

## Research Article

# Male Survivors' Disclosure of Conflict-Related Sexual Violence in Mental Health Care Settings: Results from a Phenomenological Study with Clinical Experts in Germany

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Conflict-related sexual violence (CRSV) can severely impair survivors' mental health and prompt their need for mental health care. Male survivors face gender-related barriers to disclosing experiences of sexual violence, yet the understanding of factors impeding or promoting disclosure is limited. This knowledge gap is even more pronounced regarding male disclosure in refugee settings. The high prevalence of CRSV experiences in male refugees in European host countries points to the urgency of understanding male disclosure processes along with its barriers and facilitators, in order to provide for adequate mental health care. 10 clinical experts working with male survivors of CRSV in Germany were interviewed adopting an explorative phenomenological approach and using the Problem-Centered Interview. Qualitative content analysis yielded five themes describing male disclosure of CRSV: 1. Experiences of CRSV commonly remain nonverbalized, 2. Disclosure of CRSV is a dialogical and iterative process, 3. The process of (non-)disclosure is a negotiation of agency, 4. Disclosure of CRSV affects the survivor's psychoemotional state, and 5. Disclosure and recovery are interdependent processes. Additionally, seven categories describing barriers to and facilitators of male disclosure were extracted: 1. trauma characteristics, 2. survivor variables, 3. clinician variables, 4. interpreter variables, 5. interpersonal variables, 6. contextual variables, and 7. sociocultural variables. Clinical experts emphasize the effectivity of a gender-specific communicative taboo for male refugee survivors that intersect with socio-cultural norms. Variables characterizing survivors who are at risk of not disclosing CRSV are identified. A discussion of clinical approaches to address the taboo surrounding CRSV and to support male refugee survivors in agentic disclosure and recovery is provided.

## 1. Introduction

Sexual violence (SV) against men and boys in conflict and displacement settings (conflict-related sexual violence, CRSV) is widespread. Prominent examples for settings in which CRSV against men and boys occurred are the wars in the Democratic Republic of Congo (DRC) [1] and former Yugoslavia during the 1990s [2, 3], as well as the Abu Ghraib prison in Iraq in 2003 [4]. CRSV against men and boys is also being documented for regions currently experiencing conflict, e.g., Afghanistan, Colombia, the DRC, Libya, Myanmar,

and Ukraine [5]. The same applies to displacement settings, where refugees are affected en route and in host countries [6].

Documented types of CRSV against men and boys include blunt trauma to the genitals, genital mutilation/penile amputation, castration, (gang) rape, forced masturbation, forced nudity, forced witnessing of SV against family members or peers, and forced perpetration of SV against others [7, 8]. The perpetrators are predominantly male [1]. Prevalence rates of CRSV against men, available for specific conflict-affected countries and derived from cross-sectional

surveys, vary from less than 1% (Côte d'Ivoire) up to 32.6% (Liberia) [8].

Refugees, internally displaced people, and migrant workers are particularly vulnerable to CRSV (as are men of ethnic and/or racial minorities and people with diverse sexual orientation, gender identity and/or expression, and/or sex characteristics [SOGIESC]) [4, 6]. Refugees are exposed to the risk of being sexually violated along routes, in refugee camps, at border crossings, and in host countries [6, 9]. In a clinic run by *Médécins sans Frontières* on Lesbos, a Greek island in the Mediterranean and an entry point to Europe for many migrants, 28% of the patients presenting with experiences of CRSV were male, and the majority of CRSV incidents had occurred during migration [9]. In a recent epidemiological study examining mental health in recently arrived refugees in Germany, 32.7% of male participants reported having experienced SV at some point in their life [10], and a further study found that up to 28.6% of male migrants had experienced SV after having arrived in Europe [11].

The consequences of CRSV can affect the survivors' physical, mental, reproductive, and psychosocial health and well-being. Common mental health outcomes include (complex) posttraumatic stress disorder ([C]PTSD), depression, and anxiety [7, 10], and male survivors report needing treatment for mental and physical health issues more frequently compared to men without experiences of SV [10]. The experiences can affect the survivors' sense of identity, leaving them concerned about their masculinity and/or sexual orientation [12, 13]. On the interpersonal level, they often have difficulties engaging in close or intimate relationships and may experience marital problems, lack of family cohesion, and social isolation [8, 14]. Male survivors may be criminalized within homophobic legislation, become a target of further violence, and may ultimately be forced to leave their communities [14], thereby facing significant social stigmatization and ostracism. While SV often goes unreported to authorities and care institutions in general, male survivors face specific gender-related barriers to help-seeking and disclosure [13, 15].

Disclosure refers to "verbal, interpersonal expressions of self-relevant information" [16], whereby the discloser's "concealable stigmatized identity" [16] is revealed to a confidant. Disclosures often are complex processes in which survivors choose when, to whom, and to what extent they disclose [17]. Disclosure events vary in depth (degree of intimacy of the information shared), breadth (array of topics addressed), and duration, as well as the number and intensity of emotions expressed in the process [16]. This "information management" [18] is often a lifelong task for survivors [16].

