven by the GWOT and empower communities to hold complicit governments accountable. There should be robust support for community-led and grassroot organisations that aim to mobilise communities that have been impacted

by male victim-survivors of CRSV, through research, funding, and legislation reforms.

The UK's active historical and current involvement in global affairs positions itself as both a beneficiary and a propagator of instability, furthering the axis of imperialism. This proximity to the military-industrial complex is exemplified by the participation of psychologists in the development and implementation of torture programmes during the GWOT, including at Guantanamo Bay and other ‘black sites’ in which CRSV against males take place highlights a critical ethical concern (Harper, 2007). Although, the BPS condemned the torture that took place during the GWOT in 2005, it is important to note that the ethical violations were primarily associated with psychologists employed by the CIA and regulated by the American Psychological Association (APA). The APA’s involvement and the subsequent Hoffman Report (2015) exposed significant ethical breaches, which raises significant questions about the adherence to the core ethical principle to 'do no harm,' fundamental to clinical policy within psychology (Rubenstein, 2007; LoCicero et al., 2016). Robust measures are needed to uphold ethical standards in CP, enforcing stricter accountability and consequences for ethical violations by CP bodies. Stricter regulations and reporting of CP’s roles in military, conflict, and national security settings are essential, along with strong whistle-blower protections to maintain ethical standards without fear of retribution.

4.6.4. National level policy implications

On a national level, it is crucial to acknowledge our dual role within the NHS and third-sector organisations as both rights-bearers and duty bearers. This role mandates a recognition of involvement and complicity in systemic harm, especially in policies that exacerbate the challenges faced by male victim survivors of CRSV. The NHS, as a public body for all, must assess its partnership and practices to ensure they align with the principles of human rights. Examples of policies that restrict healthcare access include obligatory charges and violation of patient confidentiality and data security between the NHS and the Home Office (Trueba et al., 2023).

Furthermore, the recent £330 million NHS contract with Palantir Technologies, an American cybernetic company with a history of international human rights violations (Campbell, 2023; Amnesty International, 2020; The New Arab, 2023) has intensified concerns. The involvement of Palantir in the NHS raises concerns, specifically regarding dissuasion and disclosure of CRSV, causing a 'chilling effect.' This example highlights the necessity for national level policy reforms to ensure that the NHS adheres to the ethical standards of protecting human rights.

The findings highlight that marginalised communities can be harmed by legislation and policy, such as the Illegal Migration Act, Rwanda Bill, and PREVENT policy that cause further harm to male victim-survivors of CRSV. Abolishing harmful systems and legislation on a national level (Younis & Jadhav, 2019) would be essential. CPs should lobby for national policies that recognise the profound psychological impact of such security and deterrent measures and advocate for the establishment of support systems that are devoid of surveillance fears, ensuring that victim-survivors feel safe to seek help without the fear of being profiled or criminalised. This can be done via creative avenues, through story-telling and artistic expression. For example, the play Liberation Squares (Bhattacharyya, 2024), portrays 3 teenager girls, that find themselves subjected to state surveillance, which sheds light on the psychological harm of the PREVENT policy in an accessible way. On a personal level, my Grandfather, an author, documented atrocities that he witnessed in Sri Lanka, and his migration journey to Europe. Similarly, my Aunt wrote about the collective experiences of CRSV against Tamil women. To my knowledge, none of the older generation in my family that survived conflict, some of whom might be male victim-survivors of CRSV have sought psychological support but have found healing in the form of written testimony. For male victim-survivors of CRSV, CPs can play a vital role by advocating for and participating in collective and artistic expressions to enhance support for survivors. By embracing testimony-based principles in books, graphic novels, and music, these creative mediums can powerfully promote awareness, justice, and liberation, that's first and foremost, rooted in community.

Furthermore, based on the findings CPs taking a more active role in advocating for policies that support reparations and restorative justice for male victim-survivors of CRSV could be transformative, this would involve access to financial, medical, and

psychological support for communities that are harmed, this not only aids in recovery but also works towards restoring justice and resisting further state violence and CRSV. For example, recently it was noted that The Global Survivors Fund is supporting 500 Ukrainian victims of CRSV with receiving reparations (financial, medical, psychological support and validation of their experiences), which is a crucial step for restoring justice (Strzyżyńska, 2024). Such reparations should be offered globally, including for racialised men. CPs should play a role in advocating for reparations by collectively mobilising to support systemic changes. This advocacy can lead to reduction of CRSV, through preventive measures and early intervention. Engaging in political activism as part of professional practice, is crucial for CPs, as it enhances the clinical impact beyond the confinement of the therapy room.

Lastly but most importantly, CPs should use their power and influence to actively speak out against crimes against humanity, particularly those exacerbated by UK complicity through an extensive matrix of harmful policies, practices (e.g., military bases and arms sales), and legislation. Preventing violence from the outset is crucial, and the most effective way to reduce CRSV against men and boys.

4.7. Conclusion

Together, these comments suggest a call for the field of clinical psychology to critically examine and realign its practices to better uphold and advocate for human rights for male victim-survivors of CRSV, ensuring that their professional actions do not inadvertently support or enforce harmful political agendas.

References

Abbas, M.-S. (2019). Conflating the Muslim refugee and the terror suspect: Responses to the Syrian refugee “crisis” in Brexit Britain. *Ethnic and Racial Studies*, *42*(14), 2450–2469. https://doi.org/10.1080/01419870.2019.1588339

Abdelhamid, S., Lindert, J., Fischer, J., & Steinisch, M. (2022). Voices of the displaced: A qualitative study of potentially traumatising and protective experiences faced by refugee children. *MedRxiv (Cold Spring Harbor Laboratory)*. https://doi.org/10.1101/2022.07.26.22277918

Afuape, T. (2011). *Power, resistance and liberation in therapy with survivors of trauma : to have our hearts broken*. Routledge.

Afuape, T., & Hughes, G. (2015). *Liberation Practices*. Routledge.

Ahmed, A. (2012). *When men are harmed: Feminism, queer theory, and torture at Abu Ghraib*. https://scholarship.law.bu.edu/cgi/viewcontent.cgi?article=4109&context=faculty_scholarship

Ahsan, S. (2020). Holding up the mirror: Deconstructing whiteness in Clinical Psychology. *Journal of Critical Psychology, Counselling and Psychotherapy*, *20*(3), 43–55.

Al-Ali, N. (2016). Sexual violence in Iraq: Challenges for transnational feminist politics. *European Journal of Women's Studies*, *25*(1), 10–27. https://doi.org/10.1177/1350506816633723

All Survivors Project . (2019). *The health of male and LGBT survivors of conflict-related sexual violence*. https://allsurvivorsproject.org/wp-content/uploads/2022/04/The-Health-of-Male-and-LGBT-Survivors-of-Conflict-Related-Sexual-Violence.pdf

American Psychological Association. (2017). *Clinical practice guideline for the treatment of PTSD*. American Psychological Association. https://www.apa.org/ptsd-guideline/ptsd.pdf

Amnesty International. (2020). *USA: Failing to do right: The urgent need for Palantir to respect human rights*. Amnesty International. https://www.amnesty.org/en/documents/amr51/3124/2020/en/

Andersen, T. H. (2007). Speaking about the unspeakable: Sexually abused men striving toward language. *American Journal of Men's Health*, *2*(1), 25–36. https://doi.org/10.1177/1557988307308107

American Psychological Association. (2015, July 2). Independent review relating to APA ethics guidelines, national security interrogations, and torture (Hoffman Report). https://www.apa.org/independent-review

Apperley, H. (2015). Hidden victims: a call to action on sexual violence against men in conflict. *Medicine, Conflict and Survival*, *31*(2), 92–99. https://doi.org/10.1080/13623699.2015.1060575

Armbruster, H. (2018). “It was the photograph of the little boy”: Reflections on the Syrian Vulnerable Persons Resettlement Programme in the UK. *Ethnic and Racial Studies*, *42*(15), 2680–2699. https://doi.org/10.1080/01419870.2018.1554226

Arntz, A., Sofi, D., & van Breukelen, G. (2013). Imagery rescripting as treatment for complicated PTSD in refugees: A multiple baseline case series study. *Behaviour Research and Therapy*, *51*(6), 274–283. https://doi.org/10.1016/j.brat.2013.02.009

Asal, V., Legault, R., Szekely, O., & Wilkenfeld, J. (2013). Gender ideologies and forms of contentious mobilization in the Middle East. *Journal of Peace Research*, *50*(3), 305–318. https://doi.org/10.1177/0022343313476528

Avery-Clark, C., Weiner, L., & Adams-Clark, A. A. (2019). Sensate focus for sexual concerns: An updated, Critical Literature Review. *Current Sexual Health Reports*, *11*(2), 84–94. https://doi.org/10.1007/s11930-019-00197-9

Ba, I., & Bhopal, R. S. (2017). Physical, mental and social consequences in civilians who have experienced war-related sexual violence: a systematic review

(1981–2014). *Public Health*, *142*(142), 121–135. https://doi.org/10.1016/j.puhe.2016.07.019

Baerwaldt, N. (2018). The European refugee crisis: Crisis for whom? *Border Criminologies*. https://blogs.law.ox.ac.uk/research-subject-groups/centre-criminology/centreborder-criminologies/blog/2018/03/european-refugee

Ballentyne, S., & Drury, J. (2023). Boundaries beyond borders: The impact of institutional discourse on the identities of asylum seekers. *Current Research in Ecological and Social Psychology*, *5*(5), 100130–100130. https://doi.org/10.1016/j.cresp.2023.100130

Bancroft, H. (2023, October 4). *Migrants sexually harassed and detained for too long at unsafe immigration centre*. The Independent. https://www.independent.co.uk/news/uk/home-news/yarls-wood-detention-centre-home-office-b2422992.html

Bar-On, D. (2001). The Silence of Psychologists. *Political Psychology*, *22*(2), 331–345. https://doi.org/10.1111/0162-895x.00242

Baumgartner, J. S., Renner, A., Wochele-Thoma, T., Wehle, P., Corrado Barbui, Purgato, M., Tedeschi, F., Tarsitani, L., Roselli, V., Ceren Acartürk, Ersin Uygun, Anttila, M., Tella Lantta, Maritta Välimäki, Churchill, R., Walker, L., Marit Sijbrandij, Pim Cuijpers, Koesters, M., & Klein, T. (2024). Impairments in

psychological functioning in refugees and asylum seekers. *Frontiers in Psychology*, *14*. https://doi.org/10.3389/fpsyg.2023.1295031

BBC. (2015, August 15). Europe migrant crisis: Dozens die in hold of Libya boat. *BBC News*. https://www.bbc.co.uk/news/world-europe-33946912

Bhaskar, R. (1975). Forms of realism. *Problems in Metaphilosophy – I*, *15*(0). https://doi.org/10.21825/philosophica.82713

Bhattacharyya, S. (2024). *Liberation Squares* [Theatre]. Fifth Word and Nottingham Playhouse, in association with Brixton House.

Bloom, M. (2005). Mother. Daughter. Sister. Bomber. *Bulletin of the Atomic Scientists*, *61*(6), 54–62. https://doi.org/10.2968/061006015

Bloom, M. (2010). Death becomes her: Women, occupation, and terrorist mobilization. *PS: Political Science & Politics*, *43*(03), 445–450. https://doi.org/10.1017/s1049096510000703

Bond, J. (2013). Softening up the enemy and sex-based humiliation. *Minnesota Journal of Law & Inequality Minnesota Journal of Law & Inequality*, *31*(1).

Bosworth, M. (2021). The politics of pain in immigration detention. *Punishment & Society*, *Vol. 25(2) 307–323*(2), 146247452110488. https://doi.org/10.1177/14624745211048811

Boutahar, Y. (2013). White womanhood and the predicament of colonial discourse in contemporary captivity narratives. In *Comparativism, Identity, Communication* (pp. 1–283). Universitaria, Craiova.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage Publications.

