

Sexual Abuse Characteristics and Psychological Functioning among Male Survivors of
Childhood Sexual Abuse

Jennifer Lyons

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School of Psychology
Faculty of Social Sciences
University of Ottawa

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Abstract

Childhood sexual abuse among males has been associated with many negative psychological outcomes. Studies have attempted to identify which sexual abuse characteristics (e.g., duration, age of onset) are associated with mental health difficulties. While informative, this research has been mostly limited to variable-centered analyses, which do not capture the heterogeneity in males' abuse experiences and psychological presentations. This two-part dissertation advances our understanding of how best to measure childhood sexual abuse and how to account for the diversity of sexual abuse experiences and outcomes among men using a person-centered approach. Given that there are few validated measures of childhood sexual abuse, the first study examined the psychometric properties of a commonly-used measure in the sexual abuse literature, the Sexual Victimization Survey (SVS; Finkelhor, 1979). Once the validity and reliability of the SVS were established, the SVS was used to generate profiles on the basis of abuse characteristics (Study 2). Data for both studies were drawn from a sample of 302 males (85% Caucasian) aged 18 to 65 years seeking support for childhood sexual abuse. Participants completed a modified version of the SVS as well as the sexual abuse subscale of the Childhood Experiences of Violence Questionnaire-Short Form (CEVQ-SF; Tanaka et al., 2012). Twenty-one males completed the SVS again one week later for test-retest purposes. The SVS showed high inter-rater reliability on sexual abuse status and sexual abuse characteristics. Most males (85%) who endorsed sexual abuse on the SVS did so on the CEVQ-SF, resulting in fair concurrent validity. The SVS showed perfect one-week test-retest reliability on abuse status, as well as good to excellent agreement on sexual abuse characteristics between the initial and one week time points. Given the strong psychometric properties of the modified SVS, it was then used to generate childhood sexual abuse profiles in Study 2. Once participants with significant

missing data were deleted, 215 men remained and were included in the generation of profiles. Latent profile analyses revealed three distinct profiles which varied in the severity of abuse experiences. The Severe profile ($n = 56$, 26%) depicted sexual abuse which began in mid-childhood and consisted of a one or two time fondling by an unfamiliar extrafamilial perpetrator. Men in the More Severe profile ($n = 71$, 33%) also experienced abuse in mid-childhood by an extrafamilial perpetrator, but experienced more severe sexual acts that spanned several months to several years. Men in this profile were emotionally closer to their perpetrators prior to abuse onset than males in the Severe profile. The Most Severe profile ($n = 88$, 41%) depicted abuse which began in early childhood and consisted of very severe sexual acts by trusted individuals both within and outside of the family. Men in the Most Severe were significantly more likely to concurrently have experienced child emotional and physical abuse as well as a greater number of non-victimization adversities, compared with men in the other two profiles. Profiles varied with respect to psychological outcomes. Males in the More Severe and Most Severe profiles reported significantly more internalizing problems than men in the Severe profile, and men in the Most Severe profile reported significantly more trauma symptoms than men in the Severe profile. Certain contextual variables were also associated with greater psychological difficulties, namely greater present-day use of avoidant coping predicted more internalizing and externalizing problems, as well as greater trauma symptoms. Worse childhood family functioning was associated with more internalizing and externalizing problems, and disclosure of the abuse (compared to non-disclosure) was associated with more externalizing problems and trauma symptoms. These results have several research and clinical implications, including tailoring assessment and treatment to meet the individual needs of male survivors.

Keywords: male sexual abuse; child maltreatment, profiles, psychological outcomes

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General Introduction

Childhood sexual abuse is a reality for a large number of boys and has been associated with immediate and long-term mental health problems. Nonetheless, the knowledge base for this population remains under-developed. There remain gaps in our understanding of the sexual abuse experiences of males and how these experiences might be linked to mental health outcomes. Existing research (albeit limited) has used variable-centered analyses, which may not capture the diversity of experiences among males. Thus, the overarching objective of this dissertation was to understand the childhood sexual abuse experiences of men using a person-centered approach. Study 1 evaluated the psychometric properties of a commonly-used measure of sexual abuse, namely the Sexual Victimization Survey (SVS; Finkelhor, 1979). Study 2 then used the SVS to create profiles of males based on sexual abuse characteristics, and linked these profiles to adult psychological outcomes. Study 2 also examined how the relationship between profiles and outcomes might be moderated by abuse-related contextual variables.

