

Understanding the Psychological and Adaptive Functioning of Adult Males Who Have
Experienced Childhood Sexual Abuse

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Abstract

Men who are victims of childhood sexual abuse (CSA) are a marginalized and often silenced population. However, they are becoming increasingly recognized as a population that is substantial in size and that warrants further understanding. With a commonly accepted statistic of 1 in 6 men having experienced CSA, broader knowledge gaps linked to comprehensively understanding the psychological and domain-specific outcomes for this population still remain. Furthermore, there has been little in the way of in-depth research on the concept of emotion regulation among adult men with histories of CSA and the important emotional mechanisms and modulation strategies which have potentially hindered their overall well-being. This two-article dissertation, using multi-method information from 109 Ottawa-based men (69 with histories of CSA and 40 non-CSA men), brings awareness to the unique impact of CSA on broader areas of psychological and adaptive functioning, as well as provides a more specific and comprehensive understanding of the link between CSA, emotion regulation and functioning outcomes. In Study 1, I examined CSA characteristics among a sample of Canadian men (e.g., age of onset, disclosure experiences, perpetrator profiles) and expanded upon the limited examination of CSA effects within the context of co-occurring maltreatment (i.e., physical abuse, neglect, emotional abuse, and neglect) and non-maltreatment childhood adversities (e.g., parental divorce, parental health impairments). I also looked more comprehensively at the impact of CSA in males across various areas of psychological functioning (e.g., depression, anxiety, stress, dissociation, anger, PTSD), both from a self-report and clinician-administered perspective. Findings from Study 1 highlight the importance of controlling for both maltreatment and non-maltreatment childhood experiences, as well as the unique contribution of CSA to poorer psychological and adaptive outcomes. Building on these results, Study 2 comprehensively examined men's emotion

regulation, using a multi-method approach (e.g., trait and state-based, and from a semi-structured interview), and how these facets of emotion regulation are linked to psychological and adaptive functioning outcomes among adult males. Study 2 findings outline a more detailed understanding of the larger concept of emotion regulation and the importance of specific and maladaptive emotion regulation strategies as part of trauma treatment and its associations with mental health. Although further research is needed with a large-scale prospective study design, these two studies represent important research and clinical implications, including tailoring assessment and treatment to meet the individual needs of males with histories of CSA.

Keywords: male sexual abuse; child maltreatment, psychological outcomes, adaptive outcomes, emotion regulation

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Content of Thesis and Contributions of Authors

This dissertation follows a multiple-article format and is divided into two studies: (1) The psychological and adaptive functioning of adult males who have experienced childhood sexual abuse; and (2) The role of emotion regulation on psychological outcomes among males with histories of childhood sexual abuse. Study 1 is currently in the process of being written up as a manuscript to be submitted to the journal of Child Abuse & Neglect. The writer of the thesis will appear as the first author and the thesis supervisor will appear as a co-author. Ms. Moorman took the lead in every aspect of this dissertation, including the literature review and conceptualization of the project, development and implementation of study procedures and methods, ethics review board applications, data collection, data scoring and analysis, and writing of the thesis. Dr. Romano adopted an advisory role throughout the process and oversaw all abovementioned activities.

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Understanding the Psychological and Adaptive Functioning of Adult Males Who Have
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General Introduction

Today's attitudes are shifting more than ever before, resulting in a social landscape where individuals with sexual abuse histories are more able to come forward with their experiences. Despite the increase in reporting and attention to childhood sexual abuse (CSA), males with histories of sexual abuse remain stigmatized, marginalized, and under-researched. An analysis of the scope of the problem makes it apparent that CSA is a widely prevalent issue, and males are becoming increasingly recognized as a population that is substantial in size and that warrants further understanding. Although research has examined different types of childhood maltreatment as well as possible short- and long-term sequelae, there remains a significant knowledge gap for males with CSA histories with respect to its impact on various psychopathologies, adaptive functioning, and emotion regulation.

Definition and Prevalence

While there is a growing awareness within the clinical research community of the reality of CSA in males, definitional variability continues to contribute to discrepancies within the body of literature. In large part, definitions often vary regarding the type of sexual activity experienced and victim-perpetrator age difference (Hulme, 2004; Lyons & Romano, 2019). CSA can cover a wide range of behaviours (from exhibitionism to penetration) between a child and an older individual who often holds greater power, both physically and psychologically (Valente, 2005; Walker, Carey, Mohr, Steen, & Seedat, 2004). More generally, CSA can be defined as a crime often involving a child below the legal age of consent, which is typically 14 to 18 years, who is involved in sexual activity with an adult, young person, or same-aged peer

(Lyons & Romano, 2019; Berliner, 2011; Gilbert et al., 2009). While CSA is often conceptualized as involving bodily contact (e.g., Briere & Elliott, 2003; Dube et al., 2005; Hébert et al., 2009), some research has also included non-contact behaviours such as sexual invitations and exhibitionism (e.g., Finkelhor, Turner, Shattuck, & Hamby, 2014; MacMillan, Tanaka, Duku, Vaillancourt, & Boyle, 2013). Contact acts include unwanted touching, oral-genital contact, digital penetration, and vaginal/anal penetration. Non-contact acts include voyeurism, exhibitionism, exposure to sexual comments, and exposure to child pornography (Deb, Bhattacharyya, & Thomas, 2016; Gilbert et al. 2009; Putnam 2003).

The definitional variability is further complicated by consideration of age differences between a child and perpetrator. Lloyd and Operario (2012) noted that it is common to define CSA as involving a child aged 12 years or younger with a perpetrator who is at least five years older or as involving a youth 13 – 16 years with a perpetrator at least 10 years older. However, two meta-analyses defined CSA as extending to individuals up to 18 years of age (Butt, Chou, & Browne, 2011; Kendall-Tackett, Williams, & Finkelhor, 1993). A literature review of retrospective CSA instruments found that the upper age limit of the victim typically ranges from 12 to 17 years, with studies that use younger age limits undoubtedly yielding lower frequencies (Lyons & Romano, 2019; Hulme, 2004). Definitions of CSA, which include perpetrators who are not much older than the child (Maltz, 2001, 2002; Ratican, 1992), suggest that a 5-year age difference may be limited in scope. Other researchers have suggested that CSA occurs when there is a disparity in age or developmental level between children engaged in sexual behaviours (Kellogg & Menard, 2003). In such instances, it is common for the older child to direct the younger child in the sexual activity and to obtain compliance through physical force or threats, such as reporting the activity to adults (Kellogg & Menard, 2003).

A final factor contributing to discrepancies related to CSA prevalence may also come from differences in sampling procedures (e.g., clinical vs. community samples), sample size, data collection method (e.g., questionnaire vs. clinical interview), and age of respondent (Easton & Kong, 2017; Lloyd, 2013). The number of questions about sexually abusive experiences can also influence the frequency of sexual abuse, with studies asking fewer questions undoubtedly obtaining lower rates (Hulme, 2004). Moreover, studies using face-to-face or phone interviews (e.g., Hébert, Tourigny, Cyr, McDuff, & Joly, 2009; Molnar, Buka, & Kessler, 2001; Perez-Fuentes et al., 2013) have found lower rates of sexual abuse compared to studies using anonymous questionnaires (e.g., Briere & Elliott, 2003; Dube et al., 2005).

With these considerations in mind, a meta-analysis found that 8% of males worldwide have experienced some form of sexual abuse prior to the age of 18 (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). In a review of the (primarily North American) literature on CSA prevalence, Tourigny and Baril (2011) similarly established that 1 in 10 males disclosed having experienced sexual abuse during the course of their childhood. In a more recent review of Canadian community data, Afifi et al. (2014) found a prevalence rate of 5.8% for CSA among males. Across different male populations, the prevalence of CSA appears to range from 4.8-28% in university students, 2.8- 16% in community samples, and 3-23% in clinical samples (Romano & De Luca, 2014). A well-accepted statistic is that 1 in 6 males has experienced sexual abuse during childhood (Briere, 1996; Finkelhor, et al., 2014; Gartner, 1999; Romano & De Luca, 2001).

Although the 1 in 6 statistic is widely accepted, it is important to note that there are approximately 3-4 times as many cases of CSA than are actually disclosed or reported (Crowder, 1995; Romano & De Luca, 2014; Violato & Genuis, 1993). Males in particular face challenges

in sharing and disclosing their CSA, largely in relation to societal stereotypes and expectations of masculinity (Dorahy & Clearwater, 2012; Gartner, 2017). Hegemonic masculinity ideals characterize *real* men in western contexts as strong, sexually assertive, heterosexual, dominant, active and in control of their emotions, so much so that a history of sexual abuse goes against gender norms and is often perceived as male weakness or vulnerability (Alaggia, 2010; Anderson, 2011; Bolton, Morris, & MacEachron, 1989; Gartner, 2017; Grossman, Kia-Keating, & Sorsoli, 2006; Hunter, 2009; Levant, 1996; Lisak, 1994; Sorsoli, Kia-Keating, & Grossman, 2008). Being a male victim of sexual assault stands in contrast to hegemonic or conventional norms of masculinity. According to these gender norms, men are expected to seek and actively engage in sexual activity. If they are abused as a child or attacked, they are also expected to be able to defend themselves. Therefore, men with histories of CSA or even assault come to be seen as feminized victims and sexual objects: damaged, weak, powerless and helpless in the face of sexual violence (Kwon, Lee, Kim, & Kim, 2007). Conventional, and perhaps toxic, masculinity norms therefore have the potential to generate self-blaming attributions that shape and influence how men respond to the experience of CSA. Understandably then, these norms and stereotypes play a contributory role in decreasing male disclosure of CSA, even across the lifespan (Gagnier & Collin-Vezina, 2016). This important factor certainly warrants a much bigger discussion but is outside of the scope of the current study's larger objectives.

O'Leary and Barber (2008) confirmed gender differences in disclosure rates in finding that males are less likely than females to disclose at the time of abuse and take considerably longer to either discuss or seek treatment for CSA. As previously mentioned, males may be less likely to disclose CSA because of shame regarding their perceived lack of masculinity, perceived inability to be self-reliant and independent, and/or because of fear they may be labelled

homosexual in instances where there is a same-sex perpetrator (Aosved, Long, & Voller, 2011; Barth, Bermetz, Helm, & Tonia, 2012; Easton, Saltzman, & Willis, 2014; Maikovich-Fong & Jaffee, 2010; O’Leary & Barber, 2008; Pereda, Guilera, Forns, Gómez-Benito, 2009; Stoltenborgh et al., 2011; Walker et al., 2004). Males also tend to remain silent because they long to forget the abuse altogether, wanting to protect the perpetrator and/or fearing the potential response of others to their disclosure (Easton, 2013; Holmes & Slap, 1998). Such fears may be justified as males are more likely to be blamed and scrutinized for their victimization (Gartner, 2017; Spencer & Tan, 2000), leading to a host of complex and challenging psychosocial outcomes to navigate after the abuse has ended. Lastly, males often report feeling helpless, isolated, guilty, weak, shameful, or “unmanly” because of their CSA experience, which may also keep them from disclosing (Alaggia & Millington, 2008; Gartner, 2017; Valente, 2005).

Impact of Childhood Sexual Abuse on Adult Males

At various stages of development, there are age-related events, roles, and domains that characterize important and significant areas in one’s life (Elder, 1998; Oesterle, Hawkins, Hill, & Bailey, 2010). Completing school, moving into full-time employment, getting married, and becoming a parent are several of the key transitions to adulthood in Western cultures (Booth, Crouter, & Shanahan, 1999; Cohen, Kasen, Chen, Hartmark, & Gordon, 2003; Macmillan & Copher, 2005). These transitional markers evolve into significant areas of adaptive functioning throughout adulthood, and they can be conceptualized as important areas that are directly impacted by developmental, emotional, cognitive, and psychosocial factors. Consideration of the diverse ways in which individuals move from childhood to adulthood is important because different pathways have potentially important implications for later adult functioning, well-being, and quality of life (Gartner, 2017; Macmillan & Eliason, 2003; Shanahan, 2000).

Experiencing CSA often has a significant impact on how individuals' transition and function in various important adaptive domains of life, such as relationships, parenting, and employment (Gartner, 2017).

With regard to interpersonal relationships, it is common for adult males who have experienced CSA to report difficulties in peer and intimate partner relationships (Browne & Finkelhor, 1986; Courtois, 1988; Crowder, 1995; Dubé et al., 2005; Maniglio, 2010; Romano & De Luca, 2001, 2014; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Spiegel, 2003). Males often report difficulty trusting others and are more likely to have a history of failed relationships or marriages (deYoung, 1988; Russell, 1986), as well as fewer friends (Gold, 1986). These findings may not be altogether surprising given that children who experience sexual abuse (especially by a caregiving figure) often develop insecure attachment, and these early attachment difficulties lay the foundation for relational functioning at later stages of development (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Cicchetti & Lynch, 1993).

One significant interpersonal relationship for many adults is the parent-child relationship. Researchers have found that adults with CSA histories often experience parenting difficulties that include the failure to establish clear generational boundaries, inadequate monitoring and supervision, and the use of harsh or inconsistent discipline (Banyard, Williams, & Siegel, 2003; DiLillo & Damashek, 2003). Experts caution, however, that the influence of CSA (and childhood adversity more generally) on parenting difficulties is complex and may be influenced by such factors as individuals' mental health concerns, substance abuse, and intimate partner violence (Banyard et al., 2003; Locke & Newcomb, 2004; Schuetze & Eiden, 2005).

Specifically for males, there are several factors that can contribute to the broader aforementioned issues with parenting. Studies have found that fathers with a CSA history may

view sexual abuse perpetration as a moral issue (i.e., that they are/are not destined to perpetrate abuse because it has happened/did not happen to them), which has and can continue to interfere with their judgement (Price-Robertson, 2012). This finding supports the conceptual work of Alaggia and Millington (2008), who argued that a CSA history can lead to significant moral confusion and subsequent worries over being an appropriate role model, over creating appropriate boundaries, and over possibly sexually abusing one's own children. With regard to this last point, researchers have noted that relationships and interactions between adult males and children are influenced by an increased awareness of the issue of CSA (Furedi, 2006; Gartner, 2017; Hayes, 2008; Price-Robertson, 2012). Hayes stated that "concern over child sexual abuse has, to some extent, altered the nature of relationships and the behaviour of fathers and male members of extended families particularly" (p. 62). Hayes' statement links well to findings by Gartner (2017) who also described difficulties among males with histories of CSA and their perception of inconsistency in their parenting, lack of relational closeness between father and child, and at times, feelings of uneasiness in their role as fathers.

Turning to workplace functioning, it can be influenced by a range of CSA-related psychological effects that include a sense of vulnerability, anger, grief, helplessness, and low mood (McLean & Gallop, 2003; Wohab & Ahkter, 2010). The broader sense of vulnerability has been shown to have an impact on individual ability, motivation, and way of thinking (Martha & Rhoda, 1981; Wohab & Akhter, 2010), all of which would inevitably result in difficulties in employment tasks and career aspirations. The ways in which males might cope with these various feelings can also impact their work, such as if they are resorting to substances to manage symptoms (Miller & Mancuco, 2004; Whiting, Simmons, Havens, Smith, & Oka, 2009). In this thesis, I examined employment because it is a particularly salient domain for males who often

define their identity and worth through their ability to have paid employment and to be able to support themselves and their family (Hosteler, Sweet, & Moen, 2007). Males tend to hold an agentic orientation of independent action and achievement that emphasizes the attainment of money, power, and advancement in their careers (Eddleston, Veiga, & Powell, 2006; Mainiero & Sullivan, 2006). Strong cultural norms further encourage the notion of the 'breadwinner role' among males (Greenhaus, Peng, & Allen, 2012; Hostetler et al., 2007), leaving many males to construe their family role substantially in terms of fulfilling their family's economic needs (Greenhaus et al., 2012).

In addition to the various areas of adaptive functioning, there are also a range of mental health difficulties that have been associated with a history of CSA. Males who have experienced CSA are two to four times more likely to develop clinical sequelae when compared with non-abused counterparts (Butt et al., 2011; Valente, 2005). Several clinical outcomes for these males include dissociation, rage, extreme passivity, violence, self-injury, aggression, and more frequent health service needs (Butt et al., 2011; Valente, 2005). With respect to level of dissociation for example, one study found that 6.3% of the general population suffered from three or more frequently occurring dissociative symptoms. Among these individuals (across a sample of males and females), researchers noted that the rate of CSA was two and a half times as high and the rate of physical abuse was five times as high (Mulder, Beautrais, Joyce, & Fergusson, 1998). Those who experience CSA are also generally more likely to be diagnosed with mental health disorders (Afifi et al., 2014; Afifi, Henriksen, Asmundson, & Sareen, 2012; MacMillan et al., 2013; Molnar et al., 2001; Pérez-Fuentes et al., 2013; Walker et al., 2004), to have suicide-related behaviour (Afifi et al., 2014; Easton, Renner, & O'Leary, 2013; Holmes & Slap, 1998; O'Leary & Gould, 2009), and to be at increased likelihood for experiencing adult victimization

(Afifi, MacMillan, Cox, Asmundson, Stein, & Sareen, 2009; Desai, Arias, Thompson, & Basile, 2002). Problematic substance use is also often over-represented in males with CSA histories as it may serve as a coping strategy to manage difficult emotions and situations (Foa, Keane, Friedman, & Cohen, 2009; Holmes & Slap, 1998; Romano & De Luca, 2001, 2014; Schulte, Dinwiddie, Pribor, & Yutzy, 1995).

While there are many different types of mental health difficulties that males may experience as a result of CSA, two that are often associated with early childhood maltreatment (and with one another) are Borderline Personality Disorder (BPD) and Post-Traumatic Stress Disorder (PTSD; Cattane, Rossi, Lanfredi, & Cattaneo, 2017). Despite the importance of understanding the role of CSA in the development of BPD symptoms, which is intricately linked with an individual's emotion regulation capabilities (Cattane et al., 2017; Pagura et al., 2010), I did not examine BPD as an outcome largely because it would be challenging to accurately tease out BPD symptoms from other complex psychological symptoms without appropriate diagnostic tools which would allow for a comprehensive background assessment and collateral information from important interpersonal sources.

Research has found that the most frequent diagnoses for adult males with CSA histories were anxiety and acute stress disorders, including PTSD (Romano & De Luca, 2014; Spataro et al., 2004). Research has also found that males tend to exhibit post-traumatic stress symptoms at levels equal to females with similar abuse histories (Freedman et al., 2002; Maikovich, Koenen, & Jaffee, 2009; Romano & De Luca, 2014; Spataro et al., 2004). While PTSD is often linked with childhood trauma, not all males with CSA histories have symptoms that meet diagnostic criteria for PTSD, yet they may still experience a range of impairments across emotional and social domains of functioning (Dohrenwend, Yager, Wall, & Adams, 2013). It is imperative

then to take a broad view of CSA effects that extend beyond diagnoses, especially exclusively PTSD. As such, it seems important to consider psychological outcomes not represented in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) and trauma-related responses within particular domains of functioning that either fall below the threshold of mental health disorders or that even reflect resilience.

Conceptual Framework for Understanding CSA Effects

One way to understand how CSA impacts psychological well-being and functioning is through the lens of complex trauma. The traumatic stress field has adopted the term “complex trauma” to describe the experience of multiple, chronic, and developmentally adverse traumatic events, most often of an interpersonal nature (Cook et al., 2005; Gaskill & Perry, 2012; Kinniburgh, Spinazzolla, Blaustein, & van der Kolk, 2005; van der Kolk, 2014). More broadly, complex trauma refers to traumatic experiences that are repetitive and chronic in nature, involve harm and/or neglect by caregivers or other responsible adults, and occur in early childhood (Ford & Courtois, 2009). Complex trauma also refers to the many varied short- and long-term outcomes associated with having experienced trauma. The model states that complex trauma interferes with the completion of key developmental processes, such as attachment, emotion regulation, and brain development, that form the foundation for many common mental health problems (e.g., depression, PTSD, aggression, substance use) displayed by individuals with histories of childhood abuse (National Child Traumatic Stress Network Task Force, 2003).

A key developmental task during infancy and early childhood is attachment, which helps the developing child begin to differentiate between and modulate emotional states and behavioural responses of both oneself and the attachment figure (Bowlby, 1988). Through relationships with attachment figures, children learn how to interact with their external world and

come to understand themselves in relation to others. When a child's attachment figure is a source of fear, an insecure attachment pattern may ensue (Kinniburgh et al., 2005). Kinniburgh et al. (2005) discuss four major competencies that are negatively impacted by complex trauma: (1) Interpersonal competencies, such as building secure attachment relationships, positive peer relationships, and healthy relationships in adulthood; (2) Intrapersonal competencies, such as the development of a positive self-concept, awareness of internal states, realistic assessment of self-competencies, and capacity to integrate self-states; (3) Cognitive competencies, such as language development as well as academic performance and achievement; and (4) Emotional competencies, such as emotion regulation which underlies the majority of difficulties in well-being and functioning.

In the context of an insecure attachment, no healthy framework for interpreting emotional states is provided, and as a result, children struggle to regulate their emotional responses (Lyons & Romano, 2019; National Child Traumatic Stress Network Task Force, 2003; van der Kolk et al., 2005). In the absence of healthy emotion regulation afforded by secure attachment, individuals may instead internalize or externalize their emotional reactions. Moreover, when an attachment figure is dangerous or unpredictable, children learn that they cannot rely on others to help them, and they may develop a view that they are not good enough, that relationships are unsafe, that individuals cannot be trusted, and that the world is a dangerous place (Lyons & Romano, 2019). Unsurprisingly, insecure attachments may also lead to impairments in self-esteem, sense of agency, and interpersonal relationships (Lyons & Romano, 2019). Taken together then, difficulties with emotion regulation, self-esteem, sense of agency, and interpersonal functioning increase individuals' risk of depression, anxiety, post-traumatic stress, and conduct disorders throughout the lifespan (Lyons & Romano, 2019; National Child

Traumatic Stress Network Task Force, 2003). In the absence of trauma, most children have the chance to invest in developing various competencies, but children with complex trauma must devote their energy to survival, thereby limiting their ability to effectively attain various developmental competencies that “set the stage” for later adaptive functioning and sense of well-being.

This dissertation was guided primarily by the complex trauma model as it is supported by research (e.g., Anda et al., 2006; Cook et al., 2005) and offers a comprehensive framework that focuses on the most influential system in determining outcomes – the child-caregiver relationship and the family system. Also, the majority of males with histories of CSA report experiences that are consistent with the definition of complex trauma, that is, early childhood trauma by a caregiving figure that is prolonged and severe (Ford & Courtois, 2009). When male CSA is not perpetrated by an attachment figure (Frias & Erviti, 2014), it often occurs alongside other types of maltreatment and non-maltreatment adversities by caregivers (Anda et al., 2006; Gaskill & Perry, 2012; Perez-Fuentes et al., 2013; Turner, Taillieu, Cheung, & Afifi, 2017), which further contributes to poor attachment and instability throughout key developmental years. Although other theories have been used to explain the impact of CSA (e.g., Traumagenic Dynamics Model; Finkelhor & Browne, 1985), they have limited empirical support and often do not account for the range of abusive experiences and symptoms observed in individuals with histories of CSA (Freeman & Morris, 2001). There have also been additional theories proposed, including the post-traumatic stress model (Wolfe, Gentile, & Wolfe, 1989) and the information-processing model (Hartman & Burgess, 1988). However, similar to that of the traumagenic model these theories have scarcely been examined empirically, leaving a gap between theoretical work, which is wide in scope, and empirical research, which usually focuses on a few variables

in isolation. The complex trauma model, in contrast, has received increasing empirical attention in both studies on sexual abuse and in the child maltreatment literature more generally (Cook et al., 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Finally, it is important to note that CSA does not result in one pathway towards domain-specific impairments or psychopathology. Not all males with CSA histories will struggle with the same type of psychopathology and conversely, a number will address their experiences and by doing so, even demonstrate resilient functioning. The experience of positive changes, such as greater appreciation for life or better understanding of relationships with others, is known as posttraumatic growth (Lev-Wiesel, Amir, & Besser, 2005; Shakespeare-Finch & de Dassel, 2009; Tedeschi & Calhoun, 2004). People who experience posttraumatic growth in the aftermath of traumatic events typically describe improvements in three areas of their lives: view of self (e.g., greater sense of personal strength, greater compassion toward themselves); life philosophy (e.g., increased sense of meaning or spirituality, reordering of life priorities, greater appreciation of their life); and relationships with others (e.g., increased empathy and altruism, heightened sense of closeness; Joseph & Linley, 2006; Tedeschi & Calhoun, 2004). In one study exclusively focused on posttraumatic growth and males with histories of CSA, researchers expected certain CSA characteristics to be related to higher levels of growth, such as understanding CSA, perceived disclosure support, adherence to masculine norms, experience of a turning point, time delay between onset of abuse and disclosure, and the perpetration of CSA by a clergyman (Easton, Coohey, Rhodes, & Moorthy, 2013). Study results found that only men's understanding of the abuse and their placement of responsibility on the perpetrator was related to higher levels of growth; there was no statistical significance among the other aforementioned CSA characteristics (Easton et al., 2013). While there is evidence that female

survivors of CSA experience levels of posttraumatic growth comparable to other female trauma survivors (Shakespeare-Finch & de Dassel, 2009), researchers argue that some factors involved in growth after CSA may be gender specific (Easton et al., 2013). These differences may be due, in part, to women being more likely than men to engage in active processing of a traumatic event and more likely to employ processing-oriented coping strategies that include seeking social support (Easton et al., 2013). Therefore, while I did include an adult measure of resilience, I focused more specifically in this thesis on psychopathology to further understand the difficulties in well-being (mental health) and domain-specific functioning (e.g., parenting, employment) associated with male CSA.

I also focused additional attention on emotional competencies because experiencing CSA often negatively and severely impacts emotion regulation skills, which then have subsequent impacts on development and functioning in adulthood (both intra- and interpersonal; Dvir, Ford, Hill, & Frazier, 2014; McLaughlin, Hatzenbuehler, Mennin, & Nolen-Hoeksema, 2011). Emotion regulation is the critical ability to modulate and maintain feelings, behaviours, and physiological responses that constitute an emotion (Gross, 2002). Extensive research now shows that poor emotion regulation contributes to an array of psychiatric conditions, including depression and PTSD (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Bradley et al., 2011), in a manner distinct from negative affect alone (Bradley et al., 2011). Emotion regulation difficulties are often found in individuals exposed to trauma, particularly childhood abuse (Michopoulos et al., 2015; Pollak, 2008; Shields, Cicchetti, & Ryan, 1994), and can have long-term detrimental effects on the recognition, management, and expression of emotion (Michopoulos et al., 2015; Southam-Gerow & Kendall, 2002). Retrospective studies have also shown that trauma-related problems with emotion regulation in childhood are linked with dysregulation in multiple

domains of informational processing (physiological, sensory, emotional, and cognitive) as well as in self- and relational dysregulation throughout adulthood (Dvir et al., 2014; McLaughlin et al., 2011). Understanding this key process not only furthers the body of literature for this population but it can also contribute to improving males' mental health.

Thesis Objectives

Over the past two decades, male CSA has received increasing empirical attention. Male CSA is a serious societal and mental health issue because it has been associated with a range of negative outcomes that impact one's sense of well-being and functioning across important adaptive domains (e.g., work, relationships). While research on male CSA is emerging, there remain important gaps in our understanding. First, the impact of CSA in the context of males and in the context of other forms of maltreatment and non-maltreatment adversities that commonly occur alongside CSA is limited. In understanding the psychological impact of CSA, it is imperative to take these additional adverse experiences into account in order to not potentially overinflate the contribution of CSA. Second, most of the research (albeit limited) on male CSA has relied on self-report measures to describe both maltreatment experiences and adversity as well as psychological functioning (Easton, 2013; Easton & Kong, 2017; O'Leary, 2009; O'Leary, Coohey, & Easton, 2010). While informative, these measures do not map onto clinical diagnoses which capture psychopathologies that are at levels causing significant distress and/or functioning impairments. Furthermore, most studies which examine childhood maltreatment, including male CSA, focus primarily (if not exclusively) on PTSD. Third, studies on the long-term outcomes associated with CSA among males have not included a comparison group of males without maltreatment histories (Alaggia & Millington, 2008; Easton & Kong, 2017; Easton et al., 2014; O'Leary et al., 2010), which would provide a further examination of

the possible unique impact of CSA. Fourth, while research has suggested that emotional competencies in general are impacted by childhood trauma (Kinniburgh et al., 2005) and that experiencing CSA often negatively and severely impacts emotion regulation skills (Dvir et al., 2014), there have been no studies examining in what ways emotion regulation links a history of CSA with psychological functioning among adult males.

To address these gaps, I compared a group of males with CSA histories to males with no history of CSA. For maltreatment and non-maltreatment adversity, I first tested for significant differences between the two groups of males on the presence of other forms of childhood maltreatment and non-maltreatment childhood adversity more generally. Second, I analysed how the two groups differed significantly on the presence/absence of several trauma-relevant clinical diagnoses that include, but go beyond, PTSD (e.g., anxiety, substance use, mood disorders) by way of the most recent DSM-5 structured diagnostic interview. Third, I aimed to see in what way the two groups of males differed significantly on a number of relevant psychological outcomes (e.g., mood symptoms, anxiety and stress symptoms, dissociation, anger) and domains of adaptive functioning (e.g., interpersonal relationships and parenting) using self-report instruments. In this way, my thesis made use of a multi-method approach. Finally, I examined emotion regulation among both the CSA and non-CSA groups, using both quantitative and qualitative methods, to better understand its role in the link between CSA and psychological functioning. Findings from my thesis hold applied implications, first and foremost by broadening awareness and understanding about the possible unique impact that a history of CSA has on males as it relates to abuse-related outcomes, clinical presentations of traumatic symptoms, related clinical disorders, and adaptive functioning. Additionally, findings can

inform existing treatment interventions by highlighting key factors and processes, most notably emotion regulation, that are associated with impaired well-being and functioning.

Study 1

Psychological and Adaptive Functioning Among Males with Histories of Childhood Sexual Abuse

The immediate and longer-term outcomes of childhood sexual abuse (CSA) have been well documented in clinical and research studies over the past two decades (Cicchetti & Toth, 1995; Fergusson, McLeod, & Horwood, 2013; Kendall-Tackett et al., 1993; Maikovich-Fong & Jaffee, 2010; Mendel, 1995; Paolucci, Genius, & Violato, 2001). However, it is difficult to understand the unique impact of CSA on males because most research studies have focused exclusively on females or, if both sexes are included, there is a tendency to have a relatively greater number of females than males. Additionally, studies that have been exclusively composed of males typically have included small samples and have relied on retrospective accounts of childhood experiences (Briggs & Hawkins, 1995; Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Feiring, Taska, & Lewis, 1999; Lab & Moore, 2005). Finally, male samples have tended to focus on specialized samples that are not representative of all males with CSA histories, including males who are street-involved or in prison (Darves-Bornoz, Choquet, Ledoux, Gasquet, & Manfredi, 1998; Watkins & Bentovim, 1992). With these limitations in mind, the following sections discuss the more commonly reported longer-term adult outcomes of male CSA since the present thesis focuses on this developmental period. Outcomes of particular relevance to males with histories of CSA are detailed, including adaptive functioning (e.g., interpersonal relationships, parenting, and employment), mood, anxiety, dissociation, anger, substance use, and finally, trauma symptoms and PTSD. Although the review is not exhaustive,

it covers those CSA-related outcomes that appear most often in the research literature and that were examined in the current study.

Adaptive Functioning

Long-term data indicate that males with histories of maltreatment often experience a poorer quality of life in adulthood, compared with non-maltreated males (Corso, Edwards, Fang, & Mercy, 2008). Among adult males with histories of CSA, common long-term influences which impact life satisfaction, outside of specific psychological outcomes, include interpersonal problems (Browne & Finkelhor, 1986; Dube et al., 2005; Feiring & Cleland, 2007; Whiffen, Thompson, & Aube, 2000; Young, Harford, King, & Savell, 2007), poor self-image (Holmes & Slap, 1998), fear and anxiety (Gartner, 1999; Lisak, 1994), and employment problems (Lisak & Luster, 1994; Wohab & Akhter, 2010). These effects, some of which begin to arise in adolescence, appear to continue into later adulthood for many males with histories of CSA (Draper et al., 2008; Romano & De Luca, 2001).

As previously discussed in the general introduction, CSA has an impact on specific areas of adaptive functioning, such as relationships, parenting, and employment. Research has shown that males with CSA histories have difficulties trusting others and report experiencing failed relationships or marriages (deYoung, 1982; Russell, 1986) and having fewer friends (Gold, 1986). When it comes to parenting, fathers with CSA histories may view sexual abuse perpetration as a moral issue, which may interfere with their perceived parenting judgement (Price-Robertson, 2012). Finally, males tend to hold an agentic orientation of independent action and achievement that emphasizes the attainment of money, power, and advancement in their careers (Eddleston et al., 2006; Mainiero & Sullivan, 2006). CSA-related feelings of anger, vulnerability, grief, and helplessness (McLean & Gallop, 2003; Wohab & Ahkter, 2010) may

hinder their ability to maintain gainful employment. While there is a bidirectional relationship between adaptive functioning and psychological functioning (Aspinwall & Taylor, 1997; Buckner, Mezzacappa, & Beardslee, 2003; Carver & Scheier, 1998; Karoly, 1993; Vohs & Ciarocco, 2004), there is little research on adaptive functioning in males with CSA histories, which therefore was a focus of the current thesis. Additionally, psychological functioning is discussed in greater detail in the following sections, bearing in mind the interrelatedness of adaptive and psychological functioning.