Research on the association between disclosure and psychological distress in trauma-affected individuals has produced mixed findings. Ullman and Filipas [19] found that extent of interpersonal disclosure of child sexual abuse was negatively associated with PTSD symptom severity, and avoidance of trauma disclosure was shown to mediate the relationship between trauma exposure and the risk for developing PTSD and complex PTSD [20]. Other studies

found no association between extent of trauma disclosure and PTSD symptoms [21, 22]. The confidantes' responses are however a robust predictor of the impact of disclosure on the discloser's psychopathology [23, 24]. Receiving negative social reactions has consistently been shown to be associated with a higher severity in psychopathology, including PTSD, depression, and general distress [23]. Accordingly, anticipation of stigma and fear of rejection are common reasons for nondisclosure [15, 16, 25].

Gender has a relevant influence on disclosure behavior [15, 17, 25]. In many societies, displaying agency, invulnerability, and self-reliance is imperative for men to achieve a socially dominant, i.e., *hegemonic* form of masculinity [14, 26], thus rendering masculinity and sexual victimization irreconcilable and male sexual victimization a taboo phenomenon. The cultural expectation of invulnerability extends to a man's ability to cope after an incident, and some feel that seeking out help would symbolically reinforce their victimization [14]. Accordingly, men are less likely than women to disclose abuse and interpersonal violence [19, 27]. Upon having been sexually victimized, they are often reluctant to seek out support services [25]. Within care settings, denial and nondisclosure of sexual torture have been described as coping strategies characteristic of male survivors [12]. Individuals of ethnic and/or SOGIESC minority groups experience additional disincentives to disclose, such as the risk of experiencing further discrimination and stigmatization [6, 25].

Nondisclosure can therefore be recognized as an act of self-protection from stigma, and as a vehicle to preserve and/or rebuild a masculine identity through exercising agency [6, 28]. From a mental health perspective, however, disclosure within health care settings remains a desirable outcome. It is considered important for establishing the alliance between client and practitioner, as well as facilitating therapeutic progress [16]. Nondisclosure can only be a matter of agency if genuine options for disclosure exist, and the availability of sensitized health services is a pivotal disclosure condition [28, 29]. Being able to execute agency through nondisclosure has therefore been described as "contingent upon local opportunity structures" [28].

In Germany, psychosocial care centers for refugees and torture survivors (PCCs) represent part of these safer opportunity structures. Services include psychosocial counseling, psychotherapy, documentation of torture sequelae, legal and social support during the asylum process, and a range of other services [30]. Affected refugees can also access local counseling centers that offer psychosocial services to (male) survivors of SV. The language barrier between clinicians and clients is addressed by engaging interpreters [30]. The triad of counselor, client, and interpreter forms the immediate setting in which disclosure processes of male survivors of CRSV are likely to take place. So far, there is little evidence on how refugee male survivors address the topic of CRSV in transcultural mental health care settings in Western high-income host countries, which barriers and facilitators affect the process and how survivors can be supported in disclosing CRSV.

The high prevalence of experiences of SV found in recently arrived male refugees in Germany and its associations with mental health symptoms [10] underscores the urgency to understand male disclosure processes of CRSV within psychosocial and mental health care settings and to identify barriers to and facilitators of disclosure. Because mental health clinicians from PCCs/counseling centers are central agents in delivering mental health care for refugees in need, they are expert informants who hold *procedural knowledge* [31] regarding disclosure processes of male CRSV survivors. Procedural knowledge is experiential knowledge gained in the operational context [31]. This clinical perspective on male disclosure of CRSV can shed light on the survivors' navigation of silence and disclosure, as well as internal and external aspects affecting these processes. The present study seeks to answer the following research questions:

- (1) How do mental health clinicians working with male refugee survivors of CRSV describe their clients' disclosure processes during treatment/counseling?
- (2) Which barriers and facilitators to disclosure do they identify?

## 2. Methods

A phenomenological approach [32] was utilized to explore the clinical experts' perspectives [31] on male disclosure of CRSV in mental health care settings in Germany. This approach situates the subjective understanding of a phenomenon within the *lifeworlds* of the study subjects [32]. By addressing them as clinical experts, their narratives were explicitly framed within their professional backgrounds. The Problem-Centered Interview [33] was applied. It is a "*discursive-dialogical method*" [34] in which respondents are addressed as experts on their own perspectives and the researcher flexibly engages in the dialogue to gain comprehension of their accounts, aligning with the tenets of phenomenological research. It includes stimulating elements to foster narration and reflection, as well as structuring elements derived from the researcher's theoretical knowledge [33]. A field manual incorporating these features was developed according to Helfferich [35]. The interviews were conducted by the first and last authors, both psychologists. Despite their considerable theoretical knowledge of the phenomenon of CRSV against men, they lacked practical experience with male survivors of CRSV at the time. Both authors had received their psychological education from universities in Germany, which fostered a shared understanding of psychological concepts with the clinical experts (sample described below). Thus, the research predominantly adopts a health care providers' perspective, rooted in psychological concepts taught at universities in Western high-income countries.

**2.1. Data Collection.** Participants were reached through gatekeepers in PCCs and counseling centers. Clinicians were invited to participate in the study if they reported having engaged at least once in a counseling/therapy process with a male CRSV survivor. A total of  $N=17$  interviews were conducted by the first and the last author between June and

September 2020 in three German cities. Interview duration ranged between 68 and 120 minutes ( $M=96.4$  minutes). Interviews were taped with an electronic audio recorder and subsequently transcribed verbatim. All participants received a 10€ bookshop voucher as a thank-you gift.