In order to provide context for this dissertation, the following introduction offers an overview of the existing variable-centered research on male childhood sexual abuse. Specifically, the introduction reviews its frequency, common outcomes reported by males, and three theoretical models of sexual abuse outcomes. Sexual abuse characteristics and contextual variables relevant to Study 2 (i.e., family functioning, coping, and disclosure experiences) are also reviewed. The introduction concludes with a synopsis of the sexual abuse literature on males and the overall objectives of the dissertation.

How Common is Childhood Sexual Abuse in Males?

Childhood sexual abuse refers to sexual activity involving a child below the legal age of consent, which is typically 14 to 18 years (Berliner, 2011). Researchers and clinicians alike are becoming increasingly aware of the reality of childhood sexual abuse in males, but there is wide variability in reported rates of occurrence. Studies using community samples have identified frequencies ranging from 2% to 25% (Barth, Bermtz, Heims, Trelle, & Tonia, 2013; Briere & Elliott, 2003; Dube et al., 2005; Finkelhor, Shattuck, Turner, & Hamby, 2014; Hébert, Tourigny, Cyr, McDuff, & Joly, 2009; MacMillan, Tanaka, Duku, & Vaillancourt, 2013; Molnar, Buka, & Kessler, 2001; Pereda, Guilera, Forns, & Gomez-Benito, 2009; Perez-Fuentes et al., 2013), while frequencies of childhood sexual abuse in male clinical samples range from 10% to 37% (Berthelot, Godbout, Hébert, Goulet, & Bergeron, 2014; Huang, Schwandt, Ramchandani, George, & Heilig, 2012; Lab & Moore, 2005; Muenzenmaier et al., 2014). The Canadian Incidence Study of Reported Child Abuse and Neglect-2008 (CIS-2008; Trocmé et al., 2010) examined 15,980 child maltreatment investigations conducted in a representative sample of 112 child welfare organizations across Canada in the fall of 2008. National estimates from these data indicated that the incidence of substantiated childhood sexual abuse in 2008 was 0.4% and that close to one-fifth (17%) of these cases involved male children and adolescents.

There are a number of explanations for the variability in rates of male childhood sexual abuse. First, there is a lack of consensus on the definition of childhood sexual abuse. Definitions vary with regard to the upper age limit of the victim, type of sexual activity experienced, and victim-perpetrator age difference (Hulme, 2004). A literature review of retrospective childhood sexual abuse 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 (Hulme, 2004). In addition, while childhood sexual abuse is 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 et al., 2014; MacMillan et al., 2013). The definition of sexual abuse is further blurred when we consider the age difference between the perpetrator and victim. Although many studies stipulate an age difference of 5 or more years (e.g., Dube et al., 2005; Lab & Moore, 2005), others have included experiences involving older children or siblings as perpetrators who are within 5 years of the victim (e.g., Briere & Elliott, 2003).

Second, the data collection method can influence rates of childhood sexual abuse (Pereda et al., 2009). Studies in which males self-identify as “sexual abuse victims” tend to yield lower rates of abuse than those which use clear behavioural descriptions (e.g., “Someone touched your genitals or other parts of your body in a sexual way”; Fricker, Smith, Davis, & Hanson, 2003). 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 et al., 2009; Molnar et al., 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). Despite these variations, it is generally accepted that 1 in 6 males experiences childhood sexual abuse before the age of 18 (Dube et al., 2005).

What Makes Males Reluctant to Disclose Childhood Sexual Abuse?