BPS. (2016). *Exploring the unique needs of asylum-seekers and refugees*. BPS. https://www.bps.org.uk/psychologist/exploring-unique-needs-asylum-seekers-and-refugees

Braithwaite, A., Salehyan, I., & Savun, B. (2018). Refugees, forced migration, and conflict: Introduction to the special issue. *Journal of Peace Research*, *56*(1), 5–11. https://doi.org/10.1177/0022343318814128

Braun, V., & Clarke, V. (2006). Using thematic analysis in Psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. *APA Handbook of Research Methods in Psychology, Vol 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological.*, *2*(2), 57–71. APA PsycNet. https://doi.org/10.1037/13620-004

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2020). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/capr.12360

Broban, A., Van den Bergh, R., Russell, W., Benedetti, G., Caluwaerts, S., Owiti, P., Reid, A., & De Plecker, E. (2020). Assault and care characteristics of victims of sexual violence in eleven Médecins Sans Frontières programs in Africa. What about men and boys? *PLOS ONE*, *15*(8), e0237060. https://doi.org/10.1371/journal.pone.0237060

Brown, P., Gill, S., & Halsall, J. P. (2022). The impact of housing on refugees: an evidence synthesis. *Housing Studies*, *39*(1), 1–45. https://doi.org/10.1080/02673037.2022.2045007

Brownmiller, S. (1975). *Against our will : Men, women, and rape*. MysteriousPress.com/Open Road Integrated Media.

Campbell, K., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. (2021). Reflexive Thematic Analysis for Applied

Qualitative Health Research. *The Qualitative Report*, *26*(6). https://doi.org/10.46743/2160-3715/2021.5010

Cautain, Di. (2023, May 5). *Asylum seekers crossing the English channel: Why don't they stay in France?* United against Inhumanity. https://www.against-inhumanity.org/2023/05/05/asylum-seekers-crossing-the-english-channel-why-dont-they-stay-in-france-by-marie-leveille/

Chak, F. M. (2018). Europe's dystopia: The exploitation of unaccompanied and separated child refugees. *Policy Perspectives*, *15*(3), 7. https://doi.org/10.13169/polipers.15.3.0007

Chynoweth, S. K., Buscher, D., Martin, S., & Zwi, A. B. (2020). Characteristics and impacts of sexual violence against men and boys in conflict and displacement: A multicountry exploratory study. *Journal of Interpersonal Violence*, *37*(9-10), 088626052096713. https://doi.org/10.1177/0886260520967132

Chynoweth, S. K., Freccero, J., & Touquet, H. (2017). Sexual violence against men and boys in conflict and forced displacement: implications for the health sector. *Reproductive Health Matters*, *25*(51), 90–94. https://doi.org/10.1080/09688080.2017.1401895

Clark, J. N. (2018). De-centring trauma: conflict-related sexual violence and the importance of resilience discourse. *The International Journal of Human Rights*, *22*(6), 801–821. https://doi.org/10.1080/13642987.2018.1454908

Clifford, C., & McCauley, M. (2019). Male psychosexual therapy in the UK military. *Journal of the Royal Army Medical Corps*, *165*(2), 94–97. https://doi.org/10.1136/jramc-2018-001046

Cohen, D. K. (2013). Explaining rape during civil war: Cross-national evidence (1980-2009). *The American Political Science Review*, *107*(3), 461–477. https://www.jstor.org/stable/43654918

Cohen, D. K. (2017). The ties that bind: How armed groups use violence to socialize fighters. *Journal of Peace Research*, *54*(5), 701–714. https://doi.org/10.1177/0022343317713559

Cohen, D. K., Green, A. H., & Wood, E. J. (2013). *Wartime sexual violence misconceptions, implications, and ways forward*. https://projects.iq.harvard.edu/files/wappp/files/wartime_sexual_violence_.pdf

Cohen, D. K., & Nordås, R. (2015). Do states delegate shameful violence to militias? Patterns of sexual violence in recent armed conflicts. *Journal of Conflict Resolution*, *59*(5), 877–898. https://doi.org/10.1177/0022002715576748

Collyer, M., & Shahani, U. (2023). Offshoring refugees: Colonial echoes of the UK-Rwanda migration and economic development partnership. *Social Sciences*, *12*(8), 451–451. https://doi.org/10.3390/socsci12080451

Connell, R. W. (2005). *Masculinities*. Cambridge Polity.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society*, *19*(6), 829–859.

Crawford, K. F. (2017). *Wartime sexual violence from silence to condemnation of a weapon of war*. Georgetown University Press.

Crawley, H., & Hagen-Zanker, J. (2018). Deciding where to go: policies, people and perceptions shaping destination preferences. *International Migration*, *57*(1). https://doi.org/10.1111/imig.12537

Crawley, H., & Skleparis, D. (2017). Refugees, migrants, neither, both: categorical fetishism and the politics of bounding in Europe's "migration crisis." *Journal of Ethnic and Migration Studies*, *44*(1), 48–64. https://doi.org/10.1080/1369183x.2017.1348224

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative & mixed methods approaches* (5th ed.). Sage.

Cuddy, A. (2024, February 17). Diego Garcia asylum seekers feel unsafe on remote British island territory. *BBC News*. https://www.bbc.co.uk/news/world-68326365

Cushman, E. (1996). The rhetorician as an agent of social change. *College Composition and Communication*, *47*(1), 7. https://doi.org/10.2307/358271

Davenport, C., Mokleiv Nygård, H., Fjelde, H., & Armstrong, D. (2019). The consequences of contention: Understanding the aftereffects of political conflict and violence. *Annual Review of Political Science*, *22*(1), 361–377. https://doi.org/10.1146/annurev-polisci-050317-064057

Davies, P. C. W., & Gribbin, J. (2007). *The matter myth : dramatic discoveries that challenge our understanding of physical reality*. Simon & Schuster.

Davis, A. Y. (1981). Rape, racism and the capitalist setting. *The Black Scholar*, *12*(6), 39–45. https://www.jstor.org/stable/41066856

Davis, E., & Loft , P. (2023, April 14). *Conflict-related sexual violence and the UK's approach*. https://researchbriefings.files.parliament.uk/documents/CBP-9577/CBP-9577.pdf

De Beauvoir, S., & HalimiG. (1964). *Djamila Boupacha*. Seix Barral.

de Jong, K., Ford, N., van de Kam, S., Lokuge, K., Fromm, S., van Galen, R., Reilley, B., & Kleber, R. (2008). Conflict in the Indian Kashmir Valley I: exposure to violence. *Conflict and Health*, *2*(1). https://doi.org/10.1186/1752-1505-2-10

de Jong, K., Kam, S. van de, Ford, N., Lokuge, K., Fromm, S., van Galen, R., Reilley, B., & Kleber, R. (2008). Conflict in the Indian Kashmir Valley II: psychosocial impact. *Conflict and Health*, *2*(11), 11. https://doi.org/10.1186/1752-1505-2-11

Denborough, D. (2018). *Do you want to hear a story? : adventures in collective narrative practice*. Dulwich Centre Publications.

Dhakal, K. (2022). NVivo. *Journal of the Medical Library Association*, *110*(2), 270–272. https://doi.org/10.5195/jmla.2022.1271

Dhaliwal, S., & Forkert, K. (2015). Deserving and undeserving migrants. *Soundings*, *61*(61), 49–61. https://doi.org/10.3898/136266215816772205

DiAngelo, R. (2021). *Nice Racism*. Penguin UK.

Diniz De Figueiredo, E. H., & Martinez, J. (2019). The locus of enunciation as a way to confront epistemological racism and decolonize scholarly knowledge. *Applied Linguistics*, *42*(2). https://doi.org/10.1093/applin/amz061

Dolan, C., Hovil, L., & Pasquero, L. (2024). Translating survivor-centredness into pedagogical approaches to training on sexual violence in conflict and emergency settings: A case study. *International Review of the Red Cross*, 1–24. https://doi.org/10.1017/s1816383123000607

Dorussen, H. (2022). *Handbook on peacekeeping and International Relations*. Edward Elgar Publishing.

Du Bois, W. E. B. (1903). *The souls of Black folk*. A. C. McClurg and Co.

Dugard, J. (2023). Israel's impunity from peremptory norms. *Brill | Nijhoff EBooks*, 199–222. https://doi.org/10.1163/9789004503939_011

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345. https://doi.org/10.1016/s0005-7967(99)00123-0

Eichert, D. (2018). "Homosexualization" revisited: an audience-focused theorization of wartime male sexual violence. *International Feminist Journal of Politics*, *21*(3), 409–433. https://doi.org/10.1080/14616742.2018.1522264

El-Haj-Ibrahim, R. (2023, December 27). *Prophetic lessons from the Muslim men In Gaza*. MuslimMatters.org. https://muslimmatters.org/2023/12/27/prophetic-lessons-from-the-muslim-men-in-gaza/

El-Kurd, M. (2023, November 27). *The right to speak for ourselves*. Www.thenation.com. https://www.thenation.com/article/world/palestinians-claim-the-right-to-narrate/

Engle, K. (2020). *The grip of sexual violence in conflict: feminist interventions in international law*. Stanford University Press.

Engle, K., Francis, W., Daniel-Sen, D., Davis, A., Halley, J., Kennedy, D., Knop, K., Weisburd, M., Weiss, D., Freeman, J., Beth, M., Lixinski, L., & Roberts, J. (2004). *"Calling in the Troops": The Uneasy Relationship Among Women's Rights, Human Rights, and Humanitarian Intervention man for important discussions and feedback on the project. I am also indebted to*.

Erakat, N. (2019). *Justice for Some*. Stanford University Press.

Fallwell, L., & Williams, K. V. (2016). Gender and the representation of evil. In *Google Books*. Routledge.

Fanon, F. (1963). *The wretched of the Earth*. Grove.

Fanon, F., Khalfa, J., & Young, R. (2018). *Alienation and freedom*. Bloomsbury Academic.

Farooq, R., Appiah, A., Abbas, S., & Addy, C. (2023). Making psychology "just"? The challenges and opportunities of delivering human rights based pedagogical & experiential teaching to trainee clinical psychologists. *Clinical Psychology Forum*, *1*(368), 23–32. https://doi.org/10.53841/bpscpf.2023.1.368.23

Fernando, S. (2017). *Institutional Racism in Psychiatry and Clinical Psychology : Race Matters in Mental Health*. Springer International Publishing : Imprint : Palgrave Macmillan.

Féron, E. (2018). *Wartime sexual violence against men*. Men and Masculinities in a Transnational World.

Freedom From Torture. (2019). *Supreme Court reasserts the role of medical experts in asylum claims by torture survivors | Freedom from Torture*. Www.freedomfromtorture.org. https://www.freedomfromtorture.org/news/supreme-court-reasserts-the-role-of-medical-experts-in-asylum-claims-by-torture-survivors

Freedom From Torture. (2022a). *Why torture survivors take dangerous journeys to seek protection in the UK FLEEING A BURNING HOUSE*. https://www.freedomfromtorture.org/sites/default/files/2022-11/FFT_BurningHouseReport_A4_v5.pdf

Freedom From Torture. (2022b). *Detention*. Detention Is extremely harmful to the physical and mental health of torture survivors since being detained can bring back the memories of the torture that they fled. That's why we are campaigning to stop survivors being detained. https://www.freedomfromtorture.org/what-we-do/asylum-and-rights/detention

Freedom From Torture. (2023). *Decision-making*. Poor Home Office decision-making can be a huge problem for people who have been tortured. Through our campaigning and advocacy work, including our proving torture campaign, we are fighting to change this. https://www.freedomfromtorture.org/what-we-do/asylum-and-rights/decision-making

Frontex. (2016). *Risk analysis for 2016*. https://frontex.europa.eu/assets/Publications/Risk_Analysis/Annula_Risk_Analysis_2016.pdf

Galatzer-Levy, I. R., & Bryant, R. A. (2013). 636,120 ways to have Posttraumatic Stress Disorder. *Perspectives on Psychological Science*, *8*(6), 651–662. http://www.jstor.com/stable/44290070

Gewirtz-Meydan, A., & Opuda, E. (2020). The impact of child sexual abuse on men's sexual function: A Systematic Review. *Trauma, Violence, & Abuse*, *23*(1), 152483802093913. https://doi.org/10.1177/1524838020939134

Giuffrida, A. (2023, February 26). Children among 59 people killed in sailboat wreck off Italy's coast. *The Guardian*. https://www.theguardian.com/world/2023/feb/26/dozens-of-bodies-believed-to-be-refugees-found-on-beach-in-southern-italy

Goldberg, D., Jadhav, S., & Younis, T. (2017). Prevent: What is pre-criminal space? *BJPsych Bulletin*, *41*(4), 208–211. https://doi.org/10.1192/pb.bp.116.054585

Gorris, E. A. P. (2015). Invisible victims? Where are male victims of conflict-related sexual violence in international law and policy? *European Journal of Women's Studies*, *22*(4), 412–427. https://doi.org/10.1177/1350506815605345

Goodman, L. A. (1961). Snowball sampling. *The annals of mathematical statistics*, *32*(1), 148–170. https://doi.org/10.1214/aoms/1177705148

GOV UK. (2022). *Preventing sexual violence in conflict initiative strategy*. https://assets.publishing.service.gov.uk/media/63810376d3bf7f153b8b3260/preventing-sexual-violence-in-conflict-initiative-strategy.pdf

Gray, H., & Franck, A. K. (2019). Refugees as/at risk: the gendered and racialized underpinnings of securitization in British media narratives. *Security Dialogue*, *50*(3), 275–291. https://doi.org/10.1177/0967010619830590

Griffiths, M. (2015). "Here, Man Is Nothing!" *Men and Masculinities*, *18*(4), 468–488. https://doi.org/10.1177/1097184x15575111

Gronnvoll, Marita. (2008). Gender (In)Visibility at Abu Ghraib. *Rhetoric & Public Affairs*, *10*(3), 371–398. https://doi.org/10.1353/rap.2008.0016

Grosfoguel, R. (2007). The epistemic decolonial turn: beyond political-economy Paradigms. *Cultural Studies*, *21*(2-3), 211–223.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Hacking, I. (2012). *Menschenarten : The looping effects of human kinds*. Sphères.