$N=10$  interviews were analyzed in depth for the present study. Case inclusion aimed at a maximum variance of age, gender, professional background, types of services offered, and centers represented, to ensure a rich variation of perspectives included. The decision on case exclusion was based on a combinatory criterion of information density in the interviews and balancing out the number of participants per center within the data. Information density was determined by checking for self-produced information by participants, i.e., whether clinicians did actively narrate and reflect upon their experiences. Two participants were excluded because it became clear during the interview that they had not counseled or treated a male survivor in a mental health care setting.

**2.2. Ethical Considerations.** The study was conducted in accordance with the Declaration of Helsinki. Participants were fully informed about the purpose of the study, the procedure of the research, voluntary nature of participation, and subsequent data management. All participants provided written informed consent prior to participation. Since the study did not involve patients/vulnerable groups or expose participants to any risks that go beyond their everyday life experiences or other exceptional risks, ethics approval was not required [36].

**2.3. Participants.** The sample consists of  $N=10$  clinicians ( $n=6$  female,  $n=3$  male, and  $n=1$  nonbinary) with a mean age of  $M=43.3$  years (range 29–67 years). They varied significantly in years of practice and number of survivors treated/counseled, with a minimum of two years of practice and two survivors counseled/treated, and a maximum of 23 years of practice and more than 15 survivors counseled/treated. All clinicians were socialized in German-speaking European countries. They were associated with five different institutions (two PCCs [ $n=6$ ], two counseling centers addressing affected men [ $n=2$ ], and one counseling center addressing SOGIESC refugees [ $n=2$ ]).

**2.4. Gender-Based Analysis.** Analyses regarding the survivors' gender are based on the World Health Organization's [37] definition, according to which gender refers to socially constructed characteristics and includes "norms, behaviors and roles associated with being a woman, man, girl or boy" that can vary between societies and change over time [37]. Since we did not interview survivors themselves, we base our analyses on the clinicians' perceptions of the survivors' male gender. The analysis incorporated the clinicians' gender as deemed relevant by the clinicians themselves.

**2.5. Data Analysis.** Qualitative content analysis for manifest and latent content [38, 39] with a deductive-inductive approach was used. A baseline coding manual representing

a system of *a priori* categories [39] was developed. After a close reading of all interviews, three researchers independently segmented the manifest content of one interview with high information density into meaning units [38] and clustered the units in the *a priori* system using the analysis software MAXQDA20 [40]. Newly emerging aspects were recorded in memos. The researchers then discussed the meaning units until they reached agreement upon their semantic content and segmentation (consensual coding following Hopf and Schmidt [41]). This method was used to gain a common understanding of the experts' perspectives, as well as for inductively refining the category system according to the data. The category system was then (re-) applied to the entire text material by two researchers per interview independently, and the process of consensual coding was repeated. The final intercoder agreement measured with Kappa [42] was  $K = 0.84$ .

To determine barriers to and facilitators of disclosure, meaning units that were assembled in the subcategory "*Clients' disclosure behavior within the setting*" were abstracted to codes and clustered into inductive categories according to Graneheim and Lundman [38]. Categories represent mutually exclusive clusters of codes and refer to a descriptive, i.e., manifest level of content and answer the question "What?". This first step of analysis was used to answer research question 2. The latent content of the text that recurred in narratives across categories was then formulated into themes. Themes are considered "thread[s] of an underlying meaning [...] on an interpretive level" [38] and answer the question "How?". This second step of analysis was used to answer research question 1. The second and third authors supervised all analytical steps. The results of the analysis were ultimately discussed with a group of qualitative researchers who had not been involved in the analytical process.

### 3. Results

Five themes describing disclosure in its processual character were formulated to answer research question 1. Seven main categories of barriers to and facilitators of disclosure on the individual, interpersonal, contextual, and sociocultural levels were identified to answer research question 2. The result of the analysis is visualized in Figure 1: Visualization of disclosure themes, barriers, and facilitators.

#### 3.1. Central Themes Describing Male Disclosure Processes of CRSV

**3.1.1. Experiences of CRSV Commonly Remain Nonverbalized.** Clinicians in PCCs without exclusive focus on survivors of SV assumed that a significant number of their male clients/patients were affected by CRSV but not disclosing it. Survivors rarely disclosed outside the centers, hence nondisclosure in the setting likely implied general nondisclosure. Clinicians in centers explicitly targeting male survivors of SV reported high barriers for their clients to verbalize experiences of SV. They described active avoidance of the topic, e.g., survivors would leave out entire

biographical passages to avoid speaking of their victimization, or other (apparently minor) topics would be prioritized. Along with shame and emotional distress associated with disclosure, the act of verbalization itself was described as challenging, because survivors lacked words for their experiences, and were unfamiliar with discussing sexuality-related topics. Although survivors might indicate that violence had occurred, they often refrained from disclosing *the full story* [21] and indicated the unspeakable nature of their experiences.

"It starts with, "Something bad happened. I can't talk about it." And then when I hear certain catchphrases, for example, like, "yeah, there was this thing back in Libya", alarm bells start to go off for me that the person might have suffered from any number of forms of violence people get subjected to. I think with sexual violence, it's hidden even more, it gets held so tightly, deep down inside. The inhibitions are even greater to say it out loud."—Female clinician, 29 years old

When survivors verbalized their experiences, they often did so by choosing implicit or trivializing language ("*The man came to me every night*"; "*They flirted with me*"). Disclosures were also described as inherently selective, with more shame-associated events or details of SV remaining nonverbalized.