While rates of childhood sexual abuse among males are concerning, they are likely underestimates when one considers that there are approximately 3 to 4 times as many cases of

sexual abuse than are actually disclosed or reported to family members and/or authorities (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Mills et al., 2016). This is an especially significant problem among males (Goodman-Brown et al., 2003; Ullman & Filipas, 2005). A number of factors may explain what makes it difficult for males to disclose childhood sexual abuse. First, males who are sexually victimized by female perpetrators are often faced with societal norms that encourage early sexual experiences with older female partners (Weiss, 2010). According to Holmes, Offen, and Waller (1997), boys may be less likely to label sexual experiences with females as abusive because they often respond in a physiological manner (e.g., erection, ejaculation), contributing to the perception that they somehow encouraged or desired the sexual experience. Second, pervasive cultural stereotypes often associate masculinity with invulnerability and with the idea that male victimization is not serious or harmful (Alaggia, 2005; Hilton, Harris, & Rice, 2003; Romano & De Luca, 2014). As such, males may not report abusive experiences because they do not want to appear vulnerable and/or do not want to admit that they need help (Alaggia, 2005). Third, because most perpetrators of childhood sexual abuse are male, male survivors may not disclose the abuse for fear that they will be labeled as homosexual (Easton, Saltzman, & Willis, 2014). Finally, in terms of rates of occurrence, the risk for sexual victimization is about 2.5 to 3 times greater for females than males (Briere & Elliott, 2003; Dube et al., 2005). The relatively lower occurrence of childhood sexual abuse in males may have made it difficult to recognize these individuals as a population also in need of research and clinical attention (Holmes et al., 1997). As a result, professionals in areas such as medicine, mental health, and child protection may not inquire about sexual abuse in males and/or may minimize its seriousness when reported (Lab, Feigenbaum, & De Silva, 2000).

What is the Impact of Childhood Sexual Abuse in Males?

Given that the aim of Study 2 was to link sexual abuse profiles to psychological outcomes, it was important to review the common mental health difficulties experienced by male survivors of childhood sexual abuse. The immediate and longer-term outcomes of childhood sexual abuse have been well documented in clinical writings and research studies (Chen et al., 2010; Fergusson, McLeod, & Horwood, 2013; Hillberg, Hamilton-Giachritsis, & Dixon, 2011; Kendall-Tackett, Williams, & Finkelhor, 1993; Maikovich-Fong & Jaffee, 2010; Putnam, 2003; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Tyler, 2002). Most research studies have tended to rely exclusively on females or, in the case of mixed-sex samples, to have relatively greater numbers of females than males. Those studies comprised exclusively of males typically have small samples and include men retrospectively recalling childhood experiences (Alaggia, 2005; Holmes, Foa, & Sammel, 2005; Lab & Moore, 2005). Furthermore, studies on male childhood sexual abuse frequently use specialized samples such as pedophiles or prison inmates (Glasser et al., 2001; Johnson et al., 2006), which are not representative of the majority of male survivors. Due to these limitations, there are significant gaps in our understanding of childhood sexual abuse experiences among males.

Short-term influences. Studies have reported heightened levels of maladjustment in children who have experienced sexual abuse relative to non-sexually abused children (Fontanella, Harrington, & Zuravin, 2000; Kendall-Tackett et al., 1993; Maikovich-Fong & Jaffee, 2010; Spataro et al., 2004). Among the more frequently-reported problems are those of aggression, sleep problems, suicidal ideation, post-traumatic stress disorder (PTSD), depression, anxiety, and inappropriate or early sexual behaviour (Calam, Horne, Glasgow, & Cox, 1998; Feiring, Simon, & Cleland, 2007; Fontanella et al., 2000; Tyler, 2002). Although dated, a

frequently cited meta-analytic review of 45 quantitative studies of sexually abused children found that children who had experienced sexual abuse exhibited more symptoms (e.g., PTSD, low self-esteem, depression) than non-abused children, with sexual abuse accounting for 15-45% of the variance in symptomatology differences (Kendall-Tackett et al., 1993).

Research has also examined sexual abuse-related outcomes which are of particular relevance for adolescents, namely risky sexual behaviour, substance use, and suicidality. Research suggests that adolescents with sexual abuse histories initiate sexual behaviour earlier and are more likely to engage in risky sexual practices, including lack of condom use and sex with multiple partners (Homma, Wang, Saewyc, & Kishor, 2012; Kendall-Tackett et al., 1993). This sexual risk taking behaviour, combined with the finding that individuals with childhood sexual abuse histories are more likely to use substances, is thought to increase their vulnerability to further sexual victimization (Barnes, Noll, Putnam, & Trickett, 2009; Classen, Palesh, & Aggarwal, 2005).