Hammad, J., & Tribe, R. (2020). Culturally informed resilience in conflict settings: a literature review of Sumud in the occupied Palestinian territories. *International Review of Psychiatry*, *33*(1-2), 1–8. https://doi.org/10.1080/09540261.2020.1741259

Harper, D. (2011). Choosing a qualitative research method. In *Qualitative research methods in mental health and psychotherapy*. Wiley-Blackwell.

Harper, D. (2007). The complicity of psychology in the Security State. In *Just war: psychology and terrorism*. PCCS Books.

Harper, D. (2013). Clinical Psychology. In *The SAGE Handbook of Qualitative Research in Psychology*. Sage Publications.

Haslam, N., & Loughnan, S. (2014). Dehumanization and infrahumanization. *Annual Review of Psychology*, *65*(1), 399–423. https://doi.org/10.1146/annurev-psych-010213-115045

Hayes, M. A., & Cowie, H. (2005). Psychology and religion: mapping the relationship. *Mental Health, Religion & Culture*, *8*(1), 27–33. https://doi.org/10.1080/13674670410001666589

Herman, J. L. (2015). *Trauma and recovery: Aftermath of violence from domestic abuse to political terror*. Basic books.

Hirt, N. (2010). “Dreams don’t come true in Eritrea”: Anomie and family disintegration due to the structural militarization of society. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.1541908

HM Government . (2023). *Asylum support*. GOV.UK

Hogg, C. L., & Buckinx, B. (2023). *Conflict-related sexual violence against boys: from recognition to response* (pp. 1–26). Liechtenstein Institute on Self Determination.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, *3*(3), 345–357. https://doi.org/10.1177/1468794103033004

Holmwood, J., & Aitlhadj, L. (2022). *A response to the Shawcross Report*. https://peoplesreviewofprevent.org/wp-content/uploads/2023/06/response-to-shawcross-1.pdf

Home Office. (2023a). *Illegal migration bill*. GOV.UK. https://www.gov.uk/government/collections/illegal-migration-bill

Home Office. (2023b, December 31). *Prevent duty guidance: England, Scotland and Wales (2015)*. GOV.UK. https://gov.uk/government/publications/prevent-duty-guidance-england-scotland-and-wales-2015

Horne, C. M. (2023). Accountability for atrocity crimes in Ukraine: Gendering transitional justice. *Women's Studies International Forum*, *96*(96), 102666. https://doi.org/10.1016/j.wsif.2022.102666

Hossain, M., Zimmerman, C., Kiss, L., Kone, D., Bakayoko-Topolska, M., Manan K A, D., Lehmann, H., & Watts, C. (2014). Men's and women's experiences of violence and traumatic events in rural Côte d'Ivoire before, during and after a period of armed conflict. *BMJ Open*, *4*(2), e003644. https://doi.org/10.1136/bmjopen-2013-003644

Howick, J. H. (2011). *The philosophy of evidence-based medicine*. John Wiley & Sons.

Humaid, L. A. (2023). *“Like we were lesser humans”: Gaza boys, men recall Israeli arrest, torture*. Al Jazeera. https://www.aljazeera.com/features/2023/12/12/like-we-were-lesser-humans-gaza-boys-men-recall-israeli-arrests-torture

Human Rights Watch. (2009, July 16). *Soldiers who rape, commanders who condone: Sexual violence and military reform in the Democratic Republic of Congo - Democratic Republic of the Congo | ReliefWeb*. Reliefweb.int. https://reliefweb.int/report/democratic-republic-congo/soldiers-who-rape-commanders-who-condone-sexual-violence-and

Martín-Baró, I. (1996). Writings for a Liberation Psychology. Harvard University Press.

Murad, N. (2021). The Murad Code: A global code of conduct for gathering and using information about sexual violence crimes. Murad Code Initiative. https://www.muradcode.com

International Truth and Justice Project . (2016). *Silenced: survivors of torture and sexual violence in 2015*. https://itjpsl.com/assets/Silenced-jan-2016.pdf

Isaacs, A., Burns, N., Macdonald, S., & O’Donnell, C. A. (2020). “I don’t think there’s anything I can do which can keep me healthy”: how the UK immigration and asylum system shapes the health & wellbeing of refugees and asylum

seekers in Scotland. *Critical Public Health*, *32*(3), 1–11. https://doi.org/10.1080/09581596.2020.1853058

Jabbour, S., Leaning, J., Nuwayhid, I., Ager, A., Cammett, M., Dewachi, O., Fouad, F. M., Giacaman, R., Sapir, D. G., Hage, G., Majed, Z., Nasser, R., Sparrow, A., Spiegel, P., Tarakji, A., Whitson, S. L., & Yassin, N. (2021a). 10 years of the Syrian conflict: a time to act and not merely to remember. *The Lancet*, *397*(10281). https://doi.org/10.1016/s0140-6736(21)00623-1

Jabr, S., & Berger, E. (2023). Community mental health, psychoanalysis, and freedom: The case of Palestine. *International Journal of Applied Psychoanalytic Studies*, *20*(2), 285–301. https://doi.org/10.1002/aps.1801

Jabr, S., & Seddik, Y. (2018). *Derrière les fronts : chroniques d'une psychiatre psychothérapeute palestinienne sous occupation*. Éditions Premiers Matins De Novembre ; [Paris.

Jacobs, S. F. (2017). Collective narrative practice with unaccompanied refugee minors: "The Tree of Life" as a response to hardship. *Clinical Child Psychology and Psychiatry*, *23*(2), 279–293. https://doi.org/10.1177/1359104517744246

Jafari, S. (2016). Religion and spirituality within counselling/clinical psychology training programmes: a systematic review. *British Journal of Guidance & Counselling*, *44*(3), 257–267. https://doi.org/10.1080/03069885.2016.1153038

Javaid, A. (2017). The unknown victims: Hegemonic masculinity, masculinities, and male sexual victimisation. *Sociological Research Online*, *22*(1), 1–20. https://doi.org/10.5153/sro.4155

Jesuit Refugee Service UK. (2018). *Refugees reveal the reality of living in destitution A report by the Jesuit Refugee Service UK Out in the cold*. https://www.jrsuk.net/wp-content/uploads/2018/01/Out-in-the-Cold_Homelessness-among-destitute-refugees-in-London_A-report-by-JRS-UK_January-2018_FINAL.pdf

Jobe, A. (2020). Telling the right story at the right time: Women seeking asylum with stories of trafficking into the sex industry. *Sociology*, *54*(5), 936–952. https://doi.org/10.1177/0038038520932019

Joffe, H. (2012). Thematic Analysis. *In qualitative research methods in mental health and psychotherapy: A Guide for Students and Practitioners*. Wiley-Blackwell.

Johnson, K. (2010). Association of sexual violence and human rights violations with physical and mental health in territories of the Eastern Democratic Republic of the Congo. *JAMA*, *304*(5), 553. https://doi.org/10.1001/jama.2010.1086

Kanafani, G. (1969). Al-Hadaf. Popular Front for the Liberation of Palestine.

Kamali, M., Munyuzangabo, M., Siddiqui, F. J., Gaffey, M. F., Meteke, S., Als, D., Jain, R. P., Radhakrishnan, A., Shah, S., Ataullahjan, A., & Bhutta, Z. A. (2020). Delivering mental health and psychosocial support interventions to women and children in conflict settings: a systematic review. *BMJ Global Health*, *5*(3). https://doi.org/10.1136/bmjgh-2019-002014

Kanceljak, D., & Calia, C. (2023). Diversity and inclusion in UK psychology: A nationwide survey. *Clinical Psychology Forum*, *1*(369), 15–29. https://doi.org/10.53841/bpscpf.2023.1.369.15

Karim, S., & Beardsley, K. (2016). Explaining sexual exploitation and abuse in peacekeeping missions. *Journal of Peace Research*, *53*(1), 100–115. https://doi.org/10.1177/0022343315615506

Karim, S., & Beardsley, K. (2017). *Explaining sexual exploitation and abuse in peacekeeping missions: The role of female peacekeepers and gender equality in contributing countries*. https://people.duke.edu/~kcb38/SEA_Final_JPR.pdf

Kaseke, S. (2010, December 1). *"Standing together on a riverbank": Group conversations about sexual abuse in Zimbabwe.* | *International Journal of Narrative Therapy & Community Work* | *EBSCOhost*. Openurl.ebsco.com. https://openurl.ebsco.com/EPDB%3Agcd%3A6%3A26554278/detailv2?sid=ebsco%3Aplink%3Ascholar&id=ebsco%3Agcd%3A59579328&crl=c

Keating, M. (2021). Taking back control? Brexit and the territorial constitution of the United Kingdom. *Journal of European Public Policy*, *29*(4), 1–19. https://doi.org/10.1080/13501763.2021.1876156

Khairat, M., Hodge, S., & Duxbury, A. (2023). Refugees' and asylum seekers' experiences of individual psychological therapy: A qualitative meta-synthesis. *British Journal of Medical Psychology*. https://doi.org/10.1111/papt.12470

Kipling, R. (1956). *Kipling: a selection of his stories and poems*. Doubleday & Company. (Original work published 1899)

Kiss, L., Quinlan-Davidson, M., Pasquero, L., Tejero, P. O., Hogg, C., Theis, J., Park, A., Zimmerman, C., & Hossain, M. (2020). Male and LGBT survivors of sexual violence in conflict situations: a realist review of health interventions in low-and middle-income countries. *Conflict and Health*, *14*(1). https://doi.org/10.1186/s13031-020-0254-5

Kivlahan, C., AlSharif, M., Elliott, I., Pereira, A. G., Hallak, Z., Yonso, R., Odaimi, A., AlHafez, N., & Aswad, M. (2024). Long-term physical and psychological symptoms in Syrian men subjected to detention, conflict-related sexual violence and torture: cohort study of self-reported symptom evolution. *EClinicalMedicine*, *67*, 102373. https://doi.org/10.1016/j.eclinm.2023.102373

Knipschild, R., Klip, H., Winkelhorst, K., Stutterheim, T., & Agnes van Minnen. (2024). Blame-less study : a two-arm randomized controlled trial evaluating

the effects of an online psychoeducation programme for adolescents who have experienced physical/sexual violence or sexual abuse. Rationale, study design, and methods. *European Journal of Psychotraumatology*, *15*(1). https://doi.org/10.1080/20008066.2024.2315794

Koos, C. (2018). Decay or resilience? *World Politics*, *70*(2), 194–238. https://doi.org/10.1017/s0043887117000351

Kreft, A.-K. (2018). Responding to sexual violence: Women's mobilization in war. *Journal of Peace Research*, *56*(2), 220–233. https://doi.org/10.1177/0022343318800361

Leatherman, J. L. (2011). *Sexual violence and armed conflict*. Polity Press.

Leiby, M. L. (2009). Wartime sexual violence in Guatemala and Peru. *International Studies Quarterly*, *53*(2), 445–468. https://doi.org/10.1111/j.1468-2478.2009.00541.x

Lieby, M. (2020). Uncovering men's narratives of conflict-related sexual violence. In *Sexual Violence Against Men in Global Politics* (pp. 1–278). Routledge.

Lieth, E. von der. (2017). *Forced to flee: A case study analysis of sexual violence during the Syrian civil war*. Www.ceeol.com; Transnational Press London. https://www.ceeol.com/search/chapter-detail?id=843515

LoCicero, A., Marlin, R. P., Jull-Patterson, D., Sweeney, N. M., Gray, B. L., & Boyd, J. W. (2016). Enabling torture: APA, clinical psychology training and the failure to disobey. *Peace and Conflict: Journal of Peace Psychology*, *22*(4), 345–355. https://doi.org/10.1037/pac0000213

Lowe, M. (2018). Male sexual assault survivors: lessons for UK services. *Journal of Aggression, Conflict and Peace Research*, *10*(3), 181–188. https://doi.org/10.1108/jacpr-07-2017-0308

Lowe, M., & Rogers, P. (2017). The scope of male rape: A selective review of research, policy and practice. *Aggression and Violent Behavior*, *35*(35), 38–43. https://doi.org/10.1016/j.avb.2017.06.007

Madar, R. (2023). Beyond male Israeli soldiers, Palestinian women, rape, and war: Israeli state sexual violence against Palestinians. *Conflict and Society*, *9*(1), 72–88. https://doi.org/10.3167/arcs.2023.090105

McHugh, P. R., & Treisman, G. (2007). PTSD: A problematic diagnostic category. *Journal of Anxiety Disorders*, *21*(2), 211–222. https://doi.org/10.1016/j.janxdis.2006.09.003

Medawatte, D., De Mel, N., Yapa Abeywardena, S., & Gnanaraj, R. (2022). *Conjunctures of silence: Aphonias in the prosecution of conflict related sexual violence in Sri Lanka - The Vishvamadu Case*. https://thegenderhub.com/wp-content/uploads/2022/02/Conjunctures-of-Silence.pdf

Medico, D., & Santiago-Delefosse, M. (2014). From reflexivity to resonances: Accounting for interpretation phenomena in qualitative research. *Qualitative Research in Psychology*, *11*(4), 350–364. https://doi.org/10.1080/14780887.2014.915367

Medien, K. (2021). Israeli settler colonialism, “humanitarian warfare,” and sexual violence in Palestine. *International Feminist Journal of Politics*, *23*(5), 1–22. https://doi.org/10.1080/14616742.2021.1882323

Meegaswatta, T. N. K. (2022). Men and masculine identities in life narratives of Sri Lanka’s war. *South Asia: Journal of South Asian Studies*, *45*(4), 1–16. https://doi.org/10.1080/00856401.2022.2055914

Michael, L., & Schulz, S. (2019). *Unsettling whiteness*. BRILL.

Middle East Monitor . (2023, November 30). https://www.middleeastmonitor.com/20231130-ramzi-al-abbasi-sheds-light-on-negev-prison-conditions-upon-his-release/.

Morgan, G., Melluish, S., & Welham, A. (2017). Exploring the relationship between post migratory stressors and mental health for asylum seekers and refused asylum seekers in the UK. *Transcultural Psychiatry*, *54*(5-6), 653–674. https://doi.org/10.1177/1363461517737188

Moss, C., Smith, S. J., Kim, K., Hua, N., Noronha, N., Kavenagh, M., & Wekerle, C. (2023). A global systematic scoping review of literature on the sexual exploitation of boys. *Child Abuse & Neglect* , *142*, 106244–106244. https://doi.org/10.1016/j.chiabu.2023.106244

Motluk, K. (2024). The imagined island: Colonialism and constructed remoteness on Diego Garcia. *Geographical Journal*. https://doi.org/10.1111/geoj.12587

Nasir-Addameer, T. (2024). Escalating oppression: Israel's systematic violations intensify in Palestine. In *https://www.addameer.org*.

Nationality and Borders Act. (2022). *Nationality and Borders Act 2022*. Legislation.gov.uk. https://www.legislation.gov.uk/ukpga/2022/36/contents/enacted

Naylor, C., Bell, A., Baird, B., Heller, A., & Gilburt, H. (2020). *Mental health and primary care networks Understanding the opportunities*. https://www.centreformentalhealth.org.uk/wp-content/uploads/2020/08/Mental-Health-and-PCNs-online-version.pdf

Needham, C., & Carr, S. (2009). *Co-Production: An emerging evidence base for adult social care transformation.* (pp. 1–24). Social Care Institute for Excellence.

Neuner, F., Catani, C., Ruf, M., Schauer, E., Schauer, M., & Elbert, T. (2008). Narrative exposure therapy for the treatment of traumatized children and adolescents (KidNET): From Neurocognitive Theory to Field Intervention. *Child and Adolescent Psychiatric Clinics of North America*, *17*(3), 641–664. https://doi.org/10.1016/j.chc.2008.03.001

Neuner, F., Elbert, T., & Schauer, M. (2018). Narrative Exposure Therapy (NET) as a treatment for traumatized refugees and post-conflict populations. *Mental Health of Refugee and Conflict-Affected Populations*, 183–199. https://doi.org/10.1007/978-3-319-97046-2_9

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating Posttraumatic Stress Disorder in an African Refugee Settlement. *Journal of Consulting and Clinical Psychology*, *72*(4), 579–587. https://doi.org/10.1037/0022-006x.72.4.579

NHS. (2024). *NHS England» Migrants' Health*. Www.england.nhs.uk. https://www.england.nhs.uk/publication/migrants-health/

NICE. (2005, March 23). *Post-traumatic stress disorder: management | Guidance | NICE*. Nice.org.uk; NICE. https://www.nice.org.uk/guidance/CG26

Nixon, R. (2011). Slow violence and the environmentalism of the poor. https://doi.org/10.4159/harvard.9780674061194

Nordås, R., & Cohen, D. K. (2021). Conflict-related sexual violence. *Annual Review of Political Science*, *24*(1), 193–211. https://doi.org/10.1146/annurev-polisci-041719-102620

Nordås, R., & Rustad, S. C. A. (2013). Sexual exploitation and abuse by peacekeepers: Understanding Variation. *International Interactions*, *39*(4), 511–534. https://doi.org/10.1080/03050629.2013.805128

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, *16*(1), 1–13. SagePub. https://doi.org/10.1177/1609406917733847

Nowrojee, B. (1996). *Shattered lives : sexual violence during the Rwandan genocide and its aftermath.* Human Rights Watch.

Olaluwoye, T., Hoban, E., & Williams, J. (2023). Forms of sexual violence perpetrated in conflict and post-conflict settings against South Sudanese men resettled in two communities in Uganda: an exploratory qualitative study. *Conflict and Health*, *17*(1). https://doi.org/10.1186/s13031-023-00544-7

Olsson, L., Muvumba Sellström, A., Moncrief, S., Wood, E. J., Johansson, K., Lotze, W., Ruffa, C., Hoover Green, A., Sjöberg, A. K., & Kishi, R. (2020). Peacekeeping prevention: Strengthening efforts to pre-empt conflict-related

sexual violence. *International Peacekeeping*, *27*(4), 517–585. https://doi.org/10.1080/13533312.2020.1782752

Onyango, M. A., & Hampanda, K. (2011). Social constructions of masculinity and male survivors of wartime sexual violence: an Analytical Review. *International Journal of Sexual Health*, *23*(4), 237–247. https://doi.org/10.1080/19317611.2011.608415

Oparina, E., Krekel, C., & Srisuma, S. (2024). *Talking therapy: Impacts of a nationwide mental health service in England*. https://docs.iza.org/dp16839.pdf

Palattiyil, G., & Sidhva, D. (2015). Caught in a Web of Multiple Jeopardy: Post-Traumatic Stress Disorder and HIV-Positive Asylum Seekers in Scotland. *Clinical Social Work Journal*, *43*(4), 362–374. https://doi.org/10.1007/s10615-015-0542-5

Parker, I. (2005). *Qualitative psychology introducing radical research*. Maidenhead Open Univ. Press.

Parker, I. (2007). Critical psychology: What it is and what it is not. *Social and Personality Psychology Compass*, *1*(1), 1–15. https://doi.org/10.1111/j.1751-9004.2007.00008.x

Parker, S., Earnshaw, D., Penn, M., & Kumari, R. (2023). Uncertain futures: perceptions of refugees in a story completion task. *Qualitative Research Journal*, *23*(5), 545–556. https://doi.org/10.1108/qrj-11-2022-0145

Parkhurst, J. O., & Abeysinghe, S. (2016). What constitutes “good” evidence for public health and social policy-making? From hierarchies to appropriateness. *Social Epistemology*, *30*(5-6), 665–679. https://doi.org/10.1080/02691728.2016.1172365

Patel , N. (2018). The mantra of “do no harm” in international healthcare responses to refugee people. In *An uncertain safety. Integrative health care for 21st century refugees* (pp. 155–183). Springer International.

Patel , N. (2019). Human rights-based approach to applied psychology. *Human Rights and Psychology*, *24*(2). https://doi.org/10.1027/1016-9040/a000371

Patel , N., & Mahtani , A. (2004). Psychological approaches to working with political rape. In *Rape as a Method of Torture*. Medical Foundation for the Care of Victims of Torture.

Patel, N. (2003). Clinical psychology: reinforcing inequalities or facilitating empowerment? *The International Journal of Human Rights*, *7*(1), 16–39. https://doi.org/10.1080/714003792

Patel, N. (2020). Psychological care for torture survivors, their families and communities. *Edward Elgar Publishing EBooks*. https://doi.org/10.4337/9781788113960.00028

Patel, N., Tribe, R., & Yule, B. (2018). Guidelines for psychologists working with refugees and asylum seekers in the UK: Extended version. *British Psychological Society EBooks*. https://doi.org/10.53841/bpsrep.2018.inf300b

Patel, N., & Williams, A. (2022). Rehabilitation for torture survivors: Six evidence myths and their implications for future research. *Torture Journal*, *32*(1-2), 227–250. https://doi.org/10.7146/torture.v32i1-2.131776

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Sage.

PEARL. (2022). *No trials, only tribulations for Tamil victims of Sri Lanka's conflict-related sexual violence*. https://pearlaction.org/wp-content/uploads/2022/08/No-Trials-Only-Tribulations-for-Tamil-Victims-of-Sri-Lankas-CRSV-August-2022.pdf

Penney, D., & Prescott, L. (2016). *The co-optation of survivor knowledge 35 5 The co-optation of survivor knowledge: the danger of substituted values and voice*.

Pollino, M. A. (2021). Turning points from victim to survivor: an examination of sexual violence narratives. *Feminist Media Studies*, *23*(5), 1–16. https://doi.org/10.1080/14680777.2021.2006260

Price, L. (2014). Critical realist versus mainstream interdisciplinarity. *Journal of Critical Realism*, *13*(1), 52–76. https://doi.org/10.1179/1476743013z.00000000019

Pruitt, L. J. (2019). Closed due to “flooding”? UK media representations of refugees and migrants in 2015–2016 – creating a crisis of borders. *The British Journal of Politics and International Relations*, *21*(2), 383–402.

Puar, J. (2011). Citation and censorship: The politics of talking about the sexual politics of Israel. *Feminist Legal Studies*, *19*(2), 133–142. https://doi.org/10.1007/s10691-011-9176-3

Puar, J. K. (2004). Abu Ghraib: Arguing against exceptionalism. *Feminist Studies*, *30*(2), 522. https://doi.org/10.2307/20458978

Puar, J. K. (2015). Homonationalism as assemblage: Viral travels, affective sexualities. *Revista Lusófona de Estudos Culturais*, *3*(1). https://doi.org/10.21814/rlec.98

Puar, J. K. (2017). *The right to maim: Debility, capacity, disability*. Duke University Press.

Quisay, W., & Qureshi, A. (2024). *When only God can see: The faith of Muslim political prisoners*. Pluto Press.

Qurashi, F. (2018). The Prevent strategy and the UK “war on terror”: embedding infrastructures of surveillance in Muslim communities. *Palgrave Communications*, *4*(1), 1–13. https://doi.org/10.1057/s41599-017-0061-9

Re, D. (2015). Female combatants in the Syrian conflict, in the fight against or with the IS, and in the peace process. *Palgrave Macmillan UK EBooks*, 84–99. https://doi.org/10.1057/9781137516565_6

Refugee Action. (2020). *Waiting in the dark: How the system dehumanises, disempowers and damages*. https://www.refugee-action.org.uk/wp-content/uploads/2020/07/Waiting-in-the-Dark-Report.pdf

Rober, P., & Seltzer, M. (2010). Avoiding colonizer positions in the therapy room: some ideas about the challenges of dealing with the dialectic of misery and resources in Families. *Family Process*, *49*(1), 123–137. https://doi.org/10.1111/j.1545-5300.2010.01312.x

Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. Houghton Mifflin.

Rubenstein, L. S. (2007). First, do no harm: health professionals and Guantánamo. *PubMed*, *37*(3), 733–748.

Rubini, E., Valente, M., Trentin, M., Giulia Facci, Luca Ragazzoni, & Gino, S. (2023). Negative consequences of conflict-related sexual violence on survivors: a systematic review of qualitative evidence. *International Journal for Equity in Health*, *22*(1). https://doi.org/10.1186/s12939-023-02038-7

Said, E. (1978). *Orientalism*. Pantheon Books.

Said, E. W. (1979). *The question of Palestine*. Vintage.

Said, E. W. (1981). *Covering Islam how the media and the experts determine how we see the rest of the world*. London Vintage Books [Ca.

Saunders, N., & Al-Om, T. (2022). Slow resistance: Resisting the slow violence of asylum. *Millennium: Journal of International Studies*, *50*(2), 030582982110663. https://doi.org/10.1177/03058298211066339

Sharlach, L. (2000). Rape as genocide: Bangladesh, the former Yugoslavia, and Rwanda. *New Political Science*, *22*(1), 89–102. https://doi.org/10.1080/713687893

Sigvardsdotter, E., Vaez, M., Hedman, A.-M. R., & Saboonchi, F. (2016). Prevalence of torture and other war related traumatic events in forced migrants: A systematic review. *Human Rights Documents Online*, *26*(2). https://doi.org/10.1163/2210-7975_hrd-9921-2016014

Sivakumaran, S. (2005). Male/male rape and the “Taint” of homosexuality. *Human Rights Quarterly*, *27*(4), 1274–1306. https://doi.org/10.1353/hrq.2005.0053

Sivakumaran, S. (2007). Sexual violence against men in armed conflict. *European Journal of International Law*, *18*(2), 253–276. https://doi.org/10.1093/ejil/chm013

Skjelsbaek, I. (2001). Sexual violence and war: Mapping out a Complex Relationship. *European Journal of International Relations*, *7*(2), 211–237. https://doi.org/10.1177/1354066101007002003

Smith, H., & Henley, J. (2023, June 16). Greece shipwreck: hopes of finding survivors fade on final day of search. *The Guardian*. https://www.theguardian.com/world/2023/jun/16/greece-shipwreck-people-smuggling-suspects-arrested-as-search-continues

Sooka , Y., & Harrison, F. (2021). *Sri Lanka: Torture & sexual violence by security forces 2020-21*. https://itjpsl.com/assets/ITJP-Torture-report-2021-Sep-ENGLISH.pdf

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). *Quality in qualitative evaluation: A framework for assessing research evidence*. Government Chief Social Researcher’s Office. https://assets.publishing.service.gov.uk/media/5a7f49a8e5274a2e87db4f00/a_quality_framework_tcm6-38740.pdf

Steel, C., Young, K., Akbar, S., Chessell, Z., Stevens, A., Vann, M., & Arntz, A. (2022). The treatment of PTSD in refugees and asylum seekers using imagery rescripting within an NHS setting. *Behavioural and Cognitive Psychotherapy*, *51*(2), 1–14. https://doi.org/10.1017/s1352465822000650

Stiglmayer, A., Faber, M., & Gutman, R. (1994). *Mass rape: the war against women in Bosnia-Herzegovina = Massenvergewaltigung : Krieg gegen die Frauen*. University Of Nebraska Press.

Strzyżyńska, W. (2024, April 26). Reparations to be paid to survivors of wartime sexual violence in Ukraine. *The Guardian*. https://www.theguardian.com/global-development/2024/apr/26/reparations-survivors-wartime-sexual-violence-by-russian-soldiers-ukraine-war-olena-zelenska

Suhaiymah Manzoor-Khan. (2022). *Tangled in terror : uprooting Islamophobia*. Pluto Press.

Sukhera, J. (2022). Narrative reviews: Flexible, rigorous, and practical. *Journal of Graduate Medical Education*, *14*(4), 414–417. https://doi.org/10.4300/jgme-d-22-00480.1

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ*, *322*(7278), 95–98. https://doi.org/10.1136/bmj.322.7278.95

Summerfield, D. (2012). Afterword: against “global mental health.” *Transcultural Psychiatry*, *49*(3-4), 519–530. https://doi.org/10.1177/1363461512454701

Tamil Guardian. (2021). *History in flames: remembering the burning of Jaffna Library | Tamil Guardian*. Www.tamilguardian.com. https://www.tamilguardian.com/content/history-flames-remembering-burning-jaffna-library-0

Tamil Guardian . (2024). *Eelam Tamil refugees on Diego Garcia unsafe, UN calls for immediate relocation | Tamil Guardian*. Www.tamilguardian.com. https://www.tamilguardian.com/content/eelam-tamil-refugees-diego-garcia-unsafe-un-calls-immediate-relocation

Tartir, A., Seidel, T., & Dana, T. (2024). *Resisting domination in Palestine*. Bloomsbury Publishing.

Thabet, A. A. M., EL-Buhaisi, O., & Vostanis, P. (2014). Trauma , PTSD , Anxiety and Coping Strategies among Palestinians Adolescents Exposed to War in Gaza = الصدمات النفسية الناتجة عن الحرب على غزة و علاقتها بالقلق و كرب ما بعد الصدمة و طرق التأقلم لدى المراهقين الفلسطينين. *The Arab Journal of Psychiatry*, *25*(1), 71–82. https://doi.org/10.12816/0004117

The British Psychological Society . (2023). *Media portrayal of Ukrainian refugees was unusually positive*. BPS. https://www.bps.org.uk/news/media-portrayal-ukrainian-refugees-was-unusually-positive

Theisen-Womersley, G. (2021). *Trauma and resilience among displaced populations*. Springer Nature.

Tinti, P. (2018). *Migrant refugee smuggler saviour*. Hurst & C. Pub. Ltd.

Titunik, R. F. (2009). Are we all torturers now? A reconsideration of women's violence at Abu Ghraib. *Cambridge Review of International Affairs*, *22*(2), 257–277. https://doi.org/10.1080/09557570902877950

Touquet , H. (2018). Unsilenced: Male survivors speak on conflict-related sexual violence in Sri Lanka. In *Internation Truth and Justice Project* (pp. 1–26). https://www.itjpsl.com/assets/ITJP_unsilenced_report-final.pdf

Tozzini, D. (2009). El otro lado de la historia: violencia sexual contra hombres: Perú 1980-2000. *Consejería En Proyectos (PCS)*,.

Tribe, R. (2019). Using co- production within mental health training when working with refugee or migrant community groups. *International Journal of Mental Health*, *48*(4), 1–8. https://doi.org/10.1080/00207411.2019.1693087

Tribe, R. H., Sendt, K.-V., & Tracy, D. K. (2017). A systematic review of psychosocial interventions for adult refugees and asylum seekers. *Journal of Mental Health*, *28*(6), 1–15. https://doi.org/10.1080/09638237.2017.1322182

Tribe, R., & Morrissey, J. (2020). *The handbook of professional, ethical and research practice for psychologists, counsellors, psychotherapists, and psychiatrists* (3rd ed.). Routledge.

Trueba, M. L., Axelrod, T., & Ayeb-Karlsson, S. (2023). Are asylum seekers and refugees provided with appropriate mental health support in the United Kingdom? *Journal of Ethnic and Migration Studies*, *49*(13), 1–21. https://doi.org/10.1080/1369183x.2023.2181126

Tucker, B., & Triantafyllos, S. (2008). Lynndie England, Abu Ghraib, and the New Imperialism. *Canadian Review of American Studies*, *38*(1), 83–100. https://doi.org/10.3138/cras.38.1.83

Turchik, J. A., & Edwards, K. M. (2012). Myths about male rape: A literature review. *Psychology of Men & Masculinity*, *13*(2), 211–226. https://doi.org/10.1037/a0023207

Turner, L. (2019). The politics of labelling refugee men as “vulnerable.” *Social Politics: International Studies in Gender, State & Society*, *28*(1). https://doi.org/10.1093/sp/jxz033

UK Government (2022). *Preventing Sexual Violence in Conflict Initiative Strategy*. [online] Available at: https://assets.publishing.service.gov.uk/media/63810376d3bf7f153b8b3260/preventing-sexual-violence-in-conflict-initiative-strategy.pdf.

UNHCR. (2019). *Humanitarian principles*. UNHCR. https://emergency.unhcr.org/protection/protection-principles/humanitarian-principles

United Nations. (2023a). *Conflict-related sexual violence: report of the united nations secretary-general* (pp. 1–32). https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2023/07/SG-REPORT-2023SPREAD-1.pdf

United Nations. (2023b). *UK Illegal Migration Bill: UN Refugee Agency and UN Human Rights Office warn of profound impact on human rights and international refugee protection system*. OHCHR. https://www.ohchr.org/en/press-releases/2023/07/uk-illegal-migration-bill-un-refugee-agency-and-un-human-rights-office-warn

United Nations. (2020). The Handbook for United Nations Field Missions on Preventing and Responding to Conflict-Related Sexual Violence. In *https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2020/06/2020.08-UN-CRSV-Handbook.pdf* (pp. 1–170).

United Nations. (2024, May 16). *South Africa Oral Argument: Genocide in Gaza Strip (South Africa v. Israel) | Int'l Court of Justice*. YouTube. https://www.youtube.com/watch?v=O_loqkRc8ns

United Nations Security Council. (2013). *Resolution 2106* (pp. 1–6). https://www.un.org/shestandsforpeace/sites/www.un.org.shestandsforpeace/files/unscr_2106_2013_on_wps_english.pdf

United Nations Security Council . (2009). *Resolution 1888 (2009)*.

Ventriglio, A. (2022). Geopolitical determinants of mental health: Towards a global perspective. *International Journal of Social Psychiatry*, *69*(1), 002076402211123. https://doi.org/10.1177/00207640221112319

Vince, N. (2010). Transgressing Boundaries: Gender, Race, Religion, and "Francaises Musulmanes" during the Algerian War of Independence. *French Historical Studies*, *33*(3), 445–474. https://doi.org/10.1215/00161071-2010-005

Vince, N. (2016). *Our fighting sisters : nation, memory and gender in Algeria, 1954-2012.* S.N.

Vindevogel, S., Coppens, K., Derluyn, I., De Schryver, M., Loots, G., & Broekaert, E. (2011). Forced conscription of children during armed conflict: Experiences of former child soldiers in northern Uganda. *Child Abuse & Neglect*, *35*(7), 551–562. https://doi.org/10.1016/j.chiabu.2011.03.011

Vojdik, V. K. V. K. (2013). Sexual violence against men and women in War: A Masculinities Approach. *SSRN Electronic Journal*, *14*(923). https://doi.org/10.2139/ssrn.2271222

Walsh, J., & Ferazzoli, M. T. (2023). The colonised self: The politics of UK asylum practices, and the embodiment of colonial power in Lived Experience. *Social Sciences*, *12*(7), 382. https://doi.org/10.3390/socsci12070382

Webster, D. (2005). *The man in the hood and new accounts of prisoner abuse in Iraq | Vanity Fair*. Vanity Fair | the Complete Archive. https://archive.vanityfair.com/article/2005/2/the-man-in-the-hood-and-new-accounts-of-prisoner-abuse-in-iraq

Weishut, D. J. N. (2015). Sexual torture of Palestinian men by Israeli authorities. *Reproductive Health Matters*, *23*(46), 71–84. https://doi.org/10.1016/j.rhm.2015.11.019

Wheeler, S. (2020). *UN peacekeeping has a sexual abuse problem*. Human Rights Watch. https://www.hrw.org/news/2020/01/11/un-peacekeeping-has-sexual-abuse-problem

Wind, M. (2024). *Towers of ivory and steel*. Verso Books.

Wood, E. J. (2006). Variation in sexual violence during war. *Politics & Society*, *34*(3), 307–342.

Wood, E. J. (2009). Armed groups and sexual violence: When Is Wartime Rape Rare? *Politics & Society*, *37*(1), 131–161.

Wood, E. J. (2014). Conflict-related sexual violence and the policy implications of recent research. *International Review of the Red Cross*, *96*(894), 457–478. https://doi.org/10.1017/s1816383115000077

Wood, N., & Patel, N. (2017). On addressing “Whiteness” during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291. https://doi.org/10.1177/0081246317722099

Younis, T. (2022). *The Muslim, state and mind*. SAGE.

Younis, T., & Jadhav, S. (2019). Islamophobia in the National Health Service: an ethnography of institutional racism in PREVENT’s counter-radicalisation policy. *Sociology of Health & Illness*, *42*(3).

Zalewski, M., Drumond, P., PrüglE., & Stern, M. (2018). *Sexual violence against men in global politics*. Routledge.

Zraly, M., & Nyirazinyoye, L. (2010). Don’t let the suffering make you fade away: An ethnographic study of resilience among survivors of genocide-rape in

southern Rwanda. *Social Science & Medicine*, *70*(10), 1656–1664. https://doi.org/10.1016/j.socscimed.2010.01.017

APPENDICES

Appendix A: Checklist for interview and interview schedule

Checklist for day of the interview

- ❑ Date:
- ❑ Identifier (e.g. 01CRSVM):
- ❑ Has read participant information sheet:
- ❑ Has signed consent form:
- ❑ Confirm that:
  - Clinical Psychologist is a registered clinician
  - Has experience working with male victim survivors of CRSV
- ❑ Demographics* (complete below):
- ❑ Address/location of the participant for risk reasons:
- ❑ Consent to take a telephone number, in case of loss of connection:
- ❑ Happy to proceed as discussed – recording and captions:
- ❑ Questions?:
- ❑ Has the person requested a copy of the findings? If yes, contact details:

*Demographics

- Gender identity:
- Ethnicity:
- Age:
- How long they have worked in this field

Starting

- ❑ Start **recording**
- ❑ Start **transcription**
- ❑ Check Recording and transcribing
- ❑ Start interview

Ending

- Questions?
- Concerns?
- Debriefing sheet

1. What ideas, theories and frameworks do clinical psychologists draw on in relation to their work with male victim-survivors of CRSV and what informs these (in relation their experiences, training, and education)?

2. What are the key knowledge gaps that need to be addressed to improve the design and implementation of psychosocial interventions for male survivors of CRSV in the UK?

Interview Schedule

Reiterate the purpose of the interview: to gain insights into the experiences, training, education, and knowledge gaps related to the work with male victim-survivors of CRSV in the UK.

Broad topics of discussion for interviews, with prompts:

Can you tell me why you have chosen to participate? [warming the context]

Ideas, Theories, and Frameworks

- What theoretical frameworks, ideas, or approaches do you find most relevant in your work with male victim-survivors of CRSV?
- Can you describe how these frameworks inform your practice, taking into account your experiences, training, and education?
- How have your personal experiences or background influenced your approach to psychosocial interventions in this context?

Training and Education

- Can you discuss the specific training or education you've received regarding psychosocial interventions for male survivors of CRSV?
- Have there been any notable gaps or shortcomings in your training that you've had to address independently?
- How do you stay updated on the latest research and practices in this field?

Key Knowledge Gaps

- In your experience, what are the most significant knowledge gaps in the design and implementation of psychosocial interventions for male survivors of CRSV in the UK?
- Are there any challenges or barriers you've encountered in addressing these knowledge gaps?
- What recommendations do you have for addressing these gaps and improving support for male survivors of CRSV in the UK?

General prompts – responsive to what people bring:

- Where feels like a good place to start?
- Could you say more about that?

- And why do you think that is/was the case?
- What happened after that?
- What do you think about, that?
- What do others' think?

Ending:

Is there anything else you'd like to add or share regarding your work with male victim-survivors of CRSV?

Appendix B: Recruitment Flyer

RECRUITING CLINICAL PSYCHOLOGISTS

How can clinical psychologists help to improve psychosocial interventions for male victim-survivors of conflict-related sexual violence (CRSV)?

What is this research about?

The research will be exploring the perceptions of psychologists in the UK who support male victim-survivors of CRSV.

I am hoping to recruit 10-12 Clinical Psychologists working in the UK

What will happen?

An online or in person (in East London) one-to-one semi-structured interview, lasting approximately 1 hour.

.

You are eligible to take part if you :

- *Are a registered Clinical Psychologist in the UK*
- *Have worked clinically with male victim-survivors of CRSV*

Who am I?

My name is Sujeena and I am studying for a Professional Doctorate in Clinical Psychology at UEL.

If you would like to participate or have any questions please contact me via email u2195624@uel.ac.uk

University of East London

Appendix C: Participant Information Sheet

Participant Information Sheet

How can Clinical Psychologists help to improve psychosocial interventions for male victim-survivors of conflict-related sexual violence?

Contact name: Sujeena Navajeeva

Email: u2195624@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve.

If you have any questions, please contact me on: u2195624@uel.ac.uk

Who am I?
My name is Sujeena Navajeeva. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a doctorate for Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?
I am conducting research on the perceptions of working with male victim-survivors of conflict related sexual violence that have come from refugee backgrounds and currently reside in the UK. This research seeks to explore the role of Clinical Psychologists in enhancing the well-being and recovery of male victim-survivors of conflict-related sexual violence. I aim to investigate the potential ways in which clinical psychology can contribute to the development and implementation of effective psychosocial interventions tailored to the unique needs of this specific population.

Why have you been invited to take part?
To address the study aims, I am inviting Clinical Psychologists to provide insight in their perceptions of working with male victim-survivors of CRSV. The purpose of this study is to understand how Clinical Psychologists can contribute to improving psychosocial interventions for male victim-survivors of conflict-related sexual violence. Your participation is crucial to help us advance the support and care available to individuals who have experienced this form of trauma.

It is entirely up to you whether you take part or not, participation is voluntary.

What will you be asked to do if you agree to take part?
If you agree to take part, you will be asked to complete one interview, this will be like be having an informal chat, of up to an hour. The conversation will be recorded, anonymised, and confidentially stored. I do not have any connection with the Home Office or other organisations, and I will not be feeding back any information to other organisations.

You do not have to answer any of the questions you do not want to answer, and we can take breaks whenever you want. We can stop the interview and the recording if at any point you need to do so.

If you are happy to take part remotely via MS Teams then you may take part anywhere you feel is sufficiently comfortable and confidential, but it would be helpful if you have access to a video device and reasonably stable WiFi or signal.

Can you change your mind?
You can change your mind at any time before, or during the interview and withdraw without explanation, disadvantage, or consequence. After the interview, you can withdraw if you let me know within six weeks. If you do not withdraw within six weeks, I will use the anonymized data from the interview.

Are there any disadvantages to taking part?

The study involves discussing a potentially distressing topic. We will agree a plan together, so the interview feels safe. I will give you information on support providers that you could contact if needed. If you would like support now you can:

- Seek support from your GP if you experience difficulties which persist over time.
- Contact: Mind: https://www.mind.org.uk/

See the debriefing sheet for more support organisations. In the highly unlikely event that the researcher is concerned about a risk of harm to self or others, confidentiality may need to be broken.

How will the information you provide be kept secure and confidential?

I will anonymise the data by changing your name (using a pseudonym) and will change or remove any data in your interview transcript that I feel may lead to you being identified. I will securely store your personal contact details separately from the interview transcript, only until the end of the thesis project. Anonymised data will be

stored securely on MS One Drive for Business and SharePoint by Dr Lorna Farquharson, for five years at most, then deleted. Anonymised data will be available to the researcher's supervisor, examiners, and in the final thesis report.

General Data Protection Regulation (GDPR)

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's data repository: https://repository.uel.ac.uk. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public) through journal articles, presentations, magazine articles, and blogs**. In all material produced, your identity will remain anonymous.**

You have the option to receive a summary of the research findings once the study has been completed if you would like, you will need to give relevant contact.

Anonymised research data will be securely stored by Dr Lorna Farquharson for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?
My research has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Miss Sujeena Navajeeva: u2195624@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ, Email: l.farquharson@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix D: Consent form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

How can Clinical Psychologists help to improve psychosocial interventions for male victim-survivors of conflict-related sexual violence?

Contact name: Sujeena Navajeeva

Email: u2195624@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw from the study within six weeks from the date of the interview, my data will not be used.	
I understand that the interview will be recorded using MS Teams with transcription on, or with a recording device.	
I understand that my personal information and data, including video or audio recordings, from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview will be used in a thesis that will appear online, and in addiction may be used in	

material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……
……

Participant's Signature

……
……

Researcher's Name (BLOCK CAPITALS)
SUJEENA NAVAJEEVA

……
……

Researcher's Signature

……
……

Date

……
……

Appendix E: A UEL Ethics Form

University of East London

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)	
1.1	Before completing this application, please familiarise yourself with: British Psychological Society's Code of Ethics and Conduct UEL's Code of Practice for Research Ethics UEL's Research Data Management Policy UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required.

	HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: Study advertisement Participant Information Sheet (PIS) Participant Consent Form Participant Debrief Sheet Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) Permission from an external organisation (see section 7) Original and/or pre-existing questionnaire(s) and test(s) you intend to use Interview guide for qualitative studies Visual material(s) you intend showing participants

Section 2 – Your Details		
2.1	Your name:	Sujeena Navajeeva
2.2	Your supervisor's name:	Dr Lorna Farqurharson
2.3	Name(s) of additional UEL supervisors:	Dr Hannah Eades
		3rd supervisor (if applicable)
2.4	Title of your programme:	Doctorate of Clinical Psychology
2.5	UEL assignment submission date:	01/05/2024
		Re-sit date (if applicable)

Section 3 – Project Details		
Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.		
3.1	Study title: Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	How can Clinical Psychologists help to improve psychosocial interventions for male victim-survivors of conflict-related sexual violence?
3.2	Summary of study background and aims (using lay language):	In the context of conflict-related sexual violence (CRSV), the setting is deeply entrenched in the landscapes of war, genocide, and occupation. The historical narrative

		surrounding CRSV once painted a picture of a universal and inevitable experience of war, often perpetrated by men against women. However, a nuanced understanding has emerged through ongoing research, revealing a complex web of factors that shape these atrocities. The majority of victim-survivors are women and girls, but the intention, identities of both victim-survivor and perpetrator, and even the experiences of men as victim-survivors contribute to the multifaceted nature of CRSV. This backdrop of war, marked by its brutal genocidal acts and oppressive occupations, has long concealed the experiences of male victim-survivors. Structural barriers, entrenched notions of hegemonic masculinity and heterosexuality, and legal frameworks categorising CRSV as beatings or torture have collectively rendered men's experiences largely invisible in research, policy, and activism. The silence surrounding male victimisation, often perpetuated by societal expectations, becomes a tool for overlooking their suffering. Clinicians in the UK play a crucial role in this narrative, as underscored by Leiby et al. (2018). Their research emphasises the importance of clinicians recognising and acknowledging male survivors of CRSV, challenging deeply ingrained gender stereotypes that act as barriers to disclosure and access to services. The proposed research, focusing on the clinical relevance of CRSV, seeks to reshape psychological practices to meet the therapeutic needs of this often-stigmatised population. By shedding light on the silenced experiences within the settings of war, genocide, and occupation, the research aims not only to understand but also to pave the way for comprehensive and compassionate support tailored to the unique challenges faced by male survivors of CRSV.
3.3	Research question(s):	What ideas, theories and frameworks do clinical psychologists draw on in relation to their work with male victim-survivors of CRSV and what informs these (in relation their experiences, training, and education)? What are the key knowledge gaps that need to be addressed to improve the design and implementation of psychosocial interventions for male survivors of CRSV in the UK?
3.4	Research design:	Qualitative design: Semi-structured interviews will be conducted to promote a two-way conversation; with the aim of enabling participants to explore more sensitive issues relating to CRSV and their ideas in relation to working within this field. Data will be analysed using Thematic Analysis (TA), 12 participants will suffice for data saturation (Guest et al., 2006). This will enable appropriate theme generation as comparisons can be drawn across the participants, without interpretations becoming superficial (Braun & Clarke, 2012).
3.5	Participants:	12 clinical psychologists working in the UK that work with male survivors who have experienced CRSV will be interviewed. The researcher aims to interview qualified

	Include all relevant information including inclusion and exclusion criteria	psychologists that have supported men who have experienced CRSV. The researcher will recruit psychologists working only in the UK using advertisements through Twitter and reach out to social and professional networks (such as LinkedIn and Instagram). It will be likely that I will find sufficient participants due to networking in this field and also with my placement contacts (I have been placed at Freedom From Torture for one year). 12 participants will suffice.
3.6	Recruitment strategy: Provide as much detail as possible and include a backup plan if relevant	Researcher will also recruit through UK-based services that specialise in refugee mental health, men's psychosexual health, and human rights charities such as ANBU, and Freedom from Torture (FFT), from where 'snowballing' may occur. Researcher has got an established rapport with ANBU (Abuse Never Becomes Us, PEARL (People for Equality and Relief in Lanka,), and has an initial relationship with FFT as researcher has been placed there for a 12 month clinical placement.
3.7	Measures, materials or equipment: Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	Interview – interview guide will be a semi-structured interview that will ask about intimacy post conflict related sexual violence. The key resource required are joint consultations with DoS and professionals that specialise in CRSV to continue building on the interview schedule as it is preliminary. The interview guide will be created through consultation. Speaking with male CRSV victim-survivors as well as organisations with expertise in this area may inform the questions. Through networking with ANBU and PEARL, researcher has found a male victim-survivor of CRSV from the Tamil community and a human rights lawyer that has conducted extensive field research in Sri Lanka. Both people are willing to provide consultation for the interview guide. The individuals consulted won't take part in the study. [See Appendix for draft interview schedule that will be developed in consultation]. Additional resources are as follows: Laptop (My personal laptop) Password encrypted devices (dual authenticators on laptops) Microsoft (Teams, Word, Outlook, One Drive) [Participants will use own equipment]
3.8	Data collection: Provide information on how data will be collected from the point of consent to debrief	Participants that are interested can contact the researcher via University of East London (UEL) email {on social media advert – see appendix}. Telephone calls will be arranged to screen for suitability. If suitable, participant information sheets, consent forms and date of planned

		interview will be provided on Microsoft Teams. Face-to-face interviews will be organised at the UEL Campus; however, remote interviews will be offered as an alternative to cater to participants' needs (disabilities, cost of travel, comfortability, lack of time). Regular breaks would be provided to reduce the impact of emotional exhaustion and interviews will last one hour or under. If participants consent, interviews will be recorded (audio and video) [in Teams with secure storage]. Debriefs will happen after interviews, in which participants are able to openly ask questions. The transcription will be made on Teams due to ease, and this will thoroughly checked over for immediate errors and will cross-referenced with audio recordings.	
3.9	Will you be engaging in deception?	YES ☐	NO ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	n/a	
3.10	Will participants be reimbursed?	YES ☐	NO ☒
	If yes, please detail why it is necessary.	n/a	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	n/a	
3.11	Data analysis:	Interview audios will be transcribed, and data will be analysed using Reflexive Thematic Analysis (Braun & Clarke, 2006, 2021), 12 participants will suffice for data saturation (Guest et al., 2006). This will enable appropriate theme generation as comparisons can be drawn across the participants, without interpretations becoming superficial (Braun & Clarke, 2012). As participants' perceptions in relation to working with male victim-survivors will be analysed, TA was chosen as it is congruent with critical realism. As this analysis is not theory-agnostic, researcher's position, assumptions, and values will be reported through reflexive statements. Themes will be conceptualised, and meaning-based patterns will be identified (Braun & Clarke, 2013).	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations. If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.			
4.1	Will the participants be anonymised at source?	YES ☒	NO ☐
	If yes, please provide details of how the data will be anonymised.	It is imperative to minimise this risk as much as possible, so all participants will be referred to as IDs and any identifiable information will be anonymised. To maintain confidentiality any identifiable information will be destroyed after six weeks after collection, and only retained for this duration in the case that participants would like to withdraw from the study. Data pertaining participants will be anonymised by storing consent forms and data from the quantitative data separately. All documents (except consent forms) will be labelled with a randomised ID e.g., SNCRSV14678.	
4.2	Are participants' responses anonymised or are an anonymised sample?	YES X	NO ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	Data collected will not be shared with anyone beyond the researcher, thesis supervisor and field supervisor. Strong passwords alongside authenticators will be used to lock documents containing sensitive and confidential information pertaining to CRSV.	
4.3	How will you ensure participant details will be kept confidential?	Once completed, the thesis will be publicly accessible via UEL research repository. Participants will be required to consent to this prior to participation. This is to best protect participants confidentiality.	
4.4	How will data be securely stored and backed up during the research? Please include details of how you will manage access, sharing and security	All information pertaining to participants will be anonymised and participants will be allocated non identifiable ID's. Lastly, any data collected on paper will be stored in the office of the PI (located in the UEL Psychology Department) in a locked cabinet.	
4.5	Who will have access to the data and in what form? (e.g., raw data, anonymised data)	No one outside of the researcher and Dos will have access to the research data files. Only anonymised data will be shared with research supervisor(s) and examiners. Only anonymised data will be included in the thesis and any publications, presentations etc.	
4.6	Which data are of long-term value and will be retained?	Anonymised research data for dissemination purposes. This data will be stored in UEL's Arkivum which is secure archiving system, this	

	(e.g., anonymised interview transcripts, anonymised databases)	information will only be made accessible to the research team and a limited number of library staff, as recommended by the UK Research and Innovation (UKRI) guidelines. This information will be appraised every 5 years.	
4.7	What is the long-term retention plan for this data?	The thesis will remain on the repository and the dataset will be reviewed at the end of the project and every 5 years thereafter, unless another timescale is specified by the research funder, until data are destroyed or transferred, as per UEL's Research Data Management Policy. Lastly, signed consent forms will be destroyed following data analysis.	
4.8	Will anonymised data be made available for use in future research by other researchers?	YES ☐	NO ☒
	If yes, have participants been informed of this?	YES ☐	NO ☒
4.9	Will personal contact details be retained to contact participants in the future for other research studies?	YES ☐	NO ☒
	If yes, have participants been informed of this?	YES ☐	NO ☒

Section 5 – Risk Assessment			
If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.			
5.1	Are there any potential physical or psychological risks to participants related to taking part? (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	YES ☐	NO ☒
	If yes, what are these, and how will they be minimised?	As I will be interviewing Clinical Psychologists that work in this field, the potential physical and psychological risks is minimal.	
5.2	Are there any potential physical or psychological risks to you as a researcher?	YES ☒	NO ☐
	If yes, what are these, and how will they be minimised?	The topic can cause the researcher to be emotionally distressed. However, clinical supervision at FFT and personal therapy can aid this.	

5.3	If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:	YES ☒		
5.4	If necessary, have appropriate support services been identified in material provided to participants?	YES ☒	NO ☐	N/A ☐
5.5	Does the research take place outside the UEL campus?	YES ☐	NO ☒	
	If yes, where?	Please enter details about the location of the research		
5.6	Does the research take place outside the UK?	YES ☐	NO ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	YES ☐		
5.7	Additional guidance: For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk,			

	it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Section 6 – Disclosure and Barring Service (DBS) Clearance			
6.1	Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)? If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	YES ☐	NO ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?	YES X	NO ☐
6.3	Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?	YES X	NO ☐
6.4	If you have current DBS clearance, please provide your DBS certificate number:	001692981862	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	Additional guidance:		

	If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.

Section 7 – Other Permissions			
7.1	Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?	YES ☐	NO ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	YES ☐	
7.2	Additional guidance: Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.		

Section 8 – Declarations		
8.1	Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:	YES ☒
8.2	Student's name: (Typed name acts as a signature)	SUJEENA NAVAJEEVA
8.3	Student's number:	U2195624

8.4	Date:	29/03/2023
Supervisor's declaration of support is given upon their electronic submission of the application		

RISK ASSESSMENT FORM

UEL Risk Assessment Form

Name of Assessor:	Sujeena Navajeeva	Date of Assessment	18.10.2023
Activity title:	Doctoral Thesis Research	Date, time and location of activity:	UEL Campus, DOCKLANDS CAMPUS, ATRIUM, EAST BUILDING.
Signed off by Manager (Print Name)			

Please describe the activity in as much detail as possible (include nature of activity, estimated number of participants, etc)
If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

The risk assessment covers the completion of interviews to investigate perceptions of working with male victim-survivors of conflict-related sexual violence. Approximately 8 to 12 participants that are registered clinical psychologists will be recruited from NHS, charity and public domains. The interviews will approximately last 1 hour including oneshort breaks.

Overview of FIELD TRIP or EVENT:

Not applicable

Guide to risk ratings:

Likelihood of Risk	Hazard Severity	Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-5 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6-9 = High (Further control measures essential)

Which Activities Carry Risk?

Activity / Task Involved	Describe the potential hazard?	Who is at risk?	Likelihood of risk	Severity of risk	Risk Rating (Likelihood x Severity)	What precautions have been taken to reduce the risk?	State what further action is needed to reduce risk (if any) and state final risk level	Review Date
Interview done on Microsoft teams	Risk of participants becoming emotionally distressed	Participants	1	1	1	Participants are informed about the nature and content of the interview. All participants will be offered a full debrief after completing the interview. Participants will also be offered breaks and the right to withdraw at any point of the interview.	Interviews are likely to be distressing and retraumatising; distress will be carefully monitored throughout the process through regular breaks and check-ins. Where risk is deemed high, researcher's DoS will be informed to come up with a contingency plan to safeguard and minimise risk. The risk might be deemed high, for example if they express ongoing suicidality during the interview. The contingency plan, for example could be referral for psychological support/ highlight risk to named clinician within the mental health service.	

A comprehensive guide to risk assessments and health and safety in general can be found in UEL's Health & Safety handbook at http://www.uel.ac.uk/hrservices/hs/handbook/ and a comprehensive guide to risk assessment is available on the Health & Safety Executive's web site at http://www.hse.gov.uk/risk/casestudies/index.htm. An example risk assessment is also included below.

Appendix B: Ethical approval and amendments

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details

Reviewer:	Please type your full name **John Read**
Supervisor:	Please type supervisor's full name **Lorna Farquharson**
Student:	Please type student's full name **Sujeena Navajeeva**
Course:	Please type course name **Prof Doc Clinical**
Title of proposed study:	How can Clinical Psychologists help to improve psychosocial interventions for male victim-survivors of conflict-related sexual violence?

Checklist
(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐

Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options

APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The

	supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments

Please clearly detail the amendments the student is required to make

Clarify, in the ad and PIS whether 'conflict-related sexual violence' refers only to war situations or to conflicts within relationships.

{Consider whether you are likely to find enough participants}

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**J**ohn Read
Date:	**10/11/2023**
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee	
RESEARCHER PLEASE NOTE For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics	

Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

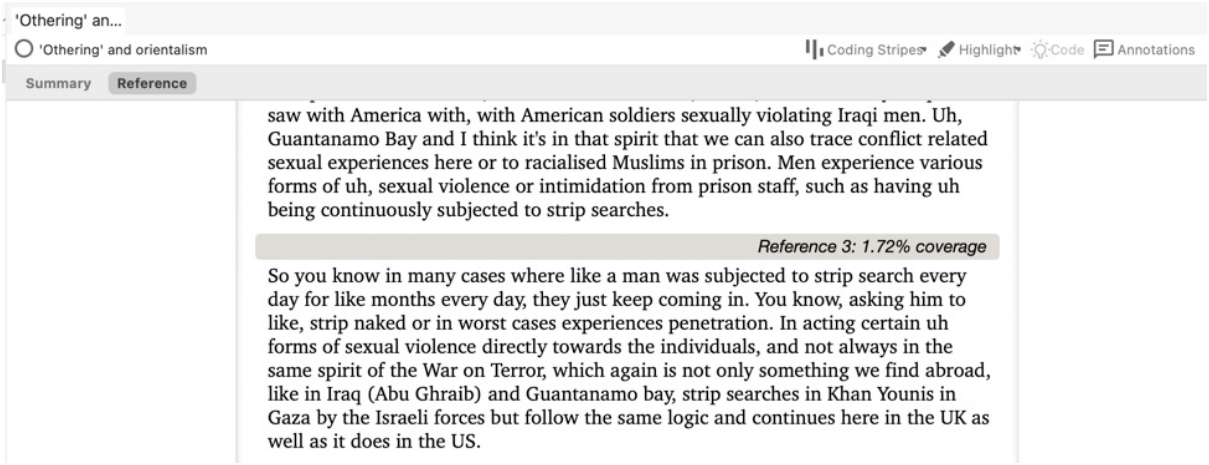
For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

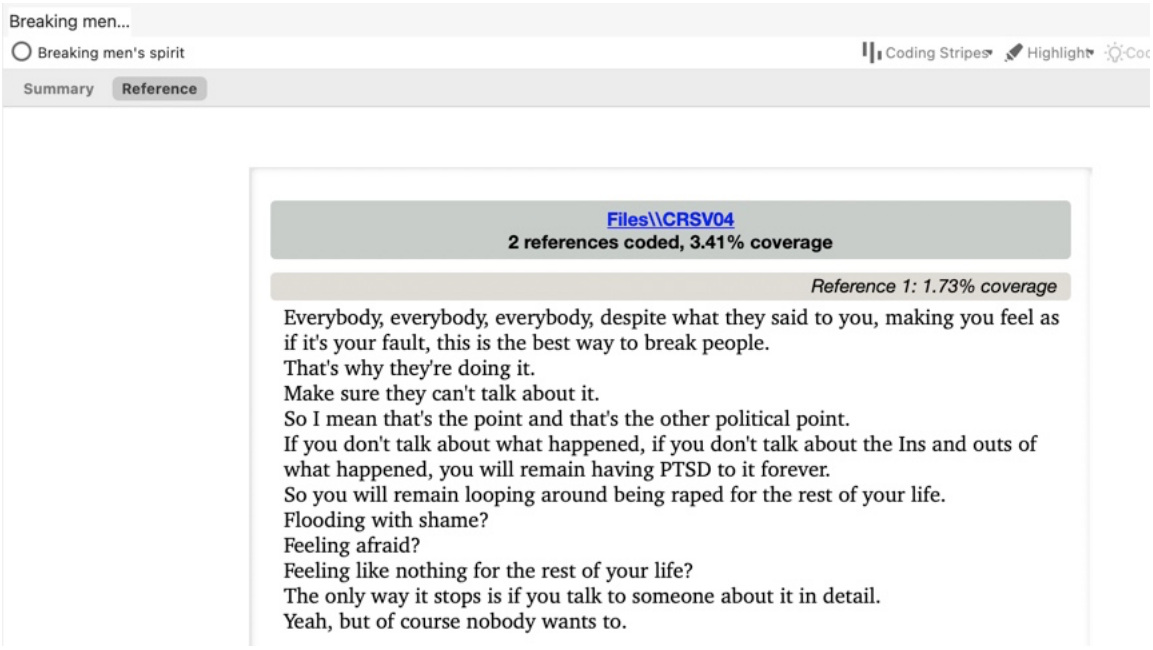
Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	**SUJEENA NAVAJEEVA**
Student number:	**U2195624**
Date:	**04/12/2023**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

Appendix F: Example of TA codes in NVivo





Files\\CRSV09
1 reference coded, 7.63% coverage

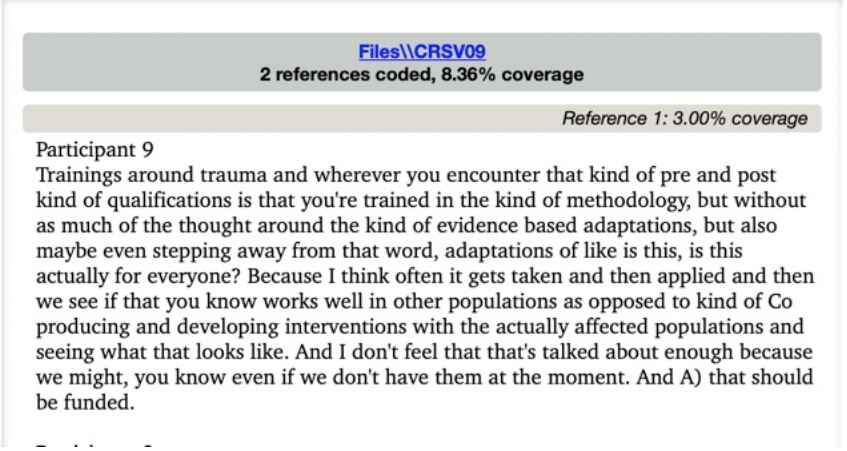
Reference 1: 7.63% coverage

Participant 9
I think there are significant knowledge gaps that are trying to be addressed and this is just broadly around kind of Co production.

Participant 9
In making sure that research you know is trying to move away from models where and by researchers, I mean clinical psychologists wanting to kind of design and implement something moving away from a model where the clinician kind of decides. I wonder if that's helpful and goes ahead and test it out, but I don't feel that I feel that there is a quite a knowledge gap in how to effectively do kind of Co developed Co produced research with the community that is actually.

Participant 9
Affected by this?


lack of funding
lack of funding
Coding Stripes
Highlight
Code
Summary
Reference
Files\\CRSV05
2 references coded, 4.07% coverage
Reference 1: 1.29% coverage
But I think some interventions where they're working with people who actually have PTSD do not necessarily deliver trauma, focus interventions for reasons that aren't clear to me, which actually means that therefore, people aren't necessarily getting exposure to an evidence based
Participant 5
Treatment And then we don't really know if that would have been helpful for them or not
Participant 5
So I think it's definitely a kind of there's a lack of funding, probably, maybe a lack of interest, I don't know
Lack of justic...
Lack of justice and accountability
Coding Stripes
Highlight
Code
Summary
Reference
Reference 2: 3.96% coverage
Forced in very precarious situations, among them sexual. Obviously as well as we were saying and very, very little accountability here actually or for these collective communities.
So I think structurally we have I think knowledge is actually really probably less the the structures will inform our our knowledge production in a way right like if we're holding different forms, if we have certain forms of accountability at hand that will inform how we produce and like rely on knowledge. Otherwise, now accountability producing knowledge that ends up being. I guess a little bit tainted from the fact that it's being developed in contexts where by accountability isn't isn't found, right? Which is would be really weird, right? It's like maybe an Israeli psychologist, for example, let's say in Palestinian prisons, you know, talking about theories of sexual violence. You can have theories of like conflict related sexual violence that Palestinians go through, but that would be like already very, very questionable given like bits. Bar-on and others have written so much on like the sexual violence that Palestinians UM, especially Palestinian prisoners might experience.
So yeah, it's one of those things where I think knowledge for me comes secondary to the actual practice and political structures that we find ourselves in.
producing appropriate psychosocial interventions for this demographic
Coding Stripes
Highlight
Code
Summary
Reference


Files\\CRSV09
2 references coded, 8.36% coverage
Reference 1: 3.00% coverage
Participant 9
Trainings around trauma and wherever you encounter that kind of pre and post kind of qualifications is that you're trained in the kind of methodology, but without as much of the thought around the kind of evidence based adaptations, but also maybe even stepping away from that word, adaptations of like is this, is this actually for everyone? Because I think often it gets taken and then applied and then we see if that you know works well in other populations as opposed to kind of Co producing and developing interventions with the actually affected populations and seeing what that looks like. And I don't feel that that's talked about enough because we might, you know even if we don't have them at the moment. And A) that should be funded.

Appendix G: NVIVO Themes (1st attempt)

Research Question 1

What ideas, theories and frameworks do clinical psychologists draw on in relation to their work with male victim-survivors of CRSV and what informs these (in relation their experiences, training, and education)?

Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Theoretical and clinical frameworks	Systemic influence	x	X	X
Use of Established Therapeutic Models: CBT framework, trauma-informed care, body-based therapy, EMDR, exposure therapy, compassion-focused therapy. Integration of Socio-Political Contexts: Bridging clinical and socio-political, colonial history impact, capitalism, anti-racism, political activism. Cultural and Spiritual Integration: Integrating faith into therapy, cultural humility, cultural literacy, non-Eurocentric therapies, spirituality.	Systemic and Institutional Barriers: NHS and third-sector dynamics, constraints of services, legal status of clients, infrastructure of therapy spaces and state actors Cultural and Identity Issues: Masculinity, cultural identity, dealing with asylum seekers, experiences of racism and Islamophobia, PREVENT. Client-Clinician Dynamics: CP's discomfort, barriers to opening up, therapeutic alliance, power dynamics within therapy.			

Research Question 2

What are the key knowledge gaps that need to be addressed to improve the design and implementation of psychosocial interventions for male survivors of CRSV in the UK?

Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
x	X	Knowledge and Training Gaps: Lack of Specific Training and Awareness: lack of training, gap in theory, inadequate services, non-disclosure and silenced, covering conflict on training courses. Need for Specialized Knowledge: sexual functioning, dealing with chronic pain, sexual torture, genocide, understanding male victim-survivors. Improving Psychosocial Interventions: development of interventions, co-production, community-based approaches, evidence-based therapy critiques.	Political and Ethical Considerations: Navigating Politics and Ethics in Therapy: adherence to status quo, CPs proximity to military industry complex, political literacy, critiquing Western liberal perspectives. Human Rights and Legal Concerns: human rights violations, international law, justice, legality, state and institutional violence.	Client Experiences and Personal Narratives: Impact of Trauma and Recovery Processes: body keeps score, memory processing for trauma, reenactment of trauma, trauma services. Client-Centered Perspectives: clients' conceptualisations of distress, clients' goals, empowerment, expert of their experience. Identity and Community: reconnecting with identity, collective and community healing, cultural identity, loss of homeland.

Appendix H: Nvivo Themes (finalised)

Research Question 1

What ideas, theories and frameworks do clinical psychologists draw on in relation to their work with male victim-survivors of CRSV and what informs these (in relation their experiences, training, and education)?

Theme 1	Theme 2	Theme 3	Theme 4
Theoretical and clinical frameworks	Critical reflexivity	X	x
Use of Established Therapeutic Models: CBT framework, trauma-focused therapies, body-based therapy, EMDR, exposure therapy, compassion-focused therapy, PTSD framework, memory processing for trauma Cultural and Spiritual Integration: Integrating faith/spirituality into therapy, cultural humility, cultural literacy, non-Eurocentric therapies/ideas (Tree of Life), liberation practices and ideologies Issues around masculinity: clients' conceptualisations of distress, clients' goals, empowerment, survivor-agency, masculinity, shame, victimhood Community mobilization and collective healing: reconnecting with identity, collective and community healing, cultural identity, loss of homeland, romantic	Political contextualisation: Bridging clinical and socio-political, Critique the notion of 'trauma,' impact of colonial history Political reflexivity: Masculinity, cultural identity, asylum seekers, experiences of racism and Islamophobia, PREVENT, securitisation, War on Terror, specific to racialised men, prison setting Personal reflexivity: CP's discomfort, barriers to opening up, therapeutic alliance, power dynamics within therapy, whiteness in CP, position, awareness and personal reflections		

relationships, social fabric			

Research Question 2

What are the key knowledge gaps that need to be addressed to improve the design and implementation of psychosocial interventions for male survivors of CRSV in the UK?

Theme 1	Theme 2	Theme 3	Theme 4
X	X	Knowledge and training gaps	Political and Ethical considerations
		Lack of Specific Training and Awareness: lack of training, gap in theory, inadequate services, covering conflict on training courses, blind spots and biases, anti-racism Need for Specialised Knowledge for racialised men: sexual functioning, dealing with chronic pain, sexual torture, understanding male victim-survivors, difference with working with female victim-survivors Advocating for survivor-led and co-produced psychosocial interventions: development of interventions, co-production, community-based approaches, evidence-based therapy critiques. Systems of accountability and justice	Systemic and Institutional Barriers: NHS and third-sector dynamics, constraints of services, legal status of clients, infrastructure of therapy spaces and state actors Navigating Politics and Ethics in Therapy: adherence to status quo, CPs proximity to military industry complex, political literacy, critiquing Western liberal perspectives. Human Rights and Legal Concerns: human rights violations, international law, justice, legality, state and institutional violence.