Risk-taking Behaviours

Risky behaviours are a topic of concern in trauma research, especially in the realm of behaviours associated with risky sexual practices, illicit drug use, and alcohol abuse (e.g., Saladin, Brady, Dansky, & Kilpatrick, 1995; Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999; Davis, DeMaio, & Fricker-Elhai, 2004). CSA has been found to be associated with a number of such behaviours that compromise one's safety and place individuals at risk for re-victimization (Homma, Wang, Saewyc, & Kishor, 2012). Unsurprisingly, certain behaviours can have considerably severe medical, legal, and interpersonal consequences (Hunt, Hopko, Bare, Lejuez, & Robinson, 2006). Although research specific to adult males is scarce, several studies have generally found risk-taking behaviours that are unique and prevalent among males. Individuals who have experienced childhood abuse and neglect, particularly CSA, appear more likely to engage in high-risk sexual behaviours (Norman et al., 2012). This can lead to a wide range of sexually transmitted infections (Cohen, Mannarino, Berliner, & Deblinger, 2000; Hillis, Anda, Felitti, Nordenberg, & Marchbanks, 2000; Norman et al., 2012; Steel & Herlitz, 2005; Young, Deardorff, Ozer, & Lahiff, 2011). Using a random population sample in Sweden, Steel and Herlitz (2005) found that a history of CSA in males was associated with younger age at

first diagnosis of a sexually transmitted infection and a greater likelihood of participation in group sex. In a large retrospective study in the United States, the prevalence of sexually transmitted diseases was 3.5 times higher for males who were exposed to three to five adverse childhood experiences (e.g., sexual abuse, witnessing intimate partner violence), compared to adults who reported no adverse childhood experiences (Hillis et al., 2000). These findings suggest that males with maltreatment histories are more likely to engage in risky-sexual behaviours, some of which result in sexually transmitted infections.

Turning to substance use as another high-risk behaviour, its association with CSA has been well established in the research literature (Butt et al., 2011; DiIorio, Hartwell, & Hansen, 2002; Dube et al., 2005; Garnefski & Arends, 1998; Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Hamburger, Leeb, & Swahn, 2008; MacMillan et al., 2001; Schraufnagel, Davis, George, & Norris, 2010). Substance use is often viewed as a strategy to cope with the distress produced by childhood maltreatment (Briere & Runtz, 1993; Miller & Mancuco, 2004; Sarin & Nolen-Hoeksema, 2010). Briere and Runtz (1993) theorized that sustained drug and/or alcohol use allows individuals with histories of maltreatment to separate psychologically from the environment, cope with distressing internal states, and temporarily forget painful memories. The higher rates of substance use problems among adults with maltreatment histories may, in part, be due to an attempt to use substances to self-medicate from such trauma symptoms as anxiety, depression, traumatic stress symptoms, and intrusive memories (Whiting et al., 2009). Among males with CSA histories, substance use is often a notable concern (Chandy, Blum, & Resnick, 1996; Garnefski & Arendas, 1998). As previously discussed, CSA appears to impact the drinking behaviours of males, including earlier onset and higher rates of binge drinking. There also appear to be higher rates of illicit drug use (e.g., cocaine), compared to males without

CSA histories (Chandy et al., 1997; Garnefski & Arends, 1998; Hamburger et al., 2008; Luster & Small, 1997; Harrison, Edwall, Hoffman, & Worthen, 1990; Harrison, Fulkerson, & Beebe, 1997). Poly-substance use (defined as using multiple substances without a preference for one in particular) appears to be more common among males with CSA histories (Holmes & Slap, 1998). A systematic review of 18 studies that are composed of clinical and community samples of males with histories of CSA found further support for the association between CSA and substance use (Butt et al., 2011), suggesting earlier onset of alcohol consumption and increased substance use at an early age (i.e., alcohol and drugs). These findings suggest that this population appears to be at increased risk for engaging in binge drinking, illicit drug use, and polysubstance use.

Finally, there is an over-representation of suicidal ideation and attempts among males who report CSA (Cutajar et al., 2010b; Easton et al., 2014; Garnefski & Arends, 1998; Molnar et al., 2001; O'Leary & Gould, 2010; Perez-Fuentes et al., 2013), which seems likely to be a function of depressed mood (Nock & Kessler, 2006). Alloy, Abramson, Smith, Gibb, and Neeren (2006) found that hopelessness was a significant mediator between CSA and suicide ideation for both males and females. They noted that children who experience CSA may be more likely to attribute negative life events to internal causes than external ones, which may lead to a higher likelihood of hopelessness (Alloy et al., 2006). Molnar et al. (2001) also found a strong association between male CSA and suicidal behaviour, even after controlling for other types of childhood maltreatment (e.g., physical abuse) and non-maltreatment adversity (e.g., parental psychopathology). Findings indicated that the odds of a suicide attempt in males with CSA histories were 4-11 times greater than that for non-maltreated males. Taken together, these findings demonstrate that males with CSA histories struggle with suicidal ideation and are at greater risk of attempting suicide, which is associated with depression.

Internalizing Behaviour

Internalizing behaviour is defined as an over-controlled, inner-directed pattern of behaviour that can include symptoms of depression and anxiety (Compton, Burns, Egger, & Robertson, 2002). While those who experience CSA tend to have equally poor outcomes overall, retrospective studies suggest that females are more likely to internalize their problems while males tend to display greater externalizing behaviours (Briere & Elliott, 2003; Garnefski & Arends, 1998; Holmes, Offen, & Waller, 1997; Ullman & Filipas, 2005). Other studies, however, have found no sex differences (Paolucci et al., 2001; Yancey, Naufel, & Hansen, 2013) or have found that males with histories of CSA have significantly higher internalizing scores (Coohey, 2010; Garnefski & Diekstra, 1997; Gold, Elhai, Lucenko, Swingle, & Sellers, 1999). Overall, internalizing symptoms can be a significant problem for males with CSA histories and given the inconsistent findings, further research is needed to clarify this relationship. As such, examining internalizing behaviours among males with CSA histories was an objective of the present thesis.

Research has shown a strong association between depressive symptoms and CSA (Beitchman et al., 1992; Chen et al., 2010; Fergusson et al., 2013; Holmes & Slap, 1998; Maniglio, 2013; Neumann, Houskamp, Pollock, & Briere, 1996; Paolucci et al., 2001). In fact, depression appears to be one of the most frequently documented outcomes of CSA for both males and females (Bagley, Wood, & Young, 1994; Kendall-Tackett et al., 1993; Maniglio, 2013). CSA has also been associated with earlier onset of depressive episodes and with prolonged durations of depression (Zlotnick, Mattia, & Zimmerman, 2001). In their literature review of 166 studies, Holmes and Slap (1998) found that the rate of major depressive disorder among males with CSA histories was 65%, followed by PTSD at 25-30%. This finding

demonstrates the strong relationship between a history of CSA among males, clinical levels of depressive symptoms, and PTSD.

Additionally, anxiety has been found to be a common problem among males with histories of CSA, second only to depression (Black & Deblassie, 1993; Fergusson et al., 2013; Holmes & Slap, 1998; Valente, 2005). It is important to note that the majority of maltreatment-related outcome studies describe anxiety symptoms quite broadly. These symptoms could include those associated with PTSD which, until the DSM-5, was classified as an anxiety disorder. Therefore, I have included a separate section discussing PTSD as it relates to a history of CSA. Since sexual abuse generally constitutes an acute traumatic event, it can result in both immediate and long-term anxiety-related symptoms (Briere & Runtz, 1993). Males with CSA histories tend to exhibit higher levels of anxiety symptoms and/or disorders either immediately after the abuse or a number of years following the abuse experience (Black & DeBlassie, 1993; Briere & Elliott, 2003; Cutajar, Mullen, Ogloff, Thomas, Wells, & Sparato, 2010a; Maniglio, 2013; Holmes & Slap, 1998; Valente, 2005). In a longitudinal study which followed 535 boys with histories of CSA and 622 matched controls for four decades, males who experienced CSA were significantly more likely to be diagnosed with an anxiety disorder than those without such a history (Cutajar et al., 2010a). Several qualitative researchers have suggested that gender-specific CSA effects for males, such as internalizing disorders, can stem from impaired masculine identity, in addition to struggles with disclosure (O'Leary & Barber, 2008; Paine & Hansen, 2002; Young et al., 2007). Another proposed mechanism for increased internalized distress is that CSA causes disruptions in the development of a child's sense of self, leading to difficulty in relating to others as well as the inability to regulate reactions to stressful events, which can then result in anxiety-related thoughts (Molnar et al., 2001).

Externalizing Behaviour

Males with histories of CSA may also externalize or outwardly “act out” their distress (Romano & De Luca, 2001; Spataro, Moss, & Wells, 2001; Spataro et al., 2004). These males tend to score higher than males without histories of CSA on measures of externalizing behaviour (De Bellis et al., 1999; Hibbard & Hartman, 1992). These externalizing behaviours may be expressed in the form of anger and aggression, which were also specific psychological outcomes of interest in the present thesis.

Difficulties with anger are often reported by males with CSA histories, who may rely on anger to suppress vulnerable and “non-masculine” emotions such as fear, guilt, or self-blame (Crowder, 1995; Romano & De Luca, 2001). These males tend to score higher on measures of anger and irritability than do males without histories of CSA (Holmes & Slap, 1998). Individuals with histories of CSA often express anger toward the abuser for taking advantage of their vulnerability, toward other family members who perhaps should have protected them or known about the abuse, toward society, and toward themselves (Dhaliwal et al., 1996; Finkelhor, 1979; Karakurt & Silver, 2014; Romano & De Luca, 2001). Research has also consistently shown an association between childhood maltreatment and adult aggression (Bagley & Mallick, 2000; Calam, Horne, Glasgow, & Cox, 1998; Keiley, Howe, Dodge, Bates, & Pettit, 2001; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Widom, 1989), which is a common way of expressing angry feelings. There is evidence to suggest that, compared to males without CSA histories, those who have experienced CSA are more likely to struggle with aggression and criminal behaviour (Bergen, Martin, Richardson, Allison, & Roeger, 2004; Collings, 1995; Garnefski & Arends, 1998; Herrera & McCloskey, 2001; Lisak & Luster, 1994; Perez-Fuentes et al., 2013; Sigfusdottir, Bryndis, Asgeirsdottir, Gudjonsson, & Sigurdsson, 2008). Aggression

among males with histories of CSA can also be expressed through such behaviours as stealing as well as breaking and/or destroying property (McClellan, Adams, Douglas, McCurry, & Storck, 1995; Sigfusdottir et al., 2008). In a nationally representative sample of 8,618 Icelandic adolescents aged 16 to 20 years, Sigfusdottir et al. (2008) found that males with histories of CSA were significantly more likely to use physical violence and steal as compared to males without CSA histories, even after controlling for demographic and family violence variables. Taken together, these results suggest that males with histories of CSA tend to experience higher rates of anger and aggression, both of which can be expressed outwardly or through criminal behaviour.

Post-traumatic Stress Disorder (PTSD)

A conceptual change in the *DSM-5* for PTSD was its removal from the anxiety disorders category and placement in a new diagnostic category named *Trauma and Stressor-related Disorders* (American Psychiatric Association, 2013). This diagnostic category is distinctive among psychiatric disorders in the requirement of exposure to a stressful event (e.g., war, sexual assault, threat of violence) as a precondition. Additionally, the *DSM-5* symptom groups are intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity (American Psychological Association, 2013). Three new symptoms were added to the PTSD criteria in the *DSM-5*: persistent negative emotional state; persistent distorted cognitions about the cause or consequences of the trauma leading to blame of self or others; and reckless or self-destructive behaviour (Pai, Suris, & North, 2017).

As CSA represents a traumatic experience, it is often considered within the context of PTSD, which is a common outcome among males with histories of CSA (Cutajar et al., 2010a; Fergusson et al., 2013; Holmes & Slap, 1998; Tolin & Foa, 2006). In a study that randomly selected participants from the general population of Ireland, results indicated that almost half of

male respondents (49%) reported a history of contact or non-contact sexual abuse under the age of 17 (McGee, Garavan, de Barra, Byrne, & Conroy, 2002). Of these males, 1 in 6 reported having experienced symptoms consistent with a diagnosis of PTSD at some time in their lives following their experience of maltreatment.

Although it is imperative to capture all forms of maltreatment and non-maltreatment adversity to examine the potential impact of co-occurring victimizations on long-term maltreatment effects (Finkelhor et al., 2007), research does suggest unique outcomes associated with CSA. In a recent study by Turner et al. (2017), findings suggested that the lack of a significant difference between experiencing CSA only and CSA along with other types of child maltreatment may indicate that CSA has a particularly detrimental impact on mental health outcomes, as compared to other types of maltreatment. Other studies have also found that CSA on its own has a strong relationship with mental disorders; however, these studies only measured one or two other types of maltreatment (Briere & Elliott, 2003; Molnar et al., 2001). Focusing research on only one type of maltreatment arguably overlooks the effects of experiencing chronic and multiple types of abuse and neglect (Bromfield, Gillingham, & Higgins, 2007; Easton, 2013; Perez-Fuentes et al., 2013), known as multiple victimization. Without assessing chronicity and the effects of other maltreatment types, erroneous conclusions might be made about the specific impact of one form of maltreatment (Bromfield et al., 2007; Higgins & McCabe, 2001). For instance, in a study of 187 adolescent outpatients, those who had experienced both sexual and physical abuse reported greater PTSD symptoms than youth who had experienced only one form (Naar-King, Silvern, Ryan, & Sebring, 2002). In addition, several nationally representative studies have found that the relationships between individual traumas (e.g., sexual abuse) and trauma symptomatology are eliminated or significantly weakened when multiple victimization is

taken into account (Finkelhor, Ormrod, Turner, & Hamby, 2005; Finkelhor, Ormrod, & Turner, 2009a). Individuals who experience multiple victimization are more likely to experience higher levels of trauma symptoms and worse outcomes as adults than those who are exposed to no or only one type of maltreatment (Finkelhor et al., 2007; Higgins & McCabe, 2001; Richmond, Elliot, Pierce, Aspelmeier, & Alexander, 2009).

Individuals who experience CSA also tend to experience additional forms of victimization and are at increased risk for traumatic symptomatology, and this is likely because exposure to a number of adversities places greater demands on a child's coping resources (Finkelhor et al., 2007; Lyons & Romano, 2019). Moreover, in environments characterized by multiple adversities, individuals who experience CSA might have limited resources to address and end the sexual abuse, resulting in more severe and chronic victimization (Easton, 2013; Lyons & Romano, 2019). These findings underscore the importance of taking into account the cumulative and interactional effects of various childhood adversities in order to truly understand specific abuse-related impacts (Finkelhor et al., 2007).

Research Objectives and Hypotheses

The current study built on the limited research on male CSA by addressing several gaps. A prominent and consistent gap is that most studies have not focused exclusively on males. Given that many studies on CSA employ mixed-sex samples or targeted male populations (e.g., abused males who are offenders), the current study contributed to the CSA literature by focusing on a community-based sample of adult males. As such, the first research objective was twofold: 1) to examine CSA characteristics among a sample of Canadian males (e.g., age of onset, disclosure experiences, perpetrator profiles) and 2) to expand upon the limited examination of CSA effects within the context of co-occurring maltreatment (i.e., physical abuse, neglect,

emotional abuse, and neglect) and non-maltreatment childhood adversities (e.g., parental divorce, parental health impairments). I hypothesized that males with histories of CSA would report greater maltreatment and non-maltreatment adversities, as compared to non-CSA males. The second research objective also had two parts: 1) to understand more comprehensively the impact of CSA in males across various areas of psychological functioning (e.g., depression, anxiety, stress, dissociation, anger, PTSD), both from a self-report and clinician-administered perspective and 2) to examine the impact of CSA in males across adaptive functioning (e.g., friendships, family, employment). I hypothesized that males with CSA histories would report greater impairments in both psychological and adaptive functioning, compared with the non-CSA group. More specifically, I anticipated that males in the CSA group would have a greater number of clinical diagnoses and would report poorer functioning across each domain of psychological functioning, compared to males in the non-CSA group.

Another gap in the research literature concerns the limited examination of CSA effects within the context of co-occurring maltreatment (i.e., physical abuse, neglect, emotional abuse, and exposure to intimate partner violence) and non-maltreatment adversities (e.g., parental divorce, parental health impairments). As such, the third research objective was to understand the possible unique impact of male CSA on psychological functioning after controlling for other types of maltreatment and non-maltreatment adversities. I hypothesized that there would be a significant relationship between CSA and psychological functioning after controlling for these other adversities. Although past research has investigated the link between CSA and psychological functioning, another gap in the literature is that there has been limited attention to broader areas of functioning. Therefore, the fourth research objective was to investigate CSA in relation to other areas of functioning, such as domains of adaptive functioning (e.g., friendships,

family, employment), after controlling for other types of maltreatment and non-maltreatment adversities. I hypothesized that there would be a significant relationship between CSA and adaptive functioning after controlling for these other adversities.

Method

Participants

Data collection for this study began in March 2018 and ended in February 2019. A total of 73 adult males with CSA histories, as well as 40 non-CSA adult males, were recruited and consented to participate in the study. Of these, four participants with a history of CSA were excluded because they did not meet the study's inclusionary criteria, namely a) they endorsed having a sexual experience *after* the age of 16 years and/or b) their experiences met the Criminal Code of Canada's definition for *consensual* sexual activity (i.e., sexual experiences between the ages of 14-15 years with individuals less than five years older where there was no relationship of authority, trust, or dependency).

The study focused on adult males aged 25-60 years old. This age limit was chosen because one of the primary measures of psychological and adaptive functioning, the Adult Self-Report (Achenbach & Rescorla, 2003), was normed on adults aged 18-59 years. Additionally, the age range helped ensure that retrospective CSA reporting was not too far removed from the present time. Although there were three males aged 60 years, they were retained for the study because Achenbach and Rescorla (2003) note that there is flexibility in the ASR for individuals approaching the age cut-offs. In the end, a total of 109 males completed the study - 69 males with a history of CSA and 40 non-CSA males.

Measures

Socio-demographic and background information. Participants provided information

on socio-demographics (e.g., age, race, marital status, educational level) and background variables that are important among adults with a history of maltreatment, including physical health (Daigenault, Vezina-Gagnon, Bourgeois, Esposito, & Hebert, 2017) and criminal/violent behaviour (Wolff & Shi, 2012; see Appendix A).

Childhood maltreatment and adversity.

Childhood trauma (non-sexual). Participants completed the *Childhood Trauma Questionnaire (CTQ)* (Bernstein & Fink, 1998), a 28-item self-report retrospective inventory of childhood maltreatment experiences. The CTQ (see Appendix B) contains five subscales, three assessing abuse (i.e., emotional, physical, and sexual) and two assessing neglect (i.e., emotional and physical). The current study utilized this measure to assess for non-sexual abuse and neglect since sexual abuse was measured in depth using the SVS (see below). Each item is rated along a 5-point scale from 1 (*never true*) to 5 (*very often true*), and subscale scores can range from 5 to 25, with higher scores indicating greater severity of maltreatment experience. Sample items include: “*People in my family said hurtful or insulting things to me*” and “*My parents were too drunk or high to take care of the family.*” The CTQ is a psychometrically-sound measure of childhood abuse (e.g., Forde, Baron, Scher, & Stein, 2012; Spinhoven, Penninx, Hickendorff, van Hemert, Bernstein, & Bernet, 2014) that has been normed on community adults with childhood trauma as well as on adolescent psychiatric inpatients. Internal consistency coefficients across the five maltreatment types have been found to range from .79 to .94 (Bernstein & Fink, 1998). The CTQ has also demonstrated good test-retest reliability over a 2- to 6-month period, with an intra-class correlation of .88 in a mixed-sex community sample (Bernstein & Fink, 1998). In the current sample of 109 males, the internal consistencies ranged from acceptable ($\alpha = .79$; emotional neglect) to excellent ($\alpha = .91$; physical abuse). Among

males with histories of CSA, the internal consistencies ranged from good ($\alpha = .81$; emotional neglect) to excellent ($\alpha = .91$; physical abuse), and a similar trend was shown for the internal consistencies among males without histories of CSA (acceptable; $\alpha = .79$; emotional neglect) to excellent $\alpha = .90$; physical abuse).

Childhood sexual abuse. Participants completed the *Sexual Victimization Survey (SVS*; Finkelhor, 1979; see Appendix C) to determine whether they had experienced CSA and, if so, to gather more detailed information about their CSA history. The current study used an adapted version of the SVS (Lyons & Romano, 2019) to address limitations from past studies, which generally have examined only the most severe experience. To understand the possible multiple sexual abuse experiences of males and to avoid assuming that the most severe experience is the earliest one, the adapted SVS provides an opportunity for participants to describe up to three sexually abusive experiences before the age of 16 years with different perpetrators. For each sexual abuse experience, participants provided information on the type of sexual act(s), characteristics of the perpetrator(s), age of abuse onset, frequency, duration, and disclosure experiences. In addition, a 5-item Likert scale ranging from 1 (*very distant*) to 5 (*very close*) was added to the SVS to measure perceived emotional closeness to the perpetrator prior to CSA onset (Schultz, Passmore, & Yoder, 2000).

The SVS asks participants to identify their sexual experiences prior to age 16 from a list of 10 sexual acts. Participants are also asked to answer additional questions on a maximum of three sexual experiences prior to the age of 16. For each experience, the same set of questions is asked, namely: *Now we would like you to think of sexual experiences you had before the age of 16 with a family member or relative, including cousins, uncles, aunts, brothers, sisters, grandparents, mother or father, or a guardian or close friend of a parent*). For each sexual

experience that participants endorse, the SVS provides follow-up questions, including the duration and frequency of the abuse, age of onset, perpetrator characteristics, the sexual acts involved, whether the perpetrator used threats of or actual physical force, and disclosure experiences.

Despite the widespread use of the SVS, there is limited research on its psychometric properties. However, recent research found that the SVS possessed high inter-rater reliability (92.7%) on sexual abuse status (abused/not abused) and on abuse characteristics (e.g., duration, age of onset; 94.3-99.3%) in a sample of 227 adult males with CSA histories from Canada and the United States (Lyons & Romano, 2019). Findings also indicated that the SVS had fair concurrent validity with the sexual abuse subscale of the Childhood Experiences of Violence Questionnaire (Walsh et al., 2008) in terms of abuse status, with a kappa value of .39 (Lyons, 2018). Finally, in terms of test-retest reliability, 100% of males who initially reported CSA continued to endorse having experienced CSA one week later, along with similar abuse characteristics (kappa values of .78-1.00 for abuse characteristics; Lyons & Romano, 2019). In accordance with the Criminal Code of Canada (Criminal Code, 1985; Department of Justice, 2004) and Canadian child protection laws (Trocmé et al., 2010), the present study defined CSA as any contact or non-contact sexual experience before the age of 16 years with an individual in a relative position of authority, trust, or dependency (e.g. parent, coach, babysitter) or sexual activity that exploits the younger person. Sexual activity was considered exploitative based on the nature and circumstances of the relationship (e.g., age of the child, age difference between the child and perpetrator). Sexual experiences occurring between the ages of 14-15 years with individuals less than five years older or occurring between the ages of 12-13 years with individuals less than two years older, where there was no relationship of authority, trust, or

dependency, were not considered sexually abusive.

The variability in reported childhood sexual experiences among participants, including accounting for sexual interactions with same-aged peers, posed a challenge to coding experiences as abusive or not. Sexual exploration and sexual play are considered developmentally healthy processes that can occur before and during puberty (Cavanaugh-Johnson, 1999). Research has highlighted that normative (or expected age appropriate) sexual behaviours are not overtly sexual, are more exploratory and playful in nature, are not hostile, aggressive, or hurtful to others, and do not involve others in a way that is non-consensual (Cavanaugh-Johnson, 1999). Within the current study, same-aged (including developmental stage) sexual experiences with peers were only considered sexually abusive if a) the participant endorsed sexual acts that are beyond what we might consider explorative for their age (e.g., anal intercourse prior to age 12); b) the participant reported that physical harm, violence, or threats were used as a method of coercion; and/or c) the participant indicated not having consented to the experience.

Non-maltreatment adverse childhood experiences. The non-maltreatment adverse childhood subscale of the *Childhood Trauma and Adversity Scale* (Turner, Finkelhor, & Ormrod, 2006; see Appendix D) was used to assess lifetime non-maltreatment adverse childhood events. Items include non-maltreatment traumas (e.g., serious illnesses, accidents, natural disasters) and more chronic adversities (e.g., caregiver substance abuse, bullying). Each of the 15 items is rated as yes or no, and a total score is calculated. The internal consistency was acceptable for males with histories of CSA ($\alpha = .75$), and for males without histories of CSA ($\alpha = .77$).

Psychological functioning (self-report).

Depression. Participants completed the *Beck Depression Inventory (BDI-II)*; Beck, Steer, & Brown, 1996; see Appendix E), that is composed of 21 groups of statements assessing such areas as hopelessness and loss of interest. For each group of statements, participants choose the one that best describes the way they have been feeling for the past two weeks. The statements are scored on a 4-point scale. A total score was computed by summing all 21 responses; scores can range from 0 to 63 where lower scores indicate fewer depressive symptoms. Clinical cut-offs also exist for this measure: scores of 0-13 indicate minimal depression; scores of 14-19 indicate mild depression; scores of 20-28 indicate moderate depression; and scores of 29-63 indicate severe depression. The BDI-II has been found to have excellent internal reliabilities of $\alpha = .92$ for outpatients and $\alpha = .93$ for non-clinical samples, and test-retest reliability was also excellent over a 1-week period in a mixed-sex community sample ($\alpha = .93$; Beck et al., 1996). In the current sample, the internal consistency was excellent for both males with histories of CSA ($\alpha = .96$), and those without histories of CSA ($\alpha = .94$).

Anxiety and stress. The *Depression, Anxiety, and Stress Scale (DASS-42)*; Lovibond & Lovibond, 1995; see Appendix F) is designed to measure the severity of the core symptoms of depression, anxiety, and stress in the past 7 days. Given that typical depression symptoms, such as sleep, appetite, and sexual disturbances are not covered by the DASS-42, the BDI was used to examine symptoms of depression. Subsequently, only the anxiety and stress subscales were used in the current study. There are 28 anxiety and stress items (out of 42 questions for the full scale) rated on a 4-point scale from 0 (*did not apply to me at all over the past week*) to 3 (*applied to me very much or most of the time over the past week*). Reliability of the anxiety and stress scales ranges from acceptable to good, with $\alpha = .79$ for anxiety and $\alpha = .81$ for stress (Lovibond & Lovibond, 1995). Within the current sample, the internal consistency was excellent for males

with histories of CSA ($\alpha = .91$ for anxiety and $\alpha = .98$ for stress) and those without histories of CSA ($\alpha = .92$ for anxiety and $\alpha = .95$ for stress). The following clinical cut-offs also exist for this measure: scores of 0-7 for anxiety and 0-14 for stress indicate a normal range; scores of 8-9 for anxiety and 15-18 for stress indicate mild severity; scores of 10-14 for anxiety and 19-25 for stress indicate moderate severity; scores of 15-19 for anxiety and 26-33 for stress are considered severe; and 20+ for anxiety and 34+ for stress are considered extremely severe.

Anger. Participants completed the *State Trait Anger Expression Inventory-2 (STAXI-2;* Spielberger, 1999; see Appendix G) to measure trait anger, state anger, and anger expression. The STAXI-2 is a 57-item self-report measure using a 4-point Likert scale. The first part of the STAXI-2 is the state anger (SANG) scale. It consists of 15 items measuring how intensely an individual experiences anger. For the state anger items, the anchors are 1 (*not at all*) and 4 (*very much so*). For all other scales, the anchors are 1 (*almost never*) and 4 (*almost always*; see Appendix X). The state anger scale consists of three subscales: state anger / feeling angry (SANGF); state anger / feel like expressing anger verbally (SANGV); and state anger / feel like expressing anger physically (SANGP). The second part of the STAXI-2 is the trait anger (TANG) scale. This scale consists of 10 items measuring an individual's proneness to experiencing angry feelings. The trait anger scale consists of two subscales: trait anger / angry temperament (TANGT) and trait anger / angry reaction (TANGR). The final part of this inventory measures the ways in which an individual expresses and controls anger. These anger expression and control scales consist of 32 items and are classified as follows: anger expression-out (AX-O) scale; anger expression-in (AX-I) scale; anger control-out (AC-O) scale; anger control-in (AC-I) scale; and anger expression index (AX). The current study focused on scores for the three broad scales: state anger; trait anger; and anger expression and control. Raw scale

scores are converted into percentiles and are categorized into the following cut-offs: low = < 25%; moderate = 25%-75%; and high = > 75%.

The STAXI-2 has been normed separately for males and females across three different age groups. Internal consistency for the three broad scales in adult male community samples ranged from acceptable to good and were found to be as follows: AX-O ($\alpha = .74$); AX-I ($\alpha = .77$); State anger ($\alpha = .82$), and trait anger ($\alpha = .84$); Spielberger, 1999). In the current sample, among males with histories of CSA, the internal consistencies among the three broad scales ranged from acceptable (AX-O/AX-I; $\alpha = .74$) to good (Trait anger; $\alpha = .82$). For males without histories of CSA, the internal consistencies among the three broad scales also ranged from acceptable (AX-O/AX-I; $\alpha = .79$) to good (Trait anger; $\alpha = .85$). Research has found strong evidence for the relationships between the STAXI-2 anger subscales and other measures of hostility and personality (e.g., Buss-Durkee Hostility Inventory; Eysenck Personality Questionnaire), which supports the convergent validity of the STAXI-2 (Spielberger, 1999).

Dissociation. The *Dissociative Experiences Scale (DES-II)*; Bernstein & Putnam, 1986; see Appendix H) measures various dissociation types, including both problematic dissociative experiences and normative dissociative experiences (e.g., day-dreaming). Participants respond to 28 questions related to experiences that they may have in their everyday life (and not while under the influence of drugs or alcohol) on a scale ranging from *0% of the time* to *100% of the time*. The total DES score is the average of all responses so the minimum score is 0 and the maximum is 100. Scores for each question are calculated by dropping the zero on the percentage of each answer (e.g., 30% = 3) and then summing each item score. The total score is then multiplied by 10 and divided by 28 (the number of questions) to calculate a participant's average score. High levels of dissociation are indicated by scores of 30 or more. The DES-II has been found to have

good test-retest reliability over a 1-week period ($r = .84$) as well as excellent internal consistency ($\alpha = .92$; Bernstein & Putnam, 1986). Males with histories of CSA and those without histories of CSA both had excellent internal consistency ($\alpha = .95$ and $\alpha = .96$, respectively).

Resilience. The *Resilience Scale for Adults (RSA)* (Friborg, Hjembal, Rosenvinge, & Martinussen, 2003; see Appendix I) was used to evaluate the following six dimensions of resilience in adults: (1) Perception of the self; (2) Planned future; (3) Social competence; (4) Family cohesion; (5) Social resources; and (6) Structured style. Participants are asked to rate 33 items along a 7-point scale from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores indicate higher levels of resilience factors. The current study focused on the total resilience score. The RSA is a reliable measure that has demonstrated stability (test-retest Pearson $r = .80$) and good internal consistency ($\alpha = .84$). The internal consistencies for males with histories of CSA ($\alpha = .96$), and males without histories of CSA ($\alpha = .93$) were excellent.

Adaptive functioning. The *Achenbach System of Empirically Based Assessment - Adult Self-Report for Ages 18 – 59 (ASR)* (Achenbach & Rescorla, 2003) examines emotional, social, and behavioural functioning over the past six months. Given that most of the questions in the ASR were addressed through individualized measures in the current study, analyses focused only on information from the following six adaptive functioning scales: *Friends*; *Spouse/Partner*; *Family*; *Job*; *Education*; and *Personal Strengths*. For the *Friends* scale, participants are asked questions about the number and quality of friendships (e.g., *About how many close friends do you have?*), and similarly for the *Family* scale, participants are asked about family composition and the quality of each of their existing relationships (e.g., *How well do you get along with your brother(s)?*). For the *Spouse/Partner*, *Job*, and *Education* scales, participants are asked to rate statements on a 3-point scale from 0 (*Not True*) to 2 (*Very True or Often True*). The *Friends* and

Family scales are scored for all participants; however, the Spouse/Partner, Job, and Education subscales are scored only for participants for whom the items are relevant at any time in the preceding 6 months. Higher scores indicate better adaptive functioning. I also examined the listed number of concerns (i.e., number of worries across life domains) and personal strengths (i.e., things that participants liked about themselves) for each participant. Using a nationally representative U.S. mixed-sex sample of clinical and non-clinical adults, the ASR showed acceptable to good test-retest reliability over a one-week period, with r ranging from .71 (Job) to .85 (Spouse/Partner) across all adaptive subscales (Achenbach & Rescorla, 2003). The internal consistencies for the ASR adaptive functioning scales were good in the current sample for both males with histories of CSA and males without histories of CSA, with numbers ranging from $\alpha = .84$ (Spouse/Partner) to $\alpha = .87$ (Friends).

Psychological functioning (clinician-administered).

Clinical diagnoses. The *Structured Clinical Interview for DSM-5 (SCID-5*; First, Williams, Karg, & Spitzer, 2015) is a semi-structured diagnostic interview that assesses the DSM-5 diagnoses most commonly seen in clinical settings, such as depressive disorders, substance use disorders, anxiety disorders, and PTSD (First, et al., 2015). In the current study, the following SCID-5 modules were administered to participants: Psychosis (rule-out); Mood episodes with specifiers; Anxiety disorders; Substance use disorders; and Trauma-related disorders. Participant information on each symptom item were written down and in great detail to ensure that clinical cut-offs could be discussed and reviewed to consensus by the study research team if there were any discrepancies.