With regard to adolescent substance use, a study that focused on adolescents aged 12 to 19 years found that males with sexual abuse histories reported rates of alcohol consumption that were nearly 3 times greater than those of non-sexually abused males (27 alcoholic drinks per month versus 10; Garnefski & Arends, 1998). Adolescent male survivors also appear more likely to engage in binge drinking (defined as consuming five or more alcoholic drinks in a row) and show higher rates of illicit drug use (e.g., cocaine, heroin) compared to non-sexually abused males (Bergen, Martin, Richardson, Allison, & Roeger, 2004; Garnefski & Arends, 1998; Hamburger, Leeb, & Swahn, 2008). Multi-substance abuse also appears more common among males with childhood sexual abuse histories (Holmes & Slap, 1998). One U.S. study found that 6.2% and 22.8% of 6th grade boys who experienced either sexual abuse or both sexual and

physical abuse reported multi-substance use, compared to 0.4% of boys without such histories (Harrison, Fulkerson, & Beebe, 1997). With regard to suicidality, a cross-sectional study of 2,485 Australian adolescents found that childhood sexual abuse was significantly associated with suicidal thoughts, plans, and threats as well as with deliberate self-injury and suicidal attempts, even after controlling for depression, hopelessness, and family dysfunction (Martin, Bergen, Richardson, Roeger, & Allison, 2003). Suicidal thoughts and behaviours seem to be particularly salient for male survivors relative to female survivors (for a systematic review, see Rhodes et al., 2011).

Longer-term influences. Among adult males with childhood sexual abuse histories, common long-term influences include interpersonal problems (Colman & Widom, 2000; Feiring & Cleland, 2007; Gold, Lucenko, Elhai, Swingle, & Sellers, 1999), sexual dysfunction (Holmes et al., 2005; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Senn, Carey, & Venable, 2008), difficulty managing emotions such as anger or rage (Alaggia & Millington, 2008; Fater & Mullaney, 2000), poor self-image (Fergusson et al., 2013), shame and guilt (Dorahy & Clearwater, 2012), and occupational problems (Wohab & Akhter, 2010). These effects appear to continue into later adulthood for many male survivors (Draper et al., 2008). With regard to mental health, studies have indicated that males with sexual abuse histories appear more likely to show symptoms of psychological disorders than non-sexually abused men, including major depressive disorder, PTSD, anxiety disorders, and substance abuse (Cutajar et al., 2010a; Fergusson et al., 2013; Holmes & Slap, 1998; Holmes et al., 2005; Molnar et al., 2001). Males and females seem to experience similar levels of distress following sexual abuse (Chen et al., 2010; Dube et al., 2005; Paolucci, Genius, & Violato, 2001; Young, Harford, Kinder, & Savell, 2007). However, it has been suggested that male survivors experience significantly greater

symptomatology in relation to normative male samples, compared with female survivors in relation to normative female samples (Gold et al., 1999; Ullman & Filipas, 2005).

It is clear that males can experience numerous longer-term difficulties following sexual abuse. The following section focuses on outcomes of particular relevance to male survivors, specifically internalizing and externalizing behaviours, substance use, and trauma symptoms. Although the review is not exhaustive of all difficulties that may be experienced by male survivors, it covers those which appear most often in the research literature.

Internalizing behaviour. Internalizing behaviour refers to an over-controlled, inner-directed pattern of behaviour and includes symptoms of depression and anxiety (Compton, Burns, Egger, & Robertson, 2002). While men and women overall have equally poor outcomes from childhood sexual abuse, retrospective studies suggest that females are more likely to internalize their problems while males display greater externalizing behaviours (Briere & Elliott, 2003; Garnefski & Arends, 1998; Holmes et al., 1997; Lewis, McElroy, Harlaar, & Runyan, 2016; Ullman & Filipas, 2005). Other studies, however, have found no sex differences (Dube et al., 2005; Paolucci et al., 2001) or have found that male survivors have significantly higher internalizing scores (Coohey, 2010; Garnefski & Diekstra, 1997; Gold et al., 1999). Nevertheless, internalizing symptoms can be a significant problem for males with sexual abuse histories.