#### 3.1.2. Disclosure of CRSV Is a Dialogical and Iterative Process.

Clinicians reported that in most cases, disclosure evolved dialogically over time, and most survivors needed a long time to open up about their experiences. To approach the topic, survivors would often use implicit references. Survivors might report symptoms, such as problems with urination, or circumstances ("*I was arrested*"). Some clinicians interpreted such indirect approaches as being the survivors' appeal to them to support disclosure dialogically. The disclosure process emerged in part as being a collaborative search for words and the establishment of a common understanding:

"When I explain things, I use the language we speak here at the center. That is, I deliberately use the term "sexual violence", and explain what I mean by it, because it has happened that someone said once they thought they were in the wrong place since it was domestic violence they had experienced. After we got to the bottom of what the man actually meant by "domestic violence" however it became clear that it was in fact a form of sexual violence he had experienced."—Male clinician, 50 years old

Clinicians reported observing that men tended to disclose their experiences to them precisely because of the role they occupied as professionals in the field. While utilizing appropriate methods for opening the dialogue was considered to be essential for supporting disclosure, men were found to commonly rely on and refer to the clinicians' assumed knowledge as a common strategy for avoiding direct verbal disclosures:

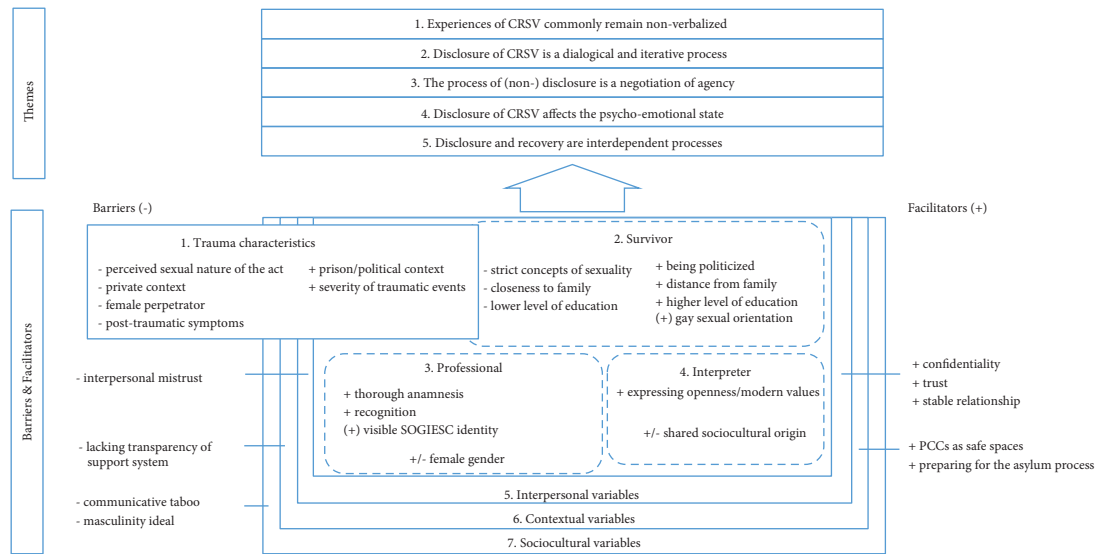


FIGURE 1: Visualization of disclosure themes, barriers, and facilitators. Symbols used: + marks facilitators of disclosure; – marks barriers to disclosure, +/- marks variables discussed as both barriers and facilitators.

“Many want to have someone vis-à-vis, who basically already knows everything, so that they don’t have to actually say what happened. They assume that because this is my job, I am aware of everything that is theoretically possible. So when they say, “Something happened with my granddad when I was five years old”, they think I already have a pretty good idea of what that might have been, whereas of course, I have no way of knowing exactly what happened.”—Male clinician, 50 years old

Disclosures often had a “tell and retreat” [43] character: Survivors would disclose enough information to let clinicians know that the violence was sexual in nature, but then signaled they did not want to further discuss the topic. Some survivors never returned to the topic, while others gradually increased breadth and intimacy of the information shared. This iterative process was characterized by nonlinearity, and varying degrees of completeness of disclosure might be realized over the course of a counseling/therapeutic process.

**3.1.3. The Process of Nondisclosure Is a Negotiation of Agency.** Survivors’ agentic information management towards clinicians regarding their victimization emerged as an ongoing task that often accompanied the counseling/therapy process. *Agency* here means the ability to choose what action to take, with intention and autonomy representing its central elements [28, 44]. Survivors exercised agency by choosing the time of disclosure and the depth of information shared, and by reassessing these decisions over the course of the counseling/therapy process. One clinician described this as follows:

“It usually takes a long time until they really open up. The topic is often omitted in the beginning or only outlined very roughly. And yes, later, when there is a lot of trust and they’re no longer afraid they can’t handle it, then –.

They want to be in control. They don’t feel like being completely exposed again, that is, being completely exposed psychologically, and not being in control.”—Female clinician, 67 years old

The survivors’ agency was found to be restricted by internal (e.g., trauma-related symptoms) or external circumstances (e.g., the asylum procedure). Trauma-related deficits in self-regulation and intrusive symptoms were described to potentially elicit excessive recounting of events, which risked the survivors’ destabilization and required clinicians to intervene in the process. The asylum law, which grants special protection to survivors of CRSV, forces them to give detailed reports of their experiences to authorities [45]. This was seen to both hasten the disclosure process and compel otherwise unwanted disclosures, as apparent in the quote of a clinician speaking from the survivors’ perspective:

“If I get an attestation somewhere that I am so deeply traumatized that I can by no means be sent back, then I can stay here. This means there is a compulsion to put these stories on the table. And this compulsion means having to breach the not-wanting-to-talk, the wanting-to-hide.”—Male clinician, 61 years old

Although the clinician emphasizes the compulsiveness of disclosure, this quote also demonstrates that survivors can strategically disclose to access their rights to protection, suggesting a concurrency of internal and external disclosure motives. Additional reported internal disclosure motives were the wish to recover from trauma and a desire to no longer feel alone with the burden.

**3.1.4. Disclosure of CRSV Affects the Survivor’s Psychoemotional State.** Clinicians emphasized the emotional distress elicited when survivors recounted events of CRSV.

Disclosure of CRSV was observed as coming at the risk of provoking significant emotional activation and destabilization, and of triggering (C)PTSD symptoms including flashbacks, psychophysiological arousal, and dissociative states:

“With some it’s like they seem absent for a moment and but then they’re back. Then you can ask “What just happened?”, “Uh yeah, that’s a subject that’s very difficult for me to talk about.” It goes as far as someone having a flashback where they suddenly stand up and imitate a posture saying, “It was like this.” Or the person might just completely shut down, that is, they are totally spaced out and unresponsive for a while. Others hyperventilate under the emotional strain and then just retreat into themselves.”—Female clinician, 67 years old

Due to the emotional distress elicited during or post disclosure, clinicians reported finding it necessary to cor-egulate and in some cases decelerate the disclosure process to avoid further destabilization.

Clinicians also reported that talking about the events often induced strong feelings of shame in male survivors, both related to the victimization itself but also to their expression of emotions in that moment. Notably, survivors were also described as showing significant relief following disclosure. This relief was explained by the possibility of further discussing the topic, and by the feeling of not having to carry the burden alone:

“He comes here with a clear intention. This is the only place he can talk about it openly, it does him good, and it’s a big release for him.”—Female clinician, 45 years old

*3.1.5. Disclosure and Recovery Are Interdependent Processes.* Disclosure and emotional processing were described as reciprocally stimulating, and disclosure was considered essential for the survivors’ recovery. Initiating and widening the dialogue on the events of CRSV in the survivors’ own terms emerged as being a central aspect of the therapeutic/counseling process. It was preceded by an initial development of emotional stability and trust in the clinician, and it enabled further processing of the trauma. Verbalization was emphasized as being a central aspect of exposure in trauma therapy. It was described to facilitate habituation to the memories, and to foster the survivors’ internal reflection on their experiences and integration of the events into their personal biography.

“[Trauma therapy] involves a high level of willingness on the patient’s part to go through with it, and is also contingent on things remaining open for discussion. If things can’t be talked about, the methods do not work. Most of the psychotherapeutic methods in trauma therapy operate a bit that way, by including narrative elements, where you tell the story and integrate it into your larger life story. It must remain discussable.”—Male clinician, 34 years old

Accordingly, nondisclosure was seen as impeding symptom reduction and recovery. Over time, emotional processing achieved through counseling/therapy made it easier for survivors to articulate their experiences and change the way they spoke about CRSV. Labeling the experiences, being able to narrate them more explicitly and in-depth, and disclosing outside of the counseling/therapy context were all considered indicators of progress in recovery.

### *3.2. Barriers and Facilitators of Male Disclosure of CRSV*

*3.2.1. Characteristics and Consequences of the Traumatic Event.* According to clinicians, the violence’s sexual nature works as a disclosure barrier, and events that were perceived as less sexual (e.g., sexual torture) were considered easier to disclose than events that were perceived as more sexual (e.g., rape). Similarly, CRSV that occurred in the context of torture or imprisonment was seen as easier to disclose compared to violence that occurred within the private sphere. A particular disclosure barrier was reported for female perpetrators.

Higher severity of the trauma, including repeated exposure to SV, often led to premature disclosure. This was attributed to the overwhelming distress and difficulties in self-regulation experienced by survivors. However, other psychological trauma consequences, such as symptoms of (C)PTSD, were generally seen as disclosure barriers. These symptoms included avoidance of trauma-related triggers, intense negative emotions, feelings of shame, and dissociative symptoms.

*3.2.2. Survivors’ Variables.* The survivor’s sociocultural beliefs and practices, his politicization, and level of education were found to be relevant for disclosure. Sexual orientation was not perceived unanimously as affecting disclosure.

Sociocultural beliefs and practices were reported to affect disclosure twofold. First, strict concepts of sexuality and of SV were seen as restricting the men’s readiness to verbalize corresponding experiences. Second, close ties to the family or community were considered a barrier, as disclosure could bring dishonor to the family. Correspondingly, being single and living at a distance from the home community were described as facilitators. Being politicized and perceiving CRSV as a political act was found to promote disclosure in that it provided survivors with greater motivation to disclose. A higher education level was reported to facilitate explicit verbalization, lower levels were associated with implicit forms of verbalization and more support needed from the clinician to disclose. Findings regarding survivors’ sexual orientation were mixed, as only some experts reported finding that gay men disclosed experiences of SV more easily. Having a diverse SOGIESC was found to be associated with a higher likelihood of having multiple experiences of SV, a factor considered promoting disclosure.