Procedure

This study was part of a larger research project examining psychological and affective functioning in males with CSA histories and incorporating neuroimaging techniques. Data for my two studies were collected simultaneously prior to participants completing the neuroimaging portion. The larger project was approved by the Office of Research Ethics and Integrity at the University of Ottawa and the Research Ethics Board (REB) at the Royal Ottawa Mental Health Centre (see Appendix J for a copy of the ethics approval).

All participants were recruited via multiple sources. Males with CSA histories were recruited through websites offering resources and information for this population, such as menandhealing.ca. Individuals at these organizations agreed to post study notices that explained the purpose of the study, outlined eligibility criteria and participation requirements, and provided my email address and phone number (see Appendix K for the recruitment poster). Study posters were also placed in community-based organizations that serve this population (e.g., Catholic Family Services, Centre for the Treatment of Sexual Abuse and Childhood Trauma) and in community-based mental health agencies more broadly (e.g., Centre for Psychological Services and Research). Finally, males for both CSA and non-CSA groups were recruited through social media platforms, such as Facebook and Kijiji. On each of these social media sites, a study website was created wherein individuals had access to the study poster and to the contact information for the primary investigator (J. Moorman).

Interested individuals were invited to contact the primary investigator using the email and/or phone number provided on the study notice. I assessed eligibility criteria via a brief telephone screener (approximately 15 minutes; see Appendix L) with each participant. All participants had to be: (a) male; (b) between the ages of 25-59; (c) fluent in English; and (d) currently residing in Ottawa or surrounding regions (as the current study was conducted in-

person). I assessed for eligibility and provided each participant with the Criminal Code of Canada definition of childhood sexual abuse. Based on how participants answered the formulated sexual experiences item (e.g., Do you have a history of childhood sexual abuse?; Have you ever had a sexual experience before the age of 16 with someone who was not your same-aged peer?), participants were either grouped into the CSA or non-CSA group. If males did not meet eligibility criteria, they were thanked for their interest, and a rationale was provided for their ineligibility. For eligible participants, an overview of procedures for both my studies was provided, as well as information about the neuroimaging component. Verbal consent was obtained, and an in-person meeting was scheduled.

I met with all participants with the exception of 13 non-CSA participants who met with another trained research assistant who was involved in the project. Given the lengthy data collection process, as well as the necessity of scheduling in-person sessions at the University of Ottawa at times that were most convenient for them (e.g., after work), my research assistant was able to provide and meet with non-CSA males during the same times that I was testing CSA participants. My research assistant was a senior clinical colleague, who received similar training as myself on the measures used in the study, particularly the SCID-5. Disagreements were few between myself and my colleague, but if there was uncertainty related to a clinical diagnosis on the SCID-5, we reviewed the detailed symptom information together and agreed on a consensus as to whether a particular disorder met criteria cut-offs. Additionally, my clinical supervisor provided an additional measure of fidelity to ensure that participant psychological outcomes were agreed upon. During the 3-hour data collection session, participants first provided written informed consent (see Appendix M), following which they completed a questionnaire package and a diagnostic interview. Participants were informed of their right to omit any questions they

did not wish to answer or to withdraw completely from the study. To control for reading ability, participants were given the option of having the research assistant read the questionnaire items aloud. At the end of the session, participants were provided with a list of mental health resources and distress lines that they could access in the event of any discomfort resulting from study participation (see Appendix N). Participants received \$40 at the end of the session. I also informed them that I would contact them in two days as a check-in to address any potential feelings of distress. Finally, a second session was scheduled with participants within one week of the first session in order to complete the additional measures for Study 2.

Data Analysis

Data analyses were carried out using the Statistical Package for the Social Sciences (SPSS) computer program (version 25.0). An a priori power calculation was conducted using G*Power 3.1 to estimate the required sample size for adequate statistical power for chi-squared, univariate and multivariate t-tests, and a one-way MANCOVA analysis (Faul, Erdfelder, Lang, & Buchner, 2007). While G*Power cannot calculate power for kappa, it can accommodate chi-squared analyses, which is a similar statistic that describes the relationship between two categorical variables. Based on past studies (Shchupak, 2015), a large effect was expected. With a final sample of 109, based on initial estimates, there was adequate statistical power ($1 - \beta = .91$) to detect a medium to large effect using a .05 alpha probability level.

Missing data. Prior to analyses, the independent (CSA, non-CSA, forms of maltreatment, non-maltreatment childhood adverse experiences) and dependent variables were examined for missing values and for univariate and multivariate outliers. The dependent variables included psychological (BDI, DASS, STAXI, DES, RSA, SCID-5) and adaptive functioning (ASR domains). The rate of missing data across the independent and dependent

variables was low (1.2%). A little MCAR test revealed that the data were missing completely at random ($\chi^2 = 6073.91$, $df = 7023$, $p = .71$). The low rate of missing data was attributed to the in-person nature of data collection which gave participants the opportunity to ask questions at any time during the session, to take their time in completing the questionnaire package, and to have a research assistant help with reading if there were literacy issues. Due to the relatively small number of missing data, Expectation Maximization was used to impute missing data instead of mean substitution or multiple imputation (Dong & Peng, 2013). There were no multivariate outliers according to the Mahalanobis distance ($p < .001$). The dataset was checked for normality using skewness and kurtosis values, and values > 3.29 were considered problematic (Tabachnick & Fidell, 2007). In order to check the normality of dichotomous variables, Tabachnick and Fidell (2007) recommend examining dichotomous variables for uneven splits, with more than a 10-90 split indicating non-normality. In the current sample, all dichotomous variables (i.e., CSA/Non-CSA, types of maltreatment, SVS abuse characteristics) were normal.

Prior to conducting the one-way Multivariate Analysis of Covariance (MANCOVA), data screening was conducted. No univariate or multivariate within-cell outliers were found at $\alpha = .001$. Assumptions of linearity, normality, homogeneity of the variance-covariance matrices, and multicollinearity were all tested and found to be satisfactory so as to proceed with the analyses. Additionally, no univariate or multivariate outliers were found at the $p < .001$ level, and homogeneity of regression was established overall. Finally, covariates were judged to have adequate reliability for the covariance analysis using Miller and Chapman's (2001) model. Once data screening was complete, the one-way MANCOVA was performed. Given that this was a novel study that made use of a multi-method approach to analyzing psychological and adaptive

functioning between CSA and non-CSA males, alpha levels were not adjusted according to the number of comparisons. The significance level for all analyses was therefore set at $p < .05$.

In the current study, data were analyzed in two different ways. First, I compared the CSA and non-CSA groups on socio-demographics as well as on maltreatment and adversity experiences (research objective 1). Independent (univariate) samples t-tests and chi-squared analyses examined potential group differences on socio-demographic information. For t-tests, Cohen's d effect sizes were also examined where .2 was small, .5 was medium, and .8 was large. Cramer's Φ assessed effect sizes for the chi-squared analyses, where .10 was small, .30 was medium, and .50 was large. Next, males in the CSA and non-CSA groups were compared on psychological (self-report and clinician-administered) and adaptive functioning outcomes (research objective 2). Here, males' scores, across both groups, on the SCID-5 (i.e., whether diagnostic criteria were met) were used to determine rates of prevalence for certain diagnoses.

For purposes of the second part of my analyses, however, SCID-5 diagnoses were analyzed using a symptom count procedure (i.e., how many symptoms of a particular disorder were endorsed by males) rather than a dichotomous yes/no variable category (i.e., whether males met diagnostic criteria). I conducted multivariate t-test equivalent analyses for the self-report measures to control for the assumed overlapping of measurement within the scales, chi-squared analyses for clinician-administered measures, and t-tests for self-report adaptive functioning measures. In addition, partial eta squared (η^2) was examined for multivariate t-test equivalents to examine effect sizes, where .01 was small, .06 was medium, and .14 was large. Last, one-way MANCOVA analyses were conducted to compare males in the CSA and non-CSA groups on psychological and adaptive functioning, controlling for additional forms of maltreatment and

non-maltreatment adverse childhood experiences, as well as significant socio-demographic variables (i.e., level of education and total household income; research objectives 3 and 4).

Results

Childhood Sexual Abuse Characteristics

Prior to considering differences between CSA and non-CSA groups, it was important to highlight characteristics of males' CSA experiences in the current sample. To address part one of the first research objective, Table 1 describes CSA characteristics among 69 males who reported a CSA history. On average, males reported 1.7 different CSA experiences ($SD = 0.8$) out of a possible 3. Slightly more than half (52.2%) reported only one CSA experience, followed by 29.0% who reported two experiences and 20.3% who reported three CSA experiences. Males reported being, on average, 8.5 years old ($SD = 2.7$, range= 5-15) when their sexual abuse began. Most males (29.0%) indicated that their CSA experiences occurred over a period of a few years, followed by a period of a few months (27.5%) and once or just a few days (21.8%). In terms of frequency, most males (26.1%) reported that their CSA experiences happened on 3-10 different occasions, followed equally by the abuse occurring once or twice (23.2%) and between 26-50 times (23.2%). The majority of males experienced CSA by male perpetrators (78.3%), with most (39.1%) reporting that the perpetrator was an older adult between 31-59 years of age, followed by a young adult 19-30 years old (26.1%) and an adolescent (aged 12-18; 26.1%). The most common relationship with the perpetrator was reported to be a caregiver's friend/acquaintance (17.4%), followed by a cousin (14.5%), stranger (11.6%), and uncle (10.1%).

In examining disclosure variables, the majority of males (62.3%) had disclosed at least one of their CSA experiences. Of those who did disclose, the average age of first disclosure was 21.9 years old ($SD = 9.5$, range 6-53), with the length of time between abuse onset and first

disclosure averaging 13.6 years ($SD = 9.4$, range = 0-46). Most males (43.5%) reported disclosing to their mother, followed by a sibling (30.4%), a trusted individual (therapist, adult partner; 30.4%), or a friend (20.3%). Following the CSA disclosure, most males (51.2%) reported that they felt supported by the individual. However, a number of males indicated that they were not believed (25.6%) or that they had received mixed messages (11.6%). For example, several males reported that “my therapist believed me but said that they did not work with people with abuse histories” or “my friend said ‘sorry’ and then tried to change the subject.”

Socio-demographic Characteristics Across CSA and Non-CSA Groups

Table 2 outlines the socio-demographic characteristics of participants by group (CSA and non-CSA). The average age was 39.7 years old ($SD = 10.9$) for males in the CSA group and 36.1 years old ($SD = 9.4$) for males in the non-CSA group; the age difference was not statistically significant. According to the 2016 Canadian census data (Statistics Canada, 2019), the average age of the male population in Ottawa is 39.2 years old and 40.0 years old for Ontario, which is comparable to the study’s mean age of 37.9 years old.

Across the CSA and non-CSA groups, there was no statistically significant difference on racial background, with the majority of participants in both groups reporting to be White (75.4% and 82.5%, respectively). These findings are comparable to the 2016 Canadian census data (Statistics Canada, 2019), which found the predominant racial group in Ottawa and Ontario as a whole is White (74.2% and 68.3% respectively). In terms of marital status, there were no significant differences between the two groups, with the majority of males reporting being married or living with a partner (CSA = 43.5%; non-CSA = 50.0%). The 2016 Canadian census data show that 58.3% of males over the age of 15 years old in Ottawa and 59.3% of males over the age of 15 years old in Ontario are married or living with a common law partner (Statistics

Canada, 2019), and this percentage was higher than the average percentage for males in the current study's total sample (46.7%).

There was a statistically significant difference between the CSA and non-CSA group with regard to education level ($\chi^2(7) = 2.3, p = .032$). Follow-up analyses showed that the difference was in terms of high school completion ($t(107) = 2.9, p = .041$). The percentage of males whose highest level of education achieved was high school was greater for the CSA group (49.3%) than for the non-CSA group (27.5%), and the effect size was medium (Cohen's $d = .04$). Compared to the 2016 Canadian census data which show that 62.8% of males in Ottawa and 71.2% of males in Ontario have a postsecondary certificate, diploma, or degree (Statistics Canada, 2019), only 44.5% of males in the CSA group and 55% of non-CSA males reported having completed post-secondary education.

The majority of males in both the CSA (63.8%) and non-CSA (65.0%) groups reported working outside the home, and the difference between groups was not statistically significant. Finally, there was a significant difference between the two groups in terms of total household income ($\chi^2(3) = 2.6, p = .043$). Specifically, a greater percentage of males in the CSA group (31.9%) reported their income to be between \$30,000 and \$59,000, compared to males in the non-CSA group (17.5%; $t(107) = 2.1, p = .037$). This effect size was small (Cohen's $d = .03$). In looking at average yearly income, males with histories of CSA (\$39,750) and males without histories of CSA (\$47,284) had a slightly lower year salary as compared to males in Ottawa (\$52,684) and in Ontario (\$48,443; Statistics Canada, 2019).

Maltreatment and Other Adverse Childhood Experiences Across CSA and Non-CSA Groups

To address the second part of the first research objective about potential differences between males with and without histories of CSA on co-occurring maltreatment and non-maltreatment experience, independent t-tests and chi-square analyses were conducted. Table 3 shows that CSA males reported having experienced at least one additional form of maltreatment while growing up ($M = 1.2$, $SD = 0.6$). This was significantly higher than males in the non-CSA group, who reported having experienced less than one form of maltreatment ($M = .93$, $SD = .3$; $t(107) = 2.6$, $p = .013$). This difference represented a medium effect (Cohen's $d = .06$). For specific maltreatment types, there was a statistically significant difference on physical abuse ($\chi^2(1) = 5.6$, $p = .011$). The frequency was higher for the CSA group (68.1%) than for the non-CSA group (20.0%), and the effect size was small (Cramer's $\Phi = .23$). There was also a statistically significant difference on emotional abuse ($\chi^2(1) = 20.9$, $p = .001$). The frequency was higher for the CSA group (43.5%) than for the non-CSA group (2.5%), and the effect size was medium (Cramer's $\Phi = .44$).

For non-maltreatment adverse childhood experiences, the mean number experienced by CSA males ($M = 6.7$, $SD = 3.0$) was significantly higher than for non-CSA males ($M = 4.9$, $SD = 2.6$; $t(107) = 3.1$, $p = .001$), and this represented a medium effect (Cohen's $d = .06$). The five most common non-maltreatment adverse childhood experiences among CSA males were as follows: someone close to you passing away (89.9%); parents (biological, step, or other primary caregivers) always arguing, yelling, and angry at one another most of the time (81.2%); someone really close to you (parent, sibling) having a bad illness where they had to be in the hospital a lot (71.0%); a family member drank or used drugs so often that it caused problems (63.8%); and someone really close to you (parent, sibling) having a bad accident where they needed to be in the hospital for many days (55.1%). The five most common non-maltreatment adverse

childhood experiences among non-CSA males were as follows: someone close to you passing away (75.0%); someone really close to you (parent, sibling) having a bad illness where they had to be in the hospital a lot (67.5%); someone really close to you (parent, sibling) ever have a bad accident where he or she had to be in the hospital for many days (45.0%); experiencing a time where your mother, father, or primary caregiver lost a job or could not find work (42.5%); and a family member drank or used drugs so often that it caused problems (40.0%).

Psychological and Adaptive Functioning Across CSA and Non-CSA Groups

Self-report measures of psychological functioning. To address the first part of the second research objective aimed at understanding more comprehensively the impact of CSA across various areas of psychological functioning (self-report and clinician-administered) between both CSA and non-CSA males, several multivariate statistics were conducted. First, a multivariate t-test confirmed that there were differences between males in the two groups on their self-reported psychological functioning ($T^2 = 2.8$, $F(9, 99) = 30.7$, $p = .002$). Table 4 shows that males in the CSA group reported significantly higher levels of depressive symptoms ($M = 15.0$, $SD = 13.3$) than non-CSA males ($M = 8.5$, $SD = 9.8$; $F(1, 107) = 5.2$, $p = .024$), resulting in a small effect (partial $\eta^2 = .05$). The average score for CSA males fell within the *mild depression* range, whereas that for males in the non-CSA group was within the *minimal depression* range.

Males in the CSA group also reported higher rates of anxiety symptoms ($M = 10.3$, $SD = 9.8$; $F(1, 107) = 4.6$, $p = .034$) and stress symptoms ($M = 17.3$, $SD = 12.1$; $F(1, 107) = 8.6$, $p = .004$), compared with non-CSA males ($M = 6.2$, $SD = 7.9$; $M = 10.8$, $SD = 9.8$, respectively). The differences represented a small effect for anxiety (partial $\eta^2 = .04$) and a medium effect for stress (partial $\eta^2 = .07$). The average anxiety score for CSA males was considered to be in the

moderate range, and the average stress score fell in the *mild* range. In contrast, males in the non-CSA group reported average anxiety and stress scores that both fell within the *normal* range. Finally, males in the non-CSA group reported significantly higher resilience scores ($M = 127.2$, $SD = 20.2$) than CSA males ($M = 111.6$, $SD = 23.2$); $F(1, 107) = 12.5$, $p = .001$). This difference represented a medium effect (partial $\eta^2 = .11$).

Clinician-administered measures of psychological functioning. Males in the CSA and non-CSA groups completed the clinician-administered SCID-5 and were compared on clinical criteria for the following diagnoses: Mood disorders; Anxiety disorders; Substance-use disorders; and Trauma-related disorders. Table 5 indicates that, for mood disorders, CSA males had nearly three times the rate of past major depressive disorder (47.8%), compared to males in the non-CSA group (15.0%; $\chi^2(1) = 11.9$, $p = .002$). This difference represented a medium effect (Cramer's $\Phi = .33$). Turning to anxiety disorders, males in the CSA group had higher rates of social anxiety disorder (15.9%; $\chi^2(1) = 4.7$, $p = .031$) and generalized anxiety disorder (40.6%; $\chi^2(1) = 3.7$, $p = .048$), compared with non-CSA males (2.5% and 22.5%, respectively). For both disorders, the differences resulted in small effects (Cramer's $\Phi = .21$ and $.18$, respectively).

Compared with non-CSA males, males in the CSA group had significantly higher rates of alcohol use (26.1% versus 2.5%; $\chi^2(1) = 9.8$, $p = .002$) and non-alcohol substance use (43.5% versus 20.0%; $\chi^2(1) = 6.1$, $p = .013$) disorders within the past 12 months, as well as higher rates of lifetime alcohol (42.0% versus 15.0%; $\chi^2(1) = 9.8$, $p = .003$) and lifetime non-alcohol substance use (40.6% versus 25.0%; $\chi^2(1) = 2.7$, $p = .041$) disorders. The effect sizes for these differences ranged from small (Cramer's $\Phi = .16$ for lifetime substance use disorders) to medium (Cramer's $\Phi = .30$ for current alcohol use disorder). Last, males in the CSA group had a

significantly higher rate of PTSD (28.9%) than non-CSA males (2.5%; $\chi^2(1) = 8.5, p = .003$).

This difference represented a medium effect (Cramer's $\Phi = .30$).

Adaptive functioning. To address the second part of the second research objective aimed at examining the impact of CSA in males across adaptive functioning (e.g., friendships, family, employment), several t-tests were conducted. Table 6 indicates statistically significant differences between CSA and non-CSA males in terms of friendship quality ($t(107) = 2.0, p = .047$), job satisfaction ($t(83) = 2.3, p = .024$), and the number of listed potential stressors and concerns ($t(107) = 2.4, p = .020$). In particular, males in the non-CSA group reported higher-quality friendships ($M = 6.3$ versus $M = 5.4$) and higher job satisfaction ($M = 1.2$ versus $M = .71$). In contrast, CSA males reported a higher number of expressed personal stressors and concerns ($M = 1.8, SD = 1.6, \text{range} = 0-5$), compared to males in the non-CSA group ($M = 1.1, SD = 2.4, \text{range} = 0-4$).

The Impact of CSA on Psychological and Adaptive Functioning

To address the third and fourth research objectives and determine whether there were any statistically significant differences between the CSA and non-CSA group means across a number of dependent outcomes, while considering multiple covariates (i.e., forms of maltreatment, non-maltreatment adverse childhood experiences, level of education, and total household income), a MANCOVA was conducted. Both level of education and total household income were included as co-variables, along with forms of maltreatment and non-maltreatment adversities, as they significantly differed between males with histories of CSA and males without histories of CSA. Results indicated that there was a statistically significant multivariate impact of CSA on males' self-reported psychological functioning, after controlling for other forms of maltreatment and non-maltreatment adverse childhood experiences ($F(9, 93) = 11.9, p = .004$, Wilks' $\lambda = .25$,

partial $\eta^2 = .53$). Follow-up univariate analyses, as seen in Table 7, showed that the presence of CSA predicted higher depressive symptoms ($p = .023$), higher stress ($p = .037$) and anger expression ($p = .002$), and lower anger control ($p = .004$). For each analysis, there were four interaction effects that were tested, namely group X other maltreatments, group X non-maltreatment adverse experiences, group X income, and group X level of education. None of the four interactions reached statistical significance.

There was also a statistically significant multivariate impact of the presence of CSA on the clinician-administered psychological functioning dependant variables, after controlling for other forms of maltreatment and non-maltreatment adverse childhood experiences, $F(13, 93) = 2.7, p = .006$, Wilks' $\lambda = .72$, partial $\eta^2 = .28$. Table 8, highlighting univariate analyses, indicates that the presence of CSA significantly and positively predicted past major depressive disorder ($p = .007$), current alcohol use disorder ($p = .010$), lifetime alcohol use disorder ($p = .039$), and PTSD ($p = .008$). The interaction effects were not significant. Last, there was no significant multivariate impact of the presence of CSA on the adaptive functioning dependent variables, after controlling for other forms of maltreatment and non-maltreatment adverse childhood experiences, $F(4, 36) = 2.5, p = .425$, Wilks' $\lambda = .12$, partial $\eta^2 = .88$. There were no significant interaction effects.

Discussion

The current study compared maltreatment and non-maltreatment adversities, as well as psychological and adaptive functioning, between males with and without histories of childhood sexual abuse (CSA). To my knowledge, this is the first empirical study to examine these variables in an exclusively male sample. As such, the study advanced knowledge in the CSA field in several ways. First, I examined the rates at which CSA males experienced other forms of

childhood maltreatment and non-maltreatment adversities. This is important in terms of raising awareness about the severe nature of male CSA and the context of adversity in which CSA commonly occurs. Findings from the present study may be especially important when considering CSA outcomes because examining only one type of maltreatment may ignore or underestimate the effects of other types that often co-occur and contribute to longer term effects (Easton, 2013; Finkelhor et al., 2009a). Second, the current study added to knowledge about the long-term outcomes associated with CSA by considering both psychological and adaptive functioning and also taking into account co-occurring maltreatment and non-maltreatment adversities. Including outcomes across multiple domains, such as life stressors, coping strategies, and situations that may impact long-term mental health, in addition to considering the potential impact of poly-victimization is in line with recommendations from several researchers (e.g., romantic relationships (intimacy), work satisfaction; Easton, 2014; Easton, Coohy, O’Leary, Zhang, & Hua 2011; O’Leary, 2009).

CSA Experiences

The first objective was to examine the frequency and characteristics of CSA experiences among a sample of Canadian males. Although the current sample, including males with and without CSA histories, was one of convenience, it was more or less representative of 2016 Census information for males across Ontario and within the Ottawa-Gatineau region, particularly with regard to age, predominant ethnicity, and marital status. The only exception was related to education, where all males in the current study reported significantly lower average rates of post-secondary education completion, compared to males in Ottawa and Ontario.

Among CSA males in the current study, an average of 1.7 CSA experiences (out of a possible 3) were reported, with a mean onset of 8.5 years old. Across all experiences, most

males reported that their perpetrator was a caregiver's friend/acquaintance, followed closely by a cousin, a stranger, and then an uncle. These findings align partially with past research which has found that, in many cases, the majority of perpetrators against boys are family members (cousin and uncle; Azzopardi, 2015; Berliner, 2011). For onset age, the current findings are similar to recent research on male CSA that gathered information from a convenience sample of 253 males across Canada and the U.S. (Lyons & Romano, 2019; Romano, Moorman, Ressel, & Lyons, 2019), as well as a study of 487 U.S. males (Easton, 2013; Easton, Roh, Kong, & Lee, 2019) which found that the age of abuse onset was middle childhood (8.5 years of age) and that most perpetrators were an extrafamilial family member (such as a friend or acquaintance of the family).

More than half the males in the current study had disclosed at least one CSA experience, waiting an average of 13.6 years. These findings were lower than those from recent studies that broadly suggest first-time disclosures for adult males often take at least 20 years (Easton, 2013; Easton et al., 2019; Gruenfeld, Willis, & Easton, 2017; O'Leary & Barber, 2008). Study findings were, however, consistent with those from a recent study that found an average of 15.4 years before males disclosed their CSA experience (Romano et al., 2019). Notwithstanding the slight variability among research findings that may be a function of sample characteristics, they all speak to the immense challenge that males face in telling someone about their sexual victimization. These challenges undoubtedly are related in part to masculinity stereotypes (e.g., males should protect themselves against aggressors, sexual activity with an older female should be considered positive, males are not victims) and abuse characteristics, such as fears of being labeled homosexual if the perpetrator was also male (Alaggia, 2010; Dorahy & Clearwater, 2012; Easton et al., 2014; Romano & De Luca, 2014; Romano et al., 2019).

Maltreatment and Non-Maltreatment Experiences Among CSA and Non-CSA Males

Consistent with the study's first hypothesis, males with CSA histories reported a significantly greater number of other maltreatment types, compared with non-CSA males. It is frequently acknowledged in the literature that experiences of multiple victimization appear to be the norm, rather than the exception, among children who have experienced maltreatment (Babchishin & Romano, 2014; Dube et al., 2005; Easton & Kong, 2017; Felitti et al., 1998; Finkelhor, Ormrod, Turner, & Holt, 2009b; Ressel, Lyons, & Romano, 2018; Romano et al., 2019). Taking a closer look at the types of maltreatment experienced by males in the current sample, those in the CSA group reported significantly higher rates of physical and emotional abuse than non-CSA males. These findings are consistent with past research showing that CSA among males often occurs alongside other types of maltreatment, most notably physical and emotional abuse (Easton, 2013; Easton et al., 2014; Edwards, Holden, Felitti, & Anda, 2003; Holmes & Slap, 1998; Lyons & Romano, 2019; Ressel et al., 2018; Romano et al., 2019). Similarly, my findings speak to Finkelhor et al.'s (2009b) model of polyvictimization and research on the detrimental effects of problem-saturated childhood environments. More specifically, Finkelhor et al. (2009b) found that a child who was physically assaulted in the past year was 5 times more likely to have also experienced CSA and more than 4 times more likely to have also been emotionally maltreated during the same time period.

The frequency of co-occurring maltreatment may be related to common underlying factors within the family, caregivers, and caregiver-child interactions. This interplay of factors may place children who have experienced CSA at increased risk for additional forms of maltreatment, such as physical punishment/abuse. This increased risk may be bidirectional in nature as research has shown that child emotional and physical abuse may increase the risk of

sexual abuse (Hulme, 2004; Lyons & Romano, 2019). Children with emotionally and physically abusive caregivers might seek out emotional connections with seemingly-caring adults outside the home, thereby increasing their risk of being sexually exploited. Black, Heyman, and Smith-Slep's (2001) systematic review on family predictors of increased CSA risk found that children living in single-parent or stepfamily households were more likely to experience sexual abuse than those living with two biological parents. The authors noted that single-parent families are at increased risk for experiencing moderately higher levels of psychiatric symptoms, more stressful life events, and less emotional support from community resources, as compared to two-parent households, potentially resulting in a lack of availability to the child, difficulty with managing their own personal struggles, and an opportunity for children to seek out adults outside of the home. Other researchers, such as Draucker and Petrovic (1996) and Azzopardi (2015), have also suggested that certain family dynamics, which may include interpersonal difficulties and physical altercations, emotional distance from the child, and parenting rigidity, may be associated with child emotional abuse and neglect and may elevate CSA risk outside of the home.

In examining the link between sexual abuse and emotional/physical abuse, it may also be true that sexual abuse increases the risk of emotional and physical maltreatment. Caregivers may resort to emotionally-abusive and physically-violent discipline in an attempt to manage misunderstood and complex CSA-related behaviours (Hébert, Parent, Daigneault, & Tourigny, 2006). With regard to previous victimization history, children who have experienced sexual abuse are almost twice as likely to be re-victimized than non-abused children (Barnes, Noll, Putnam, & Trickett, 2009). Theoretically, re-victimization may be associated with vulnerabilities related to unresolved trauma, emotional avoidance, dissociation, traumatic

sexualization leading to inappropriate behaviours with others, impaired attachment and interpersonal functioning within the family, compromised ability to process danger cues, and feelings of unworthiness (Arata, 2002; Grauerholz, 2000; Lalor & McElvaney, 2010). All of these variables may interact negatively within the parent-child dynamic and could result in further risk of re-victimization within the family (Azzopardi, 2015).

Turning to the presence of non-maltreatment adversities during childhood, males with CSA histories reported a significantly greater number of non-maltreatment adversities than non-CSA males. These findings were in line with my expectations and are consistent with past literature showing that, compared with individuals with no reported childhood adversity or maltreatment, those who reported at least 1 non-maltreatment adverse childhood experience were 2–18 times more likely to report experiencing additional adversities (Dong, Anda, Dube, Giles, & Felitti, 2003; Lyons & Romano, 2019). Similarly, Lyons and Romano (2019) found an association between CSA characteristics (e.g., earlier age of onset, longer duration) in their sample of 253 males and the number of non-maltreatment childhood adversities. The authors categorized CSA characteristics into three distinct profiles, ranging from 1–2 instances of fondling by an extrafamilial perpetrator to chronic, penetrative abuse by individuals within and outside the family. Profiles were labeled Severe (26%), More Severe (33%), and Most Severe (41%). Lyons and Romano's (2019) findings suggest that males in the highest severity profile also experienced the greatest number of non-maltreatment adversities. Regardless of the profile, however, the rates of non-maltreatment adversities ranged from 27.6%-34.5% and indicated that non-maltreatment adversity was fairly common among males with CSA histories.

This clustering effect of maltreatment and non-maltreatment adversities might be the result of commonly-shared risk factors (e.g., family stress, parental substance abuse,

interpersonal conflict between parents/caregivers; Dong et al., 2003) and/or the impact of certain environmental conditions (e.g., family instability, neighbourhood poverty). While it can be surmised that individuals who experience CSA by a family member may have additional environmental or familial stressors contributing to non-maltreatment adversities, research also indicates that sexual abuse perpetrators target vulnerable children, such as those who experience peer victimization or who live in families where there is marital conflict (Mcalinden, 2006). In line with this research, it could be argued that limited parental availability increases a child's risk of experiencing sexual victimization. More specifically, parents struggling with substance use or mental health difficulties may be less available to their children, thereby creating opportunities for sexual perpetrators to engage with youth from such family environments (Azzopardi, 2015). These past research results support Finkelhor et al.'s (2009b) conceptual model that specifies four distinct pathways for children culminating in polyvictimization, most notably the first two. These four pathways are: (a) living in a family that experiences considerable violence and conflict (dangerous families); (b) having a family beset with problems around such things as money, employment, and substance abuse that might compromise a child's supervision or create unmet emotional needs (family disruption and adversity); (c) residing in or moving into a dangerous community (dangerous neighborhoods); and (d) being a child with pre-existing emotional problems that increase risky behaviour, engender antagonism, and compromise the capacity to protect oneself (emotional problems). In these environments, children may have limited resources to address and/or end their sexual abuse.

Psychological and Adaptive Functioning Among CSA and Non-CSA Males

Self-reported psychological functioning. In terms of psychological and adaptive functioning among the current sample of males with and without histories of CSA, findings

partially supported my expectations that males in the CSA group would have a greater number of clinical diagnoses and would report poorer psychological functioning, compared to non-CSA males. For the self-report measures, males with CSA histories reported a significantly greater number of depressive, anxiety, and traumatic stress symptoms, coupled with significantly lower resilience scores, compared with non-CSA males. Findings from the current study mirror empirical evidence suggesting that the majority of male survivors exhibit significantly greater internalizing problems, such as depression and anxiety, and traumatic stress symptoms (Cutajar et al., 2010a; Lyons & Romano, 2019), compared to males without histories of CSA. Current findings also align with studies that have shown CSA to be linked with depressive symptoms for males in middle and late life (Easton & Kong, 2017; Easton, Kong, Gregas, Shen, & Shafer, 2017). Given that the majority of CSA males in the current study experienced multiple types of maltreatment, their cumulative impact may have placed increasingly greater demands on coping resources, thus increasing males' risk of psychological distress.

Turning to resilience, there are a number of potential explanations for the current study's findings that CSA males had significantly lower mean scores than non-CSA males. First, lower rates of resilience may be related to the severe histories of CSA that were reported by a number of the males, as well as the high rates of co-occurring child maltreatment and adversity. Although studies have yielded mixed results on the impact of certain CSA characteristics, there is some evidence that earlier age of onset, penetrative abuse, and the presence of violence/force are linked to poorer resilience outcomes for both males and females (Dube et al., 2005). Second, within my sample, males who experienced CSA at a younger age may also have been less equipped cognitively and emotionally to cope with their victimization, leading to increased psychological distress and lower resilient functioning that extended into adulthood. Males with

histories of CSA however, had significantly lower rates of resilience than non-CSA males, most likely because CSA is a unique and particularly damaging form of trauma involving early traumatic sexualization, betrayal, and significant societal stigmatisation that is compounded by society's views about masculinity (Finkelhor, 1979; Ressel et al., 2018).

It is interesting that there were no statistically significant differences between the two groups of males on state and trait anger, including emotional expression and control. This finding is contradictory to several qualitative studies that have found CSA to be related to anger and rage among males (Fater, & Mullaney, 2000; Lisa, 1994; Sigurdardottir, Halldorsdottir, & Bender, 2012). The findings from the current study may be partly explained by the moderate to high scores for state and trait anger, as well as anger expression and control, across both groups. These findings speak more generally to the fact that any type of early maltreatment or adversity could result in high rates of anger among males (Iverson, McLaughlin, Adair, & Monson, 2014; Rutter, Weatherill, Taft, & Orazem, 2012). Findings are consistent with research that has shown associations between anger and childhood maltreatment (i.e., physical and emotional abuse, exposure to intimate partner violence) and with theoretical work arguing that childhood family environments characterized by violence in general hinder the development of effective emotion regulation skills, particularly in the expression and modulation of anger (Cicchetti & Toth, 2005; Iverson et al., 2014; Linehan, 1993). Results from the current study are also consistent with the notion that maltreatment-related anger may develop in childhood and persist into adulthood and that this is particularly the case among males (Iverson, et al., 2014; Rutter et al., 2012).

Clinician-administered psychological functioning. Turning to clinical diagnoses, study findings from the interviewer-administered diagnostic interview supported my hypotheses and the growing empirical literature on CSA impacts on affective and anxiety disorders. In the

current study, males with histories of CSA were found to have 3 times the rate of past major depressive disorder, 6 times the rate of social anxiety disorder, 10 times the rate of alcohol use disorder, 2 times the rate of substance use disorder, and 2 times the rate of lifetime prevalence of both alcohol and substance use disorders as compared to non-CSA males. High depressive symptom scores and rates of major depressive disorder have often been noted among males with CSA histories (Bagley et al., 1994; Holmes & Slap, 1998; Kendall-Tackett et al., 1993; Magnilio, 2010). CSA has also been associated with earlier onset and prolonged durations of depression (Zlotnick et al., 2001), particularly when CSA males have also experienced additional childhood adversities (Chapman et al., 2004). Second only to depression, anxiety has also been found to be a common struggle among males with histories of CSA, as well as more prominent symptoms of physical tension and mental distress (Black & Deblasse, 1993; Easton & Kong, 2017; Fergusson et al., 2013; Holmes & Slap, 1998; Valente, 2005). To the best of my knowledge, the current study was the first to examine self-reported anxiety and traumatic stress symptoms, as well as past and current clinical anxiety disorders, compared to a control group. Nevertheless, findings are broadly aligned with past, albeit limited, research that shows the presence of greater symptoms of anxiety and higher rates of anxiety disorders in males either immediately after the CSA experience or a number of years following the abuse experience (Black & DeBlasse, 1993; Briere & Elliott, 2003; Cutajar et al., 2010a; Maniglio, 2032; Holmes & Slap, 1998; Valente, 2005).

Study findings on the relatively higher rates of substance use problems in the CSA group, compared to non-CSA males, are consistent with past research on the association between childhood maltreatment, specifically CSA, and substance abuse in males (Liebschutz et al., 2002; Tonmyr & Sheilds, 2017). The association between CSA and substance abuse has also been

shown in representative retrospective studies of males, even after adjustments for individual, family, and societal factors (Afifi et al., 2009; Afifi et al., 2014; Fuller-Thomson et al., 2016; MacMillan et al., 2001; Molnar et al., 2001). My findings are also consistent with recent studies (Fuller-Thomson et al., 2016; Tonmyr & Sheilds, 2017) suggesting a robust association between CSA and substance abuse in the Canadian population of males.

Finally, the significantly higher rates of current and lifetime PTSD among CSA males, compared with non-CSA males, are consistent with past research findings (Romano & De Luca, 2011; Spataro et al., 2004). Research has also found that CSA males exhibit post-traumatic stress symptoms at levels equal to females with similar abuse histories (Freedman et al., 2002; Maikovich, Koenen, & Jaffee, 2009; Romano & De Luca, 2014; Spataro et al., 2004). In a Canadian study examining rates of PTSD, those who met criteria for a lifetime prevalence of PTSD were significantly more likely to have a history of childhood maltreatment than non-PTSD individuals. Among males, about one-third (34.8%) of those with a PTSD diagnosis also reported childhood sexual victimization (Van Ameringen, Mancini, Patterson, & Boyle, 2008). This finding is comparable to that from the current study where 28.9% of CSA males met diagnostic criteria for PTSD.

In sum, the current study's findings on psychological functioning and diagnostic outcomes collectively indicate that CSA can have long-lasting effects on males' well-being and functioning given that males were reporting on CSA experiences that had ended 30 to 40 years ago. These findings are similar to those of Easton and Kong (2017), who found that CSA was positively related to all three psychological outcomes for males, namely depressive symptoms, somatic symptom severity, and hostility. These findings indicate that CSA can have potentially long-lasting effects and may be linked to harmful outcomes for many survivors four to five

decades after its occurrence. The findings are consistent with complex trauma theory (Herman, 1992; van der Kolk et al., 2005), which asserts that child maltreatment (e.g., CSA) can disrupt key developmental processes in childhood and adolescence, leading to later life difficulties such as feelings of despair and hopelessness, unexplained physical complaints, and anger dysregulation (Cloitre et al., 2012; van der Kolk, 2003; van der Kolk et al., 2005). Current study findings not only map onto Easton and Kong's (2017) findings but also the growing empirical literature on CSA and affective disorders (Holmes & Slap, 1998; Maniglio, 2010), and they counter findings from studies that did not find such a relationship for male survivors (Cutajar et al., 2010b; Molnar et al., 2001; Spataro et al., 2004).

Adaptive functioning. While it was expected that CSA males in the current study would report significantly more impairment across all domains of adaptive functioning than non-CSA males, findings only partially supported this initial hypothesis. Specifically, males in the non-CSA group reported significantly higher functioning in the areas of friendships and job satisfaction, but there were no significant differences between CSA and non-CSA males in the other domains (i.e., relationship with spouse/partner, parenting, and personal strengths). My findings support past, limited research which has indicated that the psychological distress associated with a history of CSA may impact functioning in other areas, including males' ability to maintain friendships or succeed in the workplace setting (Easton, 2013; Easton & Kong, 2017; Ressel et al., 2018). These domain-specific impairments have the potential to induce a negative cycle of further psychological distress and impairment. One of the most consistent findings in the resilience research is that high-quality social relationships help protect against the adverse effects of child maltreatment (Domhardt, Munzer, Fegert, & Goldbeck, 2015; Masten, 2007; Rutter, 2013) but that males with CSA histories often have difficulty developing and maintaining

relationships (Hunter, 2006; Loeb et al., 2002). If CSA-related psychological distress impacts males' ability to develop and maintain close friendships, this may lead to limited social support and connectedness.

When males with CSA histories enter into adult relationships, including friendships, it can be difficult for them to express their emotional needs (Kia-Keating, Sorsoli, & Grossman, 2010). This may lead to a number of interpersonal stressors (e.g., serious problem with a close friend, neighbour, or relative; separation due to marital difficulties; termination of a steady relationship; Easton et al., 2019) that undoubtedly overlap with functioning in other interpersonal domains, such as employment. Several studies have also cited poor physical health as a key pathway through which CSA affects the later life employment status and income of males with histories (Barrett et al., 2014; Lee & Toleman, 2006). One study of Irish males found that sickness or disability was the reason for the substantially lower employment rate among males with histories of CSA, as compared to non-CSA males (Barrett et al., 2014). It is possible that findings suggesting that males with histories of CSA having poorer friendship quality and lower employment satisfaction are also more broadly due to unresolved CSA-related feelings (e.g., betrayal, mistrust, vulnerability) and the way they may manifest (e.g., somatic health complaints) that may be magnified for males with more severe CSA backgrounds. Building on previous qualitative studies (Fater & Mullaney, 2000; Lisak, 1994; Sigurdardottir et al., 2012), results from the current study indicate that males with histories of CSA have a greater likelihood of experiencing feelings of hostility later in life than non-CSA males. Certainly, feelings of hostility or anger could be underlying mechanisms that disrupt functioning in such areas as employment, relationship quality, and general life satisfaction (Easton & Kong, 2017; Easton et al., 2019). It is also worth noting that the current study's findings related to lower job

satisfaction are aligned with recent research that has found higher resilience scores among CSA males to be associated with higher occupational functioning and satisfaction (Ressel et al., 2018). Given that the resilience scores among males with histories of CSA in the current study were lower than those for non-CSA males, it is unsurprising that the former reported lower job satisfaction.

The Unique Impact of CSA On Maltreatment-Related Psychological Outcomes and Adaptive Functioning

The first set of findings discussed above considered the impact of CSA on psychological and adaptive functioning, without controlling for other forms of maltreatment, limiting my ability to discuss the potential unique impact of CSA. The following analyses aimed to discuss potentially distinct outcomes of CSA while taking into account other maltreatment and non-maltreatment experiences. Subsequently, after controlling for other forms of maltreatment and non-maltreatment adverse childhood experiences, findings partially supported my initial hypotheses. Consistent with past research (Alaggia & Millington, 2008; Butt et al., 2011; Halcomb, 2013; Hovey et al., 2011; Kendall-Tackett et al., 1993; Shrivastava, Karia, Sonavane, & De Sousa, 2017; Valente, 2005; Young et al., 2011), the current study found evidence to support the unique impact of CSA on DSM-5 clinical disorders, most notably major depressive disorder, alcohol use (current and lifetime), and PTSD. These findings are aligned with those of Holcomb (2013), who found that after controlling for other forms of maltreatment, CSA males were at a higher risk for meeting criteria for lifetime Major Depressive Disorder, PTSD, and lifetime substance use (including both alcohol and drugs), as compared to males without histories of CSA. Fergusson et al. (2013) also found increased rates of Major Depressive Disorder and substance use disorders among males with histories of CSA as compared to those without that

persisted after taking into account other maltreatment and adverse factors in childhood, such as physical abuse, problematic parent-child attachment, and parental history of illicit drug use.

A recent meta-analysis, with mixed-gender studies (Hailes, Yu, Danese, & Fazel, 2019), also found that CSA was associated with elevated risks of long-term psychosocial, psychiatric, and physical health outcomes, with some studies controlling for other forms of maltreatment. Specifically, there was high-quality evidence for associations between CSA and two psychiatric disorders (schizophrenia, PTSD), as well as with one psychosocial outcome (substance misuse). Current study findings support recommendations by Finkelhor and colleagues (2009b) around the weighting of different victimization experiences for purposes of understanding outcomes. Through multiple regressions, these researchers evaluated the unique contribution of individual victimization experiences (as well as a cumulative score) on symptom distress while controlling for a number of potential confounds (e.g., lifetime adversity, socio-economic variables). Victimization items that were found to uniquely contribute to symptom distress, over and beyond the cumulative victimization scale, were weighted. Based on these analyses, Finkelhor et al. (2009b) suggested that sexual victimization needs to be allocated additional weight when calculating multiple victimization scores because of their particularly salient effects. Therefore, the overarching finding from the current study that there remains a unique impact of CSA, even after controlling for other forms of maltreatment and non-maltreatment adversity, supports both the growing evidence on the cumulative negative effects of multiple adverse experiences on adult mental health (Chapman et al., 2004; Dong et al., 2003; Felitti et al., 1998) as well as the unique contribution of CSA (Easton et al., 2019; Shrivastava et al., 2017).

Although I expected that significant links between CSA and adaptive functioning would remain even after controlling for other forms of maltreatment and non-maltreatment childhood

adversity, hypotheses were not supported. The ways the outcomes or impacts in each of these areas emerge and subsequently play out in the lives of those with CSA histories constitutes a complex and dynamic process. The outcomes in these areas have been shown to interact with, cause, compound, or (in some cases) help to mitigate outcomes in other areas (Fisher, Goldsmith, Hurcombe, and Soares, 2017). There may be several possibilities, the first of which is that not all individuals who experience abuse or neglect show negative consequences (Cicchetti & Doyle, 2016). Not surprisingly then, individuals may experience different outcomes even when exposed to the same type of abuse or neglect; with outcomes ranging from impairing and problematic to functioning well across domains. Second, it may be that adaptive functioning impairments are influenced more by an accumulation of maltreatment and non-maltreatment adversity, rather than by the unique impact of CSA (Fisher et al., 2017).

It is important to acknowledge that people experience ongoing internal and social and environmental change over the course of their lifetimes. Such changes include physical maturation and ageing, emotional and psychological growth, and changes in social and familial/interpersonal situations. The greatest developments occur during childhood, adolescence, and the transition to adulthood, and various instances of maltreatment and non-maltreatment experiences at these distinct life stages may provide for more of a cumulative effect on particular areas of life (e.g., relationships, friendships, education). Accordingly, different adaptive outcomes and impacts following CSA are likely to emerge or become apparent to those with histories at different life stages depending on the effect of the types of maltreatment that had previously occurred and those that are occurring at that time (Fisher et al., 2017).

Limitations and Future Directions

The first limitation of the current study is that it relied on a convenience sample in Ottawa which likely did not capture all forms of diverse CSA characteristics among males. It is important to note, however, that the sample generally was socio-demographically representative of males from Ottawa and Ontario. It would be important for future research aimed at replicating current findings to employ recruitment strategies that would ensure a more nationally-representative sample of CSA and non-CSA males. Second, I employed a sampling approach whereby males were recruited both from websites offering support for CSA and from community forums focused on the topic of CSA. As such, findings may not reflect the experiences of males who do not actively seek out CSA support or who may not consider their experiences to have been abusive in nature. Despite this limitation, however, my use of popular technological methods of recruitment did increase accessibility to a large pool of males so future research should continue to employ online recruitment methods to increase sample size and access to males from diverse populations. Third, given the novelty of the current study, Bonferroni corrections were not applied in the analyses in order to reduce the likelihood of committing Type II errors (i.e., failing to detect meaningful differences in the data). However, this approach may have increased the likelihood of Type I errors related to identifying meaningful differences in the data where there are none. It would be important for future research aimed at replicating current findings to attempt appropriate corrections to reduce the potential for Type I errors. Fourth, males were asked to report on a maximum of three CSA experiences in order to not overwhelm them both in terms of study time and emotional distress. Close to 20% of males reported at least three experiences, therefore these males may have had additional experiences that were missed and for which information was not provided. An attempt to address this possibility was made by asking males to report on their three most significant CSA experiences. Future studies may want

to incorporate all salient CSA experiences among males to capture broader CSA characteristics, if study methodology would permit appropriate emotional support and study time. Fifth, the analyses were based on cross-sectional and retrospective data so there may have been reporting biases, and conclusions around temporal ordering and causality cannot be made. Future research aiming to examine CSA, psychological and adaptive functioning may consider a large-scale prospective study design to support causal relationships between childhood sexual abuse and psychological and adaptive functioning. In doing so, access to a big prospective, longitudinal data set could help complement current study findings by offering greater insight into temporal ordering (and by extension causality as much as possible). Additionally, future studies examining CSA characteristics may also want to consider taking a similar variable-centred approach with a larger and more diverse samples of males with histories of CSA to examine CSA experiences, which may aid in providing a more nuanced understanding of a) differences across each of the three reported experiences with respect to abuse characteristics, and b) whether CSA abuse characteristics can be grouped into distinct profiles and examine potential differences on their impact on psychological and adaptive functioning.

Research and Clinical Implications

This study contributed to the sexual abuse literature in a number of ways. First, I extended the study of CSA to a community sample of adult Canadian males, which is a population that has continued to receive relatively little empirical attention. While the current study focused on CSA characteristics that have been examined in prior studies with adult females and children, I also included additional relevant maltreatment and non-maltreatment experiences, such as controlling for other forms of abuse (e.g., physical and emotional abuse), as well as including a control group of males without a history of CSA. Moreover, while previous studies

have examined short and long-term psychological outcomes of CSA (e.g., Easton, 2019; Lyons & Romano, 2019; MacMillian et al., 2013), the current study included a broad range of psychological as well as adaptive functioning across various important life domains (e.g., employment, interpersonal relationships, education).

Results from the current study largely contributed to increasing awareness of the prevalence and unique impact of CSA among males, as well as its unique impact on potential psychological and adaptive outcomes, even after controlling for additional forms of maltreatment and adverse childhood experiences. While all males in the current sample reported sexual abuse experiences that are severe, there were clear differences in the chronicity, relationship to the perpetrator, the invasiveness of sexual acts, and disclosure experiences. The study's results also showed the importance of considering other types of child maltreatment and adversity as they relate to CSA and important associations with various adult psychological and adaptive outcomes. These findings highlight the importance of continuing to document CSA abuse characteristics, as well as taking a broad approach to studying males with histories of CSA. While my analyses were mostly exploratory, additional studies with larger samples of community males with histories of CSA are recommended to validate the current study's findings as they are relative to broader areas of psychological and adaptive functioning.

From a clinical perspective, this study contributes to informing the psychosocial service needs of males with histories of CSA. On a fundamental level, this study continues to demonstrate that not all experiences of sexual abuse are alike. Given the heterogeneity of CSA experiences and the variability in psychological and adaptive outcomes, no single type of intervention is likely to be effective for all CSA males. Treatment interventions should also incorporate a strengths-based approach, wherein areas of adaptive functioning are highlighted

and reinforced to maintain existing areas of efficacy and interpersonal relationships. For example, males with histories of CSA and higher rates of other forms of maltreatment who were highly symptomatic and presented with interpersonal difficulties (i.e., poor relationship quality) might benefit from a wraparound approach that integrates mental health professionals across various sectors (e.g., psychiatry, psychology, and social work) that can help them stabilize symptoms and reconnect to supportive family members and community organizations that may aid with important functional aspects of their lives. Nevertheless, findings also suggest that clinicians need to go beyond sexual abuse-related variables for purposes of treatment planning, as well as beyond the scope of just trauma processing and PTSD. In addition to obtaining a detailed history of childhood sexual abuse, clinicians should also consider collecting data about family functioning (and how family relationships may have changed over time), parenting (e.g., how their relationship with their children may be impacted by their experience), as well as difficulties with education and employment, as it may provide information about their male client's current distress.

An important consideration for males with histories of CSA, both in terms of their psychological and adaptive well-being is coping and resiliency. It may be helpful to promote problem-solving and expressive communication and coping strategies (e.g., assertiveness, expressing and working through difficult emotions; Marriott, Hamilton-Giachristis, & Harrop, 2013), as this would undoubtedly support continued benefit in managing difficult psychological and adaptive outcomes. For instance, recent studies suggest that males with histories of CSA who use more self-compassion (i.e., adopting a kind, non-judgemental, and empathic stance towards ourselves during moments of suffering; Neff, 2003) report fewer trauma symptoms and greater resilience (Ressel et al., 2018; Romano, Lyons, & St. John, 2015). Additional studies

investigating coping strategies and skills that promote resilience among males may provide useful avenues for trauma-focused interventions.

These findings also broadly contribute to the growing CSA literature, supporting the complex trauma theory which posits that other non-maltreatment and environmental stressors in childhood can compound the effect of traumatic experiences on survivors' mental health (Ford & Courtois, 2009; van der Kolk et al., 2005). Additional stressors can magnify the psychological impact of CSA and undermine potential recovery resources such as social support, both of which can contribute to psychological problems in adulthood. Childhood adversities have also been related to more severe forms of CSA among male survivors (Easton, 2013; Easton et al., 2019), another possible route to psychopathology. Current study results supported a relationship between non-maltreatment childhood adversities, psychological outcomes, and adaptive functioning among the entire sample of males with histories of CSA, which is consistent with the growing literature on adverse childhood experiences (Chapman et al., 2004; Easton et al., 2019; Felitti et al., 1998; & Kalmakis & Chandler, 2014). These findings further support the need for comprehensive and specific treatment interventions for males with such histories. Another area for research is to improve translation of effective interventions into policy and practice, such as establishing community programs to respond to male sexual abuse more specifically. Furthermore, to prevent psychopathologies and other outcomes after sexual abuse, more research on the developmental mechanisms is necessary.

Link Between Study 1 and Study 2

My first study aimed to create a comprehensive understanding of how CSA impacts the psychological and adaptive functioning of males with maltreatment histories, as compared to males with no maltreatment histories. My first study also examined adaptive functioning (e.g.,

friendships, romantic relationships) as well as psychological outcomes beyond just PTSD, while controlling for other forms of maltreatment and non-maltreatment adversities. My second study aimed to broaden our understanding of the link between CSA on the one hand and psychological and adaptive outcomes on the other by comprehensively examining emotion regulation among males with and without histories of CSA. More specifically, Study 2 gathered multi-method information on CSA-specific emotion regulation (state/trait-based, emotion identification, modulation (i.e., efficacy of strategy use) to examine how characteristics of emotion regulation may be linked with certain psychological and adaptive functioning outcomes. In this way, Study 2 expands Study 1 findings by identifying a possible comprehensive mechanism for the unique functioning outcomes among males with histories of CSA. Therefore, the proposed studies collectively inform intervention strategies and future research that could improve the psychological health of men with histories of CSA.

Study 2

The Role of Emotion Regulation on Psychological Outcomes among Males with Histories of Childhood Sexual Abuse

The first study aimed to create a comprehensive understanding of how CSA impacts the psychological and adaptive functioning of males with CSA histories, compared to males with no CSA histories. The first study also examined domains of adaptive functioning (e.g., perceived relationship quality, employment) and psychological outcomes beyond just PTSD, while controlling for other forms of maltreatment and non-maltreatment adversities. In this second study, I aimed to further the current understanding of emotion regulation among males with CSA histories and its link with psychological and adaptive functioning outcomes. Using a multi-method approach that relied on both self-report measures and a semi-structured clinical

interview, Study 2 examined trait- and state-based measures of emotion regulation, emotion identification, and maladaptive and adaptive emotion coping strategies. Additionally, I explored how emotion regulation strategies are linked to psychological and adaptive functioning outcomes among males with histories of CSA.

Emotion Regulation

Before the 1990s, there was little empirical research regarding the processes of emotion regulation (Gross, 1998; 2013). Now however, there are a multitude of approaches to understanding the complexity that is emotion regulation. Broadly speaking, emotion regulation is defined as the ability to understand and effectively modulate emotional experiences (Gross, 1998). Facets of emotion regulation include the ability to understand and accept emotions, use emotions effectively as information, and engage in adaptive behaviours when under emotional distress (Parkhill & Pickett, 2016). There are a number of emotion-related cognitive and behavioural processes, however, which are also associated with the construct of emotion regulation, including control (e.g., increasing or decreasing affect) and awareness of emotions (Maxwell, Lynn, & Strauss, 2018; Thompson & Calkins, 1996).

Generally, the construct of emotion regulation has often been further conceptualized as both a trait (i.e., cross-situational, largely stable and enduring patterns of awareness and control) and a state phenomenon (i.e., situation-bound, goal-directed awareness and control processes). Trait conceptualizations (e.g., Gratz & Roemer, 2004) underscore individuals' tendencies to regularly manage emotions in certain ways (e.g., flexibly vs. inflexibly, acceptingly vs. avoidant) across situations and contexts with adaptive or maladaptive outcomes. Alternatively, other conceptualizations (e.g., Thompson, 1994) emphasize state-like, dynamic adjustments made by individuals during real-time emotion experience with adaptive or maladaptive consequences that

depend on situational factors and momentary goals (e.g., to hide or express affect). State conceptualizations typically have emphasized the function of contexts in shaping individuals' moment-to-moment emotions and setting parameters for emotions' functionality and adaptive value (Gross, 1998; 2013; Maxwell et al., 2018). Such context-based modulation of emotion may occur automatically (i.e., implicitly), but most published studies to date have examined effortful, goal-directed regulation (i.e., explicit attempts to alter the course or intensity of an emotion; Maxwell et al., 2018; Webb, Miles, & Sheeran, 2012).

Problems with emotion regulation can also be measured by examining an individual's non-acceptance of emotional responses, difficulties engaging in goal-directed behaviours, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity (Gratz & Roemer, 2004). Taking into consideration the additional cognitive and behavioural processes, as well as the differentiation between trait- and state-based regulation, a broad multidimensional conceptualization of emotion regulation should be further differentiated from approaches that simply view emotion regulation as limited to repressing or avoiding emotions. Additionally, emotion regulation is distinguished from self-regulation, which is a broader construct involving the regulation of attention and behaviour in conjunction with emotions (Raffaelli & Crockett, 2003). Although it is reasonable to expect that traits predict state experiences (e.g., personality traits predict the occurrence of certain behaviours; Paunonen, 2003), these trait-state relationships are often weak (e.g., Brose, Voelkle, Lövdén, Lindenberger, & Schmiedek, 2015; Kashdan & Nezlek, 2012). This suggests that trait and state indicators of emotion dysregulation are not always interchangeable, despite being related, and there is unique information to be gained from each source.

Emotion regulation modulates the occurrence, frequency, duration, and expression of different emotions. Five strategies with which the aforementioned emotion regulation process (i.e., the process model) might modulate emotion include situation selection, situation modification, attentional deployment strategies (e.g., distraction), and cognitive change strategies (e.g., reappraisal, psychological acceptance), as well as suppression strategies targeting affect, thoughts, and feelings (Gross, 1998; Maxwell et al., 2018). Trait conceptualizations of emotion regulation assume that individuals may differentially use such strategies more or less consistently across contexts and situations, suggesting individual differences in how individuals habitually identify regulation needs and select strategies. In effect, trait measures may reflect individual differences in *identification* and *selection* components of the emotion regulation process, as outlined by Gross (1998). More specifically, individual differences in how individuals identify regulation needs, how often they select particular strategies, or both, might affect these individuals' use of strategies, as measured by trait measures of emotion regulation.

Reliable individual differences in scores on measures of trait emotion regulation (e.g., Difficulties in Emotion Regulation Scale; Gratz & Roemer, 2004) across psychopathologies support the validity of trait conceptualizations of emotion regulation. For example, Aldao, Nolen-Hoeksema, and Schweizer (2010) conducted a meta-analytic review and reported that greater use of maladaptive strategies (i.e., rumination, suppression, avoidance) were associated with greater psychopathology including anxiety, depression, eating disorders, and substance use disorders, whereas greater use of adaptive strategies (i.e., acceptance, problem-solving, and reappraisal) were associated with less psychopathology. In addition, affect-related disorders (depression and anxiety) were more closely linked with certain emotion regulation problems than externalizing disorders (substance use and eating disorders). These findings indicate that reliable

differences in self-reported use of emotion regulation strategies exist across groups of individuals. Furthermore, these differences in regular use predict patterns of psychopathology are conceptually consistent with frequent or generalized use of the real-time regulation strategies (e.g., response-focused suppression) posited by state models of emotion regulation. In the context of the extended emotion regulation process model, state models of emotion may then reflect individual differences in the *implementation* component (Gross, 2015).

Numerous studies have examined more broadly how trait emotion dysregulation (routinely assessed with the Difficulties in Emotion Regulation Scale; DERS; Gratz & Roemer, 2004) relates to many domains of emotional functioning. For example, a variety of cross-sectional, self-report research using questionnaires suggests that trait emotion dysregulation is positively associated with trait negative affect (Glenn & Klonsky, 2009; Vujanovic, Zvolensky, & Bernstein, 2008), emotional intensity (Salsman & Linehan, 2012), impulsivity (Weiss, Sullivan, & Tull, 2015), and negative urgency (the urgency felt to end a negative emotional experience, indicating low distress tolerance; Cyders & Smith, 2008), and negatively associated with emotional awareness (Roemer et al., 2009). Gratz and Roemer (2004) further theorise that emotion dysregulation is also associated with ineffective emotion regulation strategy selection and implementation (which can be discussed as adaptive or maladaptive modulation).

Within clinical samples, a lab-based negative mood induction study found that individuals with histories of trauma (a population thought to exhibit pervasive emotion dysregulation; Linehan, 2015) endorsed using a higher mean number of emotion regulation strategies and a higher number of avoidant emotion regulation strategies compared to healthy control participants (Daros, Daniel, Boukhechba, & Chow, 2018). The same study found that individuals with trauma histories also judged themselves as less successful overall at reducing

their negative affect using emotion regulation strategies. Other studies with similar clinical samples have found that individuals with high (vs. low) trait emotion dysregulation tend to end distress tolerance tasks faster and are less inclined to complete a similar task again (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2006; Gratz, Tull, Matusiewicz, Breetz, & Lejuez 2013; Iverson, Follette, Pistorello, & Fruzzetti, 2012), perhaps suggesting that individuals with maltreatment histories are prone to choose suboptimal emotion regulations strategies or have difficulty applying them effectively, particularly if they also struggle with in-the-moment emotional reactions (i.e., state-based dysregulation).

There are relatively few studies which have exclusively examined state-based emotion regulation among individuals with histories of maltreatment. However, it is likely that numerous factors, including interpersonal experiences, situational factors, cognitive processes, and even other emotional processes may influence certain aspects of emotion dysregulation within comparatively short time frames for individuals with maltreatment histories (Lavender et al., 2017). For instance, certain difficulties with emotion regulation may be more likely to manifest in the context of particular emotional experiences (e.g., experiencing secondary emotions in response to nonacceptance of anger, losing behavioural control due to the experience of shame/guilt), in response to a particular level of affective intensity (e.g., maintaining goal-directed behaviour at lower levels of negative affect, but experiencing difficulties at higher levels), or, and most importantly for the current body of literature, following an aversive or traumatic interpersonal experience (e.g., in the aftermath of maltreatment; Lavender et al., 2017). There has been some research which suggests that individuals with maltreatment histories are less clear about the nature of their momentary affective experiences despite their sensitivity to experiencing distress (Daros et al., 2019). Previous research has shown that difficulties in

identifying emotions in the moment subsequently reduces an individuals' ability to select situationally appropriate emotion regulation strategies (e.g., Barrett, Gross, Christensen, & Benvenuto, 2001; Vine & Aldao, 2014), leading to further dysregulation and difficulties with implementing helpful or adaptive regulation approaches. Not surprisingly then, the difficulty in selecting appropriate emotion regulation strategies within a situational context may have multiple negative downstream effects with respect to how well individuals with maltreatment histories cope overall (Daros et al., 2019). As existing research is primarily based on laboratory studies, little is known about how trait and state-based emotion occurs among males with histories of maltreatment, in particular, CSA. The current study therefore explored this multicomponent process in addition to addressing some of the gaps in the literature with respect to emotional regulation processes among a population with a high potential for emotional dysregulation.

CSA and Emotion Regulation

Explanations for the association between childhood maltreatment and impairments in emotion regulation more broadly can be drawn from the developmental, behavioural neuroscience, and psychopathology literatures (Jerud, Zoellner, Pruitt, & Feeny, 2014). Research from these areas suggests that there may be critical periods during childhood for learning how to effectively respond to emotional stress (for reviews, see Cicchetti & Toth, 1995; Sánchez, Ladd, & Plotsky, 2001). Further, early life stress may be associated with neurobiological changes that lead to later emotion dysregulation (for a review, see Heim & Nemeroff, 2001). It has been thought that emotion regulation skills are one of the most important developmental processes acquired in humans initially during infancy and the preschool

years (Kim-Spoon, Cicchetti, & Rogosch, 2013; Widom, Kahn, Kaplow, Sepulveda-Kozakowski, & Wilson, 2007).

Experiencing maltreatment during key formative years disrupts normative developmental processes such as selecting and modifying situations that have emotional significance, deploying attention, integrating information and relationship formation and maintenance; all of which have been identified as impacting one's ability to regulate their emotions (Dvir et al., 2014; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Selcuk, Zayas, Gunaydin, Hazan, & Kross, 2012). Consequently, during these key developmental years, children with maltreatment histories are often solely focused on managing the high intensity emotions they are experiencing, and do not experience the healthy, predictable fluctuations in emotions that result in the ability to understand, tolerate, and modulate emotions and engage in appropriate behavioural responses (Gratz et al., 2009; Parkhill & Pickett, 2016). In maltreating families, parents are less likely to be available to provide support and scaffolding, from which children can learn constructive strategies to regulate their emotional states, when their children are upset. An unpredictable and disorganized environment, such as those found in maltreating homes (Howes, Cicchetti, Toth, & Rogosch, 2000), would make children particularly vulnerable to frequent negative emotional experiences including anger, frustration, reactivity, and irritability (Alessandri, 1991; Erickson, Egeland, & Pianta, 1989; Shields & Cicchetti, 1998). Thus, maltreated children are likely to experience overwhelming emotional arousal that leads to difficulties managing and processing negative emotions (Hennessy, Rabideau, Cicchetti, & Cummings, 1994).

The suggestion that exposure to CSA early in life more specifically should lead to emotion regulation difficulties, such as difficulty with emotion identification and modulation, is based on findings from developmental psychology. Research has shown that adaptive emotion

regulation is learned in interaction with primary caregivers (Calkins & Hill, 2007; Cole, Michel, & Teti, 1994). On the one hand, caregivers' own emotion regulation behaviour serves as a model for the developing child as to how to deal with emotional states. In addition, caregivers guide the child in understanding and labeling his/her own emotions and ultimately regulating them in a way to achieve his/her goals. As discussed, compromised attachment is associated with emotion regulation deficits (Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008), which supports the idea that a rupture between a child and an important interpersonal figure, particularly on account of CSA, can hinder the development of helpful emotion modulation. On a theoretical level, it is therefore conceivable that the experience of chronic interpersonal trauma, such as CSA, in early developmental stages should disrupt the development of adaptive emotion regulation, especially when the perpetrator is one of the key caregivers (Cloitre, Miranda, Stovall-McClough, & Han, 2005; Cloitre et al., 2008; Ford, 2009; van der Kolk et al., 1996). On the basis of the theoretical assumptions regarding the effects of trauma on the development of emotion regulation, a number of researchers suggest that emotion regulation difficulties are one of the complex symptoms that specifically develop after early-onset interpersonal trauma such as CSA (e.g., Cloitre et al., 2005; van der Kolk et al., 2005). Given this, it is unsurprising then that individuals with a history of CSA may have under-developed emotion regulation skills due to the pervasive interpersonal impact of their childhood experiences (Cicchetti et al., 1991).