Depression. Depressive symptoms have been associated with childhood sexual abuse in many studies (Chen et al., 2010; Fergusson et al., 2013; Holmes & Slap, 1998; Maniglio, 2010; Paolucci et al., 2001). In fact, depression appears to be one of the most commonly-documented outcomes of childhood sexual abuse for both males and females (Dube et al., 2005; Fergusson et al., 2013; Perez-Fuentes et al., 2013). A New Zealand longitudinal study of 950 individuals

followed from birth to age 30 found that 6% had experienced childhood sexual abuse (defined as unwanted sexual penetration including vaginal, oral, or anal intercourse prior to age 16). Among those who were sexually abused, 77% had met criteria for major depressive disorder at some point in the last 12 years, compared to 38% of individuals without such histories (Fergusson, McLeod, & Horwood, 2013). Childhood sexual abuse has also been associated with earlier onset of depressive episodes and with prolonged durations of depression (Zlotnick, Mattia, & Zimmerman, 2001).

A common feature of depression is suicidal ideation and behaviour (Nock & Kessler, 2006). Not surprisingly, these difficulties have been found to be elevated in individuals with childhood sexual abuse histories (Cutajar et al., 2010b; Garnefski & Arends, 1998; Molnar et al., 2001; Perez-Fuentes et al., 2013). In a nationally representative U.S. study, Molnar et al. (2001) interviewed 5,877 men and women about psychological functioning and various correlates, including childhood sexual abuse (defined as fondling or penetration), family dysfunction, and suicidality. Findings indicated a strong association between childhood sexual abuse and suicidal behaviour, even after controlling for other childhood trauma and adversity (e.g., physical abuse, parental psychopathology) with the odds of a suicide attempt in sexually abused males being 4-11 times greater than that for non sexually-abused males. Another study from Australia linked the medical records of 2,759 survivors of childhood sexual abuse with data from coroners' offices 44 years later. When compared to national rates of suicide and accidental drug-induced deaths, males who experienced childhood sexual abuse were 14 times more likely to commit suicide and 38 times more likely to die from an accidental overdose than males without such histories (0.4% versus 0.02%, and 0.5% versus 0.01%, respectively; Cutajar et al., 2010b).

The interpersonal theory of suicide states that in order to die by suicide, individuals must acquire a reduced fear associated with suicidal behaviours (Easton, Renner, & O’Leary, 2013; Joiner, 2005). This reduced fear emerges in response to repeatedly painful and fearful experiences which, over time, increase an individual’s ability to tolerate painful and potentially fatal forms of self-harm. Because childhood sexual abuse, especially abuse which involves penetration, is often fear-inducing and physically painful, it is a salient risk factor for suicidal behaviour (Easton et al., 2013). It has also been proposed that exposure to childhood maltreatment increases an individual’s susceptibility to mental illness and stressful life events, which in turn increases the risk of suicidal behaviour (Cutajar et al., 2010b).

Anxiety. Anxiety has been found to be a common response to childhood sexual abuse, second only to depression as the most frequently-reported problem by male sexual abuse survivors (Fergusson et al., 2013; Holmes & Slap, 1998). Research indicates that male and female survivors of childhood sexual abuse exhibit higher levels of anxiety symptoms and/or disorders either immediately after abuse experience or with onset years later (Briere & Elliott, 2003; Cutajar et al., 2010a; Maniglio, 2012; Holmes & Slap, 1998). In a longitudinal Australian study which followed 535 boys with sexual abuse histories (defined as contact and non-contact abuse) and 622 matched-controls for four decades, males who experienced childhood sexual abuse were significantly more likely to be diagnosed with an anxiety disorder (5%) than those without such histories (1%; Cutajar et al., 2010a). Researchers have suggested that, because sexual abuse constitutes an acute traumatic event, it generates immediate as well as long-term phobic responses and anxiety-related symptoms (Maniglio, 2012). Other researchers express caution about inferring a causal link between child sexual abuse and anxiety disorders without

taking into account, for example, the influence of physical abuse or other correlates of sexual abuse, such as family dysfunction (Briere, 1992).