*3.2.3. Clinicians’ Variables.* The clinicians’ methods, recognition of the survivor, and gender were considered relevant to the survivors’ disclosure processes.

A thorough anamnesis at the beginning of the therapeutic/counseling process facilitated initial disclosure in settings with no exclusive focus on SV. Making disclosure offers, such as asking direct questions, increased the likelihood of disclosure. Working with biography-oriented methods was considered helpful for approaching the topic of sexual trauma. Recognizing the survivors' experiences as harmful and deeply unjust enabled a sense of trust and safety, while recognizing cultural communication norms enabled clinicians to frame questions that could be perceived as inappropriate and thereby support the dialogue. The clinicians' gender was not unanimously perceived as either a barrier or facilitator. Female gender was discussed to prompt inhibitions around communicating explicit sexual content, but to facilitate communicating emotional content. SOGIESC clinicians found that their visibility helped SOGIESC survivors to feel more comfortable disclosing their experiences.

**3.2.4. Interpreters' Variables.** Clinicians emphasized the interpreters' role as active participants in the setting, whose sociocultural origins and moral beliefs were regarded as a potential influence on disclosure.

A shared sociocultural origin between survivor and interpreter was observed to have two potential outcomes. The interpreter might be seen as a representative of the community's communicative taboo regarding SV, and therefore impede disclosure. Moreover, survivors might not trust the interpreter to respect their confidentiality with other community members. At the same time, shared cultural background could also aid disclosure, as it enabled the survivor to refer to shared cultural knowledge ("*You know what happens there.*"). Interpreters who actively signaled openness and less adherence to traditional norms facilitated disclosure, indicating that this factor counteracts potential detractions associated with a shared sociocultural origin.

**3.2.5. Interpersonal Variables.** Strict confidentiality of the interaction was considered a central prerequisite to disclosure, and survivors had to be given strong assurances that the conversations would be fully confidential both on the part of the counselor and the interpreter. Yet, trust was seen as the main factor enabling disclosure. Trust included the survivors' feeling of safety with both the professional and the interpreter and their belief in the professional's capacity and readiness to bear their story. Accordingly, mistrust was found to hinder disclosure. Finally, a stable relationship was considered indispensable to the establishment of trust, referring to the continuity of the relationships between all parties, including the interpreter.

**3.2.6. Contextual Variables.** Survivors often recognized the centers as "safe spaces", an essential condition for disclosure. Although survivors sometimes had initial reservations, they appeared to come to recognize the centers as places they would not be stigmatized. Feeling safe in the setting was considered relevant for all affected, but was specifically emphasized for survivors with a diverse SOGIESC. The lack

of transparency of the support system and its communicative structures was seen as a disclosure barrier, as it fostered the survivors' mistrust.

All centers offered psychosocial and/or administrative support during the asylum procedure. The desire to receive asylum was a reason some survivors requested support in the centers to begin with, making it a factor that indirectly promoted disclosure. At the same time, the asylum procedure pressured survivors to disclose detailed information before they were sufficiently emotionally stable.

**3.2.7. Sociocultural Variables.** The communicative taboo regarding SV and a traditional ideal of masculinity were reported to affect male disclosure. These two aspects were interrelated, suggesting a male-specific communicative taboo.

The taboo and its internalization by survivors were described as a central component of the disclosure barrier that was seen as significantly contributing to the survivors' isolation and suffering. For tradition-oriented societies, the taboo was described to extend well beyond (CR)SV. It may encompass sexuality and intimacy in general and can be associated with a lack of common vocabulary for acts and/or body parts. Moreover, it emerged as gendered in nature and affecting both the acts of violence themselves and the disclosure of them: Being a victim of CRSV was found to attack the men's masculine identity and their social role. Disclosures often included emotional expressiveness, which survivors were described as feeling ashamed of, considering it a gender-threatening display of vulnerability. Accordingly, men would sometimes apologize before telling their stories, and they were found to need more guidance in disclosure than women did.

## 4. Discussion

In this phenomenological study with clinical experts, we explored male disclosure processes of CRSV in clinical settings and effective barriers and facilitators from the perspective of mental health clinicians in Germany. Our findings indicate that affected men do disclose their experiences under certain circumstances, and that experts consider disclosure as relevant for survivors' recovery. Survivors may attempt to reinstate their sense of agency during the disclosure process, which was considered beneficial for mental health outcomes. However, several barriers can impede disclosure, and even in mental health care settings specifically intended to support refugees with experiences of interpersonal violence, underreporting/nondisclosure of CRSV has been found to be prevalent among male patients/clients. This is consistent with findings regarding male reluctance to disclose [11, 16, 24]. As previous research has indicated [11, 12, 25], the taboo of disclosing CRSV emerges as gendered and intersecting with socio-cultural norms, which also reflected in a higher disclosure barrier for certain trauma characteristics. Men who adhere to traditional sociocultural beliefs and/or masculinity ideals, and who had lower access to education might find disclosure particularly challenging. Experiences of CRSV that occurred outside of immediate political arenas, that are perceived to have



a rather sexual character and included female perpetrators come with a higher disclosure barrier.

According to our findings, measures can be taken to support disclosure and foster recovery. These include clinicians performing a thorough anamnesis, actively engaging in the dialogue, and recognizing the survivor in his lived reality. Clinicians and interpreters need to signal their willingness to deal with the topic without stigmatizing the survivor. A confidential setting recognized as *safe* by survivors and characterized by interpersonal continuity and transparency is important.

*4.1. Processual and Dialogical Character of Disclosure.* Previous research has described disclosure as “a complex behavioral process that involves sustained self-regulatory efforts” [16], and our research supports this for male disclosure of CRSV. The iterative and nonlinear processes result in varying degrees of depth and completeness of disclosure. The indirect and dialogical approach described by clinicians resonates with previous findings [16, 17, 46]. Insinuations may initiate an implicit negotiation of whether and how the topic can be discussed, a “test[ing of] the waters” so to speak [16]. This behavior can be considered adaptive regarding the stigma associated with SV, the male-specific irreconcilability of gender ideals with sexual victimization that may provoke social discredit [26] and the detrimental consequences that negative social reactions to disclosure can have on mental health [23].

Disclosure is a meaningful social interaction that involves at least one confidant [16]. As clinicians, our study participants inhabit a role that can facilitate disclosure for survivors, e.g., by creating a trusting environment and reacting empathetically to disclosures [46]. Furthermore, they seem to symbolize general knowledge regarding SV, which may allow for indirect disclosures as well as a “leap of faith” in the form of spontaneous disclosure. Clinicians may pick up on the hints of information offered by survivors and engage in a process of cooperative disambiguation, e.g., by asking questions for clarification or suggesting terms to articulate the survivor’s experiences. They thereby play a significant role for survivors in finding appropriate ways to symbolize their experiences and integrate them in their process of recovery.

*4.2. Disclosure and Recovery.* According to clinicians, disclosure is a central step in the healing process and is necessary for survivors processing traumatic experiences, despite its potential of prompting survivors to re-experience the pain of the trauma to some extent [15]. Male survivors of CRSV often show significant emotional activation during disclosure, which according to Foa and Kozak [47] indicates emotional processing. However, short-term habituation is necessary for long-term emotional processing and recovery [47]. Judging from the stepwise increase of breadth and/or intimacy of information shared by survivors, and from their feedback reporting relief post disclosure, survivors seem to undergo short- and long-term habituation processes that contribute to their recovery. However, reaching a critical level of arousal can impede habituation and lead to

dissociation [48], which many survivors were reported to exhibit during disclosure. The iterative aspect of the disclosure process may reflect an adaptive management of arousal. This underlines the responsibility of clinicians to support disclosure processes that do not elicit dissociative states, thereby fostering their long-term beneficence.

Maercker and Horn [49] argue that “potentially beneficial effects of disclosure depend critically on finding the individually appropriate context, administration, and time for [it]” (pp. 471-2). Our findings suggest adding pursuing disclosure *agentically*. The re-negotiation of agency through nondisclosure in male survivors has previously been captured by Touquet and Schulz [28]. Clinicians described both agentic initiation of disclosure and self-determined refusal to disclose and indicated that exercising agency in the process was beneficial regarding its outcome. Navigating disclosure agentically seems to constitute a way of exercising control both internally, as a means of managing psychological trauma sequelae, as well as externally, by managing stigma [18]. Agentic disclosure also seems to reflect a generally higher level of psychological functioning. Survivors with lower functioning levels therefore might need more correlative support during disclosure.

*4.3. Addressing the Taboo.* In line with previous research [12, 14, 26], the disclosure barrier associated with culturally prescribed masculinity ideals emphasizes the effectiveness of a male-specific taboo. It emerged as modified by survivors’ socio-cultural beliefs and practices and may be reinforced or mitigated by the clinicians’ methods and gender as well as the interpreters’ socio-cultural origin and expressed beliefs.

For survivors holding restrictive concepts of sexuality, the taboo was described as more pressuring, and having close ties to family and/or community may reinforce this effect. Both self-stigma and the fear of social repercussions are previously reported barriers to help-seeking and disclosure [6, 12]. Interpreters can represent both restrictive communicative norms adverse to disclosure, and shared cultural knowledge conducive to disclosure if trust can be established. This emphasizes the importance of clinicians and interpreters conveying openness towards taboo subjects and ensuring absolute confidentiality [28, 50].

Male survivors seem to profit from increased guidance in disclosure, which can be provided in a thorough anamnestic process that includes direct questions regarding CRSV. Previous research indicates that questions should be behaviorally specific to avoid labeling experiences in ways survivors would prefer not to [15]. Somewhat conflicting to this, men may try to reconcile their masculine identity with their identity as a victim/survivor by exercising agency in disclosure [28]. Agency is part of many culturally hegemonic masculinity ideals and demarks the male gender stereotype [51]. The act of determining the time, pace, and mode of disclosure, as well as emotions expressed, might feed into a sense of control that aids in dealing with these “gendered harms” [28]. This demands a sensitive approach from clinicians that balances proactivity with noninterference.



The effectiveness of the taboo further interacts with contextual factors. Supporting refugees during the asylum procedure is a central service offered by the centers. According to Article 21 of the EU Directive 2013/33/EU, survivors of CRSV qualify for the benefits granted by the right to special protection. This urges survivors to break the taboo, suggesting a necessary trade-off between their interest in receiving asylum and their interest in agentic disclosure and momentary well-being.

Fortunately, many survivors seem to recognize the centers as safe spaces in which the violation of the communicative taboo will not harm them. The relevance of this was emphasized by clinicians in centers exclusively addressing SOGIESC individuals. While previous research found a higher reluctance to disclose for SOGIESC minority groups [6, 25], our findings do not confirm a generally higher barrier for SOGIESC survivors. Clinicians from other centers reported no differences in disclosure behavior, as they perceived disclosure to be difficult for male survivors in general. This finding may reflect the availability of specialized care, as some SOGIESC survivors might directly approach available specialized institutions, underlining the necessity of care institutions exclusively addressing SOGIESC persons.

*4.4. Methodological Reflection and Limitations.* In the present study, we chose an explorative phenomenological approach from the clinical experts' perspective. We chose to focus on informative content as provided by the experts, both in interview selection and during analysis. When selecting interviews, we focused on those with higher information density and quality, meaning that we included particularly those clinicians who produced more autonomous reflections on the topic. We therefore excluded clinicians from analysis who likely felt less confident reflecting. This partly prevents us from identifying knowledge gaps and insecurities clinicians may have while working with survivors. Moreover, our findings refer to clinicians working in specific care structures that are typical in Germany and which may not be internationally comparable. The clinicians' conceptualizations are necessarily embedded within their *lifeworlds* [32]. Results should be understood as how practitioners perceive interactions with male survivors in the light of their education, work experience, and general socialization in Western high-income countries. The method was chosen because the experiences of mental health clinicians were considered an important resource of knowledge regarding the work with male survivors, and because their knowledge has a high practical relevance [31]. However, professionals themselves may have preconceptions of their (male) refugee patients/clients, which could have affected both their clinical practice as well as their accounts. These were not subject of the current project and represent a knowledge gap in need of scrutiny in future research.

It must be clearly noted that this research does not include the survivors' perspectives on their reasons for and processes of disclosure. As a result, our findings are limited to interactions in which disclosure took place, and we cannot make any statements about interactions in which survivors remained entirely unrecognized as such. Similarly, the

survivors' subjective understandings of their experiences and associated sequelae may differ significantly from the clinical experts' perspectives and should be addressed in future studies.

Finally, statements in interviews are always made *for* someone [31]. Clinicians were asked to report interpersonal situations they co-create towards one of two interviewers, both psychologists who possess significant theoretical knowledge on the topic of CRSV against men. This enabled a general common understanding of the survivors' mental health needs and therapeutic/counseling approaches. However, clinicians may have felt inclined to present their views and actions in a way that underlined their expertise rather than knowledge gaps or insecurities regarding the topic.

*4.5. Conclusions and Future Directions.* Our findings suggest that male survivors are confronted with multiple behavioral expectations affecting them as men, as asylum seekers, as family members, as persons belonging to a certain culture, and as patients/clients. Hence, the barriers of and facilitators to disclosure are represented in different arenas of their social realities, suggesting that an intersectional perspective can be helpful in understanding nondisclosure.

Importantly, some men do disclose their experiences of CRSV, and disclosure can promote recovery. Exercising agency during disclosure appears to foster beneficial outcomes. The clinicians' knowledge regarding indications of CRSV experiences in men, the complexity of disclosure and its relevance to trauma processing and recovery are crucial for supporting beneficial processes. Our findings emphasize the necessity of long-term counseling and treatment opportunities in which disclosure processes can unfold in their own time, and of therapeutic interventions that include both stabilization and coregulated processing of the traumatic event. The centers represent safe spaces where male survivors learn through experience that they can tell their stories and be heard without risking stigmatization.

The individual needs of each survivor can only reasonably be met in contexts that promote awareness of and flexible responses to these needs. Gender and sociocultural background of the persons involved in the treatment/counseling process are relevant, and survivors should be offered a choice concerning with whom they speak. However, our results suggest that these variables can be counterbalanced by interpersonal continuity and professionalism. Respecting and addressing socio-cultural norms both of communication and masculinity can open a (transcultural) space for creating new communicative norms and allowing survivors to find appropriate ways to symbolize their experiences of CRSV and the associated emotional burden. This calls for communication skills trainings for clinicians that include perspectives on taboo topics and transcultural communication, specifically in the context of trauma counseling and therapy.

To identify and reduce the most pressing barriers, and to foster favorable conditions for disclosure, future research needs to integrate survivors' perspectives on barriers and facilitators, as well as on treatment preferences and expectations. The role of agency in the

disclosure process needs further investigation regarding its effect on recovery, with special attention paid to gender effects. It is necessary to investigate how to effectively address the hard-to-reach population of male survivors of CRSV, and thereby make available services more accessible and disclosure more likely. The destigmatization of survivors of CRSV remains a crucial aspect of this endeavor, with the potential of reducing social isolation and allowing for the delivery of adequate health care.

### Data Availability

The qualitative interview data used to support the findings of this study have not been made available because participants in the study objected the full release of the data.

### Disclosure

Results presented in this manuscript have been partially presented at the preconference workshop of the “Conflict-related sexual violence against men and boys” conference in Hannover (Germany) in October 2022.

### Conflicts of Interest

All authors declare that they have no conflicts of interest.

### Authors' Contributions

KS conceptualized the study, proposed the methodology, performed formal analysis, investigated the study, contributed to data curation, wrote the original draft, contributed to visualization, and performed project administration. HG conceptualized the study, proposed the methodology, reviewed and edited the manuscript, provided funding acquisition, and provided resources. YN conceptualized the study, proposed the methodology, investigated the study, reviewed and edited the manuscript, supervised the study, performed project administration, and provided funding acquisition.

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