Although numerous studies have found that childhood abuse (globally) is related to emotion regulation difficulties (Arttime & Peterson, 2012; Gratz et al., 2009), only a handful of studies have specifically examined CSA, emotion regulation, and psychological outcomes (Arttime & Peterson, 2012; Easton et al., 2011; Kia-Keating et al., 2010; O'Leary, 2009). Even fewer still have examined why this relationship exists. Given the well-documented relationship

between CSA and negative psychological and behavioural outcomes, researchers have shifted toward identifying possible mechanisms through which CSA may exert its negative effects. Within the current literature, several potential links have been examined, including cognitive distortions (e.g., self-blame), emotion regulation, and avoidant forms of coping (Ullman, Peter-Hagene, & Relyea, 2014). One potential linking mechanism that was the focus of this present study is emotion regulation. Research is increasingly suggesting that poor emotion regulation contributes to an array of psychiatric conditions (e.g., depression, PTSD; Aldao et al., 2010; Bradley et al., 2011) in a manner distinct from negative affect alone (Bradley et al., 2011; Parkhill & Pickett, 2016).

Poor emotion regulation as a result of early childhood maltreatment has been thought to be the underlying component that leads to maladaptive coping strategies and subsequently, risk to psychological well-being and further re-victimization (Messman-Moore, Walsh, & DiLillo, 2010). Among a sample of females with CSA histories, increased emotion dysregulation predicted greater engagement in maladaptive and ineffective strategies, such as denial and disengagement (Fortier et al. 2009; Johnson & Lynch, 2013). Furthermore, in a mixed-sex sample of over 400 children, researchers found that emotion regulation may mediate the effects of various forms of maltreatment, including CSA (Kim & Cicchetti, 2010). In this longitudinal study, Kim and Cicchetti (2010) also found that increased severity of childhood maltreatment and earlier age of victimization onset were both predictive of greater emotion dysregulation. Further, they observed that reduced capacity for emotion regulation predicted greater externalizing problems, such as aggressive and delinquent behaviours. Although these findings inform the literature specific to emotion regulation and maltreatment, research is sparse on adult males with CSA histories. Therefore, it remains unclear what specific aspects of emotion

regulation may be associated with psychological functioning among this population, such as differences among strategy implementation.

Research that has begun to examine emotion regulation among males with histories of maltreatment has largely focused on emotion regulation as a mediator between CSA and specific outcomes, such as substance use (Vilhenna, 2011), risky sexual behaviours (Arttime & Pederson, 2012), and later sexual perpetration (Parkhill & Pickett, 2016). Generally, these studies have found that a higher frequency and severity of CSA predicts a limited display of emotion regulation strategies, which results in increased substance use and risky sexual behaviours. These results suggest that males who experience CSA may engage in maladaptive strategies, such as aggressive behaviour or substance use, in an attempt to regulate their emotions (Jakupcak, Lisak, & Roemer, 2002; Parkhill & Pickett, 2016; Tamres et al., 2002). Although this link appears to be present among this group of males, previous studies have focused on self-report measures that have not provided detailed information related to identification and strategies for numerous emotional responses. Therefore, there is limited information on what aspects of emotion regulation may be contributing to difficulties and what specific strategies individuals may be using and finding helpful. Given the limitations of these studies, a more comprehensive understanding of the important components of emotion regulation (e.g., identification of emotions, strategies used to modulate emotional responses ((maladaptive vs. adaptive), and state vs. trait responses) among males with histories of CSA is needed to examine the potential links between CSA to broader psychological and adaptive functioning.

Some researchers have begun to understand the experience of CSA and subsequent emotional responses among males using a more qualitative approach (Foster & Hagedorn, 2014; Lisak, 1994). For example, participants in Lisak's (1994) study identified several key expressed

feelings such as betrayal, helplessness, isolation, alienation, and shame/ humiliation in relation to recalling an abusive experience. While this study inferred males with abuse histories could identify complex emotions related to their experience, it did not identify strategies to manage and modulate the expressed affect. Similarly, in the first known study to explore children's written trauma narratives about CSA, Foster and Hagedorn (2014) analyzed 21 narratives (18 girls, 3 boys) and uncovered one meta-theme related to memories of the abuse - fear and safety. While this study added to the limited research on children's firsthand accounts of sexual abuse and recovery experiences, there was minimal representation of boys and no data on how children coped with their emotions (i.e., what strategies they used). In a more recent qualitative narrative study of 19 male children who experienced CSA (Foster, 2017), the boys frequently used 'feeling words' to describe life before, during, and after CSA. The feeling words were then examined in context to better understand the boys' experiences related to CSA and possibly identify associated emotional identification processes. Anger was the most prevalent feeling, followed closely by fear. Additionally, feeling words used to describe perpetrators included fear, anger, hatred, and sadness; however, researchers noted that some boys also struggled to pinpoint their feelings. This study suggested that personal narratives could elicit emotional processes to gain a better understanding of how males managed feelings before, during, and after their CSA experience. While each of these studies has begun to gather information on key emotions experienced by individuals with CSA histories, existing research has largely focused on the emotional effects of CSA and not how individuals express and cope with these emotions, especially among males with histories of CSA.

Gender, Emotion Regulation, and Psychopathology

Over the years, different theoretical models have highlighted various emotion regulation strategies as adaptive or maladaptive (for a full review, see Aldao et al., 2010). Strategies are considered maladaptive when they fail to modulate the intensity of an emotional experience, despite an individual's intention to the contrary (Gross, 1998). For example, rumination, defined as passive focus on one's symptoms and their causes and consequences, has been shown to exacerbate negative moods (Nolen-Hoeksema, 1991). Similarly, both deliberately pushing away emotional thoughts and suppressing the outward expression of emotions are considered ineffective emotion regulation strategies because they are often unsuccessful at reducing negative emotions (Gross, 1998), as is cognitive and behavioural avoidance (Conklin et al., 2015). On the contrary, adaptive emotion regulation strategies are those that help to modulate the intensity of an emotion effectively given each situation context. A few examples of adaptive strategies that have demonstrated relationships with (less severe) psychopathology include awareness and acceptance, the process of approaching emotions non-judgmentally (Keng, Smoski, & Robins, 2011), and positive reappraisal of emotion-eliciting situations (Garnefski & Kraaij, 2006; Martin & Dahlen, 2005).

Successful emotion regulation has been associated with overall well-being and psychological health (Gross and John, 2003). On the other hand, deficits in emotion regulation have been implicated in an estimated 40–75% of different psychopathologies, including mood and anxiety disorders (Aldao et al., 2010; Gross & Jazaieri, 2014; Joormann & Stanton 2016). A characteristic of psychopathologies marked by emotion regulation deficits is the presence of significant gender differences in the prevalence of these disorders (Nolen-Hoeksema, 2012).

Many emotion regulation processes have been characterized by significant gender effects, including the frequency of employment of specific emotion regulation strategies (e.g.,

Nolen-Hoeksema & Jackson, 2001; Tamres, Helgeson, & Janicki, 2002; Nolen-Hoeksema & Aldao, 2011; Kwon, Yoon, Joormann, & Kwon, 2013). Gender differences in emotion regulation might be particularly prevalent in the context of flexible emotion regulation strategy choice. Emotion regulation flexibility is thought to comprise three components: sensitivity to situational demands (context); availability of a diverse array of strategies (repertoire); and the ability to switch strategies if needed (responsiveness to feedback; Bonanno & Burton, 2013). Some gender role theories suggest that females use more internally focused, passive responses to their emotions, such as rumination, while males are more likely to engage in suppression or avoidance, including turning to substances to avoid (for a review see Tamres et al., 2002). Males are more likely to engage in impulsive, reward-seeking behaviours in response to negative emotions (Tamres et al., 2002). Some studies suggest that the relationship between depressive affect and later alcohol use is stronger for males than females (Carney, Ameli, Tenne, Affleck, & O'Neil, 2000; Swendsen et al, 2000), suggesting that males may be more likely than females to seek the rewarding effects of alcohol in response to negative emotions. Indeed, studies of adults show that males consistently score higher on measures of “drinking to cope” compared to females (Cooper et al., 1992; Nolen-Hoeksema & Harrell, 2002; Park & Levenson, 2002). A recent study by Goubet and Chrysikou (2019) found that females also had a significantly larger repertoire than males in terms of use of adaptive emotion regulation strategies, suggesting that females may have access to a greater number of strategies than males depending on context. Females also showed higher levels of regulatory effort which would suggest that females put more effort into their affect regulation and try more emotion relation strategies than males.

More than a decade of research has shown that emotions can be regulated in many ways and that the application of emotion regulation strategies can have different consequences in

different situations (Webb et al., 2012). Conceptual accounts suggest that flexible choice between emotion regulation strategies is central to well-being and that various forms of psychopathology can be characterized by a breakdown in this flexibility (Kasdan & Rottenberg, 2010). A number of theories suggest that psychopathology can result from the inability to downregulate negative emotions through strategies such as reappraisal, acceptance, problem-solving, or attentional redeployment. Reappraisal involves finding benign or positive attributions or interpretations of an event to prevent or reduce negative mood about the event (Gross 1998). Acceptance involves acknowledging one's emotions without judging them (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Emotion regulation theories of psychopathology then argue that the inability to use these strategies to downregulate leads to negative emotions that are more uncontrollable, severe, and chronic and likely to develop into symptoms of psychopathology (Campbell-Sills & Barlow 2007; Gross & John 2003; Linehan 1993; Nolen-Hoeksema, 2012). Consistent with these theories, difficulties in reappraisal, acceptance, problem-solving, or attentional redeployment have all been shown to be related to elevated levels of depression, anxiety, or borderline personality disorder symptoms (see Aldao et al. 2010; Campbell-Sills & Barlow, 2007; McLaughlin et al., 2007; Roemer et al. 2009). The inability to deploy these strategies to downregulate negative affect may also lead individuals to engage in maladaptive behaviours, such as binge eating or binge drinking; some studies have found relationships between eating disorders or alcohol-related disorders and difficulties in using acceptance to cope (Breslin et al., 2002) and problem-solving (Van Boven & Espelage, 2006).

Psychopathology can also result from the excessive attempts to downregulate negative emotions through strategies such as suppression or avoidance (Gross 1998, Hayes et al. 1996). Various forms of suppression and avoidance have been implicated in psychopathology, including

suppression of emotional expression (Gross, 1998) and suppression of unwanted thoughts (Wenzlaff & Wegner, 2000). Hayes and colleagues (1999) used the term “experiential avoidance” to refer to the suppression or avoidance of an array of psychological experiences, including thoughts, emotions, sensations, memories, and urges. Finally, behavioural avoidance of emotionally evocative situations has a long history of study in psychology (Mowrer, 1947). Studies have confirmed that people who chronically suppress or avoid their emotions are at increased risk for depression (Wenzlaff & Wegner, 2000) and anxiety disorders, such as panic disorder (Barlow, Craske, Cerny, & Klosko, 1989), posttraumatic stress disorder (Foa & Kozak, 1986), and social phobia and anxiety (Kashdan & Breen, 2007).

Research Objectives and Hypotheses

The current study built on the limited research on male CSA by addressing several gaps. One prominent gap in the literature is that there have been no studies to date which have specifically and comprehensively examined the concept of emotion regulation among adult males with histories of CSA. As such, the current study: (1) examined how adult males with CSA histories performed on both trait- and state-based emotion regulation measures (i.e., the DERS and S-DERS), compared to males from a normative non-clinical sample ($N = 97$; Gratz & Roemer, 2004) as well as a control group of non-CSA males ($N = 40$); (2) gathered multi-method information on CSA-specific emotion identification, modulation, and expression based on a brief semi-structured interview with males after construction of their trauma narrative; and (3) examined the role of emotion regulation strategies and the link to psychological and adaptive functioning outcomes among adult males with and without CSA histories. For objective three, psychological functioning was operationalized through various self-report outcomes, namely depression, anxiety, traumatic stress, anger (state and trait), dissociation, and resilience. I did not

examine data from the SCID-5 because the goal was to better understand the level of distress among males with histories of CSA, rather than whether they met criteria for a particular diagnosis. Additionally, it was anticipated that the self-report data would provide richer information given that outcomes are based on frequency and/or severity of occurrence.

For the first research objective, I hypothesized that males with CSA histories would report greater levels of emotion dysregulation (both state and trait) compared to males from the normative and control samples. For the second research objective, I hypothesized that males with CSA histories would generally report a fewer number of emotions (i.e., identification), endorse greater use of maladaptive strategies (e.g., substance use, suppression), and use fewer adaptive and helpful strategies (e.g., positive appraisal), compared to a non-CSA sample of males. For the third research objective, I wanted to focus more specifically on the types of emotion regulation strategies among males with histories of CSA. I hypothesized that emotion regulation strategies would significantly impact psychological and adaptive functioning among CSA males. More specifically, I anticipated that maladaptive emotion regulation strategies would be linked to poorer psychological and adaptive functioning.

Method

Participants

Data collection for the current study occurred simultaneously with Study 1 between March 2018 and February 2019. A total sample of 109 males completed Study 2, namely 69 with CSA histories and 40 with no CSA histories.

Measures

Several Study 1 measures scores were re-used for Study 2 analyses, in particular group membership for CSA and non-CSA categories, the self-report psychological functioning

measure scores (i.e., BDI, DASS, STAXI-2, DERS, RSA), and adaptive functioning scale scores.

Emotion regulation.

Trait. Participants completed the *Difficulties in Emotion Regulation Scale (DERS)* (Gratz & Roemer, 2004; see Appendix O) to understand difficulties in recognizing and managing negative affect. This trait-based 36-item measure is composed of the following subscales: lack of emotional awareness (6 items); lack of emotional clarity (5 items); non-acceptance of emotional responses (6 items); difficulties engaging in goal-directed behaviour (5 items); impulse control difficulties (6 items); and limited access to emotion regulation strategies (8 items). Participants indicated how often the item applied to them using a 5-point scale from 1 (*almost never*, 0–10%) to 5 (*almost always*, 91%–100%). Higher scores on each subscale indicated greater difficulties in that aspect of emotion regulation.

One of the strengths of the DERS is its high internal consistencies for the subscale and total scores (Gratz & Roemer, 2004). The total score showed excellent internal consistency ($\alpha = .93$) and good test–retest reliability ($r = .88$) over a 4-8 week period in a mixed-sex undergraduate sample (Gratz & Roemer, 2004). The DERS total score also showed excellent internal consistency in a mixed-sex sample of 325 participants aged 18-62, with an overall score alpha of .91 (Gratz & Roemer, 2004). In addition, significant correlations between the total score and measures of emotional avoidance, negative mood regulation, and emotional expressiveness supported convergent validity (Gratz & Roemer, 2004). In the current sample, the total score was used in data analysis, and it demonstrated good internal consistency for males with histories of CSA ($\alpha = .87$) and males without histories of CSA ($\alpha = .86$).

State. Participants completed the *State Difficulties in Emotion Regulation Scale (S-DERS)* (Lavender, Tull, DiLillo, Messman-Moore, & Gratz, 2015; see Appendix P), which

assessed for several state-based dimensions of emotion regulation. This 21-item self-report measure includes the four following subscales: 1) non-acceptance (i.e., non-acceptance of current emotions; 7 items); 2) modulation (i.e., difficulties modulating emotional and behavioural responses in the moment; 7 items); 3) awareness (i.e., limited awareness of current emotions; 5 items); and 4) clarity (i.e., limited clarity about current emotions; 2 items). Participants indicated how true each statement was for their emotions in the present moment, using a 5-point scale from 1 (*Not at all*) to 5 (*Completely*). Scores for the S-DERS subscales were calculated by summing individual items for each subscale, and the S-DERS total score was calculated by summing all 21 items. Items on the Awareness subscale, which were worded opposite in direction from items on the other subscales, were reverse scored prior to calculating the sums. Higher scores indicated greater difficulty in the specific dimension of emotion regulation. In a sample of 484 young adults, the internal consistency for the total score was good ($\alpha = .86$), and the subscales ranged from acceptable ($\alpha = .75$ for clarity) to excellent ($\alpha = .92$) for non-acceptance (Lavender et al., 2015). The current sample focused only on the total score, which demonstrated good internal consistency for males with histories of CSA ($\alpha = .87$), and those without ($\alpha = .84$).

Strategies. Participants completed the *Semi-Structured Emotion Regulation Interview (SERI)*; Lee, Weathers, Sloan, Davis, & Domino, 2017; see Appendix Q), which assesses how often individuals use particular emotion regulation strategies and their effects. The SERI contains three main components: 1) an affective state assessment designed to identify emotions experienced during the past month (e.g., moderate anger, intense sadness). Strategies were only assessed for participants who endorsed experiencing a specific affective state at least twice during the past month; 2) an open-ended assessment of emotion regulation strategy use aimed at

gathering information about how participants typically regulate the emotion of interest; and 3) a systematic assessment of each strategy of interest where participants are asked if they use any of the nine commonly-used strategies (i.e., social support seeking; self-medication; deliberate self-harm; acceptance; positive reappraisal; expressive suppression; rumination, behavioural avoidance; and cognitive avoidance). Participants who endorsed using a strategy were then asked to report on how often they use the strategy (i.e., frequency) and what effect doing so had on the specified affective state (i.e., efficacy). Efficacy was rated on a 5-point scale ranging from *substantial increase* (1) to *substantial decrease* (5) with a mid-point of no discernible change. Strategy use frequency ratings demonstrated excellent discriminant validity across all three examined target emotion blocks within an undergraduate sample (N = 68; Lee, Weathers, & Sloan, 2016).

Trauma narrative. In the current study, males in the CSA group were asked to verbally construct a brief (1 paragraph, approximately 30 seconds) narrative related to their CSA experience, whereas males in the non-CSA group verbally constructed a narrative about a difficult childhood life event. Sample instructions for the traumatic script were from Frewen and Lanius' (2010) script-driven imagery method and included: *"I'm going to ask you to tell me about your experience during a traumatic event. Can you think of any particular event related to childhood sexual abuse? Please be sure to tell me about things that you actually remember rather than things that other people may have told you or that you may have heard through the media. In a few sentences, tell me about your most traumatic childhood sexual abuse experience."* Non-CSA participants were provided with the same instructions, with the exception that "childhood sexual abuse" was substituted with "most difficult childhood life

event.” All participants were prompted to include as much sensory information as possible in their narratives (see Appendix R for instructions).

Procedure

As the current study is the second part of a larger research project examining psychological and affective functioning in males with CSA histories and incorporating neuroimaging techniques, the same Study 1 ethics approval, recruitment, and screening methodology was used. Study 2 took place approximately one week after Study 1 and consisted of a 2-hour session at the University of Ottawa. Participants first completed the DERS and then the trauma narrative, which was audio-recorded to aid in transcription for a task in the neuroimaging study. Following the trauma narrative, participants completed the SERI interview, keeping in mind the specific instance of childhood sexual abuse/difficult childhood life event that they had just described as part of the trauma narrative. Last, participants completed the S-DERS. Participants received \$30 at the end of the session. I also informed them that I would contact them in two days as a check-in to address any potential feelings of distress. It should be noted that a third session was scheduled for the neuroimaging component with participants in both the CSA and non-CSA groups who met eligibility criteria. Participants were informed that their neuroimaging session would occur within 1-2 months at a local hospital.

Data Analysis

Data analyses were carried out using the Statistical Package for the Social Sciences (SPSS) computer program (version 25.0). Prior to analyses, the independent (i.e., CSA, non-CSA, trait and state emotion regulation) and dependent (i.e., psychological outcomes) variables were examined for missing values and for univariate and multivariate outliers. The rate of missing data across the independent and dependent variables was low (1.6%). A little MCAR

test revealed that the data were missing completely at random ($\chi^2 = 6073.91$, $df = 7023$, $p = .78$).

As with Study 1, the low rate of missing data in Study 2 was attributed to the in-person nature of data collection as it gave participants the opportunity to ask questions at any time during the session, to take their time in completing the questionnaire package, and to have a research assistant help with reading if there were literacy issues.

Due to the relatively small number of missing data, Expectation Maximization was used to impute missing data instead of mean substitution or multiple imputation (Dong & Peng, 2013). There were no multivariate outliers according to the Mahalanobis distance ($p < .001$). The dataset was checked for normality using skewness and kurtosis values, and values > 3.29 were considered problematic (Tabachnick & Fidell, 2007). In order to check the normality of dichotomous variables, Tabachnick and Fidell (2007) recommend examining dichotomous variables for uneven splits, with more than a 10-90 split indicating non-normality. In the current sample, all dichotomous variables (i.e., CSA/Non-CSA group) were normal.

To address objectives 1 and 2, I compared males in the CSA and non-CSA groups on trait and state measures, as well as to normed samples on the DERS, using independent t-tests and frequency and percentile descriptives. I also compared males in the CSA and non-CSA groups on characteristics of emotion regulation (e.g., number of emotions identified, the use of maladaptive and adaptive strategies) using independent t-tests and frequency and percentile descriptives. To address the third objective of examining the link between emotion regulation strategies and psychological/adaptive functioning, a correlation matrix was conducted.

Results

In this study, participants were asked to recall a particular life event. Males in the CSA group were asked to choose the most difficult CSA experience and recall it in as much detail as

was comfortable for them, whereas males in the non-CSA group were asked to recall a difficult childhood event/experience. For the latter groups, these experiences included events such as physical abuse, emotional neglect, and sudden death in the family. Both narratives were specified to be about 30 seconds in length. Responses on the trait-based emotion regulation measure were collected prior to the recall of either the CSA or non-CSA event, while data on state-based emotion regulation and emotion modulation strategies were collected following the recall task.

Trait and State Emotion Regulation

The Difficulties in Emotion Regulation Scale (*DERs*) was designed to assess trait-level emotion regulation, as defined by Gratz and Roemer's (2004) clinical-contextual framework, and the State Difficulties in Emotion Regulation Scale (*S-DErs*) was used to assess for several state-based dimensions of emotion regulation. To address the first research objective around examining potential differences in emotion regulation between CSA and non-CSA males, independent t-tests were conducted. Males with histories of CSA reported significantly more trait-based emotion dysregulation ($M = 89.1$, $SD = 17.2$), compared to non-CSA males ($M = 76.6$, $SD = 11.9$; $t(107) = 4.0$, $p = .008$), and this represented a large effect (Cohen's $d = .08$). Compared with a normative non-clinical sample of 97 males in which 17% reported at least one form of childhood maltreatment (Gratz & Roemer, 2004), CSA males in the current study reported more trait-based emotion dysregulation than the normed sample ($M = 80.6$, $SD = 18.7$; Gratz & Roemer, 2004, Table V, page 49). In contrast, non-CSA males reported less trait-based emotion dysregulation than the normed male sample, although it is important to note that these comparisons were only descriptive in nature. For state-based emotion regulation, males with CSA histories reported significantly more dysregulation following recall of their most difficult

CSA experience ($M=41.9$, $SD = 11.4$) than non-CSA males following their recall of a difficult childhood experience ($M=36.6$, $SD = 9.0$; $t(107) = 2.5$, $p = .013$), and this represented a medium effect (Cohen's $d = .05$).

Emotion Identification and Modulation Strategies

The Semi-structured Emotion Regulation Interview (*SERI*; Lee, Weathers, Sloan, Davis, & Domino, 2017) was developed to assess the frequency and perceived efficacy of various emotion regulation strategies. To address the first part of the second research objective around potential differences between CSA and non-CSA males in the mean number of emotions identified following the recall procedure, independent t-tests were conducted. Males with CSA histories identified a significantly lower number of emotions following the trauma recall task ($M = 1.5$, $SD = 1.0$), compared with non-CSA males' recall of a difficult childhood experience ($M = 2.3$, $SD = 1.2$; $t(107) = 2.3$, $p = .018$). This resulted in a medium effect (Cohen's $d = .07$).

To address the second part of the second research objective around potential differences in the use of maladaptive/adaptive strategies between CSA and non-CSA males, independent t-tests were conducted. Overall, males in the CSA group reported using a higher number of maladaptive strategies (e.g., self-medication, deliberate self-harm, expressive suppression, rumination, behavioural and cognitive avoidance) as a means of managing emotions related to memories or reminders of their childhood sexual victimization ($M = 4.1$, $SD = 1.8$), compared to non-CSA males following recollection of a difficult childhood experience ($M = 2.5$, $SD = 2.3$; $t(107) = 2.1$, $p = .017$). This resulted in a medium effect (Cohen's $d = .07$). Similarly, CSA males reported a significantly lower number of adaptive emotion regulation strategies ($M = 2.3$, $SD = 1.3$; e.g., social support seeking, acceptance, positive reappraisal) than non-CSA males ($M = 2.9$, $SD = 1.2$; $t(107) = 3.1$, $p = .026$). This resulted in a medium effect (Cohen's $d = .05$).

Table 9 presents the emotions identified by CSA and non-CSA males in the current study in recalling their most difficult childhood sexual victimation or difficult childhood experience. Among males with CSA histories, 42.0% identified *anger/frustration* as the most frequently-experienced CSA-related emotion, followed by *shame/guilt* (14.5%) and *disgust* (10.1%). For non-CSA males, 25% identified *anger/frustration* as the most frequently-experienced emotion following recollection of their most difficult childhood experience, followed by *sadness* (20.0%) and *fear/scared* (15.0%).

Table 10 outlines both the frequency of use and efficacy of various emotion regulation strategies reported by males during the recall task. For CSA males, the three most common emotion regulation strategies were all maladaptive in nature. More than 75% of the CSA males reported that *expressive suppression* was their most frequently-used emotion regulation strategy, with 18.8% experiencing “much more” and 36.2% experiencing “a little more” of their emotions after employing this strategy. Fewer than 24.6% (based on the percentage sums of “no difference in the emotion,” “little less of the emotion,” and “much less of the emotion” in Table 10) of the CSA males who used *expressive suppression* found that this strategy helped to effectively modulate their emotions. The second most common emotion regulation strategy among CSA males was *rumination* (72.5%). Of the males who used this strategy, more than 65.2% reported that they experienced at least a little more of their emotions (based on the percentage sums of “much more of the emotion” and “little more of the emotion” in Table 10), as compared to 7.1% who found that this strategy resulted in no difference in modulating their emotions. Last, *cognitive avoidance* was the third most commonly-reported emotion regulation strategy (65.6%) by CSA males. Of these males, 42% found that this strategy helped to effectively modulate their emotions (based on the percentage sums of “little less of the emotion”

and “much less of the emotion” in Table 10), whereas 14.4% found that that this strategy was not helpful (based on the percentage sum of “little more of the emotion” and “much more of the emotion” in Table 10).

Turning to the non-CSA group, the top three emotion regulation strategies used following recollection of their most difficult childhood experience were adaptive. Close to half of non-CSA males (47.5%) reported that their most frequency-used emotion regulation strategy was *positive reappraisal*, with 40% citing that it was helpful in modulating their emotions. The next most commonly-reported emotion regulation strategies were equally *acceptance* (42.5%) and *social support seeking* (42.5%). Close to 30% of the males who used *social support seeking* and *acceptance* found that both strategies helped to modulate their emotions, as compared to 12.5% (social support seeking) and 10% (acceptance) of males who reported that these strategies had no impact. Finally, non-CSA endorsed the use of *expressive suppression* (42.0%) and *rumination* (42.0%) as emotion regulation strategies for a difficult childhood experience. Of the males who used the maladaptive strategy of *expressive suppression*, only 10% found it helpful in modulating their emotions. In contrast, 22.5% of males found it made no difference, and 15% found that it was not helpful. Similarly, only 7.5% of non-CSA males who used *rumination* as an emotion regulation strategy found it to be helpful, as compared to 22.5% who found it was not helpful and 10% who found it made no difference.

The Relationship of Emotion Regulation to Psychological and Adaptive Functioning

To address the third objective around potential links between CSA emotion regulation strategies and psychological/adaptive functioning, a correlation matrix was conducted. For the sample of CSA males, Table 11 shows that adaptive emotion regulation strategies were significantly and positively correlated with one another. For example, greater reported use of

social support was associated with greater acceptance ($r(67) = .33, p = <.01$) and with positive reappraisal ($r(67) = .38, p = <.01$). There were also select maladaptive emotion regulation strategies which were also significantly and positively correlated with one another. For example, greater use of deliberate self-harm was associated with greater behavioural avoidance ($r(67) = .34, p = <.05$), and greater expressive suppression was associated with greater rumination ($r(67) = .22, p = <.05$), behavioural ($r(67) = .26, p = <.05$) and cognitive avoidance ($r(67) = .28, p = <.05$). As for the relationship between adaptive and maladaptive strategies, greater use of positive reappraisal was significantly correlated with lower use of self-medication ($r(67) = -.26, p = <.05$) and with lower use of deliberate self-harm ($r(67) = -.25, p = <.05$).

Examining the link between specific emotion regulation strategies and psychological outcomes, Table 11 shows that the greater the use of acceptance and positive reappraisal was significantly related to greater resilience ($r(67) = .37, p = <.001$ and $r(67) = .32, p = <.001$, respectively), whereas using greater social support was significantly linked with less state-based anger ($r(67) = -.28, p = <.01$). Turning to maladaptive emotion regulation strategies and psychological outcomes, results suggested that the greater the use of self-medication was significantly related to greater dissociative symptoms ($r(67) = .25, p = <.01$), greater symptoms of anxiety ($r(67) = .28, p = <.01$), greater traumatic stress symptoms ($r(67) = .35, p = <.01$), and more trait-based anger ($r(67) = .23, p = <.01$). In addition, greater use of self-medication was significantly linked with lower resilience ($r(67) = -.29, p = <.001$). Similarly, greater use of deliberate self-harm was significantly linked with greater depressive symptoms ($r(67) = .49, p = <.01$), greater symptoms of anxiety ($r(67) = .43, p = <.01$), and greater traumatic stress symptoms ($r(67) = .42, p = <.01$). In contrast, greater use of self-harm emotion regulation strategies was significantly linked with lower resilience ($r(67) = -.45, p = <.01$). The greater the

use of rumination was significantly related to greater symptoms of anxiety ($r(67) = .25, p = <.01$) and traumatic stress ($r(67) = .31, p = <.01$), and it was significantly associated with lower resilience ($r(67) = -.28, p = <.01$). Similarly, the greater the use of behavioural avoidance was significantly associated with greater symptoms of anxiety ($r(67) = .24, p = <.01$), greater symptoms of traumatic stress ($r(67) = .24, p = <.01$), and lower resilience ($r(67) = -.35, p = <.001$). Last, the greater the use of cognitive avoidance was significantly associated with lower resilience ($r(67) = -.36, p = <.001$).

Table 12 outlines the links between emotion regulation strategies and adaptive functioning among males with CSA histories. All emotion regulation strategies were correlated with one another in the same way as in Table 11, such that the three adaptive emotion regulations strategies were significantly and positively correlated with one another, and the six maladaptive emotion regulation strategies were significantly and positively correlated with one another. As for the relationship between adaptive and maladaptive strategies, greater use of positive reappraisal was significantly correlated with lower use of self-medication ($r(67) = -.26, p = <.05$) and with lower use of deliberate self-harm ($r(67) = -.25, p = <.05$). As for adaptive functioning outcomes, higher perceived friendship quality was significantly correlated with higher perceived romantic ($r(67) = .41, p = <.01$) and higher perceived family relationship quality ($r(67) = .32, p = <.01$). Greater perceived romantic relationship quality was also significantly correlated with greater perceived quality of family relationships ($r(67) = .29, p = <.05$).

Turning to the link between emotion regulation strategies and adaptive functioning outcomes, Table 12 indicates that greater use of acceptance was significantly linked with greater perceived romantic relationship quality ($r(67) = -.43, p = <.01$). Surprisingly, both the use of

social support seeking and positive reappraisal were not significantly correlated with any adaptive functioning outcomes. Turning to maladaptive emotion regulation strategies, greater use of self-medication was significantly linked with poorer perceived romantic relationship quality ($r(67) = -.41, p < .01$), whereas greater use of deliberate self-harm was significantly associated with poorer perceived quality of friendships ($r(67) = -.24, p < .05$). Greater use of expressive suppression was significantly linked with poorer perceived friendship quality ($r(67) = -.30, p < .01$), poorer perceived romantic relationship quality ($r(67) = -.33, p < .05$), and poorer perceived family relationship quality ($r(67) = -.34, p < .01$). Similarly, greater use of rumination ($r(67) = -.26, p < .01$), behavioural avoidance ($r(67) = -.30, p < .001$), and cognitive avoidance ($r(67) = -.28, p < .01$) were all significantly associated with poorer perceived quality of friendships. Last, greater use of rumination was significantly linked with poorer perceived romantic relationship quality ($r(67) = -.39, p < .01$), and greater use of cognitive avoidance was significantly associated with poorer perceived family relationship quality ($r(67) = -.32, p < .01$).

Discussion

The current study explored the complex concept of emotion regulation among males with CSA histories to provide a more complete understanding of its important facets and how they act as a potential link between CSA and specific psychological and adaptive outcomes. To the best of my knowledge, this is the first empirical study to examine these variables in an exclusively male sample. This is important in terms of understanding emotion regulation (e.g., number of emotion responses identified, adaptive/maladaptive emotion coping, and trait- and state-based characteristics) and how it may differ depending on whether males have experienced childhood sexual victimization or other forms of maltreatment and adversity (Arttime & Peterson,

2012; Easton et al, 2011; Kia-Keating et al., 2010; O’Leary, 2009). In addition, the current study added to empirical knowledge about the potential links among CSA, emotion regulation strategies, and psychological/adaptive functioning for adult males with maltreatment histories. This type of inquiry is in line with complex trauma theory (Herman, 1992; van der Kolk et al., 2005) which contends that early life stressors, such as CSA, not only impair emotion regulation and mental health outcomes but also undermine the ability of individuals to form meaningful, trusting relationships throughout their life (Cloitre et al., 2012; van der Kolk et al., 2005).

Trait and State Emotion Regulation

The first objective was to examine emotion regulation from a trait- and state-based perspective among males with histories of CSA. As hypothesized, males with CSA histories reported experiencing significantly more trait- and state-based emotion dysregulation, compared to other males without CSA histories. Additionally, males with histories of CSA also reported higher rates of trait-based emotion dysregulation as compared to a standardized norm sample. While broad areas of research have suggested that the experience of child maltreatment is associated with high levels of trait-based emotion dysregulation (Heleniak, Jenness, Vander Stoep, McCauley, & McLaughlin, 2016; McLaughlin, Conron, Koenen, & Gilman, 2010), results of the current study showed that there was something particularly unique about this relationship to a history of CSA. In particular, males with histories of CSA reported higher rates of both types of emotion dysregulation (i.e., trait- and state-based) as compared to non-CSA males, who often had a history of other serious forms of childhood maltreatment, as well as to a non-clinical normed sample (trait-based).

Current study findings that males with histories of CSA experienced higher rates of trait-based emotion regulation, as compared to those with other forms of maltreatment or no history

of maltreatment (as was the case with healthy controls), is similar to findings among broader research on maltreatment and trait-based emotion regulation. Consistent with extant literature, my findings replicate previous results which suggest that individuals with histories of CSA reported greater deficits in the awareness and control of their emotions (McLean, Toner, Jackson, Desrocher, & Stuckless, 2006), and that these deficits are most notable across more difficult trait-based responses such as anger, sadness, and fear among individuals with histories of CSA (Dutton, 1995; McLean et al., 2006). My findings also expand upon past research which has suggested that the impact of early onset intrapersonal trauma, such as CSA, on individuals results in higher rates of trait-based dysregulation (as measured by the DERS; Daros et al., 2019; Ehring & Quack, 2010) by focusing on males exclusively. Furthermore, results are in line with a small number of earlier studies (Briere & Rickards, 2007; Cloitre et al., 1997; van der Kolk et al., 1996), and taken together with past research (Ehring & Quack, 2020), supports the idea that higher rates of trait-based emotion dysregulation would be unique to those with a history of CSA as compared to those with additional forms of maltreatment.

Although there are very limited studies which have measured state-based emotion regulation directly in relation to CSA among males, the current study's findings are complementary to a few broader studies. A comparable finding of state-based measure of emotion regulation among males with histories of CSA most closely resembles that of Easton and Kong's (2017) study which found more generally that the experience of CSA among males resulted in higher rates of hostility (defined as a state-based expression of anger) as compared with non-CSA males when faced with reminders of their CSA experiences. Similarly, my results are more broadly consistent with Daros et al. (2019)'s finding that females with histories of trauma, particularly CSA, tended to report lower distress tolerance, and subsequently, higher

rates of reactionary responses to certain affect-laden situations; suggestive of higher rates of state-based emotion dysregulation. The finding that males with histories of CSA appear to have greater difficulties appropriately regulating their emotions (e.g., fear, anger) and regulatory impulses in the moment, is also more broadly consistent with research on individuals with early-onset interpersonal traumas (i.e., CSA), which found that those with a positive history reported higher rates of experiential emotional avoidance in response to situational stimuli related to their maltreatment experiences (King et al., 2018).

The current study's findings that males with histories of CSA reported higher rates of both trait- and state-based emotion dysregulation could be explained, in part, by the fact that CSA involves a significant intra- and interpersonal disruption during critical developmental periods. As discussed, a disruption during a time when key developmental competencies develop has the real potential to compromise an individual's socio-emotional development and to increase their vulnerability to difficulties in emotion regulation, attachment, and one's sense of self (Courtois & Ford, 2009). Individuals with histories of CSA may therefore develop a general trait disposition for emotional dysregulation on a broader scale (Dvir et al., 2014; Lisak, 1994), as a result of their chronic reduced awareness of the specific emotions that they feel driven to reduce (Daros et al., 2019). It is also possible that males with histories of CSA who regularly attempt to regulate their emotions in-the-moment, but feel uncertain of their specific emotional experiences, come to develop a trait self-concept that they are emotionally dysregulated, and due to perceived failed efforts at self-regulation, may continue to experience situational emotional distress that leads to reinforcing outbursts of rage and to aggressive behaviour (i.e., state-based emotion dysregulation; Dhaliwal et al., 1996; Lisak, 1994).

Characteristics of Emotion Regulation (Identification and Modulation)

The second research objective explored differences in characteristics (e.g., identification and modulation) of emotion regulation between males with and without CSA histories. As expected, males with histories of CSA identified a significantly lower number of emotions following recall of their most difficult CSA experience, compared to non-CSA males' recall of a difficult childhood experience. Additionally, as expected, males in the CSA group reported using a higher number of maladaptive emotion regulation strategies and a lower number of adaptive strategies, as compared to males in the non-CSA group. Findings fit with research that has shown that the experience of chronic interpersonal trauma, such as CSA, in early developmental stages disrupt key facets of emotion regulation; most notably in the areas of identifying and labeling one's own emotional state, tolerating negative emotions, and appropriately regulating their emotions (e.g., fear, anger) or impulses (e.g., Cloitre et al., 2005; Cloitre et al., 2008; Courtois & Ford, 2009; van der Kolk, 1996; van der Kolk et al., 2005). As discussed, this is largely thought to be rooted in the fact that when CSA occurs during key developmental periods, individuals are often solely focused on managing the high intensity emotions they are experiencing, and do not experience the healthy, predictable fluctuations in emotions that result in the ability to understand, name, and regulate their emotions (Cicchetti et al., 1991; Gratz et al., 2009; Parkhill & Pickett, 2016).

The finding that adult males with histories of CSA in the current study identified a lower number of emotions not only fits with past theoretical discussions of the impact of CSA on facets of emotion regulation, like identification, but aligns with findings from Foster's (2017) study where CSA males struggled to identify more than one emotion related to a traumatic recall. The most frequently identified emotion by close to half of the males was *anger*, and the remainder struggled to identify any CSA-related emotions (Foster, 2017). In the current study, results also

showed that about 4 in 10 males with CSA histories reported *anger* as the most frequently experienced emotion and had more difficulty identifying other CSA-related feelings, compared with non-CSA males. This finding is also similar to past research which has found that females and males who experienced CSA tended to have a harder time understanding their emotions. Specifically, individuals with histories of CSA had difficulty naming and noticing affective states than individuals with other forms of maltreatment (e.g., physical abuse), and they also had a lower perception of receiving emotional support from others, particularly in their expression of negative affect (Shipman, Edwards, Brown, Swisher, & Jennings, 2005; Shipman, Zeman, Penza, & Champion, 2000). In a similar study, Ehring and Quack (2010) found higher rates of difficulty with emotion identification among a clinical sample of males and females with histories of CSA as compared to non-traumatized controls, individuals with histories of late-onset traumas occurring over the age of 14 years (e.g., physical assault), and even early-onset non-interpersonal traumas (e.g., car accidents, fire, observed traumatic events in others). In a similar way, current study findings found higher rates of emotion identification difficulty among males with histories of CSA as compared to those without a history of CSA, further supporting the idea that the experience of CSA impacts facets of emotion regulation as part of the complex pattern of post-trauma sequelae found in this population (Cloitre et al., 2005; van der Kolk, 2005).

In examining another aspect of emotion regulation, as expected, males with CSA histories reported greater use of maladaptive strategies to cope with their CSA-related emotions than non-CSA males. These results are similar to both larger gendered studies on emotion regulation and more specific, albeit limited, research on maladaptive and adaptive strategies among males with CSA histories. A meta-analysis of differences in emotion regulation

strategies found that females with trauma histories tend to use more internally focused, passive strategies to manage their emotions (e.g., rumination), while males are more likely to engage in suppression or avoidance, including turning to substances (Tamres et al., 2002). Similarly, males with trauma histories appear more likely than females to engage in avoidant, ruminative, impulsive, or reward-seeking behaviours in response to difficult emotions, such as alcohol use (Cooper et al., 1992; Nolen-Hoeksema & Harrell, 2002; Park & Levenson, 2002). These findings are similar to the types of maladaptive strategy use among males in both the CSA and non-CSA groups in the current study.

Certain maladaptive strategies were most-commonly used among both males with histories of CSA and those without histories of CSA (e.g., expressive suppression and rumination), and this can be best explained by the fact that children exposed to traumatic events are more likely to engage in maladaptive cognitive or behavioural ways of coping with difficult emotions and levels of distress (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001). Researchers often distinguish between problem-focused coping and emotion-focused coping with maltreatment outcomes (Lazarus & Folkman, 1984; Tamres et al., 2002). Problem-focused coping behaviours are aimed at altering the stressor. Problem solving and planning are examples. Emotion-focused behaviours are those that are directed at altering the emotional response to the stressor. Examples are venting emotions, ruminating, avoidance, accepting the problem, interpreting the problem in a different way (e.g., reappraisal), and wallowing in blame/shame. The use of emotion-focused regulation strategies are typical among males and females who have a history of chronic stressors such as maltreatment (Lazarus & Folkman, 1984; Tamres et al., 2002), as there is often not a way to problem solve the experience of

maltreatment more globally, and may explain why males overall in this study showed some similarities in their use of maladaptive regulation strategies.

Based on the current study's findings, males' tendency to rely on certain emotion regulation strategies (e.g., expressive suppression) over others (e.g., social support seeking) is likely representative of the larger male experience, but as witnessed in the difference in frequency of use rates between males with histories of CSA and those without, there appears to be something particularly unique about the experience of CSA. Typical socialization of traditional masculine norms (e.g., self-reliance, toughness, and restriction of emotion; Levant, Hall, Weigold, & McCurdy, 2016; Mahalik et al., 2003) tends to encourage the inhibition of males' adaptive behaviours, reinforcing their use of maladaptive regulatory strategies in difficult experiences (Möller-Leimkühler, 2003; Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). Some experiences by their very nature, such as the experience of CSA, violate the perception of masculine norms, and may lead males with such histories to isolate themselves from experiencing emotions and distancing interpersonally from others in an attempt to cope with difficult emotions and experiences (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005). In other words, males' heightened use of maladaptive strategies may be a responsive reaction to their experienced violation of masculine norms, a characteristic common to the experience of CSA (Alaggia & Millington, 2008; Easton, et al., 2014; Sorsoli et al., 2008).

Given that CSA exemplifies a particularly traumatic and often severe experience in which outward expression of any kind of emotion or support-seeking from an adult might risk escalation of further harm, individuals may begin to rely on maladaptive strategies to cope with emotional distress which continues into adulthood (Hebert et al., 2018). As previously discussed, research has shown that the experience of CSA also results in internalized emotional

distress, such as increased shame and self-blame (e.g., (Dorahy & Clearwater, 2012; Durham, 2003). Therefore, children who experience CSA may be more at risk of using maladaptive regulation strategies to mitigate the intensity of such emotions, more so than those who experience other forms of maltreatment (Hebert et al., 2018). Current study findings support this notion then that the unique experience of CSA results in a greater tendency to use maladaptive emotion regulation strategies (Compas et al., 2001; Hebert et al., 2018), such as expressive suppression and rumination, to modulate CSA-related affect, such as shame and guilt, as compared to males in the non-CSA group in regulation their non-CSA related maltreatment affect or difficult life event affect (e.g., death of a loved one).

Associations Between CSA Emotion Regulation Strategies and Psychological and Adaptive Functioning

Psychological functioning. For the third research objective, I explored the potential links between CSA emotion regulation strategies and psychological/adaptive functioning. My hypotheses were partially supported in that certain maladaptive emotion regulation strategies were linked to poorer psychological outcomes. More specifically, psychological outcomes, such as increased symptoms of depression, anxiety, traumatic stress, and dissociation, were related to CSA males' greater use of self-medication, expressive suppression, rumination, and behavioural and cognitive avoidance. These findings are broadly consistent with research suggesting that both the greater the use of maladaptive strategies and the lower use of adaptive strategies put a person at increased risk for psychopathology (Aldao et al., 2010; Gross & Jazaieri, 2014; Kring & Sloan, 2010). Current study findings are also consistent with the notion that emotion coping strategies employed by individuals with CSA histories represent another potential determinant of the variation in long-term functioning (Walsh, Fortier, & DiLillo, 2010). Specifically,

individuals who have more adaptive means of managing their CSA-related emotions may experience less long-term distress than those who have greater difficulty processing and managing such emotions (Walsh et al., 2010). In light of research showing that emotion regulation strategies impact later adjustment and functioning (Coyne & Racioppo, 2000; Folkman & Lazarus, 1980; Walsh et al., 2010), it is reasonable to hypothesize that variability in the type and frequency of either adaptive or maladaptive coping strategies would help to account for the wide range of emotional and behavioural outcomes associated with a history of CSA.

It has been suggested that CSA itself leads to changes in emotion reactivity and habitual response patterns to emotion distress, and as such, these emotion regulation patterns are a plausible mechanism linking the experience of maltreatment with the onset of psychopathology (Walsh et al., 2010). Among a sample of females with CSA histories, increased emotion dysregulation predicted greater engagement in maladaptive and ineffective strategies, such as denial and disengagement (Fortier et al. 2009; Johnson & Lynch, 2013), which is not unlike the finding in the current study wherein males tended to suppress their CSA-related emotions through behavioural and cognitive avoidance. Similarly, Kim and Cicchetti (2010) observed that a reduced capacity for emotion regulation in youth predicted greater externalizing problems, such as aggressive and delinquent behaviours. Current study findings are in line with this past research in suggesting that more maladaptive strategies result in poorer psychological outcomes, such that CSA males may engage in maladaptive emotion regulation strategies which may result in increased aggressive behaviour (i.e., anger), increased anxiety and depressive symptoms, and struggles with substance use (Jakupcak et al., 2002; Parkhill & Pickett, 2016).

Adaptive functioning. My hypothesis was partially supported in that certain maladaptive emotion regulation strategies were linked to poorer adaptive outcomes.

Interestingly, adaptive functioning outcomes that were linked with greater use of both adaptive and maladaptive emotion regulation strategies were all interpersonal in nature. More specifically, poorer perceived friendship, romantic, and family relationship quality were linked with various combinations of all six maladaptive emotion regulation strategies. Conversely, greater use of acceptance as an emotion regulation strategy was linked with better perceived romantic relationship quality. One possible explanation for the link between CSA-related emotion regulation strategies and interpersonal adaptive functioning is the high rate of interpersonal difficulties among those with histories of CSA (Beitchman et al., 1992; Finkelhor, Hotaling, Lewis, & Smith, 1990; Mullen, Martin, Anderson, Romans, & Herbison, 1994). It is possible that greater levels of emotion regulation difficulties, alongside the greater use of maladaptive coping strategies, may exacerbate the effects of childhood maltreatment on adult relationship functioning (Rellini, 2008).

Past studies examining relational patterns between females and males with CSA histories have pinpointed several explanations. First, the longstanding effects of CSA can put pressure on aspects of communication and trust in a relationship as a direct result of the general strain involved in dealing with some of the psychological outcomes of CSA (Quadara et al., 2016). Second, differences in emotion coping styles between partners have also been found to cause problems and can lead to further emotional distress for the partner with a history of CSA (Quadara et al., 2016). In particular, if individuals with CSA histories default on the assumption that their partners will be unable or unwilling to support difficult affective states, they may be more likely to cope with their emotional distress in unhealthy ways rather than through support seeking (Shipman et al., 2005; Shipman et al., 2000). Third, it is important to understand that emotions are an essential aspect of communication and, to the extent that the clarity and

consistency of communication plays an important role in relational satisfaction (MacNeil & Byers, 2009; Rellini, et al., 2012; Wheelless, Wheelless, & Baus, 1984), clarity of emotions becomes important in the maintenance of important relationships for males with histories of CSA. Given that males with histories of CSA tend to struggle with emotion identification and rely on maladaptive coping strategies to regulate their CSA-related emotions, partners may be unsure about how to best understand, support, and provide reinforcement of helpful strategies during times of emotional distress (Quadara et al., 2016). Taken together, the current study findings support the importance of CSA-related emotion coping in adult relational adjustment (e.g., Frazeri, Tashiro, Berman, Steger, & Long, 2004; Guezlou, Cornett, & Dougherty, 2002; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Runtz & Schallow, 1997; Wyatt & Newcomb, 1990)

Limitations and Future Directions

The findings from the study should be considered in the context of several limitations. First, emotion regulation was examined specifically in the context of CSA, rather than more broadly in terms of males' general approaches to regulating difficult emotions. It will be important for future studies to examine emotion regulation across a wider range of contexts to establish a more comprehensive understanding and to better situate the role of various emotion regulation strategies on mental health and adaptive functioning. Second, the current study compared the use of certain emotion regulation strategies between males who experienced CSA and those who experienced a difficult life event (i.e., males with histories of non-CSA), some of which were other forms of maltreatment (e.g., physical abuse, emotional abuse, neglect) and some of which were not (e.g., car accident, death of a loved one). Finally, the current sample size did not allow for more complex statistical modelling. Future studies should aim to compare

emotion relation strategies across larger samples of males with histories of CSA, taking a person-centred approach, to ensure findings are more comparable.

Research and Clinical Implications

This is the first study to explore CSA-related emotion regulation strategies and their associations with psychological and adaptive functioning among males. Examining male-specific differences in emotion regulation processes is needed to understand more fully both the nuances of emotion regulation processes and to develop effective treatments for the multitude of psychopathologies that have emotion regulation deficits at their core. The current study contributed to the emotion regulation literature in several ways. First, I expanded the study of emotion regulation to males with histories of CSA, and more specifically, provided an examination into the under-researched area of CSA-related emotion regulation. I included a multi-method approach to understanding how males identify and modulate their emotions with either adaptive or maladaptive strategy use. In this way, the current study expanded upon existing literature on how maltreatment experiences, particularly CSA, can illuminate differences in coping among males and impact important life-long psychological and adaptive outcomes.

From a clinical perspective, this study contributes to the need to comprehensively assess the concept of emotion regulation for each individual client with a history of complex trauma, such as the males from the current study with CSA histories. In treatment planning, results from the current study suggest a need to explore with the client several aspects of their emotion regulation. This includes their understanding of the types of certain emotion regulation strategies they may employ in coping with difficult emotions, frequency of use of various emotion regulation strategies, and efficacy of their strategies. This implication is largely based on the clinical need to provide a tailored approach to conceptualizing emotion regulation for males in

clinical settings, without making assumptions of what functional purpose certain strategies hold, and how this may be impacting their functioning overall.

Informing the service needs of males with CSA histories in several ways; namely, the importance of incorporating and tailoring emotion regulation interventions into broader treatment protocols. Results from the current study suggest that addressing emotion regulation strategies as part of trauma treatment seems critical because of the association with mental health functioning. More specifically, current study findings speak to the need to incorporate not only a PTSD treatment approach but also a more complex trauma perspective for many males with CSA histories. Using a complex trauma lens would allow for a focus on addressing difficulties within a developmental perspective that underscores the impact of emotion regulation on several psychological and adaptive areas of functioning.

General Conclusions

Research within the past two decades, as well as systematic changes in the perception of abuse within the Canadian criminal justice system, suggests that the sexual abuse of boys is much more pervasive than initially believed (Dube et al., 2005; McDonald & Tijerino, 2013). As a consequence of the lack of good-quality, large-scale CSA studies including data on boys, important knowledge gaps persist. Much of the reticence to acknowledge that males are at risk for experiencing CSA stems from pervasive traditional social stereotypes which often associate masculinity with invulnerability and with the idea that boys cannot or are not victims (Romano & De Luca, 2014; Stoltenborgh et al., 2011). These beliefs may make it difficult to recognize males with sexual abuse histories as a population in need of research and clinical attention.

Findings from this two-study dissertation bring awareness to the frequency and seriousness of male childhood sexual abuse, and also serve to promote and inform psychological

assessment and treatment for males across broader areas of functioning. The objective of Study 1 was to examine more comprehensively characteristics of CSA, co-occurring forms of maltreatment and non-maltreatment adversities, and the unique impact of CSA on psychological and adaptive functioning. The findings from Study 1 were then examined within the context of emotion regulation, and results offered a more nuanced look at how males with histories of CSA are emotionally modulating their CSA-related affect and how these modulation strategies are associated with broad areas of well-being. Given that sexual abuse often occurs within a broadly dysfunctional home environment (Lyons & Romano, 2019), I examined male CSA within the context of other forms of maltreatment and non-maltreatment adversities, as well as compared important functioning outcomes to a control group of males without CSA histories.

Major Findings

Regarding prevalence rates and characteristics of CSA, Study 1 found similar rates of CSA occurrence, disclosure rates, and perpetrator characteristics as recent past research (Lyons & Romano, 2019; Easton et al., 2019). Males' experience of CSA more commonly occurred alongside other types of maltreatment rather than on its own. The most frequent co-occurring types of maltreatment were physical and emotional abuse, and CSA males also experienced significantly more non-maltreatment childhood adversity than males without histories of CSA. This finding is important for health care practitioners so that inquiries about CSA are made when other types of maltreatment are disclosed. This may be especially important for discovering CSA among males, because it is often an underreported type of abuse (Holmes & Slap, 1998; Turner et al., 2017). Recognizing the co-occurrence of CSA with other types of maltreatment can lead to greater awareness of CSA prevalence and may aid with greater male disclosures. Findings also showed a strong and unique contribution of CSA, after controlling for

sociodemographics, other forms of maltreatment, and non-maltreatment adversities, to broader areas of psychological functioning. CSA males reported higher rates of depression, anxiety, and traumatic stress as compared to those without a history of CSA, and conversely, reported lower rates of resilience. With respect to clinical diagnoses, males with histories of CSA had higher rates of current and lifetime diagnoses (e.g., mood disorders, anxiety disorders, and substance use) than non-CSA males. The results of Study 1, paired with continued emerging research on males with histories of CSA (e.g., Easton et al., 2019; Lyons & Romano, 2019), confirm the importance of continued research focus to inform treatment practices.

Based on Study 1 findings, I aimed to take a more in depth look at how emotion regulation might play a role in linking the experience of CSA to psychological and adaptive functioning among males. Findings showed that males with histories of CSA reported higher rates of both trait- and state-based emotion regulation, as well as greater use of maladaptive strategies, as compared to non-CSA males. When examined more closely, males' greater use of maladaptive strategies (e.g., deliberate self-harm, rumination, self-medication) was associated with both poorer psychological outcomes (e.g., higher rates of depression, anxiety, and traumatic stress), lower rates of resilience, and poorer perceived interpersonal relationship quality (e.g., romantic, familial, and friendship). In sum, these results indicate that the sexual abuse experiences of males have an overall impact on their emotion regulation, specifically resulting in higher rates of trait- and state-based emotion regulation, as well as their ability to effectively modulate CSA-related affect using efficacious emotion regulation strategies. As a result of their CSA, males may experience disruptions of this key developmental process (emotion regulation) which then contributes to impaired psychological well-being and adaptive functioning.

Theoretical Applications

This dissertation was largely guided by the complex trauma model (National Child Traumatic Stress Network Task Force, 2003; van der Kolk et al., 2005). Although other theories have been used to explain the impact of CSA (e.g., Traumagenic Dynamics Model; Finkelhor & Browne, 1985), they have limited empirical supports and do not account for the range of abusive experiences and symptoms observed in individuals with histories of sexual abuse (Freeman & Morris, 2001). The complex trauma model, however, has received increasing empirical attention in both studies on sexual abuse and in the child maltreatment literature more generally (Cook et al., 2005; van der Kolk et al., 2005). Studies have found that chronic exposure to childhood abuse, family violence, and other types of early interpersonal trauma disrupt the successful attainment of key developmental tasks, such as attachment, emotion regulation, and sense of agency, which in turn affect emotional, social, and cognitive functioning (van der Kolk et al., 2005).

Findings from the dissertation fit within a complex trauma perspective. Males who experienced childhood sexual abuse across early childhood and into early adolescence (in addition to other types of maltreatment and adversity) exhibited several psychological and adaptive functioning difficulties. Given that the complex trauma model has a growing evidence base and accounts for the broad range of experiences and difficulties exhibited by individuals with histories of childhood maltreatment, future studies examining the experience of CSA may consider adopting the complex trauma model as a theoretical framework.

The term “complex trauma” describes both exposure to multiple and chronic interpersonal traumatic events as well as the immediate and long-term outcomes of this type of exposure over multiple domains of functioning (Courtois & Ford, 2009). This dissertation focused on broad aspects of psychological functioning and included important life domains

(adaptive functioning), such as interpersonal relational quality, education, parenting, and employment. This movement in the trauma literature to look beyond PTSD as an outcome of early childhood maltreatment (van der Kolk et al., 2005) was adopted in this dissertation. In addition, I began an examination of the functionality of certain types of CSA-related emotion regulation strategies and their link with adaptive as well as psychological functioning.

Research Implications

Drawing from the two studies, there were several implications to advance research on males with CSA histories. First and perhaps most importantly, there are significant gaps in our understanding of the abuse experiences and outcomes of CSA males. The sexual abuse literature has tended to rely exclusively on females or mixed-sex samples (Chen et al., 2010). The current study's exclusive examination of males addressed several gaps in the literature from a depth, rather than breadth, perspective. Findings suggested a need for more studies with males that compare them to males without histories of CSA, but perhaps also studies that examine variations within CSA males by way of a person-centred analytic approach. Person-centered approaches, such as cluster or latent class analysis, are based on the assumption that the population is heterogeneous with respect to how predictors influence outcomes (Laursen & Hoff, 2006). As such, person-centered approaches may better capture the heterogeneity of abuse experiences for CSA males and the way various classes (profiles) of males are linked with psychological outcomes. Second, in order to continue understanding the frequency of male CSA and its relationship to long-term mental health and adaptive functioning, there needs to be replication of the current studies with a bigger and more representative male sample. Males in my dissertation were generally representative of males in Ottawa and Ontario; however, the

sample size was not a large nation-wide sample due to the comprehensive approach that I adopted for data collection.

Third, it is becoming clear that taking a multiple-method approach to examining the broader impact of male CSA on psychological and adaptive outcomes, as well as important mechanisms linking CSA with outcomes, provides for a richer exploration of this complex issue. Methodological approaches in both of my studies included self-report and researcher-administered structured interviews to examine psychological, adaptive, and emotion regulation. Future studies that take a methodological approach similar to the current dissertation would aid in continuing to connect CSA-related emotion regulation strategies and psychological outcomes. This would bolster efforts to explain ways in which the process of emotion regulation, if negatively affected during childhood, may perpetuate and maintain psychological symptomology and contribute to difficult interpersonal functioning within relationships in adulthood.

Clinical Implications

The dissertation has clinical implications for both CSA assessment and treatment. In terms of assessment, research indicates that clinicians rarely assess for CSA, in part due to fears about upsetting their clients (Lothian & Read, 2002). While clinicians worry that asking about childhood trauma will induce distress, studies indicate that not asking about childhood trauma actually causes more distress and anger among those with maltreatment histories (Lothian & Read, 2002). Clinicians may be especially unlikely to inquire about CSA with male clients, due to beliefs that sexual abuse does not occur in males or that they are not negatively affected by the experience (Alaggia & Millington, 2008). It is important for mental health professionals to include CSA, as well as other forms of maltreatment and non-maltreatment adverse childhood experiences, in screening assessments. Indeed, as highlighted in Study 1, there is benefit to a

multi-method approach to asking about maltreatment, and CSA more specifically, that includes clinical interviewing, structured diagnostic interviewing, and standardized instruments.

Validated measures of childhood sexual abuse, such as the modified version of the SVS in Study 1, can help clinicians get acquainted with the terminology and language to use when assessing childhood sexual abuse. Shorter validated measures of childhood abuse (e.g., CEVQ-SF) can also be used as a brief self-report questionnaire to screen for childhood trauma, and clinicians may follow up with individuals who have positive screens with something more structured, such as the SCID-5. The bottom line is that if males are not asked about childhood sexual abuse, their experiences are likely to remain hidden, and they may not receive an adequate treatment plan to address their symptoms (Lothian & Read, 2002).

From a treatment perspective, this dissertation highlights that: 1) CSA can have a broad impact on an individual's overall functioning, outside of psychological outcomes, such as in the area of adaptive functioning (e.g., interpersonal relationships, parenting, employment, and education); and 2) given the heterogeneity of abuse experiences and psychological and adaptive outcomes, no single type of intervention is likely to be effective for all males with histories of CSA. There are a number of empirically-supported treatments for childhood sexual abuse, but relatively few have been rigorously validated for CSA males (Taylor & Harvey, 2010).

Tailoring psychological interventions to psychological symptoms (PTSD and beyond) and to areas of adaptive functioning would provide for the opportunity to work on reducing distressing symptoms over and above potential clinical diagnoses. Additionally, armed with an understanding of how and in what areas emotion regulation is a potential mechanism in the management of an individual's symptoms (e.g., the increased use of maladaptive over adaptive emotion regulation strategies), psychological interventions can provide helpful and targeted

skills-based interventions aimed at improving emotion recognition and effective modulation.

Although distal factors that occurred many decades ago cannot be changed, the residual effect of these environments and experiences (as well as males' interpretation of their meaning) can be examined and, if necessary, reinterpreted through therapy sessions using a lens of developing emotional competence and flexibility.

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Table 1.

Characteristics of Men's Childhood Sexual Abuse Experiences (N = 69)

	<u>Percentage (Frequency)</u>	<u>M (SD)</u>	<u>Range</u>
Number of Experiences		1.7 (0.8)	
One	52.2 (36)		
Two	29.0 (20)		
Three or more	18.8 (13)		
Age of Abuse Onset		8.5 (2.7)	5-15
Duration of Abuse			
Once or a few days	21.8 (15)		
Few weeks	10.1 (7)		
Few months	27.5 (19)		
Few years	29.0 (20)		
Many years	11.6 (8)		
Frequency of Abuse			
Once or twice	23.2 (16)		
3-10 times	26.1 (18)		
11-25 times	15.9 (11)		
26-50 times	23.2 (16)		
More than 50 times	11.6 (8)		
Perpetrator Sex			
Male	78.3 (54)		
Female	18.8 (13)		
Male and Female	2.9 (2)		

Age of Perpetrator

Child (less than 12 years)	1.4 (1)
Adolescent (12 to 18 years)	26.1 (18)
Young adult (19 to 30 years)	26.1 (18)
Middle-aged adult (31 to 59years)	39.1 (27)
Older adult (60 years and older)	7.2 (5)

Relationship to Perpetrator

Friend/Acquaintance of parent(s)	17.4 (12)
Cousin	14.5 (10)
Stranger	11.6 (8)
Uncle	10.1 (7)
Neighbour	7.2 (5)
Priest/religious figure	7.2 (5)
Father	5.8 (4)
Sibling (brother or sister)	5.8 (4)
Friend of yours	5.8 (4)
Babysitter	5.8 (4)
Grandfather	4.4 (3)
Step-father	2.9 (2)
Step-mother	1.5 (1)
Mother	0% (0)
Grandmother	0% (0)
Aunt	0% (0)

Abuse Disclosure

Yes	62.3 (43)
No	37.7 (26)

Age at First Disclosure^a

21.9 (9.5) 6-53

Years Between Abuse and Disclosure^a

13.6 (9.4) 0-46

Person(s) To Whom Abuse Disclosed^b

Mother	43.5 (30)
Sibling	30.4 (21)
Other (e.g., therapist, partner)	30.4 (21)
Friend	20.3 (14)
Father	18.8 (13)

Reaction to Disclosure

Supported	51.2 (22)
Did not believe	25.6 (11)
Blamed	6.9 (3)
Ignored	4.7 (2)
Other (e.g., indifference and support)	11.6 (5)

Note. *M* = Mean; *SD* = Standard Deviation

^a Based on a subsample of 43 participants (out of 69) who disclosed their sexual abuse history; ^b Across all experiences so totals can exceed 100 since males may have disclosed to one or more individuals

Table 2.

Socio-Demographic Information for CSA and Non-CSA Men (N = 109)

	CSA (n = 69)	Non-CSA (n = 40)	
	Percentage (Frequency)	Percentage (Frequency)	T-Tests and χ^2
Age	(<i>M</i> = 39.7, <i>SD</i> = 10.9)	(<i>M</i> = 36.1, <i>SD</i> = 9.4)	<i>t</i> (107) = 1.8, <i>p</i> > .05
Ethnic/Cultural Background			χ^2 (5) = 3.9, <i>p</i> > .05
Caucasian	75.4 (52)	82.5 (33)	
Black (African/Caribbean)	1.4 (1)	5.0 (2)	
First Nations/Metis/Inuit	7.2 (5)	0 (0)	
East Asian (Chinese/Japanese/Korean/Taiwanese)	5.8 (4)	5.0 (2)	
South Asian (Indian/Pakistani/Sri	5.8 (4)	5.0 (2)	
Lankan/Bangladeshi)			
West Asian/Middle Eastern (Iranian/Iraqi)	1.4 (1)	0 (0)	
Latin American (Hispanic)	1.4 (1)	0 (0)	
Mixed background	1.4 (1)	2.5 (1)	
Marital Status			χ^2 (5) = 3.9, <i>p</i> > .05
Married or common-law	43.5 (30)	50.0 (20)	
Single (never married)	36.2 (25)	37.5 (15)	
Separated or divorced	20.3 (14)	12.5 (5)	
Highest Level of Education			χ^2 (7) = 2.3, <i>p</i> = .032
Did not complete high school	2.9 (2)	0 (0)	
High school	49.3 (34)	27.5 (11)	<i>t</i> (107) = 2.9, <i>p</i> = .041
Trade school or community college	17.4 (12)	25.0 (10)	
Undergraduate degree	27.5 (19)	30.0 (12)	
Graduate degree	2.9 (2)	17.5 (7)	

Employment			$\chi^2 (5) = 3.9, p > .05$
Working outside the home	63.8 (44)	65.0 (30)	
Not working outside the home	34.8 (24)	15.0 (6)	
Retired	1.4 (1)	10.0 (4)	
Total Household Income (before taxes)			$\chi^2 (3) = 2.6, p = .043$
Less than \$29,000	31.9 (22)	27.5 (11)	
\$30,000 to \$59,000	31.9 (22)	17.5 (7)	$t (107) = 2.1, p = .037$
\$60,000 to \$89,000	26.1 (18)	30.0 (12)	
More than \$90,000	10.1 (7)	25.0 (10)	

Note. CSA = Childhood Sexual Abuse; *M* = Mean; *SD* = Standard Deviation

Table 3.

Maltreatment and Non-Maltreatment Adverse Childhood Experiences for CSA and Non-CSA Men (N = 109)

	CSA (n = 69)	Non-CSA (n = 40)	
	Percentage (Frequency)	Percentage (Frequency)	T-Tests and χ^2
Forms of Maltreatment	<i>M</i> = 1.2, <i>SD</i> = 0.6	<i>M</i> = .93 <i>SD</i> = 0.3	<i>t</i> (107) = 2.6, <i>p</i> = .013
Physical Abuse	68.1 (47)	20.0 (8)	χ^2 (1) = 5.6, <i>p</i> = .011
Emotional Abuse	43.5 (30)	2.5 (1)	χ^2 (1) = 20.9, <i>p</i> = .009
Physical Neglect	5.8 (4)	0 (0)	
Emotional Neglect	1.4 (1)	0 (0)	
Non-Maltreatment Adverse Childhood Experiences	<i>M</i> = 6.7, <i>SD</i> = 3.0	<i>M</i> = 4.9, <i>SD</i> = 2.6	<i>t</i> (107) = 3.1, <i>p</i> = .007
Were you ever in a very bad fire, explosion, flood, tornado, hurricane, earthquake or other disaster?	18.8 (13)	12.5 (5)	
Were you ever in a very bad accident (at home, school, or in a car) where you had to be in a hospital for many days?	20.3 (14)	22.5 (9)	
Did you ever have a very bad illness where you had to be in the hospital for many days?	29.0 (20)	22.5 (9)	
Did someone you were really close to ever have a very bad accident where he or she had to	55.1 (38)	45.0 (18)	

be in the hospital for many days?

Did someone you were really close to ever have very bad illness where he or she had to be in the hospital a lot?	71.0 (49)	67.5 (27)
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Was there ever a time in your life when your family had to live on the street or in a shelter because they had no other place to stay?	17.4 (12)	10.0 (4)
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Did you ever have to do a school year over again?	15.9 (11)	25.0 (10)
---	-----------	-----------

Was there ever a time when your mother, father, or primary caregiver lost a job or couldn't find work?	60.9 (42)	42.5 (17)
--	-----------	-----------

Were you ever sent away or taken away from your family for any reason?	30.4 (21)	7.5 (3)
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Was there ever a time when either of your parents (biological, step, or other primary caregivers) ever have to go to a prison?	20.3 (14)	5.0 (2)
--	-----------	---------

Did you ever see a dead body in someone's house, or the street, or somewhere in your neighbourhood (other than at a funeral)?	23.2 (16)	25.0 (10)
Was there ever a time that a family member drank or used drugs so often that it caused problems?	63.8 (44)	40.0 (16)
Was there ever been a time when your parents (biological, step, or other primary caregivers) were always arguing, yelling, and angry at one another a lot of the time?	81.2 (56)	50.0 (20)
Was there ever a time when you were always being teased about how you looked, because of something like a physical disability, a weight problem, having a problem with pimples, or needing to wear glasses?	62.3 (43)	42.5 (17)
Did anyone close to you ever die?	89.9 (62)	75.0 (30)

Note. CSA = Childhood Sexual Abuse; *M* = Mean; *SD* = Standard Deviation

Table 4.

Self-Report Psychological Functioning Outcomes for CSA and Non-CSA Men (N = 109)

	CSA (n = 69)	Non-CSA (n = 40)		
	Mean (SD)	Mean (SD)	Multivariate T-Tests	Effect Size
Psychological Functioning -Self-Report			$T2^a = 2.8, F = 30.7, p = .002$	Partial $\eta^2 = .74$
^b Depression	15.0 (13.3)	8.5 (9.8)	$F = 5.2, p = .024$	Partial $\eta^2 = .05$
^c Anxiety	10.3 (9.8)	6.2 (7.9)	$F = 4.6, p = .034$	Partial $\eta^2 = .04$
^d Stress	17.3 (12.1)	10.8 (9.8)	$F = 8.6, p = .004$	Partial $\eta^2 = .07$
^e Anger				
State Anger	16.5 (3.2)	16.2 (3.9)	$F = 2.3, p > .05$	-
Trait Anger	19.6 (7.9)	17.2 (5.8)	$F = 1.8, p > .05$	-
Anger Expression	39.3 (4.7)	40.3 (5.0)	$F = 2.6, p > .05$	-
Anger Control	39.1 (4.5)	38.8 (4.0)	$F = 1.5, p > .05$	-
^f Dissociation	16.7 (16.5)	13.8 (12.8)	$F = 1.8, p > .05$	-
^g Resilience	111.6 (23.2)	127.2 (20.2)	$F = 12.5, p = .006$	Partial $\eta^2 = .11$

Note. CSA = Childhood Sexual Abuse; SD = Standard Deviation^a Hotelling's Trace Statistic; ^b Scores from the Beck Depression Inventory (BDI); ^{cd} Scores from the Depression Anxiety Stress Scales(DASS); ^e Scores from the State-Trait Anger Expression Inventory (STAXI-2); ^f Scores from the Dissociation Experiences Scale (DES); ^g

Scores from the Resilience Scale for Adults (RSA)

Table 5.

Psychological Disorders Among CSA and non-CSA Men (N = 109)

	CSA (n = 69)	Non-CSA (n = 40)		
	Percentage (Frequency)	Percentage (Frequency)	χ^2	Effect Size
^a Mood Disorders				
Current Major Depressive Disorder	24.6 (17)	20.0 (8)	$\chi^2 (1) = 0.3, p > .05$	-
Past Major Depressive Disorder	47.8 (33)	15.0 (6)	$\chi^2 (1) = 11.9, p = .002$	Cramer's $\Phi = .33$
Current Manic Episode	0 (0)	0 (0)	-	-
Current Hypomanic Episode	0 (0)	0 (0)	-	-
Past Manic Episode	0 (0)	0 (0)	-	-
Past Hypomanic Episode	1.4 (1)	0 (0)	$\chi^2 (1) = 0.6, p > .05$	-
Current Cyclothymic Disorder	0 (0)	0 (0)	-	-
Current Persistent Depressive Disorder	1.4 (1)	0 (0)	$\chi^2 (1) = 0.6, p > .05$	-
Past Persistent Depressive Disorder	2.9 (2)	0 (0)	$\chi^2 (1) = 1.2, p > .05$	-
Bipolar disorder due to another medical condition	1.4 (1)	0 (0)	$\chi^2 (1) = 0.6, p > .05$	-
Substance/Medication induced Depressive Disorder	0 (0)	0 (0)	-	-

Anxiety Disorders				
Panic Disorder	20.3 (14)	10.0 (4)	$\chi^2 (1) = 1.9, p > .05$	-
Agoraphobia	0 (0)	0 (0)	-	-
Social Anxiety	15.9 (11)	2.5 (1)	$\chi^2 (1) = 4.7, p = .031$	Cramer's $\Phi = .21$
Specific Phobia	4.3 (3)	5.0 (2)	$\chi^2 (1) = 0.2, p > .05$	-
Current Generalized Anxiety Disorder	40.6 (28)	22.5 (9)	$\chi^2 (1) = 3.7, p = .048$	Cramer's $\Phi = .18$
Past Generalized Anxiety Disorder	30.4 (21)	15.0 (6)	$\chi^2 (1) = 3.2, p > .05$	-
Other Specified Anxiety Disorder	2.9 (2)	0 (0)	$\chi^2 (1) = 1.2, p > .05$	-
Substance Use Disorders				
Current Alcohol Use Disorder	26.1 (18)	2.5 (1)	$\chi^2 (1) = 9.8, p = .002$	Cramer's $\Phi = .30$
Lifetime Alcohol Use Disorder	42.0 (29)	15.0 (6)	$\chi^2 (1) = 9.8, p = .003$	Cramer's $\Phi = .28$
Current Substance Use Disorder	43.5 (30)	20.0 (8)	$\chi^2 (1) = 6.1, p = .013$	Cramer's $\Phi = .24$
Lifetime Substance Use Disorder	40.6 (28)	25.0 (10)	$\chi^2 (1) = 2.7, p = .041$	Cramer's $\Phi = .16$
Trauma-Related Disorders				
Adjustment Disorder	0 (0)	0 (0)	-	-
Post-Traumatic Stress Disorder	28.9 (20)	2.5 (1)	$\chi^2 (1) = 8.5, p = .004$	Cramer's $\Phi = .32$

Note. CSA = Childhood Sexual Abuse

^a Psychological diagnoses are based on the Structured Clinical Interview for DSM-5 (SCID-5)

Table 6.

Self-Report Adaptive Functioning Outcomes for CSA and Non-CSA Men (N = 109)

	CSA (n = 69)	Non-CSA (n = 40)		
	Mean (SD)	Mean (SD)	Univariate T-Tests	Effect Size ^b
^a Areas of Adaptive Functioning				
Friends	5.4 (2.3)	6.3 (2.4)	t (107) = 2.0, $p = .047$	Cohen's $d = 0.4$
Spouse/Partner	4.2 (2.5)	4.7 (3.4)	t (48) = 0.5, $p > .05$	-
Family	7.9 (4.3)	8.8 (3.3)	t (107) = 1.2, $p > .05$	-
Job	0.71 (2.8)	1.2 (2.4)	t (83) = 2.3, $p = .024$	Cohen's $d = 0.4$
Education	3.0 (2.9)	3.9 (2.0)	t (19) = 0.8, $p > .05$	-
Personal Strengths	3.3 (1.4); 0-7	3.1 (1.1); 1-6	t (107) = 0.6, $p > .05$	-
Personal Concerns	1.8 (1.6); 0-5	1.1 (1.0); 0-4	t (107) = 2.4, $p = .020$	Cohen's $d = 0.5$

Note. CSA = Childhood Sexual Abuse; *SD* = Standard Deviation

^a Adaptive functioning scores are based on the Adult Self-Report questionnaire; ^b Effect sizes were not calculated for non-significant t-tests

Table 7.

The Impact of Child Sexual Abuse on Self-Report Psychological Functioning Outcomes (N = 109)

Dependent Variables	Univariate F	CSA Mean	Standard Deviation	Non- CSA Mean	Standard Deviation	Statistical Significance	Effect Size
Resilience	5.4	111.9	23.2	127.2	12.2	$p = .237$	Partial $\eta^2 = .01$
Depressive Symptoms	1.5	14.4	4.2	8.5	3.8	$p = .023$	Partial $\eta^2 = .05$
Anxiety Symptoms	1.9	10.2	9.8	6.1	2.9	$p = .231$	Partial $\eta^2 = .01$
Traumatic Stress Symptoms	4.5	16.9	6.2	10.7	3.7	$p = .037$	Partial $\eta^2 = .04$
STAXI-2 State Anger	3.7	16.4	3.1	15.2	3.8	$p = .546$	Partial $\eta^2 = .00$
STAXI-2 Trait Anger	2.1	19.4	7.8	17.2	5.8	$p = .159$	Partial $\eta^2 = .02$
STAXI-2 Anger Expression	30.6	41.3	4.8	38.2	5.0	$p = .002$	Partial $\eta^2 = .23$
STAXI-2 Anger Control	24.7	36.5	5.3	39.7	4.1	$p = .004$	Partial $\eta^2 = .46$
Dissociation	1.1	16.8	4.4	13.7	2.7	$p = .297$	Partial $\eta^2 = .01$

Note. These analyses controlled for other forms of maltreatment (potential range from 0-4) and non-maltreatment adverse childhood

experiences (potential range from 0-15). The dependent variables were taken from the following questionnaires: Scores from the Beck

Depression Inventory (BDI); Scores from the Depression Anxiety Stress Scales (DASS); Scores from the State-Trait Anger Expression Inventory (STAXI-2); Scores from the Dissociation Experiences Scale (DES); and Scores from the Resilience Scale for Adults (RSA). Degrees of freedom across all variables were (1,93).

Table 8.

The Impact of Child Sexual Abuse on Psychological Disorders (N = 109)

Dependent Variables	Univariate F	Significance	Effect Size
Current Major Depressive Disorder	.27	$p = .604$	Partial $\eta^2 = .00$
Past Major Depressive Disorder	7.6	$p = .007$	Partial $\eta^2 = .06$
Current Persistent Depressive Disorder	1.3	$p = .266$	Partial $\eta^2 = .01$
Past Persistent Depressive Disorder	1.2	$p = .280$	Partial $\eta^2 = .01$
Current Alcohol Use Disorder	6.9	$p = .010$	Partial $\eta^2 = .06$
Lifetime Alcohol Use Disorder	4.4	$p = .039$	Partial $\eta^2 = .04$
Current Substance Use Disorder	3.1	$p = .083$	Partial $\eta^2 = .03$
Lifetime Substance Use Disorder	.96	$p = .337$	Partial $\eta^2 = .00$
Panic Disorder	.60	$p = .446$	Partial $\eta^2 = .00$
Social Anxiety Disorder	2.8	$p = .092$	Partial $\eta^2 = .02$
Generalized Anxiety Disorder	1.1	$p = .294$	Partial $\eta^2 = .01$
Past Generalized Anxiety Disorder	2.1	$p = .140$	Partial $\eta^2 = .02$
PTSD	7.4	$p = .008$	Partial $\eta^2 = .06$

Note. These analyses controlled for other forms of maltreatment (potential range from 0-4) and non-maltreatment adverse childhood experiences (potential range from 0-15). Psychological diagnoses are based on the Structured Clinical Interview for DSM-5 (SCID-5). The dependent variables were taken from Degrees of freedom across all variables were (1,93)

Table 9.

Men's Emotional Responses to CSA and Non-CSA Experiences (N = 109)

	CSA (n = 69)	Non-CSA (n = 40)
Emotional Response	Percentage (Frequency)	Percentage (Frequency)
Anger/Rage/Frustration	42.0 (29)	25.0 (10)
Shame/Guilt	14.5 (10)	7.5 (3)
Disgust	10.1 (7)	0
Confusion	5.8 (4)	0
Fear	4.3 (3)	15.0 (6)
Sadness	4.3 (3)	20.0 (8)
Embarrassment	4.3 (3)	12.5 (5)
Vulnerability	1.4 (1)	0
Pain	1.4 (1)	0
Regret	1.4 (1)	0
Betrayal	1.4 (1)	2.5 (1)
Panic	0	2.5 (1)
Anxiety	0	12.5 (5)
Loneliness	0	2.5 (1)
Unable to identify emotions	2.9 (2)	0

Note. ^aParticipants could identify as many emotions as they wished from this list, so totals could exceed 100

Table 10.

Adaptive and Maladaptive Emotion Regulation Strategies for CSA and Non-CSA Men (N = 109)

CSA (n = 69)								Non-CSA (n = 40)						
Strategies	% ^a		Efficacy of Use (%) ^b					% ^a		Efficacy of Use (%) ^b				
	No	Yes	Much more of the emotion	Little more of the emotion	No Difference in the emotion	Little less of the emotion	Much Less of the emotion	No	Yes	Much more of the emotion	Little more of the emotion	No Difference in the emotion	Little less of the emotion	Much Less of the emotion
<i>Adaptive Strategies</i>														
Social Support Seeking	46.4	33.3	2.9	1.4	1.4	23.2	4.3	27.5	42.5	0	0	12.5	12.5	17.5
Acceptance	40.6	39.1	1.4	4.3	10.1	18.8	4.3	27.5	42.5	2.5	0	10.0	15.0	15.0
Positive Reappraisal	40.6	39.1	1.4	1.4	11.6	21.7	2.9	22.5	47.5	2.5	0	5.0	22.5	17.5
<i>Maladaptive Strategies</i>														
Self-Medication (Alcohol /Drugs)	29.0	49.3	2.9	0	5.8	18.8	21.7	25.0	40.0	0	0	2.5	15.0	5.0

Deliberate Self-Harm	65.2	14.5	0	0	0	11.6	2.9	65.0	5.0	0	0	5.0	0	0
Expressive Suppression	2.9	76.8	18.8	36.2	13.0	5.8	2.9	17.5	42.0	0	15.0	22.5	5.0	5.0
Rumination	7.2	72.5	36.2	29.0	4.3	1.4	1.4	17.5	42.0	15.0	7.5	10.0	5.0	2.5
Behavioural Avoidance	29.0	50.7	5.8	2.9	10.1	23.2	8.7	35.0	35.0	0	5.0	5.0	17.5	7.5
Cognitive Avoidance	14.5	65.2	4.3	10.1	8.7	27.5	14.5	37.5	32.5	2.5	2.5	10.0	17.5	0

Note.

^aPercentage (%) refers to the number of men who reported using or not using a particular emotion modulation strategy; ^bEfficacy of use refers to how helpful men found this strategy in regulating their emotions associated with either their most difficult CSA experience or difficult childhood experience. Percentages are represented by those men who indicated 'yes' when asked if they used each strategy.

Table 11.

Associations Between Emotion Regulation Strategies and Psychological Outcomes Among CSA Men (N = 69)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Social Support Seeking	1	.33**	.38**	-.13	-.12	-.20	-.17	-.27	-.28	-.18	-.12	-.17	-.16	-.28**	-.11	.79
2. Acceptance		1	.47**	-.20	-.21	-.09	-.21	-.19	-.11	-.09	-.15	-.18	-.14	-.21	-.20	.37***
3. Positive Reappraisal			1	-.26*	-.25*	-.10	-.18	-.11	-.06	-.11	-.06	-.15	-.16	-.04	-.07	.32***
4. Self-Medication				1	.12	.08	.06	.07	.09	.15	.25**	.28**	.35**	.05	.23**	-.29***
5. Deliberate Self-Harm					1	.09	.07	.34**	.12	.49**	.08	.43**	.42**	.10	.08	-.45**
6. Expressive Suppression						1	.22*	.26*	.28*	.13	.12	.16	.15	.06	.04	-.18
7. Rumination							1	.34**	.47**	.29**	-.06	.25**	.31**	.09	.06	-.28**
8. Behavioural Avoidance								1	.36**	.34**	.17	.24**	.24**	-.10	-.12	-.35***
9. Cognitive Avoidance									1	.18	-.02	.16	.18	-.15	-.05	-.36***

10. Depression	1	.34**	.77**	.76**	.19*	.19*	-.65**
11. Dissociation	1	.30**	.33**	.18	.22*	-.39**	
12. Anxiety			1	.76**	.12	.17	-.53**
13. Traumatic Stress				1	.27**	.36**	-.62**
14. State Anger					1	.30**	-.17
15. Trait Anger						1	-.23*
16. Resilience							1

Note. * $p < .05$ (2-tailed), ** $p < .01$ (2-tailed), *** $p < .001$ (2-tailed)

Table 12.

Associations Between Regulation Strategies and Adaptive Functioning Among Men with Histories of CSA (N = 69)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Social Support Seeking	1	.33**	.38**	-.13	-.12	-.20	-.17	-.27	-.28	.14	.20	.09	.04	.12
2. Acceptance		1	.47**	-.20	-.21	-.09	-.21	-.19	-.11	.19	.43**	.11	.02	.15
3. Positive Reappraisal			1	-.26*	-.25*	-.10	-.18	-.11	-.06	.18	.09	.17	.10	.05
4. Self-Medication				1	.12	.08	.06	.07	.09	-.10	-.41**	-.06	-.12	-.30
5. Deliberate Self-Harm					1	.09	.07	.34**	.12	-.24*	-.03	-.11	-.04	-.08
6. Expressive Suppression						1	.22*	.26*	.28*	-.30**	-.33*	-.34**	-.08	-.20
7. Rumination							1	.34**	.47**	-.26**	-.39**	-.21	-.09	-.10
8. Behavioural Avoidance								1	.36**	-.30***	-.13	-.15	-.05	-.08
9. Cognitive Avoidance									1	-.28**	-.18	-.32**	-.14	-.09

10. Friends	1	.41**	.32**	.13	.12
11. Spouse or Partner		1	.29*	.18	.09
12. Family			1	.12	.18
13. Job				1	.07
14. Education					1

Note. * $p < .05$ (2-tailed), ** $p < .01$ (2-tailed), *** $p < .001$ (2-tailed)

Appendix A

General Background Questionnaire

Case Number: _____

Date: _____

This questionnaire asks a number of questions about you and your background so that we may better understand your experiences.

Demographics

1. What is your age? __ __ Years

2. What is your date of birth? Day __ Month __ Year __

3. What is the language that you first learned at home during childhood?

(1) English

(2) French

(3) Other (please specify) _____

4. Do you have any children? __ Yes __ No

GenderAge

5. To which racial or cultural group(s) do you belong to or identify with? (Check all that apply)

_____ White (European, Caucasian)

_____ Black, African-Canadian

_____ First Nations/ Aboriginal (Cree, Micmac, Metis, Inuit)

_____ East Asian (Chinese, Japanese, Korean, Taiwanese, Mongolian, etc.)

_____ South Asian (Bangladeshi, East Indian, Pakistani, Sri Lankan, etc.)

_____ West Asian/ Middle Eastern (Afghan, Arab, Iranian, Iraqi, Turkish, etc.)

_____ Hispanic, Latin American

_____ Other, specify _____

6. What is the highest level of education that you have completed?

- (1) Grade school
- (2) High school
- (3) Trade, technical or vocational school, or business college
- (4) Community college, CEGEP, or nursing school
- (5) Bachelor or undergraduate degree, or teacher's college (e.g. B.A., B.Sc., LL.B.)
- (6) Some college or university, but no degree
- (7) Master's degree (e.g. M.A., M.Sc., M.Ed.)
- (8) Degree in medicine, dentistry, veterinary medicine, or optometry (e.g., M.D., D.D.S., D.M.D., D.V.M., O.D.)
- (9) Doctorate degree (e.g. Ph.D., D.Sc., D.Ed.)
- (10) Other (please specify) _____

7. What is the highest level of education that your father completed?

- (1) Grade school
- (2) High school
- (3) Trade, technical or vocational school, or business college
- (4) Community college, CEGEP, or nursing school
- (5) Bachelor or undergraduate degree, or teacher's college (e.g. B.A., B.Sc.)
- (6) Master's degree (e.g. M.A., M.Sc., M.Ed.)
- (7) Degree in medicine, dentistry, veterinary medicine, or optometry (e.g., M.D., D.D.S., D.M.D., D.V.M., O.D.)
- (8) Doctorate degree (e.g. Ph.D., D.Sc., D.Ed.)
- (9) Other (please specify) _____

8. What is the highest level of education that your mother completed?

- (1) Grade school
- (2) High school
- (3) Trade, technical or vocational school, or business college
- (4) Community college, CEGEP, or nursing school
- (5) Bachelor or undergraduate degree, or teacher's college (e.g. B.A., B.Sc.)
- (6) Master's degree (e.g. M.A., M.Sc., M.Ed.)
- (7) Degree in medicine, dentistry, veterinary medicine, or optometry (e.g., M.D., D.D.S., D.M.D., D.V.M., O.D.)
- (8) Doctorate degree (e.g. Ph.D., D.Sc., D.Ed.)
- (9) Other (please specify) _____

9. What do you consider to be your current main activity?

- (1) Caring for family
- (2) Working for pay or profit
- (3) Caring for family and working for pay or profit
- (4) Going to school
- (5) Recovering from illness/ on disability
- (6) Looking for work
- (7) Retired
- (8) Other (please specify) _____

10. If you are working for pay or profit, is this on a full-time or part-time basis?

- (1) Full-time basis
- (2) Part-time basis

11. For how long have you had this particular work arrangement (in months)? _____

12. In which of the following groups does your total household income fall (prior to income tax)?

- (1) Less than \$10,000
- (2) \$10,000 - \$19,999
- (3) \$20,000 - \$29,999
- (4) \$30,000 - \$39,999
- (5) \$40,000 - \$49,999
- (6) \$50,000 - \$59,999
- (7) \$60,000 - \$69,999
- (8) \$70,000 - \$79,999
- (9) \$80,000 - \$89,999
- (10) \$90,000 - \$99,999
- (11) \$100,000 - \$109,999
- (12) \$110,000 - \$119,999
- (13) \$120,000 - \$129,999
- (14) \$130,000 - \$139,999
- (15) \$140,000 - \$149,999
- (16) Over \$150,000

Physical Health

13. In general, how would you rate your health?

- (1) Excellent
- (2) Very good
- (3) Good
- (4) Fair
- (5) Poor

14. Do you have any of the following long-term conditions that have been diagnosed by a health professional? (Circle all that apply)

- (1) Food allergies
- (2) Other allergies
- (3) Asthma
- (4) Arthritis or rheumatism
- (5) Back problems excluding arthritis
- (6) High blood pressure
- (7) Migraine headaches
- (8) Chronic bronchitis or emphysema
- (9) Sinusitis
- (10) Diabetes
- (11) Epilepsy
- (12) Heart disease
- (13) Cancer
- (14) Stomach or intestinal ulcers
- (15) Effects of stroke
- (16) Urinary incontinence
- (17) Alzheimer's disease or other dementia
- (18) Cataracts
- (19) Glaucoma
- (20) Any other long term condition? (Please specify) _____
- (21) None

15. Does this condition(s) or health problem(s) prevent or limit your participation in the kind or amount of activity you can do at home, at work, or in caring for children?

- (1) No
- (2) Yes

16. Are you regularly using any medication prescribed by a physician?

(1) No

(2) Yes (Please specify) _____

17. At the present time do you smoke cigarettes daily, occasionally, or not at all?

(1) Daily

(2) Occasionally

(3) Not at all

18. Approximately how many cigarettes do you smoke on a daily basis? _____

Criminal History

19. Past criminal charges:

☐ yes

☐ no

Details:

20. Past criminal convictions:

☐ yes

☐ no

Details:

21. Current charges:

☐ yes

☐ no

Details:

22. Current status re: probation and parole

☐ yes

☐ no

Details:

23. Time spent incarcerated

☐ yes

☐ no

24. Number of occasions and Reasons:

25. Duration of each occasion (months):

26. Age at first occasion incarcerated:

27. Time since last incarceration (specify years or months):

Additional Details - Legal History:

Intimate Partner History

28. What is your current marital status?

- (1) Married
- (2) Common-law/ Living with a partner
- (3) Single (never married)
- (4) Partnered, not married
- (5) Widowed
- (6) Separated
- (7) Divorced

29. Have you been emotionally and/or physically **abusive** in your current or previous relationships?

a) Current

- ☐ Yes:
- ☐ Emotional e.g., yelling, name calling, etc.
- ☐ Physical, e.g., slapping, pushing, other physical violence
- ☐ No

Details:

b) Past

- ☐ Yes:
- ☐ Emotional e.g., yelling, name calling, etc.
- ☐ Physical, e.g., slapping, pushing, other physical violence
- ☐ No

Details:

30. Have you been emotionally and/or physically **abused** in your current or previous relationships?

a) ☐ Current

b) ☐ Past

☐ Yes: ☐ e.g. yelling, name calling, etc. ☐ e.g. slapping, pushing, other physical violence

☐ No

Details:

Family of Origin

31. Who did you live with when you were growing up?

Mother

Father

Both parents – together

Both parents – shared custody – please explain: _____

Another relative – please specify: _____

Other – please specify: _____

32. Did your family ever receive services from or have any involvement with child protection/
Children's Aid Society when you were growing up?

☐ yes ☐ no

If so, why? Please explain the circumstances surrounding their involvement.

Thank you very much for completing the questionnaire.

Appendix B

Childhood Trauma Questionnaire

Please answer the following questions about your childhood. When you were growing up please rate to which degree the following statements are true: (1) never true, (2) rarely true, (3) sometimes true, (4) often true, and (5) very often true

1	Got hit so hard that I had to see a doctor or go to the hospital.	1	2	3	4	5	Physical Abuse
2	Family hit me so hard that it left me with bruises or marks.	1	2	3	4	5	
3	I was punished with a belt/board/cord/other hard object	1	2	3	4	5	
4	I believe that I was physically abused	1	2	3	4	5	
5	Beaten so badly it was noticed by a teacher/neighbour/doctor	1	2	3	4	5	
6	Someone in my family helped me feel important or special.	1	2	3	4	5	Emotional Neglect
7	I felt loved.	1	2	3	4	5	
8	People in my family looked out for each other.	1	2	3	4	5	
9	People in my family felt close to each other.	1	2	3	4	5	
10	My family was a source of strength and support.	1	2	3	4	5	

11	People in my family called me “stupid,” “lazy,” or “ugly.”	1	2	3	4	5	Emotional Abuse
12	I thought that my parents wished I had never been born.	1	2	3	4	5	
13	People in my family said hurtful or insulting things to me.	1	2	3	4	5	
14	I felt that someone in my family hated me.	1	2	3	4	5	
15	I believe that I was emotionally abused.	1	2	3	4	5	
16	I didn’t have enough to eat.	1	2	3	4	5	Physical Neglect
17	I knew there was someone to take care of me and protect me.	1	2	3	4	5	
18	My parents were too drunk or high to take care of the family.	1	2	3	4	5	
19	I had to wear dirty clothes.	1	2	3	4	5	
20	There was someone to take me to the doctor if I needed it.	1	2	3	4	5	
21	Someone tried to touch me in a sexual way/made me touch them.	1	2	3	4	5	Sexual Abuse

23	Someone tried to make me do/watch sexual things.	1	2	3	4	5	
24	Someone molested me.	1	2	3	4	5	

Appendix C

Sexual Victimization Survey

Not available due to copyright.

Appendix D

Non-Victimization Adversity

Not available due to copyright.

Appendix E

Beck Depression Inventory (BDI-II)

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the high number for that group. Be sure that you do not choose more than one statement for any group, including item 16 (Changes in Sleeping Pattern) or Item 17 (Changes in Appetite).

1.

- (0) I do not feel sad.
- (1) I feel sad.
- (2) I am sad all the time and I can't snap out of it.
- (3) I am so sad and unhappy that I can't stand it.

2.

- (0) I am not particularly discouraged about the future.
- (1) I feel discouraged about the future.
- (2) I feel I have nothing to look forward to.
- (3) I feel the future is hopeless and that things cannot improve.

3.

- (0) I do not feel like a failure.
- (1) I feel I have failed more than the average person.
- (2) As I look back on my life, all I can see is a lot of failures.
- (3) I feel I am a complete failure as a person.

4.

- (0) I get as much satisfaction out of things as I used to.
- (1) I don't enjoy things the way I used to.
- (2) I don't get real satisfaction out of anything anymore.
- (3) I am dissatisfied or bored with everything.

5.

- (0) I don't feel particularly guilty.
- (1) I feel guilty a good part of the time.
- (2) I feel quite guilty most of the time.
- (3) I feel guilty all of the time.

6.

- (0) I don't feel I am being punished.
- (1) I feel I may be punished.
- (2) I expect to be punished.
- (3) I feel I am being punished.

7.

- (0) I don't feel disappointed in myself.
- (1) I am disappointed in myself.
- (2) I am disgusted with myself.
- (3) I hate myself.

8.

- (0) I don't feel I am any worse than anybody else.
- (1) I am critical of myself for my weaknesses or mistakes.
- (2) I blame myself all the time for my faults.
- (3) I blame myself for everything bad that happens.

9.

- (0) I don't have any thoughts of killing myself.
- (1) I have thoughts of killing myself, but I would not carry them out.
- (2) I would like to kill myself.
- (3) I would kill myself if I had the chance.

10.

- (0) I don't cry any more than usual.
- (1) I cry more now than I used to.
- (2) I cry all the time now.
- (3) I used to be able to cry, but now I can't cry even though I want to.

11.

- (0) I am no more irritated by things than I ever was.
- (1) I am slightly more irritated now than usual.
- (2) I am quite annoyed or irritated a good deal of the time.
- (3) I feel irritated all the time.

12.

- (0) I have not lost interest in other people.
- (1) I am less interested in other people than I used to be.
- (2) I have lost most of my interest in other people.
- (3) I have lost all of my interest in other people.

13.

- (0) I make decisions about as well as I ever could.
- (1) I put off making decisions more than I used to.
- (2) I have greater difficulty in making decisions more than I used to.
- (3) I can't make decisions at all anymore.

14.

- (0) I can work about as well as before.
- (1) It takes an extra effort to get started at doing something.
- (2) I have to push myself very hard to do anything.
- (3) I can't do any work at all.

15.

- (0) I can sleep as well as usual.
- (1) I don't sleep as well as I used to.
- (2) I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- (3) I wake up several hours earlier than I used to and cannot get back to sleep.

16.

- (0) I don't get more tired than usual.
- (1) I get tired more easily than I used to.
- (2) I get tired from doing almost anything.
- (3) I am too tired to do anything.

17.

- (0) My appetite is no worse than usual.
- (1) My appetite is not as good as it used to be.
- (2) My appetite is much worse now.
- (3) I have no appetite at all anymore.

18.

- (0) I haven't lost much weight, if any, lately.
- (1) I have lost more than five pounds.
- (2) I have lost more than ten pounds.
- (3) I have lost more than fifteen pounds.

19.

- (0) I don't feel that I look any worse than I used to.
- (1) I am worried that I am looking old or unattractive.
- (2) I feel there are permanent changes in my appearance that make me look unattractive.
- (3) I believe I look ugly.

20.

- (0) I am no more worried about my health than usual.
- (1) I am worried about physical problems like aches, pains, upset stomach, or constipation.

- (2) I am very worried about physical problems and it's hard to think of much else.
- (3) I am so worried about my physical problems that I cannot think of anything else.

21.

- (0) I have not noticed any recent change in my interest in sex.
- (1) I am less interested in sex than I used to be.
- (2) I have almost no interest in sex.
- (3) I have lost interest in sex completely.

Appendix F

The Depression, Anxiety, and Stress Scale

Please read each statement and select a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results any way, please speak with a qualified health professional.

0 = Did not apply to me at all

1 = Applied to me to some degree or for some of the time

2 = Applied to me to a considerable degree or for a good part of the time

3 = Applied to me very much or more of the time

1. I found myself getting upset by quite trivial things
2. I was aware of dryness in my mouth
3. I couldn't seem to experience any positive feelings at all
4. I experienced breathing difficulty (e.g., breathlessness or excessively rapid breathing in the absence of physical exertion)
5. I just couldn't seem to get going
6. I tend to over-react to situations
7. I had a feeling of shakiness (e.g., legs going to give way)
8. I found it difficult to relax
9. I found myself in situations that made me so anxious I was most relieved when they ended
10. I felt that I had nothing to look forward to
11. I found myself getting upset rather easily
12. I felt that I was using a lot of nervous energy
13. I felt sad and depressed
14. I found myself getting impatient when I was delayed in any way (e.g., elevators, traffic lights, being kept waiting)
15. I had a feeling of faintness
16. I felt that I had lost interest in just about everything
17. I felt I wasn't worth much as a person
18. I felt that I was rather touchy
19. I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion
20. I felt scared without any good reason
21. I felt that life wasn't worthwhile
22. I found it hard to wind down
23. I had difficulty swallowing
24. I couldn't seem to get any enjoyment out of the things I did
25. I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)
26. I felt down-hearted and blue
27. I found that I was very irritable

28. I felt I was close to panic
29. I found it hard to calm down after something upset me
30. I feared that I would be 'thrown' by some trivial but unfamiliar task
31. I was unable to become enthusiastic about anything
32. I found it difficult to tolerate interruptions to what I was doing
33. I was in a state of nervous tension
34. I felt I was pretty worthless
35. I was intolerant of anything that kept me from getting on with what I was doing
36. I felt terrified
37. I could see nothing in the future to be hopeful about
38. I felt that life was meaningless
39. I found myself getting agitated
40. I was worried about situations in which I might panic and make a fool of myself
41. I experienced trembling (e.g., in the hands)
42. I found it difficult to work up the initiative to do things

Appendix G

State-Trait Anger Expression Inventory-2 (STAXI-2)

Not available due to copyright.

Appendix H

Dissociative Experiences Scale

Directions: This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and blacken the appropriate circle to show what percentage of the time you have the experience from 0 – 100% (Never = 0% of the time; Always = 100% of the time).

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip.

(Never) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Always)
 0 % 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said.

(Never) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Always)
 0 % 10 20 30 40 50 60 70 80 90 100%

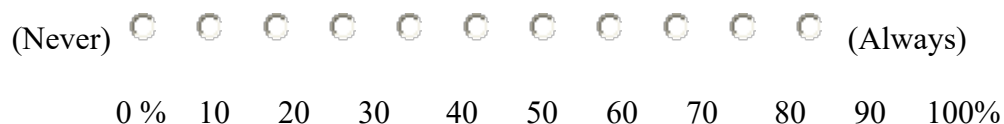
3. Some people have the experience of finding themselves in a place and having no idea how they got there.

(Never) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Always)
 0 % 10 20 30 40 50 60 70 80 90 100%

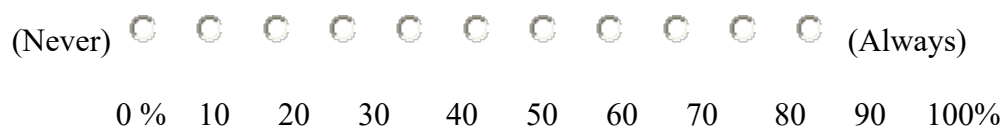
4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on.

(Never) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Always)
 0 % 10 20 30 40 50 60 70 80 90 100%

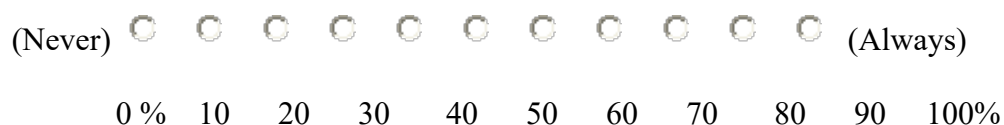
5. Some people have the experience of finding new things among their belongings that they do not remember buying.



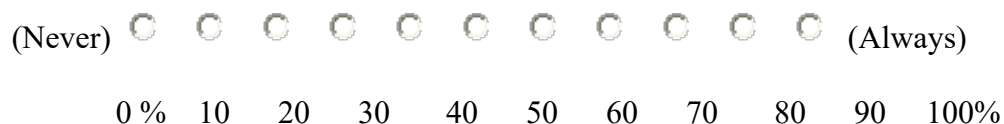
6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before.



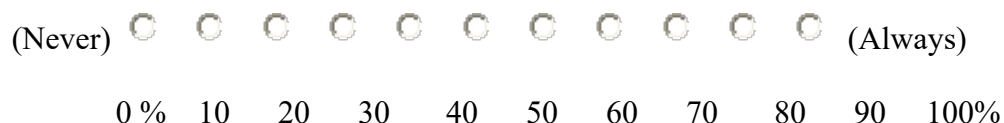
7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person.



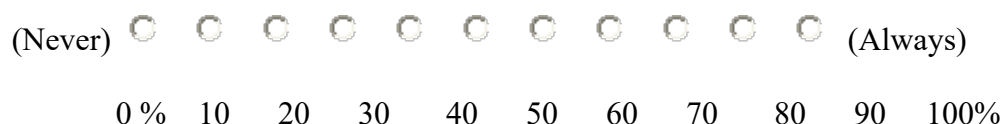
8. Some people are told that they sometimes do not recognize friends or family members.



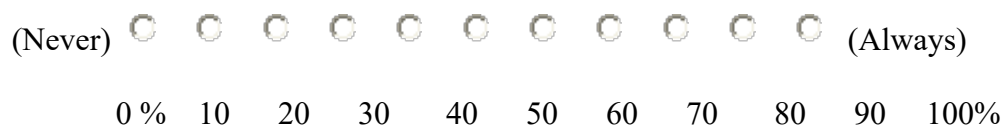
9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation).



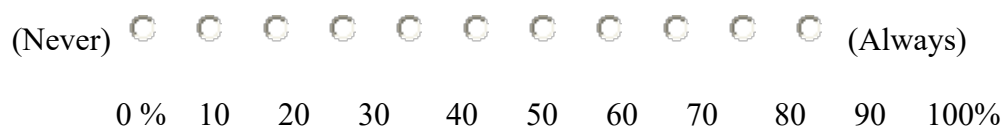
10. Some people have the experience of being accused of lying when they do not think that they have lied.



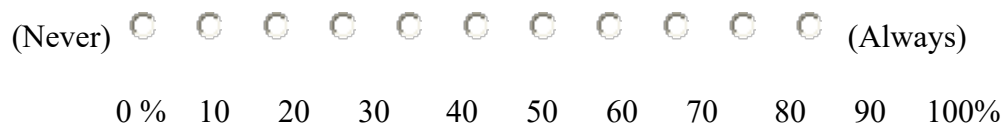
11. Some people have the experience of looking in a mirror and not recognizing themselves.



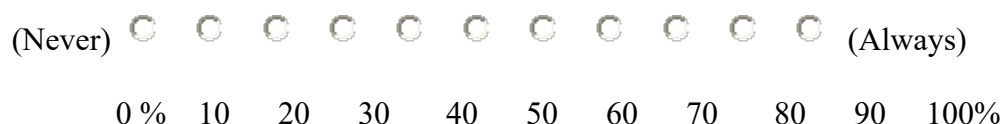
12. Some people have the experience of feeling that other people, objects, and the world around them are not real.



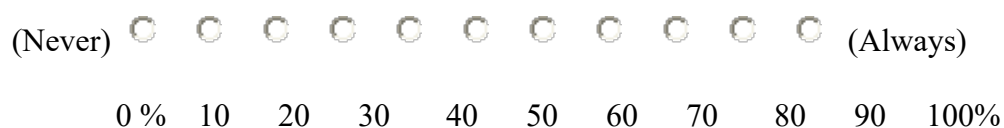
13. Some people have the experience of feeling that their body does not seem to belong to them.



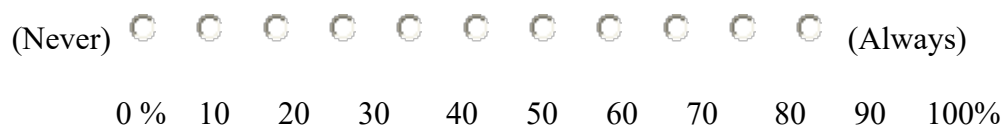
14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.



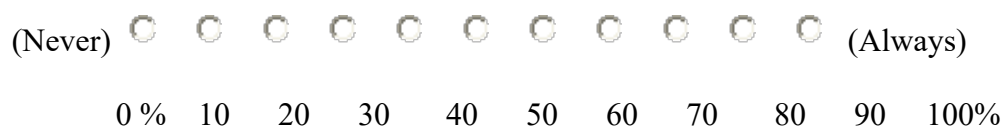
15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them.



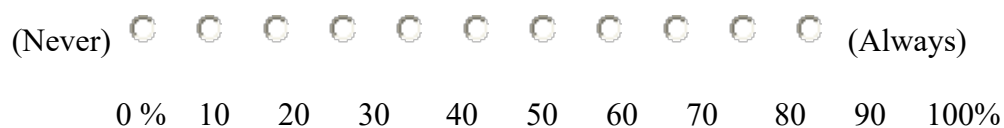
16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar.



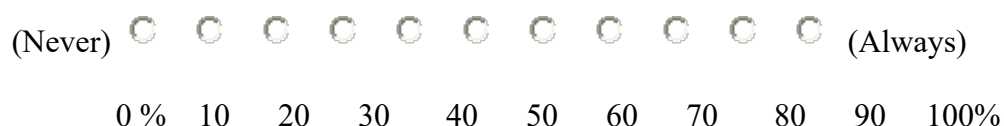
17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them.



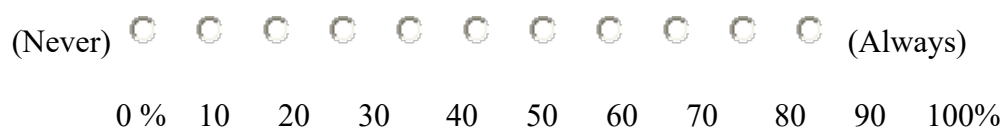
18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them.



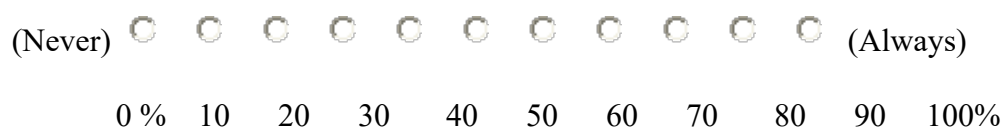
19. Some people find that they sometimes are able to ignore pain.



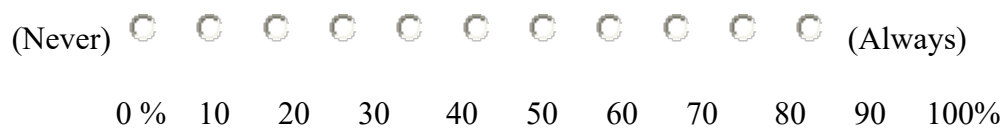
20. Some people find that that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time.



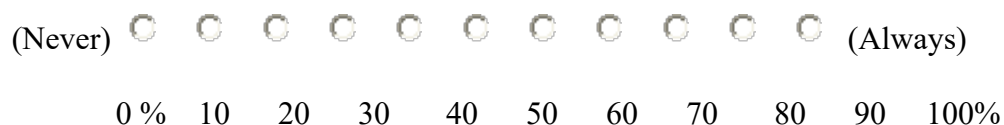
21. Some people sometimes find that when they are alone they talk out loud to themselves.



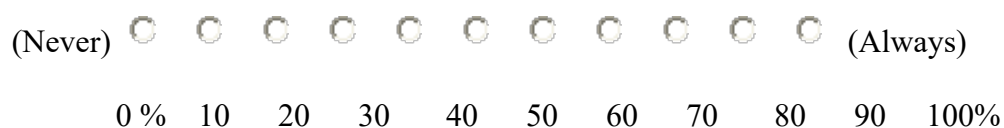
22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people.



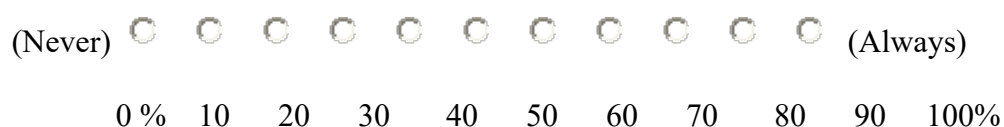
23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.).



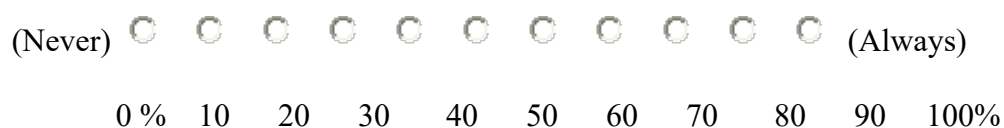
24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing it (for example, not knowing whether they have just mailed a letter or have just thought about mailing it).



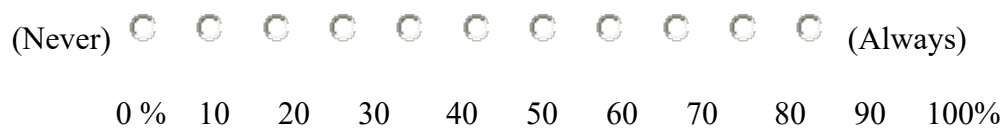
25. Some people find evidence that they have done things that they do not remember doing.



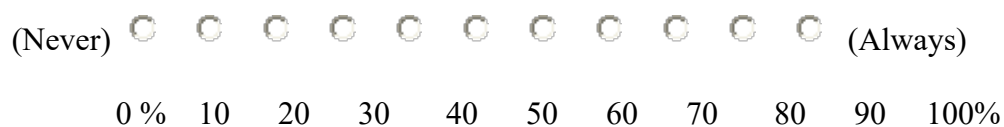
26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.



27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing.



28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear.



Appendix I

The Resilience Scale for Adults (RSA)

Not available due to copyright.

Appendix J

Office of Research Ethics and Integrity at the University of Ottawa Ethics Approval

File Number: H04-17-01

Date (mm/dd/yyyy): 05/14/2019



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
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Carley	Chiasson	Social Sciences / Psychology	Co-investigator
Jessie	Moorman	Social Sciences / Psychology	Co-investigator
Andra	Smith	Social Sciences / Psychology	Co-investigator
Elizabeth	St. John	Social Sciences / Psychology	Research Assistant
Sarah	Zak	Social Sciences / Psychology	Research Assistant

File Number: H04-17-01

Type of Project: Professor

Title: Memory and Affective Functioning in Adult Males with Childhood Maltreatment

Renewal Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
05/30/2019	05/29/2020	Renewal

Special Conditions / Comments:

N/A

Appendix K

Recruitment Poster

Understanding How Childhood Sexual Abuse Impacts Memory and Emotions in Men

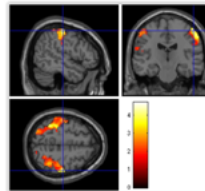
Research tells us that about 1 in 6 men will experience sexual abuse while growing up. Childhood sexual abuse can affect the way someone thinks and feels, and it can even impact important areas of the brain.

Would you like to participate in a study to help understand how childhood sexual abuse might impact men?

Doctoral researchers in Psychology from the University of Ottawa are searching for adult males (aged 25-59) to participate in a 3-part study to understand how childhood sexual abuse impacts memory, emotions, and the brain. **We are looking for men with and without histories of abuse.**

What do I need to know?

- You will be asked to attend 3 sessions over a 2 to 3 week period. The first two sessions will be at the University of Ottawa and the final one at the Royal Ottawa Brain Imaging Centre.
- The first visit could last up to 3 hours. You will complete an interview and questionnaires. You will receive \$40 for your participation.
- The second visit could last up to 2 hours. You will complete some questionnaires, develop a brief description of your childhood sexual abuse experience (or another difficult childhood experience), and complete a brief interview about your description. You will receive \$30 for your participation.
- The third visit could last up to 2 hours. You will complete several tasks while being in an MRI machine that takes pictures of your brain. The tasks will involve remembering pictures and listening to a recording of the description you made in the second visit. After your MRI pictures (45-60 minutes), you will complete a memory test. You will receive \$30 for your participation.



Are you interested? Do you have questions?



Please note that this project has received ethics approval from the University of Ottawa.

Appendix L

Study Screening Protocol

Hello this is Jessie Moorman calling from the University of Ottawa about the Memory & Emotions Study. I understand you called about participating in our study on [date]. The purpose of my call is to tell you a little about the study, and to ask you a few questions to see whether you are eligible to participate if you are still interested in doing so.

We're looking at whether there are differences in memory and emotional processing for men who have experienced childhood sexual abuse and those who have not. Participation would require two visits, for a total of 5 hours: once to the University of Ottawa and once to the Royal Ottawa Hospital. At the university you'll have an interview, complete some questionnaires, and do a brief story-writing exercise. For your second visit, you'll come to the Royal Ottawa Hospital to complete several tasks while having a brain scan in the fMRI machine.

The brain scanning is low risk for most people. You will NOT be exposed to any radiation, and nothing will be injected into you. We will explain the entire procedure in advance.

Your participation in this study is entirely voluntary; so you can withdraw at any time.

You will receive \$80 at the end of the second visit to help cover any travel and parking fees.

Do you have any questions at this point?

Before participating, I have a few questions to ask you because the fMRI has certain restrictions.

Medication

Do you take any prescription medication?

If so, what do you take?

Medication	Reason

History of Head Injury

Have you ever hit your head so hard that you lost consciousness?

Exposure-based Treatment for PTSD

Are you currently receiving any form of therapy, counselling, or treatment related to childhood sexual abuse?

Please briefly describe these services:

Substance Use

- 1) Has there been any time in the last six months when you had five or more drinks (beer, wine, liquor) on one occasion?
- 2) What are your typical drinking habits like?
- 3) Any problems caused by drinking?
- 4) Objections by others? Social/interpersonal problems?
- 5) Have you used alcohol in potentially dangerous situations?
- 6) Failure to complete your usual activities (e.g., work) because of drinking?
- 7) Legal problems?
- 8) Have you used street drugs in the last six months (marijuana, cocaine, etc.)?

Delusions & Hallucinations

- 9) When watching TV, listening to the radio, or reading the paper do you notice that they are referring to you, or that there are special messages intended specifically for you?
- 10) Are people able to read your mind and know what you are thinking?
- 11) Are there ever thoughts in your head that have been put there from the outside?
- 12) Have you seen visions (heard sounds) or other things that other people didn't see (hear)?

Magnetic Resonance Imager

Because the magnetic resonance imager uses a strong magnetic field, please answer the following questions to help us ensure that you can be safely scanned.

Have you or do you...

YES/NO

Have any metal in you? e.g. Pacemaker; heart valve prosthesis; aneurysm clip; stents, coils or filters; prosthesis; artificial limb or joint; surgical clips?	
If you have a device, what is it?	
Have you had a recent surgery? (6 months)	
Ever had heart surgery?	
How is hearing? Ever had an ear surgery/hearing aid?	
Ever had an eye surgery?	
Have previous history of metal fragments in the eye? Write YES even if removed	
Have an implanted pump, stimulator or electronic device?	
Had a previous MRI? If YES, where and when?	
Have any tattoos and/or body piercing? (check timeframe tattoo and removability piercing)	
Have removable dental work?	
Take medications for heart disease, bronchitis, asthma or high blood pressure?	
Have allergies to food or drugs?	
Have a Nicoderm patch or a medication patch?	
Wear glasses? If YES, can you see without your glasses? (e.g., license plate of car in front of you)	
Wear contacts? If YES, are they coloured?	

Are you claustrophobic (i.e., do you get panicky in small confined spaces)?

ADHD

Have you ever been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit – Hyperactivity Disorder (ADHD)?

Yes No

Now I'll ask you a few questions about attention and concentration. Please indicate the response that best describes how you have felt and conducted yourself **over the past 6 months**.

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very Often

2. How often do you have difficulty getting things in order when you have to do a task that requires organization?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very Often

3. How often do you have problems remembering appointments or obligations?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very Often

4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very Often

5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very Often

6. How often do you feel overly active and compelled to do things, like you were driven by a motor?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very Often

This quiz is adapted from the 18-question symptom checklist called the Adult ADHD Self-Report Scale (ASRS-v1.1), developed in conjunction with the World Health Organization and the Workgroup on Adult ADHD. On the original 18-question test, only 6 of the questions are directly scored to indicate ADHD symptoms, and it is these 6 questions which are included here (<http://counsellingresource.com/quizzes/adhd-asrs/index.html>)

Kessler, R. C. et al. (2005) The World Health Organization adult ADHD self-report scale (ASRS): A short screening scale for use in the general population. *Psychological Medicine*, 35, 245-256. DOI : 10.1017/S0033291704002892

Appendix M

Information Sheet and Consent Form

Title: Memory and Affective Functioning in Adult Males with Childhood Maltreatment

You have been asked to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

The researchers will:

- Discuss the study with you
- Answer your questions
- Keep confidential any information which could identify you personally
- Be available during the study to deal with problems and answer questions

Introduction and Purpose

Individuals who experience maltreatment when they are children often find that they have difficulties in the way they think and feel and the way they interact with others. There is also evidence that experiencing maltreatment as a child can change the way one's brain works. We do not know much about how maltreatment affects men who experienced maltreatment when they were young. This study will begin to answer this question by looking at whether there are differences between men who have and have not experienced maltreatment during childhood. We will be looking specifically at childhood sexual abuse and at one's memory and feelings. We will be comparing different groups, in particular men who have experienced sexual abuse when they were children and men who have not had this experience.

Procedures

- You will be asked to participate in 2 visits
- The first visit will last 3 hours and will be at the Royal Ottawa Brain Imaging Center. You will complete an interview with a research assistant. This interview will be audio-taped so we can review it to make sure we got all the information right. The tape will be destroyed 15 years after the end of the study. You will then complete some questionnaires. Finally, you will develop a brief description of the sexual abuse you experienced. If you did not experience sexual abuse, you will develop a brief description of something difficult that you experienced when you were young.
- The second visit will last 2 hours and will also be at the Royal Ottawa Brain Imaging Center. You will complete several tasks while being in an MRI machine that will take scans of your brain. The tasks will involve remembering pictures and also listening to a recording of the description you made in the first visit. While you are in the scanner, you will also have an electrode pad resting on your left hand as you complete the tasks. This pad will record the temperature of your skin and you will not feel anything from this pad. When the brain scans are finished (45-60 minutes), you will then complete a memory test with the research assistant.

- The second visit will be scheduled about 1 to 2 weeks after your first visit, depending on when you are available and when the MRI machine is free to use.
- While you are participating in the study, it will be important not to receive any mental health services as this could affect results. However, you are always free to seek mental health services if participating in the research makes you feel distress.

fMRI is a painless scanning procedure that makes it possible to take pictures of your brain using magnetic field and radiowaves. It shows the way different areas of your brain are working by measuring the amount of blood that is flowing to those areas. When we scan a brain while a person is working on different mental tasks, we can get information about the parts of the brain that are being used during those tasks.

During the scan, you will be asked to lie flat with your head stabilized on an automated bed that is moved into a two-foot wide cylinder (the scanner). While you are lying in the scanner, you will be asked to do a variety of mental tasks that will be presented on a screen near your feet. There will be a mirror on the scanner to make sure you can clearly see the screen. You will be asked to answer the items on the computer screen by pressing a button with your finger.

One task will examine memory and another task will involve looking at pictures on the screen and providing an answer by pressing a button. The last task while in the scanner will involve listening to a short (about 30 seconds) description of your sexual abuse experience or another difficult experience you had when you were young (if you did not experience sexual abuse).

Possible Risks

The brain scanning is a low risk for most people. Nothing is injected into you, no incisions will be made, and you will NOT be exposed to any radiation. Individuals with metal implants (such as a pacemaker, aneurysm clip, or metal dental implants beyond fillings) cannot take part in this study. The technologist will review this carefully with you prior to scanning. The MRI scans used in this study are not meant to detect or diagnose medical problems. In the case of an incidental finding, scans will be forwarded to a neuroradiologist for review. If further follow up is required the PI will contact the participant with the information from the neuroradiologist with guidance to visit their family physician.

The area within the scanner is pretty tight, and this may cause discomfort for some people. If you feel uncomfortable during the brain scanning, you can talk to the technologist who will always be in two-way communication with you. You will also have a button with you at all times that you can press if you wish to exit the scanner. The scanner makes a loud humming sound with occasional louder noises. You will be given headphones and earplugs to wear in the scanner to help reduce this noise.

As you talk with the research assistant and fill out questionnaires, you may feel some distress or discomfort. You will be able to talk about this with the research assistant (who is a clinical doctoral student) being supervised by the principal investigator Dr. E. Romano. You will be given a list of community resources that include a distress centre hotline and crisis services.

Possible Benefits

You will have the chance to answer questions and learn more about the way you think, feel, and behave. You will also learn about the way your brain works and may have a copy of your brain scan if you wish. The only other benefit is that you will be helping us get a better understanding of the ways in which memory and feelings are affected by childhood maltreatment. This information will help us to eventually come up with improved ways of helping men who have experienced sexual abuse when they were young.

Withdrawal

Your participation in this study is entirely voluntary. Even if you consent to begin this study, you are free to withdraw at any time without any penalty.

Compensation

You will receive \$80 for participating in the study. This money will help cover any travel and parking expenses.

Confidentiality

All personal health information will be kept confidential unless release is required by law. All the questionnaires you complete along with the audio-tape and any notes the research assistant makes will be stored in a locked filing cabinet in the locked research laboratory of Dr. Romano at the University of Ottawa. Your name will not appear on any of the questionnaires. All your information will be destroyed 15 years after the end of the study. Your fMRI scan and data from the skin conduction testing will also be kept in a locked cabinet in the locked research laboratory of Dr. Smith at the University of Ottawa. Your name will be known only to the people who are directly involved in the research study. These include the study investigators and the research assistant. Should we present the data at a conference or in a paper, we will make sure that there is no identifying information so it will not be possible for anyone to know who you are. Please note that The Ottawa Hospital Research Ethics Board and the Ottawa Hospital Research Institute may review relevant study records for audit purposes.

In some situations, confidentiality must be broken. These situations would include cases of a court order, of immediate danger to yourself or to others, of disclosures of child abuse, or of disclosures of abuse by a health care professional. In terms of child abuse, we are required by law to inform the appropriate authorities if we become aware that any child under the age of 16 is at risk of being abused. So, while this does not apply to any disclosures of your own childhood abuse experiences, it would be necessary for us to report to authorities if you disclosed to us that your abuser was still in regular, unsupervised contact with children.

Questions

This study has been approved by the Research Ethics Board (REB) which conforms to the guidelines as set out in the TCPS2 - Tri-Council Policy Statement: Ethical Conduct for Research

Involving Humans (2010) and ICH Good Clinical Practice: Consolidated Guidelines (Health Canada, 1997). The current Chair of the Research Ethics Board is Dr. Pierre Blier. For information on procedural issues, amendments, issues related to specific protocols regarding ethical and scientific issues, please contact:

Keith Busby, PhD
Research Ethics/Scientific Review Coordinator
The Royal
University of Ottawa Institute of Mental Health Research

This study has been approved by The Ottawa Hospital Research Ethics Board. The Board considers the ethical aspects of all research projects involving human subjects that are conducted at the Ottawa Hospital.

Consent Form

Memory and Affective Functioning in Adult Males with Childhood Maltreatment

I understand that I am being asked to participate in a research study about memory and emotions in adult males. This study has been explained to me by the primary researcher.

I have read this 5-page Information Sheet and Consent Form. The study procedures have been explained to me in terms I can understand. I have had a chance to ask any questions and my questions have been answered to my satisfaction. I have had enough time to think about the information discussed with me.

I voluntarily agree to participate in this study. If I decide at a later stage in the study that I would like to withdraw my consent, I may do so at any time.

I understand that there are two copies of this signed Information Sheet and Consent Form. One copy is for me to keep, and the other copy will be kept by the study investigators.

Participant (Print Name)

Signature

Date

Investigator Statement (or Person Explaining the Consent)

I have carefully explained to the research participant the nature of the above research study. To the best of my knowledge, the research participant signing this consent form understands the nature, demands, risks and benefits involved in participating in this study. I acknowledge my responsibility for the care and well-being of the above research participant, to respect the rights and wishes of the research participant, and to conduct the study according to applicable Good Clinical Practice guidelines and regulations.

Name of Investigator/Delegate (Please Print)

Signature of Investigator/Delegate

Appendix N

List of Mental Health Resources

Crisis and immediate support

Anytime, call:

Mental Health Crisis Line:

613-722-6914 (Ottawa) or 1-866-996-0991 (outside Ottawa)

- Crisis services

Ottawa Distress Centre

613-238-3311

<http://www.dcottawa.on.ca/>

- Telephone crisis support

Tel-aide

613-741-6433 (Ottawa); 819-775-3223 (Gatineau)

- Anonymous, confidential, bilingual listening line

If you are having active thoughts, a plan or an intent to harm yourself (and you do not feel you can keep yourself safe)

- **Call 911**
- **Present yourself at the following emergency rooms:**
 - **Ottawa Civic Hospital**
 - 1053 Carling Avenue
 - **Ottawa General Hospital**
 - 501 Smyth Road

Community Psychological/ Counselling Services

The Centre for Treatment of Sexual Abuse and Childhood Trauma

Various offices

613-233-4929

www.centrefortreatment.com/index.htm

- Fee-for-service, some sliding scale services.

Centre for Psychological Services (University of Ottawa)

200 Lees Ave.

613-562-5289

<http://www.sciencessociales.uottawa.ca/psy/eng/cps.asp>

- Sliding scale

Family Services of Ottawa

312 Parkdale Ave.

613-725-3601

www.familyservicesottawa.org

- Sliding scale (range \$10-\$90)

Catholic Family Services

310 Olmstead St. (Vanier)

613-233-8478

<http://www.cfsottawa.ca>

- Sliding scale; bilingual services.

Jewish Family Services

2255 Carling Ave, Suite 301

613-722-2225

<http://www.jfsottawa.com>

- Sliding scale minimum fee of \$10.00/session); services offered in English.

Counselling Centre, St. Paul University

223 Main Street

613-782-3022

http://www.ustpaul.ca/Counselling/index_e.asp

- Some sliding scale services.

Other resources

Mental Health Service Information Ontario: <http://www.mhsio.on.ca/index.html>

- Information about mental health services and supports across Ontario

Drug and Alcohol Registry of Treatment: <http://dart.on.ca>

- Information about drug and alcohol treatment centres across Ontario

Ementalhealth.ca

- An on-line resource guide to a range of mental health services across Ontario

Appendix O

Difficulties in Emotion Regulation Scale (DERS)

Not available due to copyright.

Appendix P

State Difficulties in Emotion Regulation Scale (S-DERS)

Not available due to copyright.

Appendix Q

Semi-Structured Emotion Regulation Interview (SERI)

Not available due to copyright.

Appendix R

Trauma/Autobiographical Narrative Instructions

Traumatic Event

(30 Seconds)

I'm going to ask you to tell me about your experience during a traumatic event. Can you think of any particular event? Please be sure to tell me about things that you actually remember rather than things that other people told you or that you may have heard through the media.

I want you to provide as much detail as you are comfortable revealing about the event.

Our interest is not so much in what part of the event you choose to talk about, but rather in how you describe the event. So do not feel pressured to pick any particular event.

In a few sentences, tell me about your most traumatic childhood experience (specific to sexual abuse?)

OR Most difficult or stressful event in your childhood

(30 Seconds)

I am going to ask you about the most stressful event that occurred in your childhood. The event you choose to remember should be the event that you feel most negatively about.

The event you choose must also be one that you were personally involved in, and you must have a recollection of being personally involved. Do not pick events that you heard about from others. The events must be from a specific time and place. For example, saying "the year my parents divorced" would not be sufficient. An event involving a specific occurrence, such as fight you remember having with a family member, however, would be sufficient.

Our interest is not so much in what part of the event you choose to talk about, but rather in how you describe the event.

In a few sentences, tell me about your most stressful childhood experience.

Neutral/Everyday Memory

*Establish that nothing emotionally significant happened before or after the event

(30 Seconds)

I am going to ask you about an ordinary event that occurred in your childhood. The event you choose to remember should involve an everyday sort of occurrence that you do not feel emotional about (i.e. neutral)

The event you choose must also be one that you were personally involved in, and you must have a recollection of being personally involved. Do not pick events that you heard about from others. The events must be from a specific time and place. For example, saying 'the 1990 holiday seasons' would not be sufficient. An event involving a specific occurrence, such as a particular family dinner, however would be sufficient. I want you to provide as much detail as you can about the event. Later, I will ask you to describe the event and then I will ask you some questions about it.

Our interest is not so much in what part of the event you choose to talk about, but rather in how you describe the event.

In a few sentences, tell me about a neutral memory from your childhood, that is, one without