Externalizing behaviour. Male survivors may also externalize or “act out” their distress following childhood sexual abuse (Romano & De Luca, 2001; Spataro, Moss, & Wells, 2001; Spataro et al., 2004). Boys who have experienced sexual abuse tend to score higher than non-sexually abused boys on measures of externalizing behaviour (Lewis et al., 2016; Nalavany, Ryan, & Hinterlong, 2009). Externalizing problems observed in these boys include non-compliance, hyperactivity, running away from home, and aggression (Paolucci et al., 2001; Perez-Fuentes et al., 2013; Tyler, 2002). As they age, such externalizing behaviour may be displayed as anger, aggression, and substance abuse.

Anger. Problems with anger are often reported by male survivors of childhood sexual abuse (Alaggia & Millington, 2008; Denov, 2004; Romano & De Luca, 2001). These males tend to score higher on measures of anger and irritability than do non-sexually victimized males (Holmes & Slap, 1998). Anger may be directed at themselves for having allowed the abuse to occur, at the perpetrator for having taken advantage of their vulnerability, and/or at those who should have protected them or known about the abuse (Alaggia & Millington, 2008; Denov, 2004; Romano & De Luca, 2001). It has been suggested that male survivors use anger to suppress vulnerable and “non-masculine” emotions such as fear or self-blame (Romano & De Luca, 2001).

Aggression. Research has shown an association between child maltreatment and sexual as well as non-sexual aggression in adulthood (Jespersion, Lalumière, & Seto, 2009; Kitzmann, Gaylord, Holt, & Kenny, 2003; Seifert, 2003). A meta-analysis of 17 studies on the rates of childhood abuse among male offenders found that there was a significantly higher prevalence of

childhood sexual abuse among sex offenders than non-sex offenders. There were also significantly higher rates of childhood sexual abuse among those who sexually offended against children versus those who sexually offended against adults (Jespersen et al., 2009). There is also evidence that adult males with histories of childhood sexual abuse are more likely than non-sexually abused males to struggle with aggression and criminality (Bergen et al., 2004; Collings, 1995; Garnefski & Arends, 1998; Herrera & McCloskey, 2001; Perez-Fuentes et al., 2013; Sigfusdottir, Bryndis, Asgeirsdottir, Gudjonsson, & Sigurdsson, 2008). Male survivors of sexual abuse have been found to be more likely to experience a desire to hurt others, to take tension out on others, and to steal, break, and/or destroy property (McClellan, Adams, Douglas, McCurry, & Storck, 1995; Sigfusdottir et al., 2008). In a U.S. study of 8,629 adults recruited from a healthcare centre, Whitfield, Anda, Dube, and Felitti (2003) found that males who experienced penetration before the age of 12 were significantly more likely to perpetrate intimate partner violence in adulthood (12%) compared to non-sexually abused males (3%). In a nationally representative sample of 8,618 Icelandic adolescents aged 16 to 20 years, Sigfusdottir et al. (2008) found that males with sexual abuse histories were significantly more likely to use physical violence and steal than non-sexually abused males, even after controlling for demographic and family violence variables.

Researchers have proposed several explanations for the relationship between childhood sexual abuse and adult aggression. First, since many sexually abused children also experience physical abuse and/or witness domestic violence, early exposure to such violence may predispose children to adopt violent values and model the physical aggression of their parents (Drake & Pandey, 1996; Repetti, Taylor, & Seeman, 2002). Second, it has been suggested that males with sexual abuse histories engage in antisocial behaviours, such as weapon carrying or

physical assault, due to a need for self-protection against perceived threat (Lewis et al., 2007). Finally, there may be non-causal explanations for the relationship between childhood sexual abuse and adult sexual aggression through the genetic transmission of an underlying predisposition. For instance, children who are sexually abused by family members may go on to sexually offend in adulthood not because they were sexually abused but because they inherited a genetic predisposition for sexual offending (Jespersen et al., 2009).

Substance use. Childhood sexual abuse has been linked to maladaptive substance use (Butt, Chou, & Brown, 2011; Dilorio, Hartwell, & Hansen, 2002; Dube et al., 2005; Hadland et al., 2012; Hamburger et al., 2008; Schraufnagel, Davis, George, & Norris, 2010). Several studies have suggested that alcohol use among male survivors may be of particular concern (Chandy et al., 1996; Garnefski & Arends, 1998). As previously discussed, childhood sexual abuse appears to affect the drinking behaviour of males early in life, with sexually abused adolescents showing earlier drinking initiation and higher rates of binge drinking (Bergen et al., 2004; Garnefski & Arends, 1998). The literature suggests that childhood sexual abuse is linked to substance use problems and other related difficulties for men in mid-life as well. In a sample of men aged 18 to 70 years (mean age = 32 years) deemed at high risk for contracting HIV, Dilorio and colleagues (2002) found that those who reported unwanted sexual experiences before the age of 13 were significantly more likely to report current alcohol-related problems than men without sexual abuse histories. A systematic review of 18 studies comprised of clinical and community samples of sexually abused males found support for the association between childhood sexual abuse and substance use (Butt et al., 2011). In particular, significant relationships were found between childhood sexual abuse and earlier drug initiation as well as greater frequency and variety of drug use. However, it is important to note that the majority of

the studies included in the review by Butt et al. (2011) relied on cross-sectional, retrospective data.

Substance use is often viewed as a strategy to cope with the stress produced by childhood maltreatment (Briere & Runtz, 1993; Miller & Mancuco, 2004). Briere and Runtz (1993) theorize that sustained drug and/or alcohol use allows abuse survivors to separate psychologically from the environment, cope with distressing internal states, and temporarily forget painful memories. The long-term mental health consequences of childhood sexual abuse, including depression and PTSD, might also predispose individuals who have experienced childhood sexual abuse to engage in substance and drug use (Farrugia et al., 2011; Plotzker, Metzger, & Holmes, 2007). Thus, it is possible that mental illness is an important mediator in the pathway leading from childhood sexual abuse to later substance use difficulties (Hadland et al., 2012).

Trauma symptoms. As childhood sexual abuse represents a traumatic experience, it is often considered within the context of PTSD, which involves avoidance of abuse memories, re-experiencing of the abuse through unwanted and upsetting memories, and physiological reactions such as sleep problems, irritability, and hyper-vigilance (American Psychiatric Association, 2013). A study that conducted telephone interviews with 3, 118 randomly selected participants from the general population of Ireland found that almost half of male respondents (49%) reported a history of contact or non-contact sexual abuse. Of these men, 1 in 6 reported having experienced symptoms consistent with a diagnosis of PTSD at some time in their lives following their victimization (McGee, Garavan, de Barra, Byrne, & Conroy, 2002). This is consistent with other studies showing that PTSD is a prevalent outcome among male sexual abuse survivors (Cutajar et al., 2010a; Fergusson et al., 2013; Holmes & Slap, 1998; Tolin & Foa, 2006). Several

studies have also found that males and females report similar rates of PTSD following childhood sexual abuse (Maikovich-Fong & Jaffee, 2010; Soyly et al., 2016; Tolin & Foa, 2006; Ullman & Filipas, 2005).

While there is strong evidence linking childhood sexual abuse and PTSD, some authors have suggested that focusing on individual types of trauma is problematic because it blurs the potential impact of co-occurring victimizations on individuals (Finkelhor, Ormrod, & Turner, 2007). 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 one or the other (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 (defined as experiencing more than one type, such as physical abuse, peer victimization, theft) is taken into account (Finkelhor, Ormrod, & Turner, 2009; Finkelhor, Ormrod, Turner, & Hamby, 2005). These findings underscore the importance of considering the cumulative and interactional effects of various childhood adversities (Finkelhor et al., 2007).

Theoretical Models of Sexual Abuse Outