Service-Level Barriers To Accessing Support Following Intimate Partner Violence For Men Who Have Sex With Men: Service Provider Perspectives

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ABSTRACT

Background: Research indicates that intimate partner violence occurs in male same-sex relationships at a similar or higher rate than in heterosexual relationships and is associated with significant distress and adverse physical and mental health outcomes. However, dominant understandings of intimate partner violence take a traditional feminist approach based on patriarchy and gender power imbalance; a framework which does not fit for male same-sex relationships. There is little understanding of the barriers which may impact men who have sex with men's ability to seek help and the ways in which services contribute to these barriers, particularly in the UK.

Aims: To explore mental health professionals' views and experiences of the service-level barriers that face men who have sex with men who have experienced intimate partner violence as well as what services in the UK could be doing to better support them, in the hope that this will lead to improvements in support and services.

Methods: Semi-structured interviews were conducted with seven mental health professionals and covered participants' experiences of working with men who have sex with men who have experienced intimate partner violence, their views on the barriers to accessing support and what services could be doing to better serve this community.

Results: Thematic analysis from a critical realist perspective identified three overarching themes, each with their own subthemes: 'Confined to within' ('Bound by abuse', 'Silenced by shame'), 'The system says 'no'' ('Toxic hetero-patriarchal lens', 'Intersecting layers of oppression', 'Not the 'right' client') and 'Minority becoming majority' ('Mainstream services exclude', 'Making the inaccessible accessible', 'Unlearning and re-learning').

Conclusions: Results from the analysis are discussed in the context of relevant theory, in particular the Barriers Model to Help-Seeking (St Pierre & Senn, 2010), and previous research. The study highlighted the importance of a nuanced understanding of intimate partner violence in male same-sex relationships as well as the importance of the socio-political context, including discourses of anti-LGBTQ+ prejudice, heteronormativity and hegemonic masculinity, in the setting up of structural barriers to accessing support.

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1 INTRODUCTION

1.1 Overview

This chapter provides a contextual overview of the present research, including what the relatively small literature base has found regarding same-sex intimate partner violence, and particularly male same-sex intimate partner violence. It is argued that the traditional feminist paradigm for understanding intimate partner violence cannot be applied to same-sex intimate partner violence and alternative understandings based on criticisms from queer and intersectional theorists are proposed. What is known about help-seeking in same-sex and particularly male same-sex survivors is explored, with a focus on barriers to help-seeking related to the way in which services are set up. The chapter will end with a scoping review of the literature to highlight gaps and provide a rationale for the study aims and research questions.

1.2 Terminology

The researcher endeavoured to use terminology throughout this thesis which is sensitive and respectful. There is acknowledgement that someone else may have made different choices. When it comes to terminology regarding the LGBTQ+ community, there are many alternatives and almost none of the terms are uncontested (Zwicky, 1997). The following choices were made for the sake of clarity, consistency and above all to convey respect to the participants of the study, the LGBTQ+ community and survivors of intimate partner violence.

1.2.1 Lesbian, Gay, Bisexual, Transgender, Queer, Questioning + (LGBTQ+)

Sexual identities are often amalgamated and definitions can lack consensus (Gates, 2011; Herek & Garnets, 2007; Monro & Richardson, 2010; Moradi et al., 2009). Therefore, the LGBTQ+ community as a whole is often considered a homogenous group; however, they often do not see themselves as having a common identity (Dollimore, 1997; Monro & Richardson, 2010; Prosser, 1997) and this homogenising may lead to an obscuring of widely differing experiences and identities. However, for the sake of clarity and consistency, the term LGBTQ+ will be used throughout this thesis to describe lesbian, gay, bisexual, transgender, queer, questioning and + to indicate acceptance of any other terms used by individuals (Stonewall, 2016). This is hoped to encompass the full range of sexual identities whilst allowing for individuals to identify and name themselves. Furthermore, whilst identifying as LGBTQ+ is understood as an identity, engaging in a same-sex relationship can be understood as a behaviour; not all individuals engaging in same-sex relationships identify as members of the LGBTQ+ community (Knauer, 2011) and, due to the fluid nature of sexuality (Mock & Eibach, 2012), an individual's current and past relationships may not be consistent with their current sexual identity. Therefore, for clarity and consistency, when referring to intimate partner violence (IPV) in LGBTQ+ relationships, the current study will use the term same-sex IPV.

1.2.2 Men who have sex with men (MSM)

The term 'men who have sex with men' (MSM) was coined in the US in the 1990s and, since this time, has been applied to many areas of public health research. Although the term has been criticised for obscuring the complex nature of sexual orientation (Young & Meyer, 2005), the use of the term MSM allows for the inclusion of gay- and bisexual- identified men as well as non-gay, non-bisexual identified MSM who may prefer an alternative identity label (e.g. queer, pansexual) or lack a sexual identity altogether (Hennen, 2008). Furthermore, research with the LGBTQ+ community has been criticised for erasure of bisexuality (Finneran & Stephenson, 2013), which is defined as the process in which bisexual people are made invisible (Flanders et al., 2017) or bisexuality is overlooked as a valid sexual identity (Barker & Langdridge, 2008). This is part of a larger pattern of bisexual erasure in scientific research (Turell et al., 2018) and public health discourse (Yoshino, 2017). Therefore, use of the term MSM also allows for inclusion of bisexual men in both research and discourse.

1.2.3 Anti-LGBTQ+ prejudice

The term homophobia, whilst still commonly used, is increasingly being recognised as problematic as it stems from words emphasising fear and is suggestive of mental illness (Dermer et al., 2010; Herek, 2004). Therefore, the term anti-LGBTQ+

prejudice will be used throughout this paper to refer to prejudice and discrimination against members of the LGBTQ+ community.

1.2.4 Heteronormativity

Heteronormativity is understood as the process by which heterosexual norms and behaviours are upheld as the dominant way of viewing and understanding the world (Dodds et al., 2005). A heteronormative view is one that involves the alignment of biological sex, gender, gender roles and sexuality (Lovaas & Jenkins, 2006) and discursively constructs practices related to heterosexuality as the norm or referent, whilst those who self-present or whose practices are different from what is socially recognised as heterosexual are discursively constructed as ‘deviant’ (Cannon et al., 2015).

1.2.5 Intimate Partner Violence (IPV)

The definition of intimate partner violence (termed as domestic violence in this instance) stipulated by the UK government is “*Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are, or have been intimate partners or family members, regardless of gender or sexuality*” (Home Office, 2005, p. 7). This clearly acknowledges that IPV can and does occur outside of heterosexual relationships, something which is further acknowledged within the Domestic Violence, Crime & Victims Act (2004), which states that injunctions are available to same-sex couples. Despite this, although definitions of IPV differ depending on theoretical standpoint, almost all are based on research into violence against women (Burelomova et al., 2018). The terms ‘domestic violence’ and ‘intimate partner violence’ are often used interchangeably but some important distinctions exist. Domestic violence is a broader term (Barocas et al., 2016) which refers to violence that takes place between any two people within a household, and can include both child and elder abuse. Intimate partner violence may come under the umbrella of domestic violence but specifically refers to violence which occurs between romantic partners who may or may not live together (World Health Organization, 2012). As this research is focused on violence or abuse which occurs between romantic partners, the term intimate partner violence (IPV) will be used.

1.3 Intimate Partner Violence (IPV)

IPV encompasses "*any behaviour within an intimate relationship that causes psychological, physical or sexual harm to those in the relationship*" (World Health Organization, 2012, p. 1). It is generally understood to occur in order to control, coerce, dominate and isolate another person within an intimate relationship, thereby creating an imbalance of power between the partners (Madera & Toro-Alfonso, 2005; Peterman & Dixon, 2003). IPV can include acts of physical or sexual violence, emotional or financial abuse and controlling behaviours (Madera & Toro-Alfonso, 2005; Peterman & Dixon, 2003) and once it has occurred in a relationship, it is more likely to reoccur (Tully, 2001).

The detrimental impact of IPV can affect an individual's health, social, psychological and economic welfare, and even cause loss of life (Campbell et al., 2007; Renzetti, 2009). IPV has been recognised as a major public health issue (García-Moreno et al., 2013), is thought to span all major racial groups, ages, sexual and gender identities and social classes (Berrios & Grady, 1991; Browne & Law, 2007; McDermott, 2011; Pertnoy, 2012) and be prevalent in all communities, across geographic and demographic borders with universal and wide-ranging health effects (World Health Organization, 2002). Research has found IPV to be linked to adverse physical and mental health outcomes (Bonomi et al., 2006; Ellsberg et al., 2008; Nixon et al., 2004; Plichta & Falik, 2001; Romito et al., 2005), including sexually transmitted infections (Bauer et al., 2002), chronic pain (Coker et al., 2002) and suicidal ideation (Afifi et al., 2009) and is of particular importance at the current time due to the rise in reports of IPV associated with government responses to COVID-19 (Van Gelder et al., 2020). It is estimated that between 26 and 61% of people have experienced violence within their relationships (Hamel, 2013). However, it is important to recognise that these are estimates of reported abuse; the actual figures are likely to be higher as many survivors of IPV may not report it due to lack of knowledge about IPV, feeling trapped, apprehensions about law enforcement, wanting to maintain privacy, the belief that IPV is not a serious enough problem and emotional barriers such as fear, shame and embarrassment, among other reasons (McCart et al., 2010; McClennen, 2005; Merrill & Wolfe, 2000; Wolf et al., 2003). Although IPV is recognised to be a serious and wide-ranging social and health problem, there have been calls for an improvement of the social and legal protections in the UK when it comes to prevention of IPV and supporting survivors (Burman & Chantler, 2005).

Despite a large research focus on IPV, methodological problems such as a lack of universal definition (Plichta, 2004), use of non-specific and insensitive measures (Bonomi et al., 2006) and overuse of cross-sectional samples (Ellsberg et al., 2001) are common critiques of the literature.

1.4 IPV in same-sex relationships

Although there is an extensive literature on IPV in heterosexual relationships (Hester, 2004), there is a much more limited research base on same-sex relationships (Baker et al., 2013; Cannon & Buttell, 2015; Edwards et al., 2015; Letellier & Island, 2013; Turell et al., 2012). In fact, in a 2015 review, only 3% of the literature was found to focus on IPV in same-sex relationships (Edwards et al., 2015) and within this, has mainly focused on lesbian relationships, with a relatively small literature base regarding IPV amongst MSM. This is part of a larger historical trend of exclusion of LGBTQ+ communities from public health research (Boehmer, 2002; Renn, 2010) as well as minoritized communities more generally being less well represented in anti-violence literature (Ristock & Timbang, 2005). One possible explanation for this lack of research on IPV in same-sex relationships is that research into IPV has tended to be informed by a conceptualisation of violence as rooted in hegemonic masculinity, adherence to gender norms and heteronormativity. Therefore, the questions asked and methods used tend towards a consideration of men's violence against women (Messinger, 2014). Patriarchal and heteronormative beliefs about gender roles perpetuated by the dominant Western social paradigm have contributed to myths and misunderstandings about who is and is not seen as a survivor of IPV (Brown, 2008). Such beliefs include the fallacy that only males can be perpetrators, whereas females can only be survivors. This perpetuates the myth that IPV does not occur within female same-sex relationships and does not recognise men as survivors within either heterosexual or male same-sex relationships. This then silences and obscures IPV within same-sex relationships and contributes to additional oppression and marginalisation of the LGBTQ+ community (Kaschak, 2014; Ristock, 2003).

This lack of research attention is also reflected in UK Governmental spending. Despite concerns over funding cuts for mainstream IPV services (Tesch, 2010), in 2010 the Home Secretary announced a budget of over £28 million for specialist services for domestic violence against women and girls. However, there was no mention of this funding supporting lesbian or female bisexual survivors, or male survivors (either members of LGBTQ+ or heterosexual communities).

Although an accurate prevalence rate of IPV in same-sex relationships is difficult to determine due to underreporting, problematic methodology and unclear definitions (West, 2002), it is estimated to be similar to or higher than that of heterosexual relationships (Blosnich & Bossarte, 2009; Messinger, 2011; Walters et al., 2011), with IPV being estimated to affect one in four people who are members of the LGBTQ+ community in the UK (Henderson, 2003). Research has found that underreporting of IPV in same-sex relationships is impacted by denial, anti-LGBTQ+ prejudice, stigma and fear of criticism from heterosexual communities (Jackson, 2007; Madera & Toro-Alfonso, 2005).

There are many common characteristics of violence in relationships across both heterosexual and LGBTQ+ communities (Jackson, 2007). Some common models are used to understand the experience of survivors across both communities, such as the Duluth Model and cycles of violence (Pertnoy, 2012). The Duluth model posits that perpetrators of IPV exercise power and control in order to assert dominance by committing physical, emotional, psychological, sexual and financial violence against their partners (Carvalho et al., 2011; Pertnoy, 2012). Cycles of violence maintains the idea that abusive partnerships proceed through cycles of abuse, whereby three phases are moved through; tension building, acute abuse and a honeymoon period (Walker, 1979). These phases are cyclical and repetitive in that there is a gradual increase in the frequency and severity of abusive behaviours over time and with each cycle involving a period of loving behaviour (the honeymoon period). These models have been found to apply to both opposite-sex and same-sex relationships (Burke & Owen, 2006) and demonstrate the commonalities among the experiences of survivors of IPV and the impact of all violent relationships (Pertnoy, 2012), including the role of power and control, the recurring nature of abuse and the intensification of the violence over time (Ard & Makadon, 2011; Chan & Cavacuiti, 2008). Additionally, health and quality of life impacts of both same-sex and opposite-sex IPV have been found to be similar (Blosnich & Bossarte, 2009) and many of the contextual factors found in heterosexual IPV have also been found to apply to same-sex IPV; for example, violence as a display of hegemonic masculinity, substance abuse, power and control, mental health difficulties and intergenerational trauma (Bartholomew et al., 2008; DeKeseredy & Schwartz, 2005; Hellmuth et al., 2008; Levitt et al., 2008; Lewis et al., 2012; Stanley et al., 2006).

Although some experiences of violence in relationships are universal to all survivors (e.g. physical and emotional pain), there are unique and important distinctions of same-sex IPV that have been found in the literature (Ard & Makadon, 2011; Chan & Cavacuiti, 2008; Patzel, 2005). These include the threat of being ‘outed’ by the perpetrator (exposing the survivors sexual orientation to friends, family, employers etc.), intense isolation stemming from being ‘in the closet’, meaning that survivors are not able to seek help (Rohrbaugh, 2006), and controlling a partner’s gender expression (Gillum & DiFulvio, 2012). These experiences may mean that survivors are discouraged from seeking social support from friends and family, attending counselling or contacting the police (Ard & Makadon, 2011), which can force survivors to stay in abusive relationships, keep the abuse secret and have fears about disclosing when seeking help (Kulkin et al., 2007). Survivors have also reported that the resulting isolation adds to the conviction that the violent behaviour they have experienced is normal (Ard & Makadon, 2011). In addition, experiences of discrimination in public spheres experienced by LGBTQ+ individuals may lead to a greater need to feel loved and accepted by their partner in the private sphere, increasing their reliance on their partner and putting them at greater risk of exposure to unsafe or violent behaviours (Melendez & Pinto, 2007).

1.4.1 IPV in MSM

Much of the literature on IPV in same-sex relationships has collapsed varying sexual identities into one collective group, thereby homogenising the experiences of the varying communities which fall under the LGBTQ+ umbrella. This can obscure substantive differences and unique aspects of IPV within different sexual minority groups, marginalise group-specific concerns and slow the development of accurate knowledge and understanding (Kay & Jeffries, 2010; Moradi et al., 2009). For this reason, as well as the relative lack of research focus on MSM, the current study will focus on MSM.

Research has documented hugely varied but universally high rates of IPV in MSM: 32-78% for any form of IPV (Houston & McKirnan, 2007; Pantalone et al., 2012), 12-45% for physical violence (Craft & Serovich, 2005; Stephenson et al., 2010), 53-60% for psychological violence (Walters et al., 2011) and 5-33% for sexual violence (Craft & Serovich, 2005; Greenwood et al., 2002). There is a lack of understanding of prevalence rates for financial abuse and coercive and controlling behaviours as these are infrequently measured (Finneran & Stephenson, 2013). This gap in the literature is particularly worrying as evidence suggests that psychological IPV is as strongly correlated with adverse mental health outcomes as physical IPV (Coker et al., 2000).

MSM who have experienced IPV may be at particular risk of psychological distress as they often experience a ‘double closet’ (Finneran et al., 2012) which represents feelings of shame and secrecy related to both their sexuality and being a survivor of IPV. One possible contributing factor to feelings of shame in MSM survivors is a fear of community rejection (Turell & Herrmann, 2008), due to worries around confirming negative societal stereotypes of male same-sex relationships. This societal anti-LGBTQ+ prejudice may also cause MSM to hide or ignore the realities of IPV so as to ‘protect’ the LGBTQ+ community from further stereotyping (Turell & Herrmann, 2008). Both societal and internalised anti-LGBTQ+ prejudice may contribute to the heightened psychological distress experienced by MSM survivors of IPV. Anti-LGBTQ+ prejudice, stigma and rejection from family members can adversely impact how MSM experience IPV (Frierson, 2014) and perpetrators may reinforce the belief that the survivor’s support system, such as friends, family and services, will not understand or help if they leave the abusive relationship (Kay & Jeffries, 2010).

Despite clear evidence that violence in relationships between MSM is as prevalent as in heterosexual relationships, the lack of attention and research means that it remains a hidden problem in society (Goldenberg et al., 2016; Pimentel, 2015). The identification and recognition of men as victims of IPV challenges strongly held societal narratives of men as economically, socially and politically dominant (Hines & Malley-Morrison, 2001). The lack of research on IPV in MSM and the LGBTQ+ community more widely is also reflective of societal narratives of heteronormativity and anti-LGBTQ+ prejudice (Madera & Toro-Alfonso, 2005). Laypeople tend to see same-sex IPV as taking place at a lower rate and being less of a pervasive problem than heterosexual IPV (Potoczniak et al., 2003). They also tend to have a less sympathetic attitude towards survivors of same-sex IPV, seeing abuse or violence as a 'fair fight' or normal relationship problems (Brown & Groscup, 2009; Little & Terrance, 2010; Pattavina et al., 2007; Poorman et al., 2003) rather than promoting assistance, encouragement and support to the survivor (Madera & Toro-Alfonso, 2005).

The heteronormative narratives of male abuser and female victim are an obstacle to the awareness and acceptance of differing narratives of IPV, both for survivors and those providing formal and informal support (Breiding et al., 2013; Donnelly et al., 2005). These narratives may also assume that MSM lack typical masculinity and therefore are not capable of violence or that societal pressure to be traditionally masculine does not apply to these individuals (Connell, 2005; Ristock & Timbang, 2005). However, the need to prove or threats to masculinity can be a precursor to violence in all relationships (Finneran & Stephenson, 2014). This means that the distress experienced by MSM survivors of IPV often goes unnoticed and unheard.

1.5 Theories of IPV in same-sex relationships

1.5.1 Traditional feminist theory

Traditional feminist understandings of IPV dominate lay theories and discourse surrounding IPV and aim to understand violence within relationships by exploring the sociocultural contexts in which they occur. The gender inequality and sexism endemic within patriarchal societies are understood as the main cause of IPV (Bell & Naugle, 2008). IPV is seen as primarily heterosexual violence directed by men towards women in order to maintain power and control (Mason et al., 2014) and caused by societal norms and patriarchal beliefs about female subordination and male dominance (Abrar et al., 2000; Bell & Naugle, 2008). Solutions and treatment for IPV are therefore proposed to be education to change patriarchal beliefs and domineering behaviours of men towards women, with the ultimate goal of overturning patriarchal social structures to prevent and eliminate violence against women (Dutton, 2011).

While this predominant traditional feminist paradigm has been invaluable in exposing the patriarchy present in intimate relationships and de-normalised men's violence against women, it is not able to explain IPV within same-sex relationships and views IPV through a heteronormative lens (Ristock, 2012). Whilst not the only feminist approach within this field (see, for example, poststructural feminist theory which posits that individuals may use strategies available to them based on various social locations to negotiate power dynamics), the traditional feminist viewpoint is often the dominant one and has reinforced narratives of a 'stronger' heterosexual man as perpetrator and a 'weaker' heterosexual woman as victim, thereby enforcing the idea that men cannot be victimised (Donovan & Hester, 2011) and that partners of the same sex are not able to harm each other (Barnes, 2008; Seelau et al., 2003). This explanation defines power as binary in that men have it, and use it to enact violence against women, and women do not have it, and are the victims of male violence (Cannon et al., 2015). However, this binary obscures the reality of who has access to power and how they might use it. This articulation of power is just one of several ways in which it operates and by focusing on only one form, other ways that power operates may be obscured. Similarly, by focusing on patriarchy as the main explanation for IPV, other ways in which power operates within relationships and within IPV specifically, are missed. Whilst power and dominance are important factors in understanding IPV, transposing these concepts exactly as they are from traditional feminist theories of heterosexual IPV can be problematic in that they can reinforce these heteronormative narratives (Ristock, 2012).

Framing both men and women as an already constituted, homogenous group of either oppressors or oppressed, regardless of race, class or sexuality, upholds binary structures of gender and patriarchal discourses and obscures the myriad alternative aspects of a person's identity. Taking a lens of intersectionality, which is in itself a feminist approach, (Crenshaw, 1991) can go some way to addressing this. Intersectionality offers a theoretical framework which asserts that an individual's varying social identities are interconnected and people with multiple marginalised social identities (e.g. race, sexuality, class etc.) must navigate larger systems of oppression (e.g. racism, heteronormativity, anti-LGBTQ+ prejudice) that intersect to impact a person's quality of life (Crenshaw, 1991). It also posits that each unique constellation of identities will confer specific psychological and social demands (Narváez et al., 2009). The traditional feminist paradigm for understanding IPV ignores the ways that groups of both men and women are different in terms of access to power and resources, along lines of race, class and sexuality, for example. Therefore, exclusively identifying MSM, for example, along lines of either gender or sexuality results in an incomplete view of the oppression they encounter. Taking an intersectional lens allows a means to consider the entirety of an individual's multiple circumstances and better understand what resources are available to both survivors and perpetrators of IPV and how they may access and exercise them (Cannon et al., 2015). Intersectionality also provides a framework for understanding the ways in which services that respond to IPV survivors may perceive the identities of clients and how they may further marginalise those with already multiply marginalised social identities. Attending to the intersectionality of personal and social contexts can defend against inadvertently perpetuating the invisibility and silencing of marginalised groups and unequal status quos (Narváez et al., 2009).

1.5.2 Queer theory

Critical social theories such as intersectionality (discussed above) and queer theory are vital frameworks to moving away from decontextualised knowledge production into greater understanding of the interconnected, contextual and nuanced realities of marginalised groups such as MSM who have experienced IPV (Delgado & Stefancic, 2017; Ford & Airhihenbuwa, 2010; Potvin et al., 2005; Sullivan, 2003). Just as traditional feminist theorists argue that gender is essential to understanding oppression, so too is sexuality, as anti-LGBTQ+ prejudice and heteronormativity are deeply embedded within social institutions (Sedgwick, 2008; Warner, 1993). Queer theory aims to broaden understandings of same-sex IPV by showing how heteronormative approaches not only interfere with providing effective support for survivors but also add to the marginalisation of individuals and groups based on their sexuality (Cannon et al., 2015). Therefore, the use of violence within a same-sex relationship is understood as one tactic available to people based on their social location. Even if violence looks similar to violence within a heterosexual relationship, it is understood differently as society privileges heterosexuality and therefore people who identify as heterosexual may experience less restricted access to more dominant forms of power. Applying queer theory to understanding IPV reveals the heteronormative binary of traditional feminist understandings and undermines the discursive power of the assumption that men are perpetrators and women are 'victims', which devalues male and same-sex survivors (Hoagland, 2007).

1.5.3 Power resources and social exchange theory

Holding in mind the critiques of traditional feminist theories by intersectional and queer theorists, power resources theory may offer a helpful paradigm to explain IPV within same-sex relationships by attending to all forms of power, rather than focusing solely on gender. Power resources theory (Goode, 1971) aims to identify all key areas of social inequality and how these inequalities influence individual actions and interactions within relationships. Applied to IPV, power resources theory examines how imbalances in power between two individuals may result in violence or abuse. It posits that if there is an imbalance in power within an intimate relationship, and one partner desires power and control or feels that this is threatened, they may resort to violence in order to achieve this (Kurtz, 1992). Power resources theory considers inequalities revolving around (but not limited to) level of education, social status, class, race and/or ethnicity, employment status and health and/or disability to explain IPV (Aizer, 2010; Bhatt, 1998; Bograd, 1999; Kantor & Jasinski, 1998; Melzer, 2002; Renzetti & Miley, 2014). This model has received support from studies which have found that violence is more often present within relationships in which there are perceived inequalities or an imbalance of power (Coleman, 1994; Jin & Keat, 2010; Marshall & Rose, 1990; Martín-Lanas et al., 2021; Pan et al., 1994).

A significant competing theory to power resources theory is social exchange theory. This model focuses on how power dynamics benefit the individual with most power within a relationship, and how this may lead to IPV. It argues that when one individual has access to more socially valued identities or resources, inequality results as those with less access to power incur social debts. Over time, instances of domination of power resources may become self-perpetuating and lead to an understanding that those with more power can effectively do as they wish (Cook et al., 2013). Examples of areas in which a perpetrator might exercise power over their partners are when there are socio-economic or affect related imbalances (i.e. the perpetrator has a higher income or is understood to love the other person less) (Sprecher, 1998; Van de Rijt & Macy, 2006). Young MSM have described power within relationships as stemming from numerous sources including education, income, gender roles, sexual positioning and previous relationship experiences (Kubicek et al., 2015).

As same-sex IPV may be better understood through power and control dynamics other than gender (Cannon & Buttell, 2015), it may be less helpful to take into account gender-related norms (Brown, 2008; Little & Terrance, 2010). In this way, both power resources theory and social exchange theory allow for areas of power and inequality, such as class or race, to be considered in addition to or instead of gender.

1.6 Help-seeking

1.6.1 Help-seeking in IPV survivors

Although the majority of research has been conducted with heterosexual women, these studies may provide some insight into the shared experiences of help-seeking of IPV survivors more generally. Many survivors of IPV seek support from both formal and informal sources. Common ways of seeking informal support may be asking for a safe place to stay, support with childcare, financial assistance or emotional support (Calton et al., 2016). Friends tend to be the most common source of informal support (Du Mont et al., 2005; Goodman et al., 2003). Formal sources of support may include domestic abuse services, health and social care professionals and the criminal justice system (Duterte et al., 2008; Goodman et al., 2003).

Despite the existence of support services and resources, many survivors of IPV do not seek support or report abuse (Henning & Klesges, 2002). They often report feeling reluctant to seek help due to feelings of shame and embarrassment (Simmons et al., 2011) or fear of being further victimised and judged within services

(Turell & Herrmann, 2008). Liang and colleagues (2005) noted that decision making in help-seeking following IPV is a complex and iterative process which depends on many individual, interpersonal, contextual and cultural factors.

Barriers to seeking formal support for IPV survivors include lack of response from service providers, minimisation of their experiences and lack of available IPV resources (Bent-Goodley, 2004; Fugate et al., 2005; Logan et al., 2005; Sorenson, 1996). Positive experiences with sources of help and support can encourage further help-seeking in the future, whereas negative ones can inhibit future efforts (Cattaneo & Goodman, 2010).

There is limited research on the experience of people of colour who have experienced IPV but it has been suggested that white survivors may be more likely to seek help from formal sources than survivors from ethnic minority groups (Postmus, 2015). However, the literature also notes the harm caused by viewing differences in help-seeking as internal to survivors and their communities, for example, through blaming cultural taboos or language barriers, as this shifts the responsibility from the support service to the survivor (Sokoloff & Dupont, 2005; Thiara et al., 2015) and obscures structural barriers such as racism.

1.6.2 Help-seeking in LGBTQ+ populations

In spite of legislative shifts in the past few decades, LGBTQ+ individuals remain marginalised throughout European countries and internationally, which lead to significant barriers in accessing health and social care services (EC, 2012; FRA, 2012). This discrimination impacts on LGBTQ+ people's physical and mental health outcomes, resulting in significant health inequalities (Zeeman et al., 2017) and impacts on their access to and experience of healthcare services (Williams et al., 2013). LGBTQ+ people are more likely than their heterosexual peers to report unfavourable experiences of healthcare services, including poor communication from professionals, and dissatisfaction with the care they received (Bauer et al., 2014; Elliott et al., 2015; Lyons et al., 2015; Pennant et al., 2009; Utamsingh et al., 2016).

Structural and institutional biases are often cited by LGBTQ+ individuals as a barrier to accessing care and support (Binion & Gray, 2020). The expectation of experiencing anti-LGBTQ+ prejudice and discrimination from service providers contributes to LGBTQ+ people's reluctance to seek professional help (Bacchus et al., 2018; Carvalho et al., 2011; Duke & Davidson, 2009). In fact, research has shown that this is a reality, with LGBTQ+ individuals often experiencing hostile or anti-LGBTQ+ attitudes from service providers (Kay & Jeffries, 2010), ranging from discrimination, stigma, ridicule, disbelief and even further abuse (Giorgio, 2002; Helfrich & Simpson, 2006).

1.6.3 Help-seeking in MSM IPV survivors

MSM survivors of IPV encounter many of the same barriers to help-seeking identified by heterosexual women (Cruz, 2003; St Pierre, 2008). However, despite the limited research available, there have been a number of barriers identified by previous research which are unique to the experience of MSM.

MSM survivors of IPV may not recognise that what they are experiencing is abuse due to societal narratives portraying IPV as male to female perpetrated violence (Gillum & DiFulvio, 2012). In fact, Arnocky and Vaillancourt (2014) suggested than men, regardless of sexuality, may be less likely to recognise themselves as abused than women. Traditional feminist paradigms of IPV in which men are not recognised as survivors may pervade both survivors' understandings of their experience as well as those they may turn to for support, such as friends, family or services.

The dominant heteronormative paradigm of IPV has also meant that the majority of services set up to support IPV survivors are geared towards heterosexual women, leaving MSM excluded from services (Furman et al., 2017). This leaves critical gaps in provision for MSM survivors of IPV (Brooks et al., 2021), much of which centres around mainstream organisations' lack of acknowledgement of how anti-LGBTQ+ prejudice, heteronormativity and racism operate and how these systemic issues seep into structures and policies which limit services' ability to serve all survivors of IPV, and not just some (Brooks et al., 2021). Thus, many MSM survivors report negative experiences at non-LGBTQ+ services, meaning that they feel they must rely heavily on the LGBTQ+ community for support (Bornstein et al., 2006; Merrill & Wolfe, 2000).

Fear of judgement and discrimination, particularly through anti-LGBTQ+ prejudice, may also present as a key barrier for MSM survivors accessing support through services (Carvalho et al., 2011). Experiences of anti-LGBTQ+ prejudice in other areas of their lives can lead to MSM expecting this from helping professionals (Calton et al., 2016) and research has shown this to be a reality (Kay & Jeffries, 2010). MSM IPV survivors may also be especially reluctant to seek help if their friends or family are not aware of their sexuality as they may worry about being ‘outed’ (Brotman et al., 2002) which further reduces their support system (Carvalho et al., 2011). In fact, levels of ‘outness’ have been found to be the most important factor in whether MSM will seek formal support, with higher levels of outness being related to more formal help-seeking (St. Pierre & Senn, 2010).

Traditional gender norms around masculinity have been found to shape the way in which MSM seek out support (Ball, 2011). When men are seen to deviate from strict hegemonic norms of masculinity, they are in danger of being met with social stigma and even violence (Kay & Jeffries, 2010). Gender norms which emphasise independence and self-reliance may influence the ways in which MSM seek support; research has indicated that MSM may be more likely to solve problems independently than to seek both formal or informal help (Ball, 2011; Cruz, 2003; Guadalupe-Diaz, 2013). Contrary to this, research has also suggested that MSM may be more likely than heterosexual men to accept services and express a desire for long term support (Robinson et al., 2021). However, when MSM do seek help, they may also be faced with discrimination due to violations of hegemonic masculine ideals and rigid gender expression (Barbour, 2012).

1.6.4 Barriers Model of Help-Seeking

The Barriers Model of Help-Seeking, originally developed by Grigsby and Harman (1997) to aid professionals in recognising the barriers to seeking formal help for heterosexual female IPV survivors, has been updated to be inclusive of same-sex IPV survivors by St Pierre and Senn (2010). The model posits that help-seeking is mainly impeded by social and contextual factors rather than internal or individual ones and described four layers of barriers from the broadest social and environmental factors to the most individual (see figure 1).

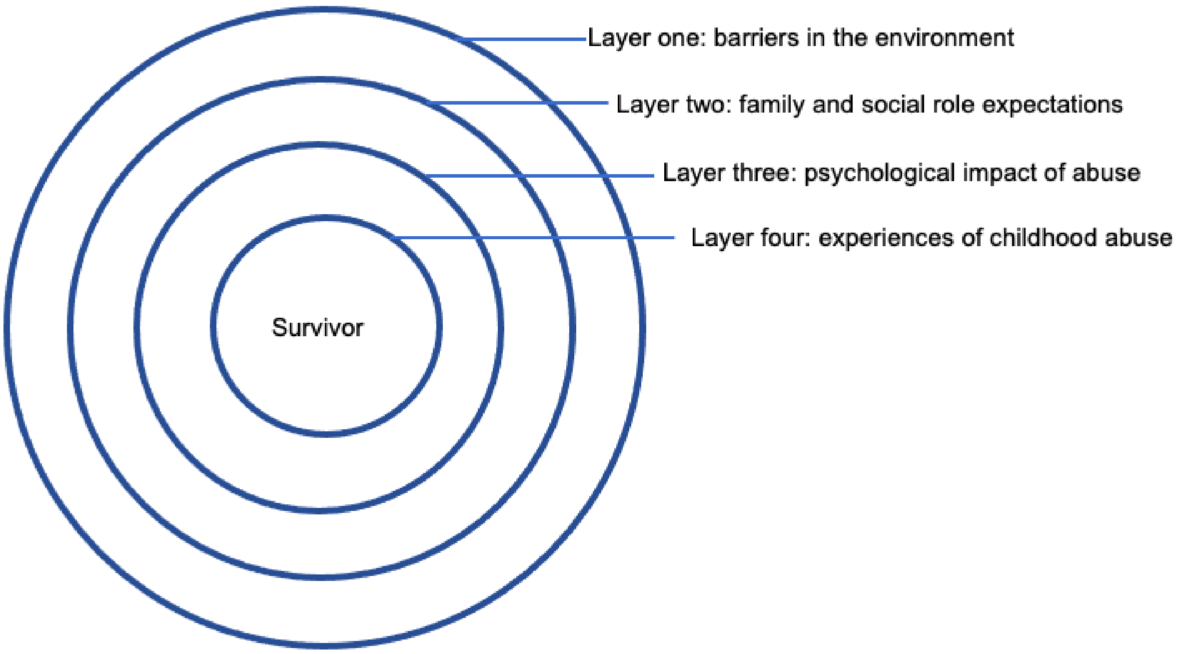

Figure 1: Barriers model of help-seeking

Layer one describes barriers in the environment, such as lack of specialist services and the inaccessibility of mainstream services. There are far fewer formal services available for same-sex IPV survivors than for heterosexual female survivors (Burke & Owen, 2006; Helfrich & Simpson, 2006), meaning that they have no choice but to use mainstream services, which are often not set up to provide adequate support (Helfrich & Simpson, 2006). This is because most mainstream IPV services are designed for heterosexual women (Furman et al., 2017) and MSM have indicated that they would be unlikely to use these services and instead need access to LGBTQ+ or male-centred services (Merrill & Wolfe, 2000).

Layer two describes barriers due to family, socialisation and role expectations, such as anti-LGBTQ+ prejudice, heteronormativity and levels of 'outness'. In Western society, significance and value is attached to heterosexuality, thereby socialising those within that society that same-sex relationships are deviant and stigmatised (Balsam, 2001). This anti-LGBTQ+ prejudice and heteronormativity may be amplified when MSM are not 'out' in their family and social networks, making it harder to seek help following IPV. Research has shown that being more open about one's sexuality (or more ‘out’) leads to more help-seeking and receipt of support (Bradford et al., 1994; Brotman et al., 2002).

Layer three describes the barriers stemming from the psychological consequences of the violence, which are common to all IPV survivors, such as depression, isolation and trauma.

Layer four of the model describes barriers which may have stemmed from childhood abuse. It has been suggested that experiencing or witnessing violence or abuse in childhood is correlated with both perpetration and victimisation of IPV in adult relationships in both heterosexual and LGBTQ+ populations (Charak et al., 2019; Clare et al., 2021; Li et al., 2019).

1.7 Service-level barriers

Police, crisis centres and telephone helplines are initial resources that IPV survivors may turn to for support (Brown & Groscup, 2009). However, police are often less likely to intervene, arrest perpetrators or provide legal protections in IPV cases with same-sex couples (Connolly et al., 2000; Letellier & Island, 2013). LGBTQ+ survivors are more likely than heterosexual survivors to be arrested following a domestic dispute and arrest of both partners is 30 times more likely than in situations involving a male perpetrator and female survivor (Hirschel et al., 2007). This is potentially due to lack of knowledge, low perceived competence or prejudice (Seelau & Seelau, 2005; Younglove et al., 2002). This means that many LGBTQ+ survivors do not contact the police in times of need (Pattavina et al., 2007; Simpson & Helfrich, 2005), and if they do, they do not necessarily perceive them to be a helpful source of support (Renzetti, 1992; Ristock, 2012). Many police, IPV services, GPs and LGBTQ+ organisations do not adequately respond to IPV in same-sex relationships (Donovan et al., 2006) and therefore the majority of LGBTQ+ individuals who have experienced IPV report their experiences solely to their friends (Donovan et al., 2006).

Formal support provided to MSM survivors of IPV is limited and services offered by many mainstream IPV services are lacking in sensitivity and adequate training regarding survivors of same-sex IPV (Elliot, 1996; Hassouneh & Glass, 2008; Simpson & Helfrich, 2005). MSM may feel invisible within these services (Huntley et al., 2019) and that services are not equipped to deal with male-to-male abuse in the same way as male-to-female abuse (Houston & McKirnan, 2007), as they are predominantly used by and set up for women (Furman et al., 2017; Merrill & Wolfe, 2000). In fact, many MSM report that they do not have access to specialist IPV services and must rely instead on LGBTQ+-oriented services (Pimentel, 2015). Most services are not equipped to provide responsive support that reflects the specific needs of LGBTQ+ survivors, such as knowledge of LGBTQ+-specific abusive behaviours (Duke & Davidson, 2009; Ford et al., 2013) and reviews of the literature have found that same-sex IPV survivors were broadly dissatisfied with formal support services (Turell & Cornell-Swanson, 2005). This is reflected in the finding that heterosexual survivors were significantly more likely to access support at an IPV shelter than LGBTQ+ survivors (Turell & Cornell-Swanson, 2005). Therefore, the need for LGBTQ+ affirming IPV services is especially clear (Ford et al., 2013; Kay & Jeffries, 2010; Renzetti, 1996). However, little evidence exists from which to develop these services (Duke & Davidson, 2009).

1.7.1 Service provider attitudes and beliefs

Many helping professionals have been shown to have more negative or harmful attitudes towards same-sex than heterosexual IPV (Boysen et al., 2006; Brown & Groscup, 2009; Wise & Bowman, 1997) which is likely to influence decisions around the delivery of services and what support to offer (Brown, 1996; Rollè et al., 2018; Wise & Bowman, 1997). Professionals often perceive same-sex IPV to be less serious, less likely to occur at all and less likely to worsen over time when compared with heterosexual IPV (Brown & Groscup, 2009; Fröberg & Strand, 2018; Seelau & Seelau, 2005; Wise & Bowman, 1997). Research also suggests that therapists hold negative stereotypes about the mental health of MSM (Boysen et al., 2006) and may treat LGBTQ+ survivors differently on the basis of sexuality, meaning that their clients may be less likely to continue to access therapy and may perceive their therapist as unhelpful (Liddle, 1996; Mohr et al., 2009). MSM survivors of IPV have described couple’s counselling in which abuse in their relationships was not acknowledged and they were actively encouraged to stay in abusive situations (Bornstein et al., 2006; Kulkin et al., 2007). This reflects the harm that can result from problematic anti-LGBTQ+ and heteronormative attitudes in helping professionals.

Even in ‘LGBTQ+-friendly’ healthcare professionals (i.e. those who do not hold explicit bigoted or prejudicial views), there are still assumptions of cisgender heterosexuality until told otherwise, meaning LGBTQ+ individuals need to ‘come out’ over and over again. In addition, there seems to be a commonly held (and misguided) view in UK health professionals that LGBTQ+ people used to experience barriers to healthcare but that things have improved and this is no longer an issue (McGlynn et al., 2020).

1.7.2 Inclusive practices

Some non-IPV specific services have begun to implement inclusive practices which have been found to encourage access among the LGBTQ+ community. This includes having and explicitly exhibiting positive attitudes towards LGBTQ+ individuals and recognises the unique experiences and challenges this population face (Willis et al., 2017). Within IPV services, this may include positive affirmation of a LGBTQ+ identity, validation of same-sex IPV and creating a space for open discussions about sexuality (Bermea et al., 2019). For example, therapists who put issues of LGBTQ+ identity ‘on the agenda’ had clients report more positive experiences of therapy (Malley & Tasker, 2004). Inclusive practice also recognises that other marginalised identities may intersect to make service access more difficult. For example, LGBTQ+ people of colour are disproportionately vulnerable to IPV (Tillery et al., 2018) but underrepresented in research (Bermea et al., 2019).

Research with helping professionals suggests that staff want to improve services for LGBTQ+ survivors but lack the knowledge or resources to do so (Helfrich & Simpson, 2006; Younglove et al., 2002). For example, systemic therapists expressed a worry about their perceived lack of knowledge about LGBTQ+ sexual identity and consequently their ability to work competently with the LGBTQ+ community (Malley & Tasker, 2004). Practices such as increasing staff knowledge of same-sex IPV and specific interventions to support LGBTQ+ survivors (McClennen et al., 2002), increasing community awareness through outreach projects (McClennen et al., 2002) and providing LGBTQ+-affirmative training to staff (Furman et al., 2017) have all been suggested as ways to improve service provision. Cruz and Firestone (1998) highlighted that support services need to focus on MSM survivors' needs as both men and as a marginalised sexual minority group but despite this finding being highlighted over two decades ago, services have yet to come anywhere near to achieving this.

Because disclosure of sexual identity is key in facilitating MSM to access support (St. Pierre & Senn, 2010), service providers must be aware that they can play a critical role in facilitating this disclosure (Bjorkman & Malterud, 2007; Boehmer & Case, 2004). By using gender-neutral language, providers reduce assumptions of heterosexuality and give MSM space to disclose (Bjorkman & Malterud, 2007; Boehmer & Case, 2004; Helfrich & Simpson, 2006). Beyond providing opportunities for safe disclosure, service providers must also validate LGBTQ+ relationships (Helfrich & Simpson, 2006), which occurs when professionals engage in honest, open and ongoing dialogue with MSM about their relationships (Boehmer & Case, 2004).

1.8 Scoping Review

Using Booth, Sutton and Papaioannou's (2016) guide, a scoping review of the literature was conducted in order to provide an overview of the current literature and to identify gaps with which to inform the focus of the current study. Booth, Sutton and Papaioannou's framework was used to define the scope of the review:

1. Who- Professionals who work with MSM survivors of IPV
2. What- Barriers to accessing support following IPV
3. How (will the study impact on the who)- Situate and rationalise the current research investigating the barriers to MSM accessing support following IPV

To identify relevant literature, three databases were searched: PSYCHINFO, Academic Search Ultimate and CINHAL complete, along with grey literature through Google Scholar and other open-source platforms (such as Research Gate). All searches were restricted to articles published in English. There was no restriction placed on time period or methodology of the studies (i.e. qualitative or quantitative).

Further details such as studies identified, search terms, inclusion and exclusion criteria can be found in Appendix A. A total of five papers were identified as addressing service providers' perspectives on the barriers faced by MSM in accessing support following IPV. Due to the small number of studies identified, each study will be summarised and evaluated separately before a synthesised summary of key gaps is presented. Although a scoping review does not rely on a formal tool to evaluate studies as is required for a systematic review, in order to ensure consistency, Yardley's (2015) principles of demonstrating validity in qualitative research were held in mind when critiquing the studies (see Appendix B).

1.8.1 Kay and Jeffries (2010)

This qualitative study aimed to gauge service providers' perspectives about IPV in MSM and the adequacy of service provision for survivors. In-depth interviews were conducted with four professionals from 'gay-friendly' community support service providers, identified as providing key support services for MSM survivors of IPV, in Brisbane, Australia. The research questions focused on the service providers' beliefs about the prevalence of IPV in MSM, the contextual triggers that are associated with IPV in MSM, the barriers to MSM leaving abusive relationships and accessing support and whether support services adequately address the needs of survivors. For the purpose of this review, the findings related to the latter two areas will be addressed. The findings identified various barriers to MSM seeking support following IPV. Participants spoke about love, hope, self-blame and a lack of social support as being barriers to MSM leaving abusive relationships. Anti-LGBTQ+ prejudice was also identified as a barrier both through use as a tool by perpetrators to 'bind' survivors to them as well as on the part of police and mainstream IPV services. Heteronormative beliefs and models of IPV were also identified as a barrier, creating gendered expectations of 'real' men and negating the possibility of a male survivor. The authors argued that the legal historical precedent in Australia, including the illegality of 'homosexuality' and exclusion of men from rape law, as well as feminist (and heteronormative) models of IPV and hegemonic masculinity have impeded the development of support services. Participants therefore acknowledged a lack of services for male survivors, meaning MSM have to attend LGBTQ+ health services which they argue are not equipped to support them with IPV. A lack of training within services, including an understanding of the unique issues underpinning IPV in MSM was also identified.

The study focused specifically on service providers' experiences of supporting MSM, unlike much of the literature in this area which treats the LGBTQ+ community as a homogenous group. However, all the services were based in the same city, meaning that the experiences of participants may have been shaped and influenced by the particular culture and narratives of this geographical area. The demographics of the participants were not reported, making it difficult to situate their responses within the context of their own identities and experiences. Similarly, there was no consideration by the authors of intersectionality and how the varying identities of MSM, including race and class, might also impact how services are likely to support or exclude them.

1.8.2 Ford, Slavin, Hilton and Holt (2013)

This community-based participatory research project aimed to understand service providers' current approaches to addressing LGBTQ+ IPV, to identify issues, needs and challenges that services face in supporting LGBTQ+ survivors of IPV and to obtain recommendations for improving prevention and intervention services. Researchers, task force members and other community stakeholders collaborated to plan and conduct this study which focused on the perspectives of staff. This study explored the perspectives of professionals affiliated with one or more IPV prevention networks in Los Angeles, California. A 33-item questionnaire was completed by 54 respondents and included frontline professionals, managers and others (e.g. lawyers). A textual analysis was conducted to identify the main themes in the open-ended responses to the questions. The findings identified that most participants felt unprepared to work with LGBTQ+ survivors, particularly men and transgender persons, due to lack of training, knowledge and resources. Just 24.4% of services routinely assessed sexual orientation or gender identity, meaning that participants felt services could not be tailored to the needs of LGBTQ+ survivors. Many participants actually felt that this was less necessary as they 'treat everyone the same', however, this does not allow for services to attend to the unique experiences of marginalised groups or be alive to inequality. Participants also identified systemic issues which impede provision of adequate services, including lack of staff and resources, lack of LGBTQ+-specific services and LGBTQ+-specific emergency housing, particularly for MSM, and current IPV services being designed for women. Recommendations they made for improving services included establishing safe housing for LGBTQ+ survivors, increased availability and accessibility of LGBTQ+-specific services and resources (including appropriate language on materials and resources of mainstream services), and regular, sensitive LGBTQ+ IPV training aimed at all levels of staff within an organisation.

Whilst this study was able to identify service providers' views on the barriers facing LGBTQ+ survivors, the focus was on service provision in Los Angeles and included discussion of policies, practices and legislation relevant to the US and California specifically. The authors acknowledge that the findings may not generalise to non-urban areas or areas with a smaller LGBTQ+ community or fewer legal protections for LGBTQ+ people. The sample was also a small, non-probability sample and the demographics were not reported, making it difficult to contextualise the views of the participants. Written survey responses also provided limited qualitative data and interviews or focus groups would likely have provided richer responses to questions. The study focused on the LGBTQ+ community as a whole, and therefore specific issues and barriers relevant to particular sexual identity groups may have been obscured.

1.8.3 Furman, Barata, Wilson and Fante-Coleman (2017)

This qualitative study aimed to examine how service provision meets the needs of lesbian, gay, bisexual, transgender, queer/questioning and two-spirit (LGBTQ2S) survivors of IPV through the perspectives of frontline staff and professionals in Ontario, Canada. Ten service providers that delivered direct support to survivors of IPV in both mainstream or LGBTQ2S-specific services (for example, in shelters, counselling services or community IPV programmes) participated in semi-structured interviews. The interviews aimed to explore whether current IPV services were functioning to support IPV survivors regardless of sexual and gender identity and what could be done to improve service provision for these communities. A thematic analysis was conducted and findings indicated that participants felt an inclusive, client-centred approach within mainstream services was more practical than developing LGBTQ2S- specific services, as long as these mainstream services were tailored to the needs of LGBTQ2S survivors. They spoke about the potential harm of dichotomising survivors into the constraints of mainstream or specialist services based on their identities by reinforcing their minority status and failing to provide them with choice about how they would like to be supported. The findings indicated that there needs to be a revision of the underlying principles and value systems of IPV services as the majority of participants acknowledged that their organisation operates from feminist-based principles and values and that this can lead to discrimination within services for LGBTQ2S communities. Along with this, participants spoke about the importance of language, explicitly welcoming LGBTQ2S survivors, training for staff, and employing staff with diverse lived experiences.

The findings of this study provide insights into service provider perspectives on how IPV services can better serve LGBTQ2S survivors. However, the findings are focused on the experiences of service providers in Ontario, Canada specifically. In addition, although there was a mix of ages, ethnicities and sexual identities in the sample, all of the participants were women which may represent a particular perspective. The purposive sampling method allowed the researchers to recruit participants who were keen to discuss LGBTQ2S inclusivity but also accumulated a sample who were openly supportive of LGBTQ2S survivors, which may or may not represent service providers more generally. The study did not separate the experiences of different groups within the LGBTQ2S community, perhaps obscuring some nuance.

1.8.4 Bermea, van Eeden-Moorefield and Khaw (2019)

This study took a phenomenological approach in order to understand practitioners' experiences of responsive practice at queer/queer-allied organisations which offer IPV services. Seven individual semi-structured interviews were conducted with professionals from five organisations in an urban city in North-Eastern USA. Findings were organised under three themes that reflected broad service provision approaches used to provide responsive care to LGBTQ+ IPV survivors: diversity, inclusion and social justice. Under the theme of diversity, participants felt that service providers needed to be representative of the client population and represent multiple identities and experiences. This was thought to address the experiences of LGBTQ+ survivors not feeling able to access mainstream services as those services do not understand them due to their lived experiences being too different. Inclusivity was described by participants as active practices which recognise and validate clients' identities and experiences and encompassed three overarching strategies. These were: creating a space which reflects a chosen family; providing affirmative support (e.g. making spaces welcoming, creating services with LGBTQ+ survivors in mind and training for staff); and developing understanding of IPV in LGBTQ+ relationships in order to combat common misconceptions and develop an awareness of biases). Taking a social justice approach was understood by participants as structural changes to increase clients access to resources for health and safety. Participants felt that working through an 'anti-oppressive framework' (i.e. considering how power, privilege and oppression impacts clients) and working to disrupt and dismantle violence (i.e. empowering clients, becoming advocates and supporting clients to advocate for themselves and others) were key to successfully supporting LGBTQ+ survivors within IPV services.

This study explores the views of service providers on what they felt their services were doing well to support LGBTQ+ survivors. However, the barriers and challenges to support were assumed through providers experiences of what works well; there was little explicit discussion of what gets in the way of services providing acceptable support or reflection on what could be done better. It was also specific to the experiences of providers in one urban US city and was acknowledged by the researchers to have a greater availability of services than many other cities. The researchers also acknowledged that the participants came from varying professions which may impact how they experience responsiveness. This study also treated the LGBTQ+ community as a homogenous group and did not explore ways in which different sexual identity groups could be supported in different ways.

1.8.5 Hyde (2021)

The aim of this qualitative comparative case study was to explore how leaders of intimate partner violence services describe the influence of leadership style on delivery of support to LGBTQ+ clients. The study utilised non-probability sampling to purposively sample experts in the field. Eight participants were recruited from IPV services in two North-eastern US states and included executive directors, managers and staff of IPV services. Participants engaged in in-depth interviews and the data was analysed using thematic analysis, within-case analysis and cross-case analysis.

Although the study did not explicitly aim to explore barriers to accessing support, the themes that were generated by the author included ideas from participants regarding what barriers exist for the LGBTQ+ community in their area. Participants spoke about the need for more LGBTQ+ training as most identified having only generic diversity training. The services participants worked in covered rural areas and they spoke about the higher likelihood of stigma in these areas, meaning that LGBTQ+ survivors are less likely to come forward for support. They did not however, acknowledge a lack of service provision or likelihood of experiencing anti-LGBTQ+ prejudice in services, thereby placing the onus on clients rather than professionals. Despite reporting very little experience or training in working with LGBTQ+ survivors, most participants reported feeling confident in working with them, a paradox that was not discussed by the author. Most participants also felt that LGBTQ+ advocacy and visibility was needed in services, however most felt that a rainbow flag, an ‘all are welcome’ sign or being involved with Pride celebrations were all that was needed.

The sample of this study was small and limited to two services in the US, making the findings difficult to generalise. The focus was also on leadership style, rather than barriers more broadly, and there was very little acknowledgement or discussion of the presence and impact of systemic discrimination both within society and within services. The sample was 75% female and 87% White (sexual identity of participants was not reported), perhaps reflecting a homogenous experience of oppression and/or privilege.

1.9 Summary: Gaps in the literature

The review of the literature suggests a paucity of up-to-date qualitative research on service providers’ experiences of the barriers to LGBTQ+ survivors accessing support following IPV, and particularly for MSM. Cultural, social, political and environmental factors are likely to impact the experiences of MSM seeking support following IPV and regular research is needed in order to stay abreast of this shifting climate. The review identified only five studies conducted since 2010 which had addressed this issue, and this is in keeping with a lack of research interest generally on the experience of MSM survivors of IPV. Of the limited research that exists, few studies have examined the barriers MSM survivors face when accessing services (Guadalupe-Diaz, 2013).

In addition, none of the studies reviewed were based in the UK. Almost all support services in the UK are provided through government funded NHS and local council health and social care services, which operate in a very different cultural and political climate to services in the US and Australia. Previous research has identified that there is a particular dearth of research on IPV in MSM in the UK and that this requires further study (Rowlands, 2006).

All but one of the studies reviewed amalgamated the experiences of all members of the LGBTQ+ community, meaning that details and nuance pertaining to the experiences of and barriers that face MSM in particular are lost, as the experiences of all genders and sexual identities are combined (Jeffries & Ball, 2008).

1.10 Research Rationale

Both the gaps in the literature and in support provision for MSM survivors of IPV point to the need for further research in order to further understand the experiences of this community and, in particular, the barriers they face when accessing support. Despite being acknowledged as a serious public health concern and social justice issue, the literature base on the barriers to MSM survivors of IPV remains small. Therefore, the current study aims to extend the current research base on professionals' experiences of the service-level barriers to support faced by MSM who have experienced IPV. To the researcher's knowledge, there are no studies to date exploring this area in the UK. This study also aims to explore professionals' views on what services in the UK could be doing to better support MSM who have experienced IPV, in the hope that this will lead to improvements in support and services. The research aims to explore professionals' views and experiences of the service-level barriers that face MSM who have experienced IPV through the following research questions:

1. What are mental health professionals’ views of service-level barriers to providing services to men who have sex with men who have experienced intimate partner violence?
2. What are mental health professionals’ views on how to overcome these barriers?

1.11 Clinical Relevance

It is well-established that there are higher rates of distress and adverse mental health outcomes among both sexual minority communities (Semlyen et al., 2016) and survivors of IPV (Shen & Kusunoki, 2019). However, there is also evidence that the way services are currently set up is not acceptable for survivors of IPV who do not fit the heteronormative image of a heterosexual woman (Houston & McKirnan, 2007). It is therefore crucial that we develop our understanding of the barriers that face MSM survivors in accessing support as well as the ways in which services can better serve this community.

2. METHOD

2.1 Overview

This chapter begins with a consideration of epistemological and ontological issues relevant to the study. It then goes on to describe the design, including materials, participants and procedure, before detailing the ethical considerations. Finally, the analytic approach will be considered along with personal reflexivity in order to examine the relationship between research and researcher.

2.2 Epistemological Position

The current research is underpinned by a critical realist position, which can be understood through an exploration of epistemological and ontological assumptions. Epistemology can be described as being "*concerned with the nature of knowledge- its possibility, its scope, its limits and the processes by which it can (or cannot) be acquired*" (Willig, 2019, p. 186). Ontology is concerned with the nature of existence and knowledge of reality (Crotty, 2020).

Realism seeks to uncover reliable knowledge about the world which exists independently and outside of the observer's awareness and occurs on a continuum from naïve to critical. Naïve realism posits that knowledge can be regarded as fact and directly mirrors a universal reality. Knowledge can therefore be acquired directly through scientific research and observation. This position is also known as positivism and can be seen in the medicalisation of distress; mental 'illnesses' are seen as an external natural disease that exists independently of awareness (Pilgrim & Bentall, 1999). A social constructionist perspective recognises that reality is mediated by history, culture and language and that multiple perspectives of reality are possible (Burr, 2015). For example, homosexuality was pathologized as a mental illness but this has now changed as societal constructs and understandings have changed (Drescher, 2015). Stemming from Bhaskar's (1978) theory, critical realism sits between these two positions and suggests that, although there is an independent 'reality', our theories and methods that we use to gain this knowledge are shaped by the social, cultural and historical context in which they are developed and are therefore, to some extent, socially constructed. Critical realism assumes a realist ontology, in that phenomena have an objective reality, can be observed and measured and exist outside of one's awareness or beliefs (Willig, 2016). However, it also assumes that there are multiple dimensions to reality, which includes the subjective experience of participants and also acknowledges the influence of the researcher (Willig, 2016).

In accordance with a critical realist position, the current study aims to explore phenomena within the experiences of participants, such as barriers to MSM accessing services, which exist in an objective reality. It assumes that the experiences of the participants are 'real' and can be explored. However, the researcher acknowledges that participants' understandings of what barriers to services exist and why, exist within a certain social, historical and cultural context, which will inevitably have an influence. In addition, the participants themselves exist within their own personal, familial, cultural and societal context which will also influence their experiences. Therefore, the current study does not intend to uncover an objective, universal 'truth' but instead aims to tentatively interpret the findings and consider them within their context and in light of its limitations.

2.3 Design

With the research questions and epistemological position in mind, a qualitative approach was adopted, as recommended for research aimed at understanding experiences and processes (Barker et al., 2015). Individual semi-structured interviews were employed in order to fully explore the views of professionals, with particular emphasis on subjective meaning and context (Yardley, 2000). A qualitative approach also allows for opportunities to gain unexpected insights (Wilkinson et al., 2004) during conversations to promote a deeper understanding of professionals' experiences and ideas. An analysis on data from open and closed questions in an online survey was also considered as it may have resulted in a larger sample. However, there is often variation in how much participants write in open-ended answers and the data gathered would not have been as rich or in-depth, limiting the type of analysis that could be performed. Therefore, individual interviews provided an opportunity for exploration of ideas and more useful data.

2.4 Participants

2.4.1 Recruitment

Convenience and snowball sampling was used to recruit the study sample. Online forums (such as Facebook groups) and social media sites (such as Twitter) were used to advertise the study with accounts created specifically for the research. Mental health training courses and several LGBTQ+ and domestic violence organisations were contacted and asked to share the study poster with their staff or trainees (see Appendix C for recruitment strategy and advertising materials).

2.4.2 Inclusion criteria

In order to recruit as representative a sample as possible, the following broad inclusion criteria were applied:

- Mental health professionals who have experience working with men who have sex with men who have experienced intimate partner violence
- Aged 18+
- Living in the UK
- Level of English to be able to understand written material and engage in a conversation without an interpreter
- Are able to access and use Microsoft Teams or a telephone

2.5 Materials

2.5.1 Demographic questions

At the start of the interview, participants were asked a number of demographic questions which consisted of age, gender, sexuality, ethnicity, job title and type of service they worked in (See Appendix D). These questions were intended to contextualise the participants' responses in terms of their social identities.

2.5.2 Interview schedule

A semi-structured interview schedule was created to guide the individual interviews (see Appendix E). The interview schedule broadly explored participants experiences of supporting MSM who have experienced IPV, their views on the service level barriers to accessing support and how they think services could improve. The interview schedule was developed with input from the research supervisor, the research questions and the literature around IPV in MSM. Questions and probes were refined and edited according to feedback. It was also a continually developing process, based on reflection and feedback as the interview process took place.

Individual interviews were chosen as they provide a safe, confidential space in order to support discussions of the participants' ideas. This meant that the views of individual participants were included and their experiences explored on their own terms (Frith & Gleeson, 2012). It was also important that participants were able to be open about what they thought services were not doing well and how they thought services could improve, which required the privacy of an individual interview. The interviews were over Microsoft Teams which meant they were flexible to participants' schedules.

2.6 Procedure

2.6.1 Initial contact

Interested participants viewed advertisements (posters/leaflets/social media posts) of the research and contacted the researcher via email. The researcher then shared further information about the study and provided the participant information sheet (PIS; Appendix F) and the consent form (Appendix G). The researcher offered participants time to consider potential challenges and benefits of taking part in the research, ask questions and make a decision about their participation. The researcher then arranged a suitable time and date for the interview to take place with those who confirmed they were interested and had completed the consent form. Consent was obtained by initialling boxes on the consent form and signing the end of the form.

2.6.2 Individual online interviews

At the start of the interview, participants confirmed they had read the PIS and consent form and were given the opportunity to ask questions. They then answered a number of demographic questions. The interview schedule was used flexibly in order to explore participants experiences as much as possible and give them space to reflect. It also gave the researcher an opportunity to ask follow up questions regarding unique ideas or experiences of participants. Interviews lasted approximately 40-60 minutes. Following the interview, a verbal debrief was given, consent was revisited, and participants were given the opportunity to ask questions. Participants were also emailed the debrief sheet. All interviews were video and audio recorded on Microsoft Teams.

2.6.3 Transcription

The researcher conducted and transcribed the interviews in order to familiarise with the data and reflect on the position as interviewer. An orthographical style of transcription was utilised, as recommended by Braun and Clarke (2012). Names were replaced by participant numbers, identifying information was replaced within [ ] and the transcription was punctuated for ease of reading. Pauses were thought to be of little analytic value (Banister et al., 2011) and therefore only pauses of longer than one second were recorded. Transcripts were checked and read multiple times in order to ensure anonymity and accuracy (Gibbs, 2018).

2.7 Ethical Considerations

2.7.1 Ethical approval

The study was registered with the University of East London (UEL), from which ethical approval was granted (see Appendices H, I, J, K) following minor amendments requested by the committee. The study complied with the BPS Ethics Guidelines for Internet-mediated Research (2017) and Code of Human Research Ethics (2014). As participants were not recruited through the NHS, no other ethical approval was needed.

2.7.2 Informed consent

Before taking part in the interviews, participants were provided with a PIS that provided detailed information about the aims of the study, what participation would involve, the benefits and potential risks of taking part and information about confidentiality and data management (see Appendix F). Participants were advised to keep a copy of this. Contact details of the researcher and research supervisor were given and participants were encouraged to contact the researcher regarding any questions or concerns. Participants were informed that they could withdraw at any time during the interview and up to 3 weeks after completing the interview. The PIS was followed by a consent form, including several statements regarding participants understanding of their rights (see Appendix G).

2.7.3 Confidentiality

Participants were informed that their information would be anonymised and how their information would remain confidential throughout data collection, analysis and storage within the PIS and verbally at the beginning of interviews. Recordings of interviews were deleted following transcription and all transcripts from the interviews were anonymised and kept on a secure cloud accessible only to the research team. Signed consent forms were stored separately to the transcripts and there was no way of linking personal details from the consent forms with interview data. Participants consented to anonymous extracts from the transcripts appearing in the final thesis; however these would not identify any participants or their clients. All data was saved on secure cloud storage and will be destroyed after three years in accordance with the Caldicott Principle (Department of Health, 2013) and the Data Protection Act (2018).

2.7.4 Potential distress

The PIS outlined the potential risks of taking part in the study. This included the small potential for difficult thoughts and feelings to arise whilst taking part, by talking about themes such as discrimination faced by clients and what the services they worked in could do better. Participants were advised that their participation is voluntary and that they can take a break or withdraw at any time. They were also given space at the end of the interview to discuss any feelings which arose and provided with a list of support services should they need to contact them.

2.7.5 Debrief

After the interviews, there was a verbal debrief with participants in which there was the opportunity to ask questions, discuss any difficult feelings and address any concerns. They were also emailed a debrief sheet which reminded them of the aims of the study, information about confidentiality and withdrawal of data, the contact details of the researcher and the list of support services (see Appendix L).

2.8 Analytic Approach

2.8.1 Thematic Analysis Justification

Reflexive thematic analysis (TA) was chosen as the most appropriate approach for the data gathered from the semi-structured interviews as this would allow for identification and analysis of patterns of meaning (Braun & Clarke, 2006). TA offers theoretical flexibility (Braun & Clarke, 2006; Willig, 2013) and therefore fits the epistemological position of the study. TA involves the process of identifying patterns that arise in the data, facilitating interpretation and sense-making (Braun & Clarke, 2006, 2013). This therefore makes reflexive TA useful for answering this study's research questions as it allows the researcher to bring together patterns that arise in participants' ideas about service-level barriers and ways in which services can do better, with a focus on views across the group of participants, rather than their lived experiences. TA also allows the researcher to interpret and make sense of patterns and reflect on their own position as researcher. It offers the researcher the opportunity to make interpretations that consider socio-cultural contexts that shape participants' account of their experiences and views. This is especially important for the current study as participants' own social, cultural and familial backgrounds, as well as the culture of the services they work within, will shape their ideas and experiences about what barriers face MSM survivors of IPV. The analysis was both inductive and deductive in approach and generated codes, themes and interpretations through close reading of the data as well as being informed by existing theory. Critical social theories such as intersectionality (Crenshaw, 1991) were drawn upon for the deductive part of the analysis as the researcher noted the importance to the research questions of holding a broad systemic lens rather than taking an individualised or blaming approach. This led to codes and themes which considered the broad social locations of MSM survivors as well as the influences of societal discourses. It also supported the answering of the research questions in that the focus of the analysis was on service-level (and wider) barriers to accessing support. The researcher notes that their own experiences, beliefs and assumptions will influence their construction of codes and themes within the data (Braun & Clarke, 2013). TA has been criticised for a lack of recognition of the researcher's role in interviews (Mishler, 1991) and the researcher therefore kept a research journal to reflect on their role in data collection and analysis (Ortlipp, 2008). To avoid the potential for decontextualization (Mishler, 1991), the researcher adopted a 'contextualist method' by acknowledging that participants' ideas and experiences were shaped by their social, historical and cultural contexts.

2.8.2 Stages of analysis

As qualitative research has been criticised for neglecting to be clear about how the research was completed (Attride-Stirling, 2001), the researcher used Braun and Clarke's (2006) six phases of analysis in order to maintain transparency and consistency.

1. Familiarisation with the data

Conducting interviews and transcribing the data was the initial process of familiarisation as this is seen as an interpretive act (Lapadat & Lindsay, 1999) and therefore immersion started from the outset of data collection. Following the initial phase the researcher then immersed themselves further in the data by repeatedly reading in an active way, both checking for accuracy and starting to note down any potential ideas or themes noticed, thereby capturing meanings and patterns. During this process, the researched noted down any 'noticings', including any initial ideas and emotions or feelings that arose when reading the transcripts.

2. Generating initial codes

Codes are the basic elements of the data that can be analysed in a meaningful way (Boyatzis, 1998). The data set was coded using NVivo (12) software which allowed coding of many possible patterns and themes which were both data- and theory-driven. Data was coded inclusively, in order to retain relevant contextual content and individual data was also often coded many times in order to capture all possible patterns and meanings. For a list of initial and intermediate codes, please see Appendix M and N.

3. Searching for themes

The researcher clustered codes sharing common or unifying features into overarching themes and subthemes. Visual mind maps were created in order to capture salient patterns in the data.

4. Reviewing themes

The researcher reviewed themes alongside original data in order to ensure coherence and accuracy of reflection. Extracts under the themes and subthemes were reviewed for consistency, and along with the research supervisor, themes and subthemes were reviewed and rearranged using visual thematic maps to further coherence.

5. Defining and naming the themes

Themes were defined and named during this phase to ensure a central organising concept (Braun & Clarke, 2013). Concise, informative names were chose in order to accurately reflect the themes and to structure the story of the research.

6. Producing the report

A coherent story of the data was brought together in the final writing of the report. Themes were supported using anonymised extracts from the transcripts in order to capture the essence of each theme and subtheme.

2.9 Reflexivity: Researcher’s position

Reflexivity can be defined as the researcher’s consideration of the influence they have on the research process and the ‘knowledge’ produced from this (Nightingale & Cromby, 1999; Willig, 2013). This is an essential component of qualitative research as the researcher plays a pivotal role in the generation and construction of data (Stratton, 2013). Reflexivity involves a continuing process of mutual shaping between the researcher and research; therefore the researcher's position must be considered in an ongoing way (Attia & Edge, 2017). This is especially pertinent when adopting a critical realist stance, as it allows for acknowledgement that the findings of the study are not framed as a universal and objective truth, and when utilising a qualitative approach, as the impact of the researcher on the generation of codes and themes and interpretation of data is inevitable.

In order to invite the reader to consider the researcher's influence on the data, various aspects of the researcher's identity and experiences have been outlined that seem pertinent to the development, conduction and analysis of the research:

- Identification as a white, heterosexual female, which may or may not result in similar lived experiences to participants, but holding different gender and sexual identities to MSM. The researcher acknowledges her privilege in terms of race and sexuality and that this may lead to power imbalances between herself and participants. In addition, dominant ideologies of whiteness and straightness may lead to potential blind spots or impact on the questions asked in interviews.
- Training as a Clinical Psychologist may lead to professional affinity with some participants, if they are also trainee or qualified Clinical Psychologists as well as the potential for very similar (or very different) professional experiences within services. This has the potential to increase social desirability during interviews, with either the researcher or participants wanting to be seen in a positive light by the other, leading to conversations that miss discussion of practices or policies that are unhelpful or exclusionary.
- Training at University of East London has influenced the researcher's critical position on both psychological theory and its application in services, as well as knowledge of the legacy of psychological and other NHS services' part in excluding minoritized groups through the wielding of systemic power.
- Personal and professional positions witnessing unhelpful experiences within NHS and other statutory services and the researcher's belief that these services can be unhelpful and exclusionary at times.

- The researcher holds strong personal beliefs in the importance of creating space to hear marginalised voices and pushing back against narratives and systems which oppress certain groups.
- The researcher holds beliefs that, although individual professionals may hold actively prejudiced views, discrimination in services often has an insidious, systemic nature and, in order to combat discrimination in a real and sustained way, changes must be made on a systemic level.

The researcher took a reflexive position throughout this study, including keeping a reflective journal which was discussed with the research supervisor, and will return to this in the discussion.

3 RESULTS

3.1 Chapter Overview

This chapter presents the themes from the data analysis of the individual interviews. Demographic information will be presented to locate the sample and contextualise the results. To ensure anonymity, participant names have been removed and numbers assigned by the researcher have been used. Reflexive thematic analysis (TA) was used to explore the research questions and a thematic map is presented to illustrate the themes and subthemes generated. The themes and subthemes will be expanded upon and extracts from the transcripts will be presented to support the researcher's interpretations. In places, minor changes have been made to the extracts to improve readability, for example, by removing repeated words or curtailed sentences. Ellipses are used where words have been removed.

3.2 Sample Characteristics

Seven participants opted to take part in the study. All participants completed the individual interviews, with no dropouts or requests to withdraw data. No concerns were raised following the interviews and no participants required follow-up. Table 1 outlines the demographic information collected from the sample. Broad information is presented in order to maintain anonymity.

Table 1: Sample demographics

Participant number	Age range	Gender	Ethnicity	Sexuality	Job title (when work took place)	Service (where work took place)	Location
1	30-34	Female	White British	Heterosexual	Trainee Clinical Psychologist	NHS Early Intervention in Psychosis Service	City
2	30-34	Male	White British	Gay	Clinical Psychologist	NHS Acute Hospital settings	City
3	30-34	Female	White British	Bisexual	Trainee Clinical Psychologist	NHS HIV and Sexual Health Psychology Service	City
4	40-44	Male	White British	Heterosexual	Principal Clinical Psychologist	NHS HIV and Sexual Health Service	City
5	60-64	Female	White British	Lesbian	Volunteer Counsellor	Local council commissioned LGBTQ+ organisation	City
6	35-39	Trans feminine	Mixed Heritage	Queer	Interim CEO (Social worker)	Non-profit LGBTQ+ organisation	City
7	30-34	Female	White British	Heterosexual	Trainee Clinical Psychologist	NHS Community Mental Health Team	Rural

3.3 Thematic Map

Using Braun and Clarke's (2013) six stage approach to TA, interview data was analysed using an inductive and deductive approach. Multiple thematic maps were constructed and refined to produce the final map (See Figure 2). The analysis employed a 'top-down' and 'bottom-up' approach, guided by the research questions. It could be argued that the subtheme 'toxic hetero-patriarchal lens' be considered an overarching theme as the discourses discussed weave through many of the other themes, and are in some ways impossible to disentangle from discussions around the impact of IPV and access to services. However, the researcher felt it was important to include it as a subtheme in its own right, as participants explicitly spoke about the toxic discourses of anti-LGBTQ+ prejudice, heteronormativity and hegemonic masculinity, and where these lenses are discussed in other subthemes, it was often as an interpretation by the researcher as part of the analysis.

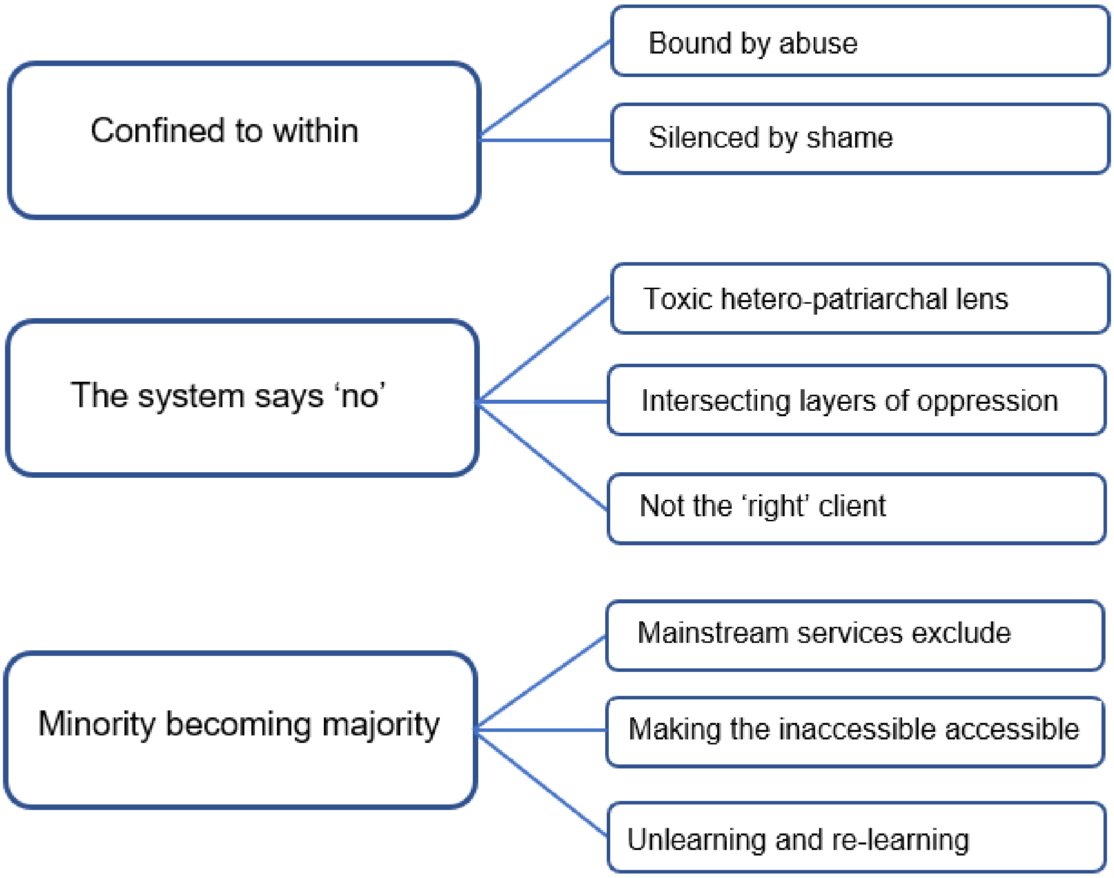

Figure 2: Thematic map

3.4 Theme 1: Confined to within

This theme captures the ways in which the experience of intimate partner violence itself can confine survivors within the abuse, making it very difficult to both leave the abusive relationship and seek help from informal (such as friends and family) and formal (such as police, emergency housing and mental health services) support networks.

3.4.1 Bound by abuse

Many participants reported that the impact of the abuse itself can be a barrier for MSM accessing support. Some of these impacts appeared to transcend gender and sexuality to apply to any abusive relationship: "*How do you transcend that to say 'actually I need help' you know? The fact that there is a cycle of abuse*" (Participant 5). This cycle of abuse was reported as making it very difficult for survivors to leave or disclose abuse in their relationship, either for fear of being harmed: "*If you've got those threats how paralyzing is that?"* (Participant 5), or due to the 'honeymoon phase': "*Trying to rationalise and normalize and he always says sorry and he loves me really*" (Participant 5).

Participants also spoke about the practical realities of safely leaving an abusive relationship: "*How would you, you know, get out there if they don't let you have your phone? If they constantly check your search history or phone? How do you safely seek help?"* (Participant 5). This will likely be exacerbated by a lack of refuges for MSM (see subtheme: 'not the 'right' client') as survivors may not have anywhere safe to go when leaving a relationship.

Experiencing IPV was described in participants' accounts as *"upsetting and… disturbing"* (Participant 2) and was reported to contribute to feelings of low self-worth:

> "I think his own sort of self-esteem and self-worth came into it…because of that experience of erm what was going on with the partner and the things he was saying and the control and the sort of psychological abuse as well how worthy he felt of being able to access support"
>
> (Participant 7)

This element of coercion and control was felt by participants to be a barrier to accessing support for MSM due to feeling less deserving of help. Self-blame was then reported to increase the distress that already results from the abuse and again makes survivors feel less deserving of support as they blame themselves for 'allowing' the abuse to happen and what this says about them as a person, leaving survivors trapped in a cycle whereby their self-worth is systematically diminished:

“’Why did I let this happen to me? Erm why did I let this carry on for so long? Why did it have to get this bad?’”

(Participant 3)

“‘I'm not the strong person I should have been to be able to like not let that happen to me I just sort of let let it happen’”

(Participant 3)

This self-blame may be linked to pervasive heteronormative and toxically masculine myths that MSM are not believed to be ‘real’ survivors of IPV or that they should have been able to protect themselves (see subtheme: ‘hetero-patriarchal lens’). These myths may make it difficult for survivors to acknowledge that abuse is happening as men are almost always framed as perpetrators. Both the experience of the abuse as well not ‘fighting back’ may also be experienced as a threat to masculinity as being a survivor violates hegemonic masculine ideals of self-reliance and being the aggressor. The fault or blame is then seen to lie with the survivor, for failing to live up to these standards, rather than the perpetrator, who has instigated the violence.

Participants also spoke about the unique elements of IPV in MSM which added to the element of control within the relationship and made it more difficult for the survivor to leave or seek support. As one participant described:

“Identity abuse which is where an element of the person's queer identity is also used as well as the domestic abuse traditional elements… further controlling a survivor… so that the perpetrator has absolute control over their lives erm and it can be very difficult to break through from that”

(Participant 6)

These aspects of IPV were described as unique to LGBTQ+ relationships. For example: *“fear of the partner who's abusive maybe going to your workplace outing you there or to family”* (Participant 5). This fear of being ‘outed’ by the perpetrator is a huge barrier for MSM leaving abusive relationships and is only present due to societal anti-LGBTQ+ prejudice and the realities of survivors being discriminated against or rejected by their families.

Although isolating the survivor from friends, family and community is a common feature of all abusive relationships, this isolation is likely to be increased for MSM:

"I think that can prevent people wanting to open up because you've worked really hard quite often to form your chosen family if you've been rejected by your birth family, which happens to many people when they're coming out, and the risk of losing your your unit, your community I think is a barrier to asking for help"

(Participant 5)

Participants felt that the risk of losing social support when leaving an abusive relationship was increased for MSM as they may not be in a position to receive support from their biological family and their partner may be heavily involved in their social circle which makes it more difficult to even acknowledge the abuse:

"for him, to acknowledge the violence in that relationship and leave it also meant leaving really any support that like social support that he had at the time erm which is really scary"

(Participant 1)

Acknowledging that abuse is happening can be very difficult for IPV survivors generally but the risk of losing social support as well as heteronormative narratives about IPV can make this acknowledgement even more difficult for MSM. Even if IPV is acknowledged, the reality of potentially losing one's social circle which may have been very carefully chosen and built up over time means that MSM may make the decision to stay in an abusive relationship.

3.4.2 Silenced by shame

Participants spoke about shame as both a trigger for distress and as a barrier to MSM seeking support following IPV. Complexly interconnected layers of shame were talked about which relate to various elements of the person's identity or experience. As participant 1 said:

> “on top of the shame that comes with experiencing intimate partner violence there's all sorts of extra layers of shame that could come with that as well”
>
> (Participant 1)

Participants indicated that there can be feelings of shame related to being a survivor of IPV and that other factors related to identity and experience can further contribute to experiences of shame for MSM. For example: *“the stigma and shame around being a survivor and particularly a male survivor”* (Participant 6). In this way, societal stigma around being a ‘victim’ of IPV was suggested as a contributor to the shame survivors may experience, making them less likely to disclose the abuse or access support. As in the above example, several participants suggested that the shame of being a survivor was compounded by the shame of being a male survivor: *“there’s that masculinity and vulnerability side of things”* (Participant 4). This suggests that masculinity and vulnerability are paradoxical within societal gender norms and that men being seen as vulnerable to abuse is a source of shame and embarrassment (see also subtheme: ‘toxic hetero-patriarchal lens’). That shame related to masculinity is based in societal narratives was also spoken about by participant 6: *“I think it creates a lot of shame around male survivors erm because of these sort of outdated ideas around masculinity”*. In Western society, masculinity is often constructed around strength, self-reliance and violence and participants suggested that being a survivor of IPV (a role usually seen as taken by women) is a threat to hegemonic ideals of masculinity and is therefore a source of shame.

Participants also highlighted the added shame of sexuality. For example: *“actually like shame about his sexuality full stop erm and… not having had experience of talking to people about it”* (Participant 3). Shame around sexuality, particularly for MSM is likely to be connected with the hegemonic masculine ideals described above, as heterosexuality or anti-LGBTQ+ prejudice is seen as a key feature of these ideals. This damaging discourse may lead to MSM experiencing interconnected layers of shame related to multiple aspects of their experience and identity, meaning they are silenced as survivors. Furthermore, levels of ‘outness’ are often cited as a mediator to LGBTQ+ individuals accessing health services and participants suggested that shame around coming out to friends, family or services could get in the way of MSM seeking help. This could be due to expecting anti-LGBTQ+ prejudice from others or fear of adding to negative stereotypes of the LGBTQ+ community: "*you don't want to let your team down your your world down by saying y'know we're not perfect and we do we are subjected to violence or emotional abuse as well"* (Participant 5). Negative societal stereotypes of male same-sex relationships may cause MSM to stay silent about the abuse they are experiencing for fear of confirming these stereotypes or 'let the side down' by admitting that abuse happens in LGBTQ+ relationships. In this way, LGBTQ+ relationships are held to a higher standard than heterosexual relationships due to the need to prove negative stereotypes wrong. This serves to silence IPV survivors and increase the risk of serious physical and psychological harm, as well as contribute to the further marginalisation of the LGBTQ+ community as a whole and uphold discourses of anti-LGBTQ+ prejudice and heteronormativity.

3.5 Theme 2: The system says 'no'

This theme explores the ways that the current system in which support services are designed and maintained is broken and works only for a particular 'type' of client. Marginalised groups within society are further marginalised within services and those with intersecting marginalised identities experience layers of oppression which make accessing services almost impossible.

3.5.1 Toxic hetero-patriarchal lens

All of the participants' accounts included in some way the impact of toxic societal lenses on MSM accessing support following intimate partner violence. In particular, anti-LGBTQ+ prejudice, heteronormativity and toxic masculinity.

Societal anti-LGBTQ+ prejudice was reported by participants to be a huge barrier to MSM accessing support. As participant 1 noted: "*there's all sorts of like unhelpful and harmful stereotypes that people might hold about queer men*". These stereotypes can be internalised, perhaps leading to MSM feeling less worthy of accessing support as well as being endorsed, consciously or unconsciously, by services and the professionals within them. This was linked to the legacy of anti-LGBTQ+ prejudice within the UK:

> "stem from so many longstanding issues: legislation, erm you know discrimination, the impact of the early AIDS epidemic, erm and kind of the perceptions of what sex you know therefore means in a sort of gay or sort of bisexual male relationship"
>
> (Participant 3)

It was acknowledged that this societal anti-LGBTQ+ prejudice also exists within services at a systemic level, as they are built on ideas of straightness and run by people who exist within society and are vulnerable to dominant narratives: "*people that work for local councils or whoever they might be working for are still people that live within society*" (Participant 6). It was noted that prejudiced views are often insidious as they may be unconscious, making them difficult to identify and change: "*even though we don't consider ourselves actively homophobic it will be unconscious biases*" (Participant 1). As well as existing within individuals, anti-LGBTQ+ prejudice was also acknowledged as a systemic problem, particularly within statutory services:

> "the sort of racism as well as homophobia, biphobia, transphobia within the NHS"
>
> (Participant 6)

> "you couldn't go to the police because the police are notoriously the- you know one of the most homophobic institutions in the land"
>
> (Participant 1)

These systemic prejudices were thought to impact MSM by making it harder for them to disclose IPV: "*internalized homophobia that actually this is just confirming what people might say the darker sides of male relationships*" (Participant 2). This was seen as being related to the shame discussed in subtheme: 'silenced by shame', in that both societal and internalised anti-LGBTQ+ attitudes contribute to MSM fearing confirming negative societal beliefs about male same-sex relationships by admitting that abuse happens in their relationships. Societal anti-LGBTQ+ prejudice was also seen as leading to IPV being less likely to be seen or believed by services: "*we have an image of who experiences intimate partner violence and it's not it's not queer* *men*" (Participant 1), meaning that MSM are less likely to be asked about IPV, to feel comfortable disclosing IPV and be taken seriously if they do disclose abuse. This fear can also be compounded if MSM hold other marginalised identities, for example along lines of class or race. Meaning that survivors may fear multiple discriminatory responses from services and 'circles of fear' are created:

"you can never be sure if the reaction or the support that you're going to receive from a professional erm so there's all sorts of there's like, so many circles of fear I guess like there's all sorts of fear around the disclosure for anybody"

(Participant 1)

This means that services are creating unsafe spaces for survivors to come forward and seek help, potentially recreating the lack of safety within the abusive relationship and thereby further abusing survivors. Understandably then, survivors do not feel able to and do not see the point of leaving one unsafe space for another. In this way, services themselves are stopping MSM survivors accessing support through not providing safe enough spaces for disclosure:

"where they think perhaps they don't feel safe or they feel that they are gonna be judged erm that could be a thing that stops them from coming forward"

(Participant 6)

Participants were very clear that these fears held by MSM about experiencing judgement or discrimination from professionals was a very real fear and often based on previous experiences of anti-LGBTQ+ prejudice in health and social care services:

"the very real possibility that your practitioner might hold homophobic views or, might erm not consider your relationship you know real or serious"

(Participant 1)

"I think that's based on experience"

(Participant 5)

As well as societal discourses of anti-LGBTQ+ prejudice, many participants also spoke about heteronormativity both within society and within services: "*when we think about ((air quotes)) victims of domestic abuse we're constantly told this heteronormative model around men beating women*" (Participant 6). This narrative around men as perpetrators was thought to be pervasive within modern society and leading to men not being seen or believed to be survivors of IPV:

> "the only way we recognize it because… of the language and and the examples that we see in the media and everything else is men versus you know men abusing women, men are stronger, macho, women are weak, timid and this is the sort of narratives that feed into to everything we do really that's in terms of domestic abuse, that people actually believe, that that is you know we have in our mind a picture of what a victim looks like and it's not a man"
>
> (Participant 6)

These pervasive and dominant ideas hold ideological power within society and are seen as taken-for-granted and universal truths which impact the way that MSM see themselves and their experiences, making it difficult for MSM survivors to identify their experiences as abuse:

> "drips down into the people themselves who find it more difficult to make sense of 'I'm a man so why is my my man sort of doing this to me? Does it count as sort of something? Is it domestic abuse? Is it not?'"
>
> (Participant 3)

Participant 3 spoke about a client she had worked with who experienced "*less of seeing himself as a victim*" (Participant 3), meaning that seeking support was not something he had even considered. Not seeing oneself as a 'victim' is likely a result of both heteronormative understandings of IPV, which negate men as survivors, and hegemonic masculinity, which suggests men should be able to defend themselves and cannot be subject to abuse.

As well as making survivors less likely to come forward, societal heteronormativity was also thought to make MSM survivors less likely to be seen by services: "*services don't think, and won't ask and just aren't alive to it in the same way*" (Participant 2). This was often put down to a lack of knowledge about IPV in MSM, possibly due to insufficient training around the topic: "*the processes that are set up to train staff fail them to support this group of people*" (Participant 2) and subscribing to heteronormative myths that IPV does not happen in male same-sex relationships: "*I don't know if people would think it was that important because I don't think people think it's that common*" (Participant 1). Participants also thought that these narratives may affect professionals decision making around identifying IPV: "*you can communicate the same pattern as a female, and the presentation will be not read in the same way*" (Participant 2). It was thought by participants that a male presenting to services may describe the same experiences of abuse as a female but professionals will be less likely to see it as IPV, leading to active, if possibly unconscious, discrimination against MSM.

On a broader service level, it was thought that heteronormativity impacts the way that IPV is dealt with in policy: "*a mix of societal kind of heteronormativity and straightness, and that it means that it's not really written into policy*" (Participant 1). It was noted that, if there was an IPV policy within the participants' service, it was written using heteronormative language and an assumption of a female survivor and male perpetrator:

> "when I go to our intimate partner violence [policy], it does not mention men once… or it does mention men it says the perpetrator that is male, which is really broken and not very effective"
>
> (Participant 2)

This heteronormative view of IPV is likely due to both heteronormative discourses in society more generally, but also the way in which IPV has traditionally been researched and understood, with a focus on patriarchy and traditional gender norms. These discourses then drip down into service policies and processes and render MSM survivors invisible. There was an acknowledgement by participants of why IPV policies are often set up for women, as women make up the majority of IPV survivors, but participants were also clear that this makes other survivors difficult to see and support within services:

> “because of that language and those processes that we've set up in society it really undermines any sort of other victims erm and it plays into a very heteronormative sort of approach on domestic abuse”
>
> (Participant 6)

Societal narratives around hegemonic masculinity and how this related to being a survivor of IPV also featured regularly in participant’s descriptions of barriers to MSM accessing support:

> “there's all this pressure around toxic masculinity and all these ideas about how men should behave and how men shouldn't be victims and I feel like that feeds into not only like the solution but also the ability to… open up about your own victimhood and say ‘I'm a survivor here you know this is what's happened to me’”
>
> (Participant 6)

Participants felt that hegemonic masculinity contributed to men not being seen as survivors of IPV by society which, as participant 6 notes above, makes it much more difficult to open up about being a survivor as this means going against dominant societal narratives and potentially seeing oneself, and being seen by others, as ‘less of a man’:

> “to say that ‘somebody is hitting me’ that's- and ‘I can't defend myself’ that’s kind of a… demasculinising experience for some gay men that maybe worked really hard to build up a male identity”
>
> (Participant 2)

Participant 2 spoke about MSM perhaps being more vulnerable to discourses around masculinity as their masculinity may already be questioned by society simply due to their identity as MSM. As Western society has institutionalised heterosexuality as the norm, it is awarded a higher status and legitimacy than an LGBTQ+ identity, thereby conferring social and ideological power to heterosexuals. MSM are therefore positioned as ‘less than’. Furthermore, society also operates through a lens of hegemonic masculinity, conferring social and ideological power to men who fit rigid gender norms (e.g. heterosexual and holding anti-LGBTQ+ attitudes). Therefore, MSM are also positioned as ‘less than’ in terms of masculine ideals. In this way, MSM are subjected to oppression and discrimination and to potentially further reduce one’s own masculinity in the eyes of others and be further subjected to oppression by disclosing experiences of IPV was seen by participants as a very difficult thing to do.

Participants also spoke about the risk of professionals responding negatively to MSM disclosing abuse due to “*this idea about masculinity that men are big and bold and therefore are strong and can defend themselves and all this shit*” (Participant 2). As participant 2 makes clear here, none of the participants subscribed to these ideas about masculinity but spoke about how prevalent they may be within society and therefore within services. Common discourses spoken about by participants were around men being physically similar to their abusive partner: “*being a male why can't you defend yourself?*” (Participant 5), men not showing emotion: “‘*big boys don't cry pull yourself together*’” (Participant 5) and confusion around what ‘counts’ as abuse between men: “*could a man rape another man? or you know erm can a man one man emotionally manipulate or abuse another man?*” (Participant 1). These discourses stem from prevalent ideas around patriarchy, hegemonic masculinity and anti-LGBTQ+ prejudice. Being physically assaulted, showing emotion and being sexually or emotionally abused are all seen as singularly female experiences and, although they are eschewed by society, they are also paradoxically seen as acceptable for women, and not men, to experience. Some participants even spoke about experiences of these discourses being explicitly endorsed by professionals:

> “I once took a person to a homeless persons interview and the the representative for the local council said ‘you're a man why don't you just punch him back?’”
>
> (Participant 6)

Despite many participants putting discrimination down to unconscious bias, the above quote demonstrates that overt and explicit oppression does still happen in services. Although there is often a general feeling among service providers that they have ‘achieved’ equality and that direct discrimination is a thing of the past, this is a myth.

These damaging societal discourses of anti-LGBTQ+ prejudice, heteronormativity and hegemonic masculinity were cited by the majority of the participants to be barriers to MSM accessing services through making IPV more difficult to identify and acknowledge by survivors themselves, making services less accessible to MSM and through individual professionals’ negative reactions to clients.

3.5.2 Intersecting layers of oppression

Several of the participants spoke about the multiple layers of oppression and discrimination that face MSM who have experienced IPV and serve as barriers to accessing support: “*there's just… barriers at every level really*” (Participant 1). These included both internal barriers, often internalised from damaging societal discourses, which stop MSM coming forward to seek help and external barriers in the way services are set up.

Simply being male was cited by participants as a potential barrier to accessing services as men are less likely to seek help: “*I don't know how much men ((laughs)) access, I mean men are notorious for not seeking help outside aren’t we?*” (Participant 4). This was understood by participants to relate to both the shame around masculinity discussed in subtheme: ‘silenced by shame’, and the hegemonic masculinity discussed in subtheme: ‘toxic hetero-patriarchal lens’. Research has consistently shown that men are less likely to seek help from health and social care services and this is often linked with toxic or hegemonic masculinity. For many, the tasks associated with asking for help (e.g. emotional vulnerability, reliance on others, admitting a problem or a need for help) conflict with socially constructed messages around gender norms that men receive in society. Therefore, seeking help may be experienced by some as a threat to these masculine norms, or simply not considered as an option. This may also be compounded for MSM, whose adherence to strict masculine norms may already be questioned by society.

Participants also spoke about the way that clients may relate to their own sexuality, often based on the cultural and family narratives they have grown up with and how this can be interwoven with internalised anti-LGBTQ+ prejudice. For example:

> “his faith as well so Roman Catholic really strong faith, again kind of from his family upbringing… he had some conflicts I think with obviously the way that the Roman Catholic Church views homosexuality”
>
> (Participant 3)

Here participant 3 spoke about a client she worked with who struggled to speak to anyone in his family and social network about the abuse he was experiencing due to narratives from his Roman Catholic upbringing which have a negative view of same-sex relationships. In a similar way, participant 5 spoke about the cultural and familial expectations often faced by MSM:

> “a young Muslim guy with somebody, the fear of being outed to your family and community even, you know, greater than, you know, ‘I'll live with it rather than challenge it because I don't want to lose my family and it's bad enough that I'm not married already to a woman’”
>
> (Participant 5)

As well as the fear of being outed to family by the abusive partner (see subtheme: ‘bound by abuse’), MSM may not have friend and family networks to support them in disclosing IPV and may worry about these networks finding out about their sexuality through the process of disclosing to services such as the police, health services or IPV organisations. Many participants felt that MSM having to hide their sexuality or live their romantic or sex lives in secrecy acted as a barrier to seeking help following IPV.

Many participants noted that the more marginalised identities a person has, the more barriers they face when accessing services: “*for queer men it's not just the experience of intimate partner violence it's how… interwoven that can be with other, difficult life experiences and aspects of identity*” (Participant 1). This was related to the way that services are set up to serve majority populations and that, if a person does not fit a particular set of identities, they are less likely to get a good service:

> “hospitals tend to cater to a white, middle class erm demographic of heteronormative people that aren’t disenfranchised in some way- that's who's going to get the best out of a hospital”
>
> (Participant 2)

These ideas are related to the damaging societal narratives discussed in subtheme: ‘toxic hetero-patriarchal lens’ and often result in institutionalised prejudice and discrimination. One participant spoke about health professionals being less likely to identify bruising resulting from IPV on people of colour as they are trained to identify bruising on white skin as the default:

> “is the educational system racist to the point where it would not recognize (a survivor of) domestic abuse’s bruising because they're not taught, they're taught about… bruising on white people and that's the main educational focus”
>
> (Participant 6)

This is consistent with research reporting institutionalised racism within health services in the UK and adds another intersecting barrier to accessing support following IPV for MSM of colour.

MSM who are asylum seeking or refugee people were noted by participants as also facing additional barriers to accessing services. Current UK domestic violence legislation actively excludes asylum seeking and refugee people:

> “the Domestic Abuse Act which recently came in also sort of says that the resources from that act cannot be spent on asylum seekers or people without recourse to public funds which it never used to do”
>
> (Participant 6)

This effectively bans many IPV services which are funded under the Domestic Abuse Act from accepting referrals for asylum seeking and refugee people and therefore hugely reduces the services available to support them through direct discrimination. This is part of a wider pattern of anti-refugee discourses in UK governmental policies and in mainstream media. One participant also spoke about the unique experiences of being an asylum-seeking person and the systemic trauma and abuse they have experienced:

> “we had young clients who were refugees and asylum seekers who’d escaped through horrendous routes…in France that camp they were abused there, then they got transported to the UK, they were taken into detention centres where they were abused sexually, and you know they were 17 by the time they got to us and all this had happened already and how do you at such a young age then understand that that's not healthy normal relationships? That they're not power based or abuse based?”
>
> (Participant 5)

As well as making it difficult for these MSM to identify and engage in healthy relationships, these experiences also constitute gross violations of trust by people in power and services who were supposed to be supporting them. Experiences of trauma and abuse are re-enacted by the state and then support is denied. This makes it incredibly unlikely that asylum seeking MSM will be able to trust services enough to disclose their experiences of both intimate partner and institutionalised abuse.

Despite services being in existence in order to provide survivors of IPV with help and support with their safety, health and wellbeing, in reality they often contribute to the further oppression and marginalisation of already marginalised groups. The layers of oppression that survivors experience in society are reflected in their experiences of services, making them effectively impossible to access.

3.5.3 Not the ‘right’ client

Participants spoke about a lack of available services for MSM who have experienced IPV. This is also reflected in the services the participants worked for; only two of the participants worked at LGBTQ+ specific services. The other participants all worked for mainstream NHS services.

Participants highlighted the lack of services aimed at men: *“there's a lack of services full stop for men*” (Participant 6) which means that if MSM want to access IPV services, they often have to access ones which are set up for and aimed at women, if they are able to access these services at all. Given the shame related to masculinity and the societal discourses around hegemonic masculinity discussed in subthemes ‘silenced by shame’ and ‘toxic hetero-patriarchal lens’, this may not be seen as an option for MSM. This then leaves MSM survivors excluded from services and left without support as well as contributes to further marginalisation. It may also create a cycle whereby MSM are excluded from IPV services and therefore do not access them, and it is then assumed by those commissioning services that this is because the need is not there.

Participants also spoke about a lack of LGBTQ+ specific services: “*there are no LGBT domestic abuse provisions*” (Participant 6), which again means that MSM often have no choice but to access services set up to support survivors of IPV in heterosexual relationships. Both the lack of male- and LGBTQ+-specialist services are likely due to the dominant heteronormative paradigms of IPV as well societal discourses of anti-LGBTQ+ prejudice obscuring and silencing the experiences of MSM survivors.

Participants working in mainstream NHS services also spoke about a lack of knowledge of the few specialist services that are available for MSM: “*a lack of professionals knowing about the available services in their area*” (Participant 1), especially crisis and emergency services:

> “if you’re a queer man in a violent relationship and you need immediate help to manage or to leave that violent relationship, if you're in immediate danger then… a mental health service isn't the place you're going to go… you're going to go to, well God knows where you'd go actually I don't know, where would you go?”
>
> (Participant 1)

Here participant 1 reflects both the lack of services available for MSM and the lack of training and knowledge that mainstream services hold about survivors of IPV that are not heterosexual women. This was a sentiment shared by participant 4 who noted: "*is there emergency housing?... I don't know the answer to that unfortunately*" (Participant 4). This lack of knowledge of where to signpost may be a direct impact of the lack of policy around IPV in MSM.

Some participants also acknowledged a "*bit of a postcode lottery*" (Participant 4) in that there are often more services available in larger cities, with much less available in towns and rural areas. This was thought to be across mental and physical health services but especially for specialist IPV or LGBTQ+ services:

> "where I was it's quite a big area and there's not always very specific services that people can access so sometimes it does feel more more generic than than maybe a specialized service that would be helpful for that person"
>
> (Participant 7)

This means that the few specialist services that are available are only available to those in larger cities. Despite this lack of specialist provision, participants also thought that mainstream services were set up in a way that makes them difficult to access for MSM: "*statutory mental health services are inaccessible to most people*" (Participant 1). This was often in reference to narratives of anti-LGBTQ+ prejudice and heteronormativity within society and, therefore, services but participants also spoke about services being set up in such a way that clients need to fit into specific boxes in order to be eligible for mainstream services:

> "it's a gateway isn't it? … I think people feel they have to say the right things in order to then access the service"
>
> (Participant 7).

This may become a further barrier to MSM disclosing both their sexuality and the abusive relationship as they feel that these are not the 'right things' to say to enter the service. It also means that only a certain 'type' of person may be able to get a service from mainstream provisions:

"it's easier for clients who sort of are easy you know, they if they fill in the right forms properly and they erm attend their appointments on time and they say the right things, then they get sort of put on the lists and seen"

(Participant 3)

This preference for 'easy clients' may be a result of the institutionalised prejudice discussed in subtheme 'hetero-patriarchal lens' but was also often attributed by participants to a lack of funding and resources leading to understaffing and very long waiting lists. This also means that services are often only able to see clients in times of crisis:

"if you were somebody who was kind of you know just doing OK and just like trotting along in the background, doing OK relative to people who were maybe needing hospitalization or were homeless or, then you're not really going to get much of a look in"

(Participant 1)

Related to this, participants spoke about clients being bounced around services as no one service feels they are best placed to support their specific need. Due to the lack of specialist services for MSM who have experienced IPV, this could be particularly relevant as professionals working within mainstream services feel de-skilled or lack in confidence in working with this community. This may lead to MSM survivors presenting at services with a different problem in order to ultimately get support:

"if he was literally just being referred to a mental health service for work on the sort of partner violence then he probably wouldn't have been eligible for our service"

(Participant 3).

Having to fit into a particular box in order to receive support gives MSM survivors the message that they are too 'difficult' to work with, discourages open disclosure of IPV and ultimately excludes MSM from services. As the 'right' client is likely one that fits dominant social norms (i.e. White, heterosexual male), anyone holding minoritized (and especially multiply minoritized) identities will not be seen as the 'right' client.

This also leads to discrimination against those with more limited social and cultural capital, such as resources or contacts. One participant noted about a client they worked with:

> “it's really about knowing how to do that and having the right contact with agencies, so if he wasn't really well connected, then he would never really be able to escape, I think it would be very difficult for him”
>
> (Participant 6)

This has the effect of further marginalising already marginalised groups and means that those who are most in need of support from services are least likely to be able to access this support due to barriers installed by the wider system.

3.6 Theme 3: Minority becoming majority

This theme captures the exclusionary nature of mainstream services as they are currently designed and delivered and the participants’ ideas about what they want to see from services moving forward.

3.6.1 Mainstream services exclude

Participants were somewhat divided in whether they felt that specialist or mainstream support would be better placed to support MSM survivors of IPV. Some felt that this was very much needed: “*I think there needs to be specialist provision for queer men”* (Participant 6) and some felt specialist services may be difficult for some people to access due to ongoing anti-LGBTQ+ prejudice in society: “*just the explicit identification of his sexuality in front of other people you know, if he was seen walking out of that service by someone in his local community*” (Participant 3). However, the general consensus between the participants was that clients should be offered choice about whether to access specialist or mainstream provision, and that if mainstream services were set up to be inclusive and accessible from the outset, that specialist provision would not be needed:

> “if services are at a more accessible level across the board then you don't need to commission specialist services”
>
> (Participant 5)

> “they don't necessarily want to be in a LGBT specific service some of them would absolutely love that but some of them won't so it's not like a one solution fits all type thing, we need to think about the different ways of delivering services, some of that's about specific services but some of it's also about making sure existing services and new services… are inclusive and supportive from the beginning”
>
> (Participant 6)

All of the participants felt that more needed to be done to make mainstream services more inclusive and accessible, particularly for MSM survivors of IPV. They acknowledged that this was difficult to change as “*the whole [IPV] sector’s been built on violence against women and girls*” (Participant 6) and that services are built in such a way as to exclude marginalised groups of people. This marginalisation and exclusion of minority groups in mainstream services was felt to be the main reason that they were not acceptable to many communities and why specialist services are better placed to support them within the current system. One participant spoke about a service she worked at in which all clinicians had to identify as LGBTQ+: “*it felt like that's the whole world and we all said how lucky we felt to work together because our world we- it was like being in the majority in our little bubble*” (Participant 5). She also thought that this was how the clients felt within this service; like the majority in their own space and all the privileges and safety that come with this.

Participants also felt that that services believe they have ‘reached’ inclusivity in recent years but that this was a myth:

> “if you think about NHS [and] local authorities, and there's an assumption that in 2022 you don't need specialist services because everybody's up on all their equality and diversity but they’re not”
>
> (Participant 5)

This sense of sitting back and being pleased with the improvements in accessibility that services think they have made may lull them into a false sense of security that there is nothing more that needs to be done and make it harder to see or admit where services and policies are still exclusionary. Participant 2 felt that it takes a serious commitment from services to not fall into this trap and continue to question their practices: "*it takes quite … sustained and ongoing process I think of continuing to evaluate, notice, see blind spots*" (Participant 2). It was also acknowledged that on some level, services need to be rebuilt from the ground up so as not to have support for white, middle class, heterosexual clients as the standard and 'adaptations' to the norm are made for anyone who does not fit this demographic:

> "that's why charitable services specifically for queer people exist because it will always, unless the service is completely rebuilt in a restructuring, then it- it will always feel a bit like an add on"
>
> (Participant 1)

A major barrier to inclusivity identified by participants was the ability of services to have 'difficult conversations', particularly where there are differences in lived experience between clients and professionals: "*services aren't set up in a way to facilitate those difficult conversations*" (Participant 1). This difficulty of, for example, heterosexual clinicians speaking about sexuality with LGBTQ+ clients, has led to particular professionals in the team, often identifying as LGBTQ+ themselves, having to take on the practical and emotional burden of leading these conversations. Participant 2, spoke about receiving referrals for LGBTQ+ clients which specifically request his input out of a team of ten clinicians:

> "I think it's 'cause they know I'm gay 'cause I'm out at work and they think that there's something gay going on, and I don't mean that in a derogatory way I think they think there's like something to do with sexuality"
>
> (Participant 2)

Participant 2 felt that these referrals being directed specifically to him were based on an assumption that he would be better placed to support them: "*they just kind of assume every gay person needs to see another gay person*" (Participant 2). This assumption not only puts a burden on LGBTQ+ clinicians, but also means that heterosexual clinicians are not required to provide inclusive and person-centred support for their clients and conveys a message that conversations about sexuality should only take place between individuals who identify as LGBTQ+, thereby framing this community as 'other'. Participants did sometimes think that it was helpful for LGBTQ+ clients to see a LGBTQ+ therapist, as being actively engaged in the LGBTQ+ community was thought to lend nuance and understanding to the conversations between client and professional:

"there's a lot of things that are very nuanced in a part of our community… and a lot of them like a lot of the the vast majority of heterosexual cisgendered housing officers and people in local authorities and so on aren't really that aware of those types of nuanced sort of very community specific trends and issues, so you need somebody that's really engaged with the communities so that they can respond appropriately"

(Participant 6)

However, it was also acknowledged that "*anyone could have these conversations*" (Participant 2) and burden does not need to fall to LGBTQ+ therapists; it was described by one participant as "*you're going up an uphill slog really*" (Participant 2). Participants also felt that this sentiment was shared by clients:

"they felt they had to educate the therapist about their sexuality, their relationships, the community, coming out to family, friends, work, all all the complexities of identifying as er being LGBT"

(Participant 5)

Having to educate majority groups about their experiences is a common burden reported by minority individuals and all of the participants felt that providing training and open, reflective conversations about difference was a step in the right direction for encouraging all professionals to be able to have these conversations with their clients (see subtheme 'unlearning and re-learning).

As well as the emotional burden on LGBTQ+ professionals, having only one 'champion' who has knowledge of or interest in LGBTQ+ experiences and, in particular, IPV, means that the responsibility for having those conversations often rests on one person within a team. As participant 5 stated: "*it should not always be the (one) in the team who has to be the you know rainbow flag flyer it needs to be generic and across services*" (Participant 5). Having the responsibility for picking up on IPV in MSM or working with MSM survivors placed on one person within the team increases the chances of IPV being missed or clients disengaging from services due to not feeling safe to talk about their experiences. Many participants felt that employing screening questions about IPV for everyone who enters a service would help IPV to be picked up, explicitly show that it is on the table to talk about and reduces the current approach of "*leaving it to the individual clinicians and their attunement and ability and willingness to to ask*" (Participant 4). Some services that participants worked in explicitly asked about IPV, but most didn't, even in conversations around risk. This suggests that particular types of risk (e.g. risk to self) are privileged over others and also relates back to heteronormative assumptions attached to IPV. For example, clinicians may be more willing to ask about IPV in a risk assessment with a heterosexual woman.

The lack of open conversations within services around areas of difference in lived experience and IPV was also thought to lead to professionals fearing getting it wrong when talking about different lived experiences with their clients:

> "there was definitely for me like this fear of like not wanting to step wrong not wanting to say the wrong thing which I guess potentially then could have been a barrier of him even talking about his sexuality with me"
>
> (Participant 7)

Participant 7 felt that receiving training and having access to open, reflective spaces helped her to feel more comfortable having conversations and reduced her worry about 'getting it wrong'. However, she acknowledged that she accessed these spaces though her professional training course and not through the services she was working in.

3.6.2 Making the inaccessible accessible

When asked what would make services more accessible to MSM survivors, most participants spoke about the importance of language and visibility of MSM within the service:

> "you need to ensure that if it's non-specialist, all the generic service providers have an understanding of language, of you know visible posters and you know information on their websites and things"
>
> (Participant 5)

It was felt that, to combat the heteronormative narratives that often pervade support for IPV, having clear visible messages welcoming MSM to the service are important. Participants spoke about having posters displayed in services and information on service websites depicting and providing information on IPV in LGBTQ+ relationships. Participants also spoke about having MSM physically present in services, both as clients and as professionals and clinicians: "*do they see any queer people erm you know people that they might imagine to be queer delivering services?*" (Participant 6). Co-production was thought by many participants to be key to developing inclusive and accessible services so as to provide support which is asked for by clients rather than given by services:

> "I would want whatever service that would be to be co-produced and service user led cause I think that that's something that we could do better with erm across all services is that it's often set up by what we think people need rather than by what the people accessing those services would say that they erm would need"
>
> (Participant 7)

There is a legacy of services doing 'to' clients rather than doing 'with' and participants felt that ensuring true co-production of services would make services more acceptable to clients from a variety of backgrounds and identities. It was also felt to be important to have LGBTQ+ communities involved in delivering services as well as developing them: "*actually making the community deliver our own services in partnership with the local authority or whoever*" (Participant 6). This means that services are providing support that is actually wanted and needed by communities but also makes minority groups more visible within these services.

It was also felt by participants that the language used both in service materials and the language used by professionals was key to supporting MSM to access support and that this was inextricably linked with education and training within services: "*I think a lot of it sits in in terms of education and language*" (Participant 5). This was thought to be because of the often unconscious biases constructed through living and working within heteronormative society and services: "*it's that whole erm heteronormative language that's out there without people realising they're using it*" (Participant 5). Therefore, use of inclusive language was thought to be very important in not unintentionally excluding particular groups from services. In addition to this, using language and questioning carefully and sensitively with those accessing the service was thought to be crucial. Participant 5 gave the example of flippantly asking a client about their sexuality when collecting demographic information: "*if you're identifying yourself based on who you choose to love to have sex with, it's a loaded question it's not just a demographic*" (Participant 5). Coming out to professionals within services was acknowledged to be a different process with different meanings for everyone but could, for a lot of people, be very difficult and come with a lot of fear and worry due to societal anti-LGBTQ+ prejudice. Therefore participant 5 suggested asking this question tentatively and sensitively, if at all, and wanted professionals to be aware of the gravity of asking about sexuality.

A move away from heteronormative language was also spoken about in terms of policy within services: "*having a policy that reflects that it can happen in multiple ways and these are the ways to support it manage it*" (Participant 2). Participant 2 spoke about policy being explicit in acknowledging that IPV can happen in any relationship regardless of sexuality or gender and should include practical steps professionals can take in supporting someone who has disclosed IPV.

Despite acknowledging it's importance, many participants also spoke about the dangers of tokenism when thinking about visibility and language within services:

“it's all like really cheesy little things, whether it's rainbow lanyards, posters, err things like that which although, you know, would say you know that's not the solution but the visibility of that does help a survivor feel more comfortable to talk, but you we also need to make sure that it's not just tokenistic things”

(Participant 6)

Participants felt that although it was important to display messages which explicitly welcome MSM into the service and to ensure language is used carefully, this was certainly not the solution or the only thing that needed to change. In fact, making these small, simple changes can often lull services into thinking they have ‘achieved’ inclusivity. All participants felt that this was a challenging, ongoing process requiring change at every level but that these small changes in visibility and language were a first step in making MSM feel welcome in mainstream services. These initial steps were thought to be important in creating a safe and trusting space for MSM to access support:

“having posters up things like that that make somebody feel like I'm gonna be OK to come out here it's gonna feel safe because they can see themselves in the service”

(Participant 6).

Several participants wondered how to create safe and trusting relationships and spaces for MSM to feel able to talk about both their sexuality, being a survivor of IPV and any other adverse experiences or aspects of their identity which were important to them. As participant 6 mentioned above, being able to see themselves in the service and know that other MSM are also accessing the service was one way to do this. Participant 1 asked:

“a queer man who's had that experience, like how is it made abundantly clear to them from the from the get-go that they can safely talk to their practitioner about that experience?”

(Participant 1).

Other participants also did not immediately have answers to this question as it was felt that services are not set up in a way to nurture trust and safety. Participants gave examples of lack of IPV screening questions, long waiting lists and short-term interventions as ways in which services make trust with a professional difficult to establish. As participant 2 noted: "*basically you go 'here's a stranger tell them all of what's going on in your deep dark secrets' who the hell wants to do that?*" (Participant 2). Disclosing painful and personal information about oneself to a 'stranger' was thought to be difficult for anyone to do but considering also the shame, fear of not being believed and the potential for anti-LGBTQ+ or heteronormative responses from services, this makes disclosure for MSM survivors almost impossible in services set up as they currently are. Several participants spoke explicitly about the responsibility for creating safe and trusting spaces being squarely on services and professionals: "*it needs to be our responsibility to talk about differences and similarities in the room and to ask questions about intimate partner violence*" (Participant 1). Actively asking questions about experiences of IPV in a sensitive way was thought to signal to clients that IPV is a topic that is 'on the table' and not making assumptions that MSM have not experienced IPV by directly asking everyone about it pushes back against heteronormative myths about IPV. Talking about difference and similarity between clients and professionals was also thought to show that this is 'okay' to talk about and to open up conversations that clients may not have otherwise felt safe to bring. When asked about a therapeutic relationship in which a client had felt able to disclose IPV, participant 1 spoke about having an explicit conversation about their similarities and differences in the first session and how she felt this had helped to create safety:

> "actively bringing that into the session just kind of sets a groundwork for 'listen like I'm OK to talk about these things, I'm open to hearing totally different viewpoints from mine' and I think that set the foundation for us to, to yeah, have a good therapeutic relationship and it was safe"
>
> (Participant 1)

This was thought to signal to clients that the service is taking responsibility for starting these conversations in safe and tentative ways and allows professional and client to understand each other better, thereby creating a more trusting relationship.

3.6.3 Unlearning and relearning

All of the participants spoke in some way about services needing to learn about the experiences of MSM survivors of IPV but many also spoke about the need to unlearn the heteronormative or anti-LGBTQ+ myths that surround IPV first. Often it was only through the experience of working with particular clients that the participants learned more about the experiences of MSM survivors:

> "I only kind of really got that sort of in depth knowledge when I started working in that particular service but it it's so useful for informing my view of all my other clients as well and you know for helping to make sense of that"
>
> (Participant 3)

Here participant 3 spoke about only learning about the needs and experiences of MSM survivors of IPV after working in an HIV service and having more MSM clients generally but also working with one client who had experienced IPV; before this it had not been on her radar as much and she felt she lacked knowledge. This was a common experience for the participants and they often spoke about wanting the knowledge they gained through experience (and often even more knowledge than this) to be widely available throughout services: "*making it part of normal training like just part of the course of training somebody, when they come into their mandatory training*" (Participant 2). This normalising of inclusive training around IPV and around the LGBTQ+ community more generally was hoped to reflect the normalising of conversations about IPV in MSM and make it part of everyday conversation, rather than as an 'add on' to 'regular' IPV or equality and diversity training. This idea was thought to be important by participant 2 as "*it facilitates conversation, creates change*" (Participant 2). Making training and knowledge available to everyone who works in an organisation or service was also thought to contribute to this normalisation of talking about LGBTQ+ experiences, including IPV:

> "making sure that there's a baseline awareness with all staff and that includes cleaners and you know everybody, not just the people that are doing the casework, everybody should be given training and support around the LGBT community"
>
> (Participant 6)

This was thought to convey the importance of inclusivity and be part of building an inclusive service from the ground up, rather than as an add-on or adaptation to a service which is built on exclusionary policies and practices. This also includes a culture of having honest, open conversations and sensitively holding others to account within services. Participant 3 spoke about a training which she attended in which the heteronormative assumptions were questioned by clients who were present:

> "the guest speaker was pulled up for just like making assumptions of heterosexuality the entire way through, erm by the clients you know erm just you know trying to highlight it"
>
> (Participant 3)

This highlights the need for services and the professionals within them to unlearn sometimes unconscious biases and assumptions and to support colleagues to do the same. That the heteronormative assumptions in participant 3's example were questioned by clients rather than service providers perhaps further exemplifies this need.

Participants also highlighted the need for services to be armed with knowledge about their own limitations in supporting MSM survivors and other services that might be better placed to support them:

> "even if frontline [staff like] NHS, police can't offer that, they need to be resourced so they know who to sign post you to because that communicates 'we care enough to know, we care enough to recognize our limitations but here's a service that can support you'"
>
> (Participant 5)

This was thought to convey respect and an acknowledgement that the person's needs are important and taken seriously. It was also hoped to reduce 'bouncing around' services when nobody knows how best to support the person and who the best support would be.

Despite acknowledging the importance of training in services, many of the participants spoke about the dangers of this being tokenistic:

> "as great as I'm sure the quality of those trainings are from charitable institutions… it's only gonna scratch the surface and it's not gonna make people… look at their own unconscious bias towards queer men"
>
> (Participant 1)

Many of the participants had experience of attending training which felt like it had 'ticked a box' in order for the service to meet its targets around equality and diversity but which actually created very little change within the service. As participant 1 asks: "*how are people going to change their literal practice?*" (Participant 1). It was felt that training had to be not only embedded within services but also continuous and reflective: "*it's not a one day training or an e-learning (odd) job it's got to be discursive and alive*" (Participant 5). Having a one-off training on, for example 'LGBTQ+ issues' can contribute to the othering of this community and endorses heteronormative discourses in that heterosexuality is seen as the default, with extra training around 'adaptations' or 'considerations' for the LGBTQ+ community framed as an 'add on'. It was also felt that it was useful to have ongoing training or reflective spaces developed and delivered by people with lived experience of being a MSM survivor of IPV in order to ensure sensitivity and authenticity.

In order to ensure that services do not subscribe to a 'one-off training', several participants spoke about the need for safe and discursive reflective spaces within services. They wanted this to be a space to not only continue the conversations started in any trainings offered, but also to reflect on their own assumptions and biases: "*have reflective spaces to be able to talk about maybe their own assumptions their own biases their own comfort with talking about these erm difficulties*" (Participant 7). There was a feeling from some participants that lack of experience talking about differences in lived experiences between clients and professionals led to a discomfort in having conversations about those differences. Participant 7 spoke about this coming up for her in her work with a client:

> “I went back to supervision and I was like ‘What was this about? Why wasn't I able to just feel OK?’ and then we were like well maybe it's like my own discomfort of like what if I step wrong and say the wrong thing and I wonder if that comes up for other sort of professionals as well”
>
> (Participant 7)

Here participant 7 spoke about using supervision to reflect on the worry she felt about ‘getting it wrong’, whether that was using language in a clumsy way or offending the client through their conversation and therefore damaging the therapeutic relationship. She felt that supervision was an invaluable space for being able to reflect on this and feel more comfortable to bring up areas of lived difference in the next session with her client. Participant 5 also picked up on the need for having supervisory and reflective spaces where professionals are ‘allowed’ to get it wrong and learn how to have difficult and sensitive conversations with their clients: “*safe space that people can talk about not knowing or you know getting the language wrong and not feeling that they they might say something wrong*” (Participant 5). If professionals are able to enter safe spaces to reflect on their biases and discomforts, as well as share knowledge, language and best practice with each other, this is hoped in turn to create a safe space for clients in their interactions with professionals, as professionals may then be able to explicitly let clients know that they can bring issues around their sexuality or IPV to the sessions.

Some participants did not want the unlearning and relearning to be restricted to services. Many felt that research and education more broadly would be helpful in combating harmful societal narratives. As participant 5 said: “*I want national agenda OK?*” (Participant 5). She suggested including more education on LGBTQ+ issues in schools but also having training and campaigns throughout governmental organisations: “*Department of Education, Department of Health, er Police Crime Commission, you know across the board*” (Participant 5). She felt that arming the public with knowledge and positive messages about the LGBTQ+ community as well as education on IPV and doing this at every level would go some way to making society an easier place for MSM to be themselves: “*so if you build it up- from school we go out into the world don't we, into the workplace and if workplaces pick it up*” (Participant 5). This idea of having explicit public messages and campaigns was also picked up by participant 2: “*you could do a public campaign about it and stuff but I think you've got to have a way of maintaining the narrative*” (Participants 2). Here he warns again of the dangers of tokenism; that there must be an ongoing commitment to keep the conversations going and make this knowledge and education part of everyday practice. In this way, inclusive practice is not seen as learning about and adapting to the ‘issues’ pertinent to ‘minority groups’, but as dismantling damaging discourses of otherness and building services from the ground up that are person-centred and attend to power and oppression.

4 DISCUSSION

4.1 Chapter Overview

In this chapter, the main findings are considered in relation to the research questions and existing literature. This is followed by a consideration of the research and clinical implications of the study and a critical appraisal. The researcher shares final reflections, and a conclusion is provided.

4.2 Summary of study aims and findings

Previous research suggests that MSM experience IPV at the same level as heterosexual women (Blosnich & Bossarte, 2009; Breiding et al., 2013; Messinger, 2011), and yet services are currently not set up to support this community adequately (Houston & McKirnan, 2007). The current findings expand on previous research by exploring UK mental health professionals' perspectives on barriers to services providing adequate support to MSM survivors and what services can do to better serve this community. Thematic analysis generated three overarching themes, each of which help to better understand the experiences of MSM who have experienced IPV, as well as mental health professionals' views on barriers to access which result from the ways in which services are currently set up: *Confined to within*, *The system says 'no'* and *Minority becoming majority*. Taking a critical realist perspective, where links are made to theory, these should be seen as one possible interpretation of the data. Without presuming that the researcher's interpretation of participants' experiences is a universal truth, the intent of the discussion is to explore mental health professionals' views and experiences whilst working with MSM survivors.

4.3 What are mental health professionals' views of service-level barriers to providing services to men who have sex with men who have experienced intimate partner violence?

The Barriers Model of Help-Seeking (St. Pierre & Senn, 2010) is a useful framework in which to frame the findings of the current study. The barriers to MSM survivors of IPV accessing support which were identified by participants fell under layers one (psychological consequences of IPV), two (socialisation, family and role expectations) and three (environmental barriers) of the model.

The themes of being confined by abuse and shame described how the consequences and impact of abuse acted as a barrier to participants' clients accessing support. The cycle of abuse is a well-documented phenomenon within IPV (Ard & Makadon, 2011; Burke & Owen, 2006; Chan & Cavacuiti, 2008; Pertnoy, 2012) and has been cited regularly as a barrier to survivors feeling able to leave abusive relationships and seek support. This view was shared by participants who reflected on how difficult it can be for survivors to break out of that cycle. In addition to this, participants spoke about the particular impact of coercive and controlling behaviours and how this may reduce a survivors self-worth and belief that they are worthy of support, a finding which is consistent across the IPV literature (Kay & Jeffries, 2010; Murray et al., 2007). The unique aspects of IPV in same-sex relationships was also cited as a barrier to accessing support, including a fear of being 'outed' to friends, family or workplaces (Ard & Makadon, 2011; Chan & Cavacuiti, 2008; Patzel, 2005), as well as the particular isolation that may be present for LGBTQ+ survivors, due to stigma and minoritisation (Ard & Makadon, 2011; Kulkin et al., 2007; Melendez & Pinto, 2007). Interconnected layers of shame relating to being a survivor of IPV, particularly a male survivor, as well as shame related to sexuality was thought to interact with the barriers above in order to make IPV incredibly difficult for MSM to acknowledge, disclose to others, and ultimately seek support for.

Despite being described as a separate layer in the Barriers model, factors related to socialisation, family and role expectations are intimately tied to the impact of abuse, as this is the frame survivors likely use to understand and make sense of their experiences. The theme of a toxic hetero-patriarchal lens relates to damaging societal discourses of anti-LGBTQ+ prejudice, heteronormativity and hegemonic masculinity which are well documented in the literature as sources of distress as well as barriers to seeking support (Breiding et al., 2013; Donnelly et al., 2005; Donovan & Hester, 2011; Frierson, 2014; Ristock, 2003). Participants linked these discourses to the ways in which MSM survivors may make sense of their own experiences, as well as the ways in which family, friends, services and society in general may respond when a survivor discloses IPV or seeks support. Previous research has documented that professionals take IPV more seriously if it fits the heteronormative assumptions of a male perpetrator and female 'victim' (Fröberg & Strand, 2018; Poorman et al., 2003; Seelau & Seelau, 2005). Queer theorists have critiqued dominant traditional feminist understandings of IPV for the pervasive heteronormative approach taken in services (Cannon et al., 2015). These discourses have the very real impact of rendering IPV that does not fit heteronormative assumptions invisible to service providers and interacts with hegemonic masculinity to ensure that MSM are not seen or believed as survivors. Not only were these discourses thought to impact direct interactions between clients and service providers, but the way in which entire services are set up. The legacy of understanding IPV through a traditional feminist lens results in services that are commissioned, built and run from a perspective of violence against women (Furman et al., 2017), meaning that policies, practices and support provided directly excludes MSM survivors. This is consistent with research in the UK describing the impact of structural discrimination (Harvey et al., 2014; Hester et al., 2012; LeFrançois, 2013; McDermott, 2015; McDermott et al., 2018; Sherriff et al., 2011). This discrimination is compounded by dominant ideas of hegemonic masculinity. Men being less likely to seek help from health and social care services and the link with toxic or hegemonic masculinity has been well documented in the literature (Addis & Mahalik, 2003; Galdas et al., 2005; O'brien et al., 2005). This was reflected in participants descriptions of damaging discourses they experienced within services which promote ideas around men being able to defend themselves and a lack of acknowledgement of anything other than physical abuse between men, and even this being seen as a 'fair fight'. This lens was seen to be particularly damaging for MSM as their masculinity may already be questioned by society for not fitting the hegemonic masculine ideal of straightness.

In the theme of intersecting layers of oppression, participants were clear that, in their experience, the more marginalised identities and experiences an individual has, the more barriers they face when accessing services. MSM of colour, for example, are likely to experience not only anti-LGBTQ+ prejudice and heteronormativity within services, but also racism. Examples of this given by participants included teaching on identification of bruising using white skin as the default and the exclusion of asylum seeking and refugee people (many but not all of whom will be people of colour) from accessing services funded through the Domestic Abuse Act. This is consistent with research reporting institutionalised racism within health services in the UK (Blofeld, 2003; McKenzie & Bhui, 2007; Patel, 2022) and directly discriminates against people of colour, again further marginalising already marginalised communities. The theme of interconnecting layers of oppression also reinforces the need for services to take an intersectional lens (Crenshaw, 1991) when designing services and support for MSM survivors. This allows for consideration of all aspects of a person’s identity and experiences rather than the privileging or obscuring of certain aspects.

Using layer one of the Barriers model as a framework, participants descriptions of environmental barriers can be understood. As a direct result of the anti-LGBTQ+ prejudice, heteronormativity, hegemonic masculinity and racism which pervades service provision, participants reported a persistent lack of available support for MSM survivors. Under the theme of not being the ‘right’ client, this was discussed as a lack of services directly aimed at supporting men and members of the LGBTQ+ community, meaning that MSM may be doubly marginalised. This has been raised as a significant issue by previous researchers (Finneran et al., 2012) and is reiterated by the current study. This lack of service provision for MSM survivors was only seen as a problem by participants due to the concurrent lack of inclusive mainstream services. Due to services being set up based on the damaging dominant discourses described above, many MSM report not feeling able to access mainstream services, for reasons ranging from lack of LGBTQ+ visibility (Huntley et al., 2019), assumptions of heteronormativity (Brown, 2008) and explicit anti-LGBTQ+ prejudice (Kay & Jeffries, 2010).

4.4 What are mental health professionals’ views on how to overcome these barriers?

In the theme of making the inaccessible accessible, participants spoke about making mainstream services more person-centred and offering client choice whether to access specialist or mainstream services. Suggested ways to increase inclusivity and accessibility included ongoing and discursive training for staff on IPV in same-sex relationships as well as broader issues that impact the LGBTQ+ community. This has been identified by previous researchers as an area which is lacking and requires improvement (Hyde, 2021). In order for this training to avoid tokenism, participants wanted it to be regular, delivered by those with lived experience, and allow space for reflection on societal discourses. As part of this, participants felt it was important to question taken-for-granted assumptions and practice having conversations that may feel difficult for some professionals, especially around areas of difference in lived experience or minoritized identities. Having to ‘educate’ majority groups about their experience is a common burden reported by minoritized individuals (Foster et al., 2021; Rodríguez et al., 2015), which is one of the reasons participants felt it was so important for learning and reflection to be undertaken as a team with buy-in from management in order for it to be embedded in everyday practice. Although some participants highlighted the importance of having members of the LGBTQ+ community delivering services, a finding which has also been noted by previous researchers (Love et al., 2017), services must be wary of contributing to ‘us and them’ discourses in mental health (Pilgrim, 2019), othering the LGBTQ+ community and implying that heterosexual clinicians cannot or should not have these conversations with LGBTQ+ clients.

Participants’ accounts of what they would like to see in services often centred around the importance of language and visibility. This included clear visible messages welcoming LGBTQ+ clients to services, as well as including members of the LGBTQ+ community in designing and delivering services, in order for services to be representative of the populations they are serving (Bermea et al., 2019). Inclusive use of language in service materials, resources and policies was also thought to be crucial in ensuring equitable and non-discriminatory practice within services. These ideas were hoped by participants to be initial steps towards creating safe and trusting spaces for clients to be able to talk openly about their experiences without the fear of not being believed, taken seriously or directly discriminated against. Compassion, connectedness and a sense of security (Gilbert & Irons, 2005) could provide a helpful frame for developing safety and acceptance. Participants were clear that the responsibility for creating trust and safety was on services and the professionals working in them, rather than survivors themselves. Professionals therefore need to put conversations around IPV, sexuality, gender and race 'on the table', letting clients know that they are welcome to bring these issues if they wish, whilst not making assumptions about experiences or identities that clients may hold. This call for creation of safe spaces within services is not new (Harvey et al., 2014; Hester et al., 2012; LeFrançois, 2013; McDermott, 2015; McDermott et al., 2018; Rymer & Cartei, 2015; Sherriff et al., 2011), but the finding that this was consistently highlighted by participants suggests services still have a long way to go.

This study's findings that mainstream services which provide support to survivors of IPV must shift towards greater inclusion is supported by other recent research (Brooks et al., 2021). This shift is critical in promoting physical and mental health and well-being, especially among those who have been historically marginalised. Brooks and colleagues (2021) argue that for this to occur, social justice must be foundational within services and that full and equal participation in shaping access and opportunities to meet the needs of clients are particularly important when considering the discourses of racism, anti-LGBTQ+ prejudice and heteronormativity which pervade society (Brooks et al., 2021). This is because IPV does not occur within a vacuum, and therefore services must address how these discourses manifest within policies, practices and service provision more widely, as well as acknowledge and grapple with how power, privilege and oppression function to further marginalise already marginalised populations. This fits with findings that suggest communities are already calling for survivor-centred and community driven approaches to supporting survivors of IPV (Kulkarni, 2019).

4.5 Implications and Recommendations

4.5.1 Research

To the researcher's knowledge, this was the first UK study exploring the perspective of service providers on service-level barriers to MSM survivors of IPV. The importance of giving space to the voices of MSM survivors was an important finding of the current study, and future research should expand upon this study by including the voices and experiences of MSM survivors themselves. Considering the difficulties the researcher faced in recruiting MSM survivors for the original design of the study, future research should prioritise consultation with MSM and survivor communities in order to ensure that engaging in research feels safe for participants and will lead to real change. In addition, as it is common for studies to collapse the experiences of the varying sexual identities under the LGBTQ+ umbrella, exploration of barriers which may impact other specific sexual identity groups within the LGBTQ+ community should also be prioritised, such as bisexual and transgender peoples, as currently a focus on these groups is almost completely absent from the literature. It is important that research such as the current study contributes towards real, measurable change within services, in that they are acceptable and accessible to the clients they serve. Therefore, regular research on the current barriers for MSM survivors as well as the effectiveness of services in addressing these barriers is key. The findings of this study suggest that taking an intersectional lens is crucial in understanding and responding to the experiences of MSM survivors and previous researchers have also recommended enhanced use of mixed methods approaches in order to reach more nuanced understandings of the ways in which race, class and culture impact experiences of IPV (Mechanic & Pole, 2013). It is imperative for the framing of any future research to locate the responsibility for accessibility and inclusivity within services and wider societal structures, rather than within clients, especially those from marginalised groups as this will likely contribute to further marginalisation.

4.5.2 Practice

This study's findings highlight the importance of addressing MSM's experiences of IPV, in sociocultural contexts in which anti-LGBTQ+ prejudice and heteronormativity is pervasive. For this reason, Bronfenbrenner's (1979) Ecological Systems Theory (see Figure 3) will be used as a frame to present the implications and recommendations for practice.

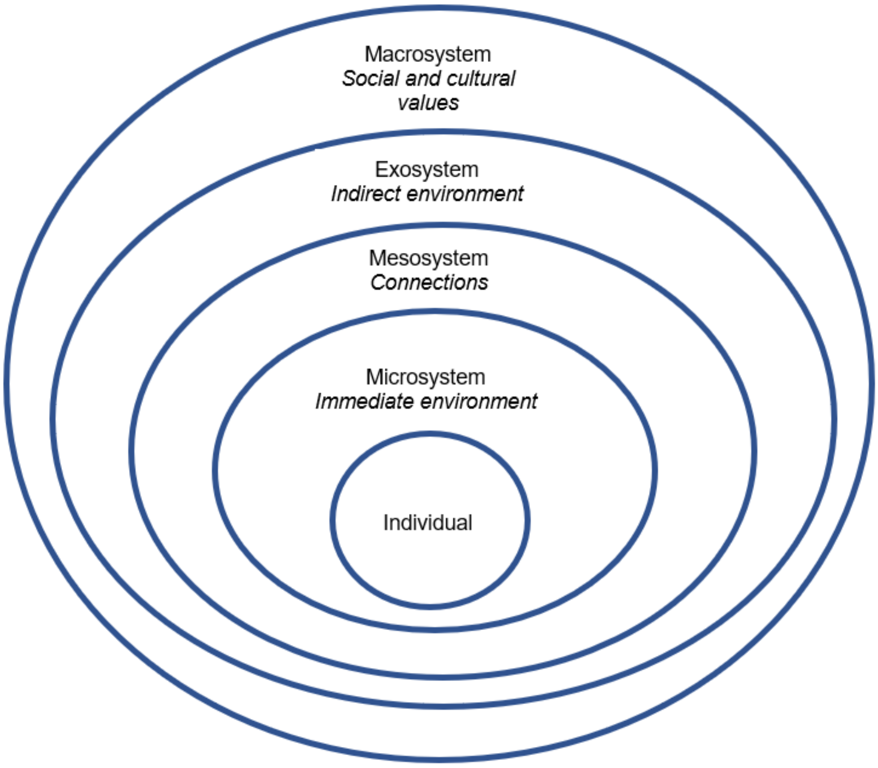

Figure 3: Bronfenbrenner's Ecological Systems Theory

At an individual level, the findings suggest that numerous barriers stand in the way of MSM accessing support, leading to exclusion from services. As effectiveness of individual interventions is reduced in discriminatory environments, and this effect is further compounded for individuals who experience multiple forms of oppression (Purdie-Vaughns & Eibach, 2008), increasing accessibility and inclusivity in services is key to supporting MSM survivors. Sharing stories can shine a light on everyday acts of resistance to violence (Wade, 1997). In this way, creating spaces where experiences of IPV, anti-LGBTQ+ prejudice and heteronormativity can be heard may increase connection and reduce distress. However, it is crucial that these stories are not framed as ones of 'individual resilience' as this can reduce responsibility on services and wider society to protect minoritized groups (Meyer, 2015).

At the exosystem level, this study emphasised a wide range of service-level barriers to MSM survivors accessing support and indicates that services must become easier to access. Whilst discussion of 'services' homogenises diverse organisations, it is hoped that the factors identified may broadly influence the improvement of experiences for MSM seeking support following IPV. Services must be built from the ground up with MSM survivors in mind, rather than 'adapting' support and interventions designed for heterosexual white women. Questioning the stereotypes (Love et al., 2017) and implicit assumptions (Rymer & Cartei, 2015) held in service design could help services recognise intersectional invisibility and review how inclusive they are. Taking an intersectional lens in a genuine and committed way can deepen appreciation of individuals' myriad experiences and identities (Love et al., 2017). This could scaffold services to implement policies and practices that authentically make services more acceptable for marginalised groups and goes some way to avoiding tokenism.

Staff training and ongoing reflective practice exploring MSM survivors' experiences and how anti-LGBTQ+ prejudice and heteronormativity persists within services could increase understanding and confidence in staff. In order to cultivate the nuanced understanding of the experiences of sexual minorities required in order to work in a compassionate and competent way, training should be interwoven throughout curriculums of both services and professional training (Burnes et al., 2017). For example, in a survey of 23 UK Clinical Psychology training programmes, only 57% of courses dedicated more than two hours to specifically learning about working with LGBTQ+ clients (Shaw et al., 2008). Establishing acceptance of sexual identities through explicitly naming entrenched anti-LGBTQ+ and heteronormative discourses could expose how these are privileged in services, and in society (Butler, 2002; Chambers, 2007; LeFrançois, 2013) and could begin conversations around subverting the power these discourses hold.

The difficulties faced by this researcher in recruiting MSM survivors of IPV for the original design of this project suggest that careful thought must be put into reaching out to this community. Consultation and collaboration with both LGBTQ+ and survivor groups is vital to ensuring that service design, support offered, and resources and materials used are acceptable and inclusive. For example, it may be that community outreach projects reach more MSM survivors in a more acceptable way than clinic-based support.

At a macrosystem level, collaborating with communities, critique of social structures and engaging in social action could advance social justice for MSM survivors and attend to multiple layers of oppression (Rosenthal, 2016). As one participant passionately expressed: *"I want a national agenda, ok?".* This could involve education and challenging of stigma at broad systemic levels, such as in schools, workplaces and in mass media. Recognising and addressing biases in social and legal systems and bringing attention to the invisibility of minoritized groups may facilitate social change (Hodson, 2019; Murphy & Hine, 2019). Acknowledging the legacy of anti-LGBTQ+ prejudice and heteronormativity as well as the invisibility of LGBTQ+ survivors in the UK may expose the biases and assumptions that contribute towards acceptance of LGBTQ+ marginalisation. In this way, this research hopes to bring the perspective of MSM survivors into debates on IPV that have previously centred heterosexual women (Cannon & Buttell, 2015).

4.6 Critical Review

The following critical review is guided by Yardley's (2015) principles: sensitivity to context, commitment and rigour, coherence and transparency and impact and importance. Limitations of the research are also discussed.

4.6.1 Sensitivity to context

The present research is grounded in relevant theoretical literature as well as the historical and socio-cultural context as outlined in chapter one. Additionally, the researcher continually reflected on her position in relation to the literature and in interactions with participants as well as her position relative to MSM survivors, in order to consider the social context and issues of power and oppression, through a reflexive journal and supervision. Aspects of the researcher's identity and relationship to the topic were also considered in chapter one.

4.6.2 Commitment and rigour

The researcher reviewed multiple resources and thematic analytic approaches (Braun & Clarke, 2006), utilised supervision and took a reflective approach throughout to ensure rigour in the design and implementation of the research. The researcher was committed to prioritising the experiences of participants, as well as the needs and experiences of their clients, by giving them the opportunity to share what was important to them. The data collection was participant-led and minimal prompts were planned in the interview schedule. Instead, prompts were asked on an ad-hoc basis, depending on where the participants wanted to take the conversation. A conscious effort was made to understand and represent the variation and complexity in participant's responses through in-depth engagement with multiple iterations of the data. Additionally, the researcher was careful to utilise direct quotes to support themes and represent a balanced selection of participant's perspectives.

4.6.3 Coherence and transparency

In order to present a coherent and transparent account of the research, the methodology and results sections (chapters two and three) document the process of research design, data collection and analysis. For further transparency around the design and analytic process, an extract of a coded section of interview transcript and extracts from the researcher's reflexive journal are included in appendix O and P respectively, as well as early versions of thematic maps in appendix Q. A discussion of the limitations of the research (following) also aims to situate this research and guide consideration of its findings.

4.6.4 Impact and importance

This study achieved its aims of exploring the service-level barriers that face MSM survivors of IPV in the UK and offers a more nuanced understanding of how services may contribute to the further marginalisation of marginalised groups. It offers novel and valuable insights into how services may better serve MSM survivors. This study was the first of its kind in the UK to gain the views of mental health professionals in this area.

4.6.5 Limitations

The original design of the study was a mixed methods approach which aimed to explore the experiences of MSM survivors themselves of the barriers to accessing support and their views on how services could improve. This involved an option to take part in an anonymous online survey and/or individual interviews. However, despite a rigorous recruitment strategy over a period of five months, it was not possible to recruit any participants. This may have been due to the sensitivity of the topic, combined with difficulty reaching the target population (e.g. very few organisations which directly serve MSM survivors). Many of the barriers which obstruct MSM from accessing support may also have stopped them coming forward to participate in the research. Difficulties recruiting LGBTQ+ adults has been highlighted by previous researchers (e.g. Hester et al., 2012), and it has been suggested that careful thought is required to engage larger numbers of LGBTQ+ people in research. This means that the voices of MSM survivors were not able to be heard in this particular study. This is, however, a recommendation for future research (see section 4.5.1).

Participation was voluntary and participants self-selected. Although effort was made to be as inclusive as possible by advertising on multiple platforms and having wide inclusion criterion, this may have resulted in a sample who were highly motivated to talk about LGBTQ+ inclusivity. This was potentially helpful for this study as it may have meant participants were knowledgeable about the experiences of the LGBTQ+ community, however it may not represent the views and experiences of mental health professionals more generally. In addition, six of the seven participants identified as White British, which does not accurately reflect the UK population (Office for National Statistics, 2011), however is closer in reflecting mental health professionals, and particularly Clinical Psychologists, 88% of whom are White (British Psychological Society, 2015). The small number of participants from ethnic minorities is problematic as the LGBTQ+ literature often excludes perspectives of ethnic minorities (Butler et al., 2016) and White professionals are likely to be less alive to particular issues facing MSM survivors of colour due to Whiteness (Ahsan, 2020).

Additionally, as the sample included professionals who had worked with MSM survivors within services, their experiences were based on survivors who have already accessed services on at least one occasion. This will likely exclude the experiences of MSM survivors who have never accessed services, further highlighting the importance of conducting research with survivors themselves.

4.7 Researcher reflections

A researcher's commitment to personal reflexivity is imperative to ethically conducting qualitative research (Attia & Edge, 2017). I came to this research hoping to be an ally, in that I aimed to contribute to creating a space where MSM survivors, who are subjected to power, have their needs and experiences heard and privileged (Reynolds, 2013). The privileges my identities afford me motivated me to access the power I hold as a trainee clinical psychologist to conduct research which shines a light on the experiences of MSM survivors. However, my identities may also have affected how participants responded as well as how I designed and conducted the research and interpreted the results. I continually questioned how this could have been influenced had I held different identities (e.g. as a man or LGBTQ+) and considered the minoritized identities I do hold (e.g. a woman) in order to attempt this. Following the significant challenges with recruitment for the original design of the study (as described in section 4.6.5), I questioned whether I was best placed to conduct this research, identifying as neither a man nor as a member of the LGBTQ+ community. In addition, I questioned whether my identities had led to aspects of the design which meant that MSM survivors were not volunteering to take part.

Whilst taking a critical approach to examining the literature and data, as a White, heterosexual woman raised within UK society, it was important for me to reflect on potential blind-spots in my own world view that could perpetuate pervasive and dominant anti-LGBTQ+, heteronormative or racist ideas and discourses. I am aware of the social and educational privilege I hold (Savage, 2015) and how this could inadvertently marginalise other voices.

As many of the participants were trainee or qualified clinical psychologists, I noticed my own identification as a ‘partial-insider’ (Chavez, 2008) and reflected on the impact of this position on the study.

Throughout the process of this study, I actively questioned previously taken-for-granted assumptions and I came to appreciate the importance of the project beyond the purpose of my thesis. It reinforced the need for me to continue to work towards being an ally and overtly challenge services to be inclusive as well as question exclusionary practices in my clinical work.

4.8 Conclusion

This study was the first UK based exploration of mental health professionals’ views on the barriers to MSM survivors of IPV accessing support and how services could address these barriers. The qualitative approach and focus on service-level barriers aimed to intentionally disrupt the individualising of distress by positioning the research in wider sociocultural contexts and exploring the role of services, as well as broader societal discourses. The findings emphasised the impact of service practice and policy, as well as societal discourses in shaping both the distress experienced and ability to access support of MSM survivors.

The findings suggest that services still have a long way to go in order to increase inclusivity, accessibility and acceptability for MSM survivors. Currently, services are premised on a heteronormative framework, once which directly excludes MSM survivors and are also impacted by anti-LGBTQ+ prejudice and hegemonic masculinity. MSM are likely to be further marginalised by services if they hold multiple and intersecting minoritized identities, highlighting the need for services to take an intersectional approach.

Services must be developed with MSM survivors in mind from the ground up, rather than ‘adapting’ practices already built on discourses which harm MSM. All work towards inclusivity must be an ongoing, discursive commitment from all levels of services and must include actively acknowledging and challenging discourses of oppression and power.

Through building on these initial findings, it is hoped that future research will explore the experiences of MSM survivors themselves, in order to build a more nuanced understanding of same-sex IPV, as well as how services can work towards inclusivity. Moreover, it is hoped that as a collective, we aim to challenge the harmful societal discourses which affect MSM survivors, both inside and outside of clinical practice.

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APPENDICES

Appendix A: Literature Search

To identify relevant literature, three databases were searched: PSYCHINFO, Academic Search Ultimate and CINHAL complete, along with grey literature through Google Scholar and other open-source platforms (such as Research Gate).

Search terms pertaining to intimate partner violence included: 'domestic violence', 'intimate partner violence', 'abusive relationships', 'LGBTQ partner abuse'. Search terms pertaining to men who have sex with men included: 'LGBTQ', 'sexual minority groups', 'same sex couples', 'sexual minority men', 'men who have sex with men', 'bisexuals'.

Inclusion and exclusion criteria were employed to identify relevant publications and reduce bias.

Inclusion criteria:

- Studies in which the participants were service providers or mental health professionals
- Studies which explored barriers to MSM survivors of IPV accessing services

Exclusion criteria:

- Studies not written in English
- Studies which did not separate domestic violence (e.g. child abuse, elder abuse) from intimate partner violence
- Papers which were a review of previous literature

Abstracts of all studies were read and their reference lists reviewed. 212 studies were retrieved from PsychINFO (2 met the inclusion criteria), 176 studies were retrieved from Academic Search Ultimate (2 met the inclusion criteria), 82 studies were retrieved from CINHAL Complete (0 met the inclusion criteria), and 1 study was retrieved from Google Scholar. As a result, the literature review contained five studies.

Appendix B: Yardley’s (2015) Principles for Evaluating Qualitative Research

1. Sensitivity to context
2. Commitment and rigour
3. Coherence and transparency
4. Impact and importance

Appendix C: Recruitment Strategy and Materials

Emails

The below email and subsequent follow up email were sent out to a large number of organisations. These included LGBTQ+ organisations, domestic violence organisations and training courses for mental health professionals. All organisations are not included as this could compromise the anonymity of participants. Types of organisation are outlines below:

- 20 LGBTQ+ organisations
- 13 domestic violence organisations
- 37 mental health training courses (e.g. Clinical Psychology, CBT, Mental Heath Nursing)

Initial email

Hello,

I am a Trainee Clinical Psychologist studying at the University of East London and was wondering if you would be able to share my doctoral thesis project with your staff team?

My research aims to explore the views of mental health professionals on the barriers to accessing support for men who have experienced violence in a relationship with another man. I want to find out what service providers think services, particularly mainstream mental health services, can do to better support queer survivors of intimate partner violence. The study has ethical approval from the University of East London School of Psychology.

I am hoping to speak to any mental health workers (e.g. therapists, social workers, support workers, helpline workers etc) who have experience supporting queer men who have experienced intimate partner violence.

Please do let me know if you are able to share the attached poster with your team (and anyone else you think may be interested!).

Many thanks,

Esther Coroneo-Seaman
Trainee Clinical Psychologist
School of Psychology
The University of East London Stratford Campus
Water Lane

London E15 4LZ
Email: u1945419@uel.ac.uk

Follow-up email

Hello,

I just wanted to follow up on my previous email. Would it possible to share the information about my research project and the attached poster with your staff team? Do let me know if you have any questions about the research.

Best wishes,

Esther Coroneo-Seaman
Trainee Clinical Psychologist
School of Psychology
The University of East London Stratford Campus
Water Lane
London E15 4LZ
Email: u1945419@uel.ac.uk

Facebook

A Facebook account was created for the research and Facebook groups for mental health professionals were joined and posted on with both written information and posters. A total of 64 Facebook posts were made on various groups.

Example of Facebook post

Are you a mental health professional (e.g. therapist, social worker, mental health nurse, OT, helpline worker etc.) that has experience working with men who have experienced intimate partner violence in a relationship with another man? This could be in a current or previous role and within any service.
I am a trainee clinical psychologist from the University of East London and recruiting for my doctoral thesis on the service level barriers to queer men accessing support following intimate partner violence. Please contact me on u1945419@uel.ac.uk for more information and further details on taking part.

Poster created for the project

SERVICE LEVEL BARRIERS TO ACCESSING SUPPORT FOLLOWING INTMATE PARTNER VIOLENCE FOR MEN WHO HAVE SEX WITH MEN: SERVICE PROVIDER PERSPECTIVES

RESEARCH AIMS

The research aims to explore professionals views on the barriers to queer men accessing support following intimate partner violence in order to improve services and support offered.

WHO CAN TAKE PART?

Are you a mental health professional that has experience providing support for men who have experienced intimate partner violence whilst in a relationship with another man?

WHAT IS INVOLVED?

I would like to meet with you for a video chat on MS Teams to explore your views

To find out more, please email Esther on u1945419@uel.ac.uk

UEL
University of East London

Appendix D: Demographic Questions

Age	
Gender	
Ethnicity	
Sexuality	
Job title	
Type of service you work/ed in (e.g. social services, charity etc.)	
Geographical area	

Appendix E: Semi-Structured Interview Schedule

1. Can you tell me a bit about the service you work in?
   (What type of support does it provide?)
   (Is there an explicit offer of support for MSM who have experienced IPV?)
   (Does the service regularly screen for or ask about IPV?)
   (If not, do you have any ideas why that might be?)
   (How well known is it within the community that support is available from your service?)
   (Do you or your colleagues have much knowledge about what other local services there are that you could signpost to?)
   (How much does your service liaise with other organisations?)

2. In your experience of providing support to men who have sex with men following intimate partner violence, what has come up that is a barrier to them accessing the support?

3. In your experience, what are some of the barriers at a service level?
   (What are services not doing?)
   (Where are these messages coming from?)
   (Who makes these decisions?)

4. From your experience, what has worked well in supporting MSM who have experienced IPV?
   (Are there things you tried or would like to try?)

5. What do you think services could do to make support easier to access?
   (If you had unlimited funding, what kind of service would you set up for this group?)
   (From your experience working with marginalised groups more generally, what things might help them to access support?)

Appendix F: Participant Information Sheet

Version: 1
Date: 03/12/2021

PARTICIPANT INFORMATION SHEET

Service-level barriers to accessing support for intimate partner violence in men who have sex with men
Contact person: Esther Coroneo
Email: u1945419@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. Feel free to talk with others about the study (e.g., friends, colleagues etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Esther Coroneo. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Clinical Psychology Doctorate. 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 into professionals' views about the service-level barriers to men who have sex with men accessing support for intimate partner violence. Current research suggests that numbers of men who have sex with men seeking support from services are low and I therefore hope that this research will help to improve services and support.

Why have I been invited to take part?

To address the study aims, I am inviting professionals who work in services that offer mental health support to men who have sex with men who have experienced intimate partner violence to take part in my research. If you are aged 18+ and work in a service that may support these men in the UK, you are eligible to take part in the study.

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

What will I be asked to do if I agree to take part?
If you agree to take part, you will be asked to take part in an online interview over Microsoft Teams (you do not need to download this - I will send you a link and you can access this on a laptop or smartphone). If you are not able to access Microsoft Teams, you will be offered the option to take part in an audio recorded telephone interview. We will need roughly one hour, but it might be helpful to block out one and a half hours in case we need extra time. During this interview, I will ask you some brief demographic information, about your experiences of working with men who have sex with men who have experienced intimate violence, what you think might get in the way of these men accessing services and how you think services could improve. You can choose not to answer any of the questions and do not need to provide a reason. You can take breaks or end the interview at any time. The interview will be recorded so that I can analyse our conversation for my study.

Can I change my mind?
Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview, you can do so at any time by letting me know that you do not want to continue. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?
The interviews should not be distressing in any way. Some participants may feel uncomfortable talking about how services, particularly the service they work in, could do better to support men who have sex with men. A list of support services will be provided following the interview, should you wish to speak to someone. All information given during interviews is kept secure and confidential. No names of people or services will be used.

How will the information I provide be kept secure and confidential?
Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research. You will be given a pseudonym (a fake name) and potential identifiers (e.g. names of local services, people or places) will be changed. The audio recordings of the interview will be transcribed and then the audio

recordings will be deleted. Only myself and my research supervisor will have access to the anonymised transcripts and this will be password protected on a secure cloud storage system. Personal contact details will also be stored on the secure cloud system and will be kept separately from all interview data. Once the study is completed (Estimated date: September 2022), all contact details and electronic consent forms will be erased.

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 online Repository (Registry of Open Access Repositories or ROAR). Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations and talks. Short, anonymised quotes from the interviews may be used in any material produced, but your identity will remain anonymous, in that, it will not be possible to identify you personally as personally identifying information will either be removed or replaced with a pseudonym.

You will be given the option to receive a summary of the research findings once the study has been completed. If you choose to receive this summary, this is the only reason you will be contacted and your contact details will be erased when the study is completed.

Anonymised research data will be securely stored by Dr Trishna Patel, the research supervisor, 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 Research 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. My details are at the top of this document.

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

or

Chair of School Research 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 G: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Service-level barriers to accessing support for intimate partner violence in men who have sex with men
Contact person: Esther Coroneo
Email: u1945419@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 03/12/2021 (version 1) 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 during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams or audio recorded over the telephone if you are not able to access Microsoft Teams	
I understand that my personal information and data, including audio/video 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 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)

……

Researcher’s Signature

……

Date

……

Appendix H: Ethics Application

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:	Esther Coroneo-Seaman
2.2	Your supervisor's name:	Dr Trishna Patel
2.3	Name(s) of additional UEL supervisors:	Dr Christina Trigeorgis 3rd supervisor (if applicable)
2.4	Title of your programme:	Professional Doctorate in Clinical Psychology
2.5	UEL assignment submission date:	23/05/2022

		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	Service level barriers to accessing support for intimate partner violence in men who have sex with men.
3.2	Summary of study background and aims (using lay language):	Background: Intimate partner violence (IPV) has been recognised as a major public health issue (García-Moreno, Pallitto, Devries, Stöckl, Watts & Abrahams, 2013) with wide-ranging consequences on physical and mental health (Sloan & Edmond, 1996) and is of particular importance at the current time due to the rise in reports of IPV associated with government responses to COVID-19 (Van Gelder, Peterman, Potts, O'Donnell, Thompson, Shah & Oertelt-Prigione, 2020). Although there is an extensive literature on IPV in heterosexual relationships (Hester, 2004), only 3% of the literature focuses on IPV in LGBT relationships (Edwards, Sylaska & Neal, 2015) and has mainly focused on lesbian relationships, with a small literature base regarding IPV amongst men who have sex with men (Seelau et al., 2003). Although an accurate prevalence rate of IPV in LGBT relationships is difficult to determine, it is estimated to be similar to or higher than that of heterosexual relationships (Walters, Chen & Breiding, 2013). However, LGBT survivors of IPV do not often seek help from formal support services such as domestic violence agencies or the police due to fearing not being believed, minimisation of their experiences or experiencing homophobia from professionals (Donovan & Hester, 2011, 2014). It has also been found that LGBT individuals access mental health services less than their heterosexual peers (Hudson-Sharp & Metcalf, 2016), despite experiencing higher

		levels of distress (Collier, van Beusekom, Bos & Sandfort, 2013). Services specifically designed for LGBT victims of IPV are few and far between and generic services may not adequately cater for this group (Home Affairs Select Committee, 2008). Aims: Using a qualitative approach, the aims of this research are to explore what professionals describe as the service-level barriers to accessing support for intimate partner violence in men who have sex with men and how they think services could do better.
3.3	Research question(s):	1. What are professionals' views about service-level barriers to providing appropriate services to men who have sex with men who have experienced intimate partner violence? 2. What do professionals think is needed to overcome these barriers?
3.4	Research design:	A qualitative methodology is proposed. Participants will be invited to take part in online, individual semi-structured interviews asking about what they think are the service-level barriers to men who have sex with men accessing support for intimate partner violence and how they think services could address these.
3.5	Participants: Include all relevant information including inclusion and exclusion criteria	Inclusion criteria: -Mental health professionals working in services which support men who have sex with men who have experienced intimate partner violence. -Professionals from services such as: LGBT organisations, domestic violence support services, social care, mental health services. -Aged 18+ - Level of English to be able to understand written material and engage in a conversation without an interpreter.
3.6	Recruitment strategy: Provide as much detail as possible and include a backup plan if relevant	Mental health professionals will be recruited through LGBT and domestic violence organisations as well as other support services. Third sector organisations will be contacted by phone and email to ask if they would like to participate. The study will be advertised via posters, newsletters, social media

		and word of mouth. The researcher's professional networks will also be contacted to both advertise the study and to recruit participants. Plan B: If recruitment difficulties occur, participants will be recruited across professional disciplines in order to widen the recruitment pool. Professionals will also be recruited who have not had direct experience of working with men who have sex with men who have experienced intimate partner violence but who work for organisations who offer support for them (e.g. mainstream domestic violence organisations).
3.7	Measures, materials or equipment: Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	Microsoft Teams will be used to conduct and transcribe the interviews. For participants that are not able to access or use Microsoft Teams, they will be offered the option to have audio recorded telephone interviews. The audio will be recorded using Microsoft Teams and therefore this will not affect the way data is handled and stored. NVivo will be used to analyse the data.
3.8	Data collection: Provide information on how data will be collected from the point of consent to debrief	Participants will be sent a participant information sheet and consent form prior to the interview. They will be given the opportunity to ask questions before taking part and verbal consent will also be taken at the start and end of the interviews. Participants will be given the opportunity to take breaks during the interviews and to withdraw at any time. Interviews will take place via Microsoft Teams and will last between 40-60 minutes. Following the interviews, participants will be sent a debrief sheet reminding them of the aims of the study and key information about what will happen to the data they provided and how to withdraw following the interviews. It is unlikely that the interviews will cause any distress as the questions will cover conversations that professionals are likely to have as part of their work but if any of the participants would like to speak with someone following the interviews, support services will be listed in the debrief sheet.

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?	If you selected yes, please provide more information here	
3.10	Will participants be reimbursed?	YES ☐	NO ☒
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	Please state the value of vouchers	
3.11	Data analysis:	The data from the semi-structured interviews will be analysed using thematic analysis. The current study will aim for 8-12 interviews as data saturation is most likely to occur after 12 interviews (Guest, Bunce & Johnson, 2006).	

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.	Please detail how data will be anonymised	
4.2	Are participants' responses anonymised or are an anonymised sample?	YES ☒	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.).	All transcripts will have identifiable information removed (e.g. names and places). Data will be analysed anonymously and participants will be allocated a pseudonym. Short extracts of transcripts will be provided in the final research and any subsequent publications; however, identifiable information will not be included in these extracts.	

		Only broad demographic information will be reported to avoid participants being identifiable.
4.3	How will you ensure participant details will be kept confidential?	Transcription of interviews will be undertaken only by the researcher to protect confidentiality of participants. No personal information will be collected or stored and any identifying information will be anonymised during transcription of interviews by using pseudonyms and removing any identifying information (such as locations, names of services etc.) Email addresses of participants will be stored separately to audio data and anonymised transcripts in a password protected document.
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 data will be electronic and stored on UEL OneDrive for business cloud. No data will be stored on the researcher's or research supervisor's personal devices. This is in line with data storage requirements. Audio files of interviews will be downloaded from Microsoft Teams immediately after the interview and saved on a UEL OneDrive for business. The audio files will then be deleted from Microsoft Teams and from any download folders on the researcher's laptop. Automatic syncing to personal cloud storage will also be disabled. The audio files will be kept until the interview has been transcribed and checked and then this file will be deleted. Audio files and transcripts will be stored in separate password protected folders on UEL OneDrive for business. Only the researcher will have access to the audio files. Only the researcher and supervisor will have access to the transcripts and examiners if requested. Any data shared with the research supervisor will be shared via secure UEL email. Transcripts will be stored on both the researcher's and supervisor's secure UEL OneDrive account to ensure there is a backup. No list will be kept of participant pseudonyms linked to personal identifying information. Electronic consent forms will be sent to participants via email and will be saved on the UEL OneDrive for business. These will be kept separate to research data and deleted upon study completion. Contact details and other identifiable

		information will be stored in a folder separate from the audio files and transcripts.	
4.5	Who will have access to the data and in what form? (e.g., raw data, anonymised data)	Only the researcher will have access to audio recordings from Microsoft Teams. And due to these visually identifying an individual they will be deleted as soon as the interview has been transcribed. The researcher will review and edit the transcripts (removing identifiable information in the process) before downloading into a Microsoft Word document. The transcript will then be stored in a password protected folder on both the researcher's and supervisor's secure OneDrive accounts. Only the researcher, supervisor and examiners will have access to the anonymised transcripts. Anonymised interview transcripts will be shared with the research supervisor via UEL OneDrive for Business. Anonymised data may be requested by examiners.	
4.6	Which data are of long-term value and will be retained? (e.g., anonymised interview transcripts, anonymised databases)	Anonymised interview transcripts will be retained.	
4.7	What is the long-term retention plan for this data?	Electronic copies of consent forms will be kept until the thesis has been examined and passed. They will then be erased from the secure server. Audio files will be deleted as soon as they have been transcribed. Anonymised interview transcripts will be kept for three years following the end of the study for dissemination purposes. All anonymised research data will be kept by the research supervisor on the UEL OneDrive once the researcher leaves UEL. No data will be kept on the researcher's personal device.	
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. 3				
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?	There is a small risk that participants will feel distressed if they recall particular upsetting incidents during the interviews. Participants will be given the opportunity to take breaks and to stop at any time. They will also be provided with details of support services in the debrief information.		
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?	There is a small risk that hearing about upsetting incidents recalled by participants could be distressing to the researcher. The researcher will be in regular contact with the research supervisor following interviews and will discuss any distressing materials from interviews.		
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 ☐	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 ☐	NO ☐
6.4	If you have current DBS clearance, please provide your DBS certificate number:	Please enter your DBS certificate number	
	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	YES ☒

	and feasibility of this research proposal with my supervisor:	
8.2	Student's name: (Typed name acts as a signature)	Esther Coroneo-Seaman
8.3	Student's number:	1945419
8.4	Date:	19/01/2022
Supervisor's declaration of support is given upon their electronic submission of the application		

Appendix I: Ethical Approval

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:	Lydia Tan
Supervisor:	Trishna Patel
Student:	Esther Coroneo-Seaman
Course:	Prof Doc Clinical Psychology
Title of proposed study:	Please type title of proposed study

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 BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made before 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 with minor amendments

Minor amendments
Please clearly detail the amendments the student is required to make
Section 5.5: Interviews are taking place via MS Teams, so should be off-campus? **Participant Debrief Sheet: Please remove Samaritans as a contact.**

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
	YES	☐

Has an adequate risk assessment been offered in the application form?	☐	
	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:		
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)	Lydia Tan
Date:	8 Feb 2022

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research 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 Research 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)	Esther Coroneo-Seaman
Student number:	1945419
Date:	14/02/2022
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 J: Amendment Form

University of East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are <u>not</u> to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	YES ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	YES ☒
A copy of the approval of your initial ethics application.	YES

	☒

Details

Name of applicant:	Esther Coroneo-Seaman
Programme of study:	Professional Doctorate in Clinical Psychology
Title of research:	Service-level barriers to accessing support following intimate partner violence for men who have sex with men: service provider perspectives
Name of supervisor:	Dr Trishna Patel

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
To give participants the option to engage in audio recorded telephone interviews if they are not able to access or use Microsoft Teams. The audio will be recorded over Microsoft Teams with the participant on speakerphone so this will not impact the way data is handled or stored.	To allow participants who do not have access to Microsoft Teams to take part in the research.
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	YES ☒	NO ☐

Student's signature

Student: (Typed name to act as signature)	Esther Coroneo-Seaman
Date:	17/06/2022

Reviewer's decision		
Amendment(s) approved:	YES ☒	NO ☐
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	Trishna Patel	
Date:	17/06/2022	

Appendix K: Change of Title Approval

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents	
A copy of the approval of your initial ethics application.	YES ☒

Details	
Name of applicant:	Esther Coroneo-Seaman
Programme of study:	Professional Doctorate in Clinical Psychology

Title of research:	Service-level barriers to accessing support following intimate partner violence for men who have sex with men: service provider perspectives
Name of supervisor:	Dr Trishna Patel

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Service level barriers to accessing support for intimate partner violence in men who have sex with men.
New title:	Service-level barriers to accessing support following intimate partner violence for men who have sex with men: service provider perspectives
Rationale:	The new title makes it much clearer that I am exploring service provider perspectives and not the perspective of survivors of intimate partner violence themselves

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	YES ☒	NO ☐
Does your change of title impact the process of how you collected your data/conducted your research?	YES ☐	NO ☒

Student's signature

Student: (Typed name to act as signature)	Esther Coroneo-Seaman
Date:	04/04/2022

Reviewer's decision

Title change approved:	YES ☒	NO ☐
Comments:	The new title reflects better the perspective of the research study and will not impact the process of how the data are collected or how the research is conducted.	
Reviewer: (Typed name to act as signature)	Dr Jérémy Lemoine	
Date:	06/04/2022	

Appendix L: Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Service-level barriers to accessing support for intimate partner violence in men who have sex with men

Thank you for participating in my research study on service-level barriers to accessing intimate partner violence services for men who have sex with men. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. 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. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

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 publically available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations and talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as personally identifying information will either be removed or replaced with a pseudonym.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Trishna Patel, the research supervisor, for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

SANEline

Website: http://www.sane.org.uk/

Telephone: 0300 304 7000

SANEline is a national out-of-hours mental health helpline offering specialist emotional support, guidance and information to anyone affected my mental illness, including family, friends and carers. They are open every day of the year from 4:30pm to 10:30pm.

Switchboard

Website: https://switchboard.lgbt/

Telephone: 0300 330 0630

Email: chris@switchboard.lgbt

Switchboard provides a one-stop listening service for LGBT+ people on the phone, by email and through Instant Messaging.

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.

Researcher: Esther Coroneo
Email: u1945419@uel.ac.uk

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

or

Chair of School Research 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 part in my study

Appendix M: Initial Codes

'Easy' clients get a service
Abuse itself as a barrier
Accepting of HIV diagnosis
Access through physical health services
Access to accommodation
Access to financial support
Additional mental health needs
Administration difficulties
Advocacy
Aim of psychology assessment
Alternative therapies
Appropriate language on materials
Asking about trauma
Assessment
Assessment can be tick boxy
Assumed shared knowledge with queer clinicians
Assumption that all services are accessible and inclusive
Assumptions
Audit
Awareness of IPV generally
Basic needs
Being a 'good' client
Being culturally sensitive
Beliefs about men as IPV survivors
Beliefs about sexuality based on past abuse
Benefit of video over telephone
Biases
Blurred boundary between dominant-submissive relationship and abuse
Blurred boundary between extreme sexual practices and abuse
Broad referral criteria
Bruising not recognized on BAME skin
LGBT-specific IPV services
LGBTQ identity
Liaison with NHS services
Liaison with other services
Liaison with third sector services
Lifelong follow up in HIV services
Linking with other services
Links with third sector services
Long therapy waitlists
Long waiting lists
Losing connections with LGBT community
Low self-worth
Mainstream mental health service
Male identity
Male-male violence as only physical
Male-specific IPV service
Male-specific services
Meeting multiple professionals
Meeting referral criteria
Men less likely to seek help
Men not seen as victims
Mental health services less inclusive
Microaggressions
More difficult for marginalized communities
More likely to screen in services where it is more common
More services in bigger cities
Moved away from current home
MSM find it more difficult to access services
MSM having to educate straight therapists
MSM IPV normalized
MSM may not feel welcome in services

Building trust	MSM seen as less important
Calling out inappropriate behaviour from professionals	MSM using sex work to get away from home
Champions	National agenda
Changing practice	Need for male-specific services
Clear visual was of welcoming MSM to services	Need for policy
Clear ways of communicating IPV	Need for screening
Client choice	Need for straight clinicians to have conversations
Clients don't always want direct support for IPV	Need to unlearn
Clinicians only get knowledge through experience	Negative experiences of services
Co-production of services	Network
Coming out	NHS services inaccessible
Coming out to professionals	No direct IPV screening question
Commissioning	No explicit referral for IPV
Commitment from services	No financial support
Community projects	No IPV policy
Community-specific nuances	No IPV screening
Complexity	No IPV-specific service
Confidence of clinicians to talk about MSM IPV	No recourse to public funds
Cons of specific services	No specialist support for MSM
Consultation	Non-physical IPV not picked up
Creating safe space	Non-physical IPV not taken seriously
Cultural perspective	Normalisation of abuse
Cultural pressures	Normalise LGBT issues
Culture-specific LGBT services	Not being taken seriously
Dangers of tokenism	Not knowing how professionals will respond
Database of local services	Not many men coming forward
Different lived experiences as barrier	Not seeing self as victim
Different lived experiences as facilitator	Offering patient choice to see queer clinician
Different lived experiences between professionals	Only engaging with formal support at crisis point
Different lived experiences of professional and client	Open conversations about difference
Differing opportunities for reflective spaces	Open conversations about MSM IPV
Difficult conversations	Open conversations early in life
Difficult for older MSM	Outness
Difficult system to navigate	Outreach

Difficult to accept HIV diagnosis	Part of mandatory training
Difficult to ask for help	Past experiences of abuse
Difficult to change societal narratives	Patterns of relationships
Difficult to disclose IPV	Peer support
Difficult to find services	Perpetrator becomes more loving at times of sickness
Difficult to have conversations about difference	Person-centred approach
Difficult to leave abusive relationships	Physical IPV more likely to be picked up
Difficulties liaising with NHS when lots of trusts involved	Policy not inclusive
Difficulty completing therapy	Poor links with other services
Difficulty of setting up reflective practice in services	Positive experiences
Difficulty seeing a GP	Positive experiences of MSM in DV services
Disclosing both sexuality and abuse	Postcode lottery
Disclosing IPV to friends	Power differences
Disclosing multiple times	Pressure on specialist services
Discrimination	Previous negative experiences of services
Discussion about what client wants professional to do with IPV disclosure	Professional intuition
Distress	Professionals don't know about IPV for MSM
Diverse workforce	Professionals don't see IPV for MSM
Don't know how professional will react	Professionals don't speak about IPV for MSM
Drug use	Professionals don't talk about sexual relationships
Drug use as barrier	Professionals don't think about IPV for MSM
Drug use linked to IPV	Professionals fear getting it wrong
DV groups	Professionals holding homophobic views
Easier to disclose IPV non-verbally	Professionals learning through experience
Easier to stay in abusive relationship than leave	Professionals' personal values
Education	Promoting positive sexual health practices
Education in schools	Pros of specific services
Effects of abuse- not worthy of support	Psychological abuse
Emergency housing for women and children only	Psychology assessments seen as less tick boxy
Emotional burden on clinicians	Public awareness
Escalation of abuse	Queer inclusive services
Experience of temporary staff	Queer men have to work harder to develop masculine identity

Experiences of people of colour	Queer professionals as a facilitator
Faith	Queer therapists not as common
Family narratives	Questionnaires as mechanical
Family pressures	Quick screening tools
Family rejection	Rebuilding connections
Fear of adding to negative view of male-male relationships	Recovery model
Fear of bad reaction from professional	Reducing shame
Fear of being harmed by partner	Reducing the number of professionals people see
Fear of being outed by partner	Reduction of shame in HIV services
Fear of homophobia	Referral to inappropriate services
Feeling like the majority	Referrals to specialist IPV services
Financial control	Reflection in supervision
Financial power	Reflective practice
Flexibility of services	Reflective spaces available on psychology training
Funding	Refugee and asylum seeker experiences
Gatekeeping of services	Regular contact with HIV services
Gender norms	Relation to own sexuality
General mental health services see lots of different presentations	Relationship based practice
Generic services need to be more accessible	Remote working makes IPV easier to miss
Group work	Remote working making services more accessible
Hard to admit IPV happens in LGBT relationships	Research
Hard to disclose to professionals that don't seem comfortable	Responsibility on client to disclose
Harder to disclose face to face	Responsibility on individual clinician
Having a queer therapist as a barrier	Responsibility on queer clinicians
Having a queer therapist as a facilitator	Rights of survivors
Hegemonic masculinity	Risk of losing home
Heteronormative view of IPV	Risk of losing social support
Heteronormativity	Risky sexual practices
Hidden problem	Safe, discursive training
High caseloads	Safeguarding responsibility
Historical homophobia	Screening
HIV services more inclusive	Screening asking about cohabiting partners only
HIV services more open	Secrecy

HIV services more used to working with MSM	Seeing other gay men in service
HIV status makes leaving relationship more difficult	Self-blame
HIV status used to abuse MSM	Self-reliance
HIV stigma	Service changes due to COVID
Homelessness	Service referral criteria
Homophobia	Services being representative of their client group
Homophobia (internal and external) as risk factor for IPV	Services by and for the LGBTQ+ community
Hope for change	Services difficult to navigate
Hopelessness	Services don't do a good enough job of supporting any IPV survivor
Housing First model	Services explicitly welcoming MSM
Identity	Services having to prioritise clients in crisis
Identity abuse	Services not seen as helpful
Impact of IPV	Services not set up to support MSM IPV
Impact of physical health	Services set up for women
Importance of both refuges and therapeutic interventions	Sex as self-indulgent
Importance of language	Sex workers may find it difficult to recognise abuse
Importance of naming IPV	Sexual abuse
Importance of sensitivity	Sexual abuse harder to disclose
Inaccessible mental health services	Sexual IPV less clearly defined
Inappropriate behaviour from professionals	Sexual practices
Inclusive IPV training	Sexual practices as risk factor for IPV
Inclusivity	Sexuality as barrier
Individual therapy	Shame
Informal approaches	Shame about drug use
Information displayed about MSM IPV	Shame about HIV
Initial assessments	Shame about IPV
Institutionalised racism	Shame about sex
Institutionalised prejudice	Shame about sexuality
Internalised homophobia	Shame from failed expectations of others
Inviting clients to tell us what they need	Shame from religion
IPV can't happen between men	Shame related to background
IPV comes up as part of assessment	Shame related to masculinity

IPV comes up as part of other work	Signposting to appropriate services
IPV difficult to acknowledge	Skilling up of mainstream services
IPV difficult to recognise	Small community- all know people
IPV difficult to understand	Small LGBT community- client and queer clinician may know same people
IPV disclosure as part of formulation	Sober spaces
IPV hard to accept	Social media presence
IPV in MSM harder to acknowledge	Societal homophobia
IPV in MSM less important	Societal narratives
IPV obscured by sexuality	Societal understandings of IPV
IPV screening as part of risk assessment	Some inclusion of MSM in DV services
IPV services based on violence against women	Specialist professionals within mainstream services
Isolation	Specialist support for queer men
Knowledge of LGBTQ experiences	Specific spaces within services
Knowledge of local services	Specific vs generic services
Lack of emergency housing for MSM	Split of physical and mental health
Lack of IPV services for MSM	Staff not trained
Lack of knowledge of queer relationships	Staff support
Lack of knowledge of specialist services for MSM	Staffing issues
Lack of LGBT IPV services	Stereotypes about MSM
Lack of MSM accessing services= services not commissioned	Straightness
Lack of reflective spaces in services	Supervision
Lack of services	Support from friends
Lack of services for men	Talking about sex
Lack of specialist provision	Therapist-client fit
Lack of time with professionals	Therapists don’t self-disclose
Lack of training on difference	Therapy is difficult
Larger LGBT communities in cities	Therapy only opportunity to disclose
Layers of barriers	Third sector filling gaps in statutory services
Legislation	Time and space to talk in teams
Legislation excludes refugees and asylum seekers	Timing of support
Less likely to disclose in mental health services	Toxic masculinity
Less specific support for men	Training
Less support in rural areas	Training all staff within services on LGBT issues

Letting clients know they can talk about IPV	Training from people with lived experience
Letting the side down	Trauma
LGBT communities not accessing mainstream services	Trauma very difficult to talk about
LGBT health information	Traumatic experiences covered in assessment
LGBT inclusive services	Uncomfortable conversations
LGBT issues more live to queer clinicians	Unconscious bias
LGBT parenting group	Under-resourced services
LGBT refuge	Use of trauma measures
LGBT specialist service	Video sessions easier to disclose
LGBT specific abuse	Visiting clients in their homes
LGBT stigma	Well known within community
LGBT visibility within services	Who decides when abuse is happening
LGBT-only therapists	Working against heteronormativity
	Worry about HIV affecting relationships

Appendix N: Intermediate Codes

Abuse itself as a barrier	Visiting clients in their homes
Beliefs about sexuality based on past abuse	Community-specific nuances
Difficult to leave abusive relationships	Cons of specific services
Distress	Culture-specific LGBT services
Easier to stay in abusive relationship than leave	Feeling like the majority
Effects of abuse- not worthy of support	Generic services need to be more accessible
Escalation of abuse	Lack of male-specific services
Fear of being harmed by partner	Lack of specialist provision
Fear of being outed by partner	LGBT communities not accessing mainstream services
Financial power	LGBT inclusive services
HIV status makes leaving relationship more difficult	LGBT specialist service
HIV status used to abuse MSM	Mainstream mental health service
Homelessness	Male-specific services
Hopelessness	Pressure on specialist services
Identity abuse	Pros of specific services
Impact of IPV	Referrals to specialist IPV services
Isolation	Some inclusion of MSM in mainstream services
Low self-worth	Specialist professionals within mainstream services
Normalisation of abuse	Specific vs generic services
Past experiences of abuse	No financial support
Patterns of relationships	Access through physical health services
Perpetrator becomes more loving at times of sickness	Administration difficulties
Power differences	Assessment can be tick boxy
Psychological abuse	'Easy' clients get a service
Risk of losing home	Assessment
Risk of losing social support	Assumption that all services are accessible and inclusive
Self-blame	Being a 'good' client
Sexual abuse	Broad referral criteria
Sexual abuse harder to disclose	Clear ways of communicating IPV
Trauma	Difficult system to navigate

Accepting HIV diagnosis	Difficult to disclose IPV
Additional mental health needs	Difficulties liaising with NHS when lots of trusts involved
Beliefs about sexuality based on past abuse	Difficulty completing therapy
Bruising not recognised on BAME skin	Difficulty seeing a GP
Cultural pressures	Disclosing multiple times
Difficult for older MSM	Emergency housing for women and children only
Drug use	Funding
Drug use as barrier	Gatekeeping of services
Drug use linked to IPV	Inaccessible mental health services
Experiences of people of colour	Initial assessments
Family narratives	IPV services based on violence against women
Family pressures	Lack of emergency housing for MSM
HIV status makes leaving relationship more difficult	Lack of knowledge of specialist services for MSM
Identity	Lack of MSM accessing services= services not commissioned
Layers of barriers	Lack of time with professionals
Legislation excludes refugees and asylum seekers	Long waiting lists
LGBTQ identity	Meeting multiple professionals
Male identity	Meeting referral criteria
Men less likely to seek help	Mental health services less inclusive
More difficult for marginalised communities	NHS services inaccessible
MSM find it more difficult to access services	No direct IPV screening question
MSM using sex work to get away from home	No IPV policy
No recourse to public funds	No IPV screening
Refugee and asylum seeker experiences	Policy not inclusive
Relation to own sexuality	Poor links with other services
Sex workers may find it difficult to recognise abuse	Postcode lottery
Worry about HIV affecting relationships	Questionnaires as mechanical
Reducing shame	Referral to inappropriate services
Reduction of shame in HIV services	Remote working makes IPV easier to miss
Shame	Responsibility on client to disclose
Shame about drug use	Screening
Shame about HIV	Screening asking about cohabiting partners only

Shame about IPV	Service changes due to COVID
Shame about sex	Service referral criteria
Shame about sexuality	Services difficult to navigate
Shame related to masculinity	Services having to prioritise clients in crisis
Impact of physical health	Services not seen as helpful
IPV comes up as part of assessment	Services not set up to support MSM IPV
IPV comes up as part of other work	Services set up for women
IPV difficult to acknowledge	Staffing issues
IPV difficult to recognise	Therapy only opportunity to disclose
IPV difficult to understand	Trauma very difficult to talk about
IPV disclosure as part of formulation	Under-resourced services
IPV hard to accept	General mental health services see lots of different presentations
Larger LGBT communities in cities	IPV screening as part of risk assessment
Legislation	More likely to screen in services where it is more common
Less likely to disclose in mental health services	No explicit referral for IPV
Changing practice	Assumed shared knowledge with queer clinicians
Client choice	Clinicians only get knowledge through experience
Commissioning	Confidence of clinicians to talk about MSM IPV
Commitment from services	Different lived experiences as barrier
Dangers of tokenism	Different lived experiences as facilitator
HIV services more inclusive	Different lived experiences between professionals
HIV services more open	Different lived experiences of professional and client
Appropriate language on materials	Differing opportunities for reflective spaces
Asking about trauma	Difficult conversations
Being culturally sensitive	Difficulty of setting up reflective practice in services
Building trust	Don't know how professional will react
Calling out inappropriate behaviour from professionals	Emotional burden on clinicians
Champions	Experience of temporary staff
Clear visual ways of welcoming MSM to services	Fear of bad reaction from professional
Co-production of services	Hard to disclose to professionals that don’t seem comfortable
Consultation	Having a queer therapist as a barrier
Creating safe space	Having a queer therapist as a facilitator

Cultural perspective	High caseloads
Diverse workforce	Inappropriate behaviour from professionals
Importance of language	Lack of reflective spaces in services
Importance of naming IPV	Lack of training
Importance of sensitivity	LGBT issues more live to queer clinicians
Inclusivity	MSM having to educate straight therapists
Information displayed about MSM IPV	Need for straight clinicians to have conversations
Letting clients know they can talk about IPV	Non-physical IPV not picked up
LGBT visibility within services	Not being taken seriously
LGBT-only therapists	Not knowing how professionals will respond
Need for policy	Physical IPV more likely to be picked up
Need for screening	Professional intuition
Normalise LGBT issues	Professionals don't know about IPV for MSM
Offering patient choice to see queer clinician	Professionals don't see IPV for MSM
Open conversations about difference	Professionals don't speak about IPV for MSM
Person-centred approach	Professionals don't talk about sexual relationships
Rights of survivors	Professionals fear getting it wrong
Services being representative of their client group	Professionals holding homophobic views
Services by and for the LGBTQ+ community	Professionals learning through experience
Services explicitly welcoming MSM	Professionals' personal values
Talking about sex	Queer professionals as a facilitator
Use of trauma measures	Queer therapists not as common
Working against heteronormativity	Reflective spaces available on psychology training
Advocacy	Responsibility on individual clinician
Alternative therapies	Responsibility on queer clinicians
Champions	Safeguarding responsibility
Community projects	Therapists don’t self-disclose
DV groups	Who decides when abuse is happening
Group work	Remote working making services more accessible
Housing First model	Awareness of IPV generally
Importance of both refuges and therapeutic interventions	Beliefs about men as IPV survivors
Individual therapy	Difficult to change societal narratives
Informal approaches	Fear of adding to negative view of male-male relationships

LGBT health information	Fear of homophobia
LGBT parenting group	Gender norms
LGBT refuge	Hard to admit IPV happens in LGBT relationships
National agenda	Hegemonic masculinity
Network	Heteronormative view of IPV
Outreach	Heteronormativity
Peer support	Historical homophobia
Person-centred approach	Homophobia
Promoting positive sexual health practices	Homophobia (internal and external) as risk factor for IPV
Public awareness	Institutionalised racism
Rebuilding connections	Institutionalised prejudice
Recovery model	Internalised homophobia
Relationship based practice	IPV can't happen between men
Sober spaces	IPV obscured by sexuality
Audit	Letting the side down
Education	LGBT stigma
Inclusive IPV training	Male-male violence as only physical
Knowledge of LGBTQ experiences	Men not seen as victims
Knowledge of local services	Microaggressions
Liaison with other services	MSM IPV normalised
Open conversations about MSM IPV	MSM may not feel welcome in services
Open conversations early in life	MSM seen as less important
Public awareness	Need to unlearn
Reflective practice	Negative experiences of services
Research	Non-physical IPV not taken seriously
Signposting to appropriate services	Previous negative experiences of services
Skilling up of mainstream services	Professionals holding homophobic views
Social media presence	Societal homophobia
Staff support	Societal narratives
Supervision	Societal understandings of IPV
Time and space to talk in teams	Stereotypes about MSM
Training	Straightness
Well known within community	Toxic masculinity
Lifelong follow up in HIV services	Unconscious bias
Positive experiences	Split of physical and mental health

Positive experiences of MSM in DV services	Third sector filling gaps in statutory services
Regular contact with HIV services	Traumatic experiences covered in assessment
Benefit of video over telephone	Psychology assessments seen as less tick boxy
Clients don't always want direct support for IPV	Risky sexual practices
Discussion about what client wants professional to do with IPV disclosure	Self-reliance
Flexibility of services	Services don't do a good enough job of supporting any IPV survivor
Inviting clients to tell us what they need	Services not seen as helpful
Quick screening tools	Sex as self-indulgent
Reducing the number of professionals people see	Sexual IPV less clearly defined
Remote working making services more accessible	Sexual practices
Therapist-client fit	Sexual practices as risk factor for IPV
Timing of support	Small community- all know people
Video sessions easier to disclose	Support from friends
	Therapy is difficult

Appendix O: Coded Extract Example

Societal narratives

Biases

Unconscious biases
Beliefs about men as survivors

Shame around IPV
Shame around masculinity

Heteronormativity
Toxic masculinity

IPV services based on violence against women

Heteronormativity
Importance of language

Gender norms
Men not seen as victims

You said that the kind of the ideas are kind of societal but it's it sounds like they kind of filter through to to professionals?
Yeah exactly but I think you need to remember that people that work for local councils or whoever they might be working for are still people that live within society and just because you have a job doesn't necessarily mean you're gonna be doing everything by the book or or your own bias isn't gonna come into it and I think it absolutely does come into it in a lot of cases so yeah I feel like there's definitely a lot of things that people say and even that might might have been a Freudian slip or whatever but it is actually suggests that what their deeper beliefs are around men being survivors
And you used the word shame erm just then that there's kind of a that creates a lot of shame I was wondering if you could speak to that a little bit more?
Yeah I think like erm, yeah it's just the stigma and shame around being a survivor and particularly a male survivor because again we have these ideas around masculinity and and and who when we think about ((air quotes)) victims of domestic abuse we're constantly told this heteronormative model around men beating women that's what the whole sectors been built on violence against women and girls violence you know it and absolutely in the vast majority of cases it is it is a man hitting a woman but because of those sort of erm because of that language and those processes that we've set up in society it really undermines any sort of other victims erm and it plays into a very heteronormative sort of approach on domestic abuse so the only way we recognize it because because of the language and and the examples that we see in the media and everything else is men versus you know men abusing women men are stronger macho women are weak timid and this is the sort of narratives that feed into to everything we do really that's in terms of domestic abuse that people actually believe that that is you know we have in our mind a picture of what a victim looks like and it's not a man

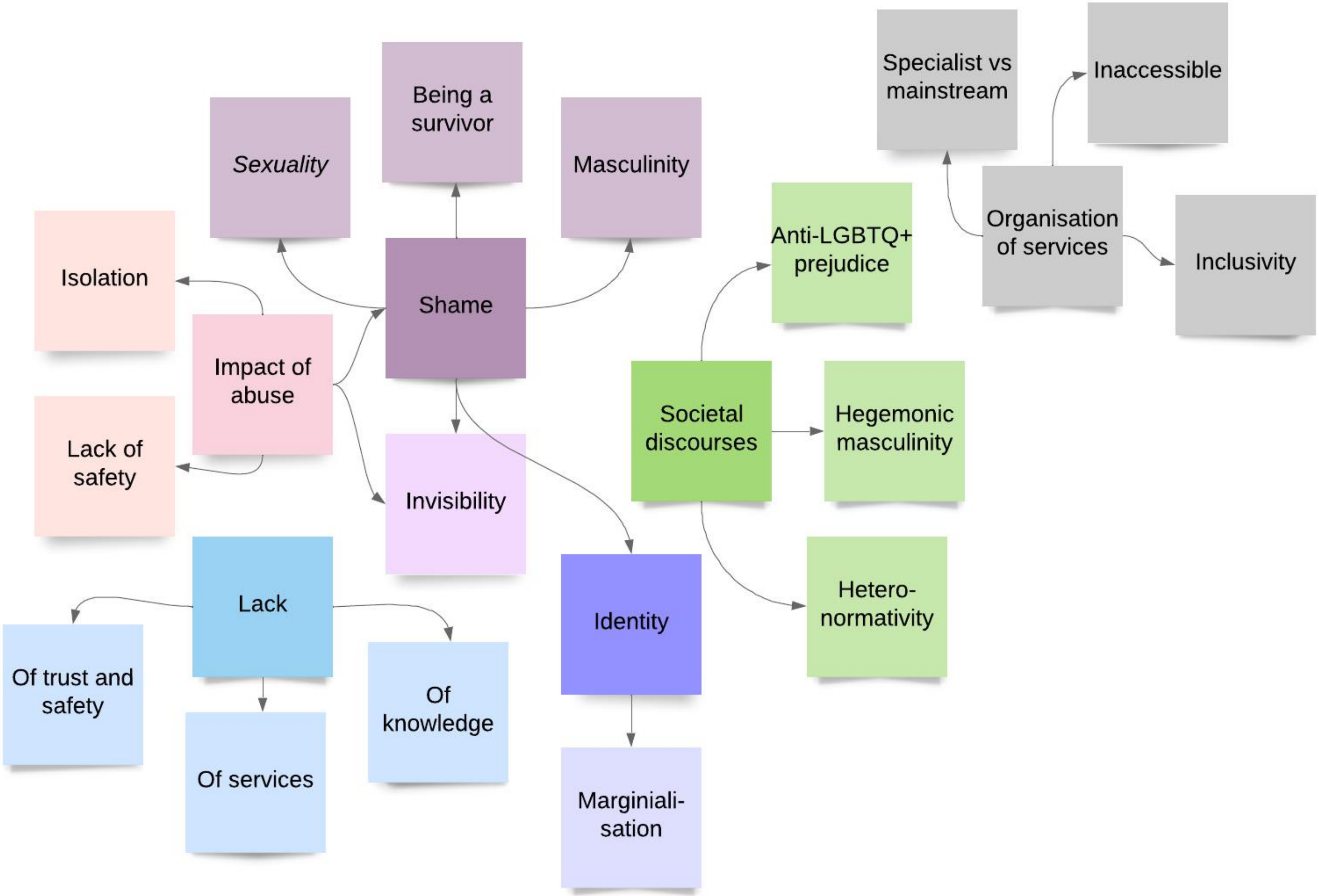
Appendix P: Extract from Researcher's Reflexive Journal

Original design of the project

When designing this project initially, I had hoped to recruit MSM survivors themselves, in order to centre their voices. However, following a rigorous 5 month recruitment process, it was not possible to recruit any participants. Whilst reflecting on why this might have been, I wondered whether many of the barriers highlighted in the results of this study may have also been present during the recruitment process. Perhaps shame or concerns about their own safety played a part in MSM not wanting to speak about their experiences of IPV. Potential participants may also have been worried (and understandably so) about experiencing anti-LGBTQ+ prejudice, racism or heteronormative assumptions and stereotypes from myself as a researcher. I also wondered whether I had designed both the recruitment and research materials in a way which encouraged MSM survivors to come forward and feel safe and comfortable participating in the research. As a heterosexual woman who has not experienced IPV myself, there are likely to have been blind spots in the ways in which I presented information and designed the study. I had hoped to engage in a process of consultation with LGBTQ+ and/or survivor organisations in order to receive feedback on the design and materials used in the study. This would have been invaluable and I hope this would have allowed more participants to come forward for the original study. However, none of the organisations contacted were able to engage in this, due to demands on time and resources.

Appendix Q: Thematic Maps

Thematic map 1



Thematic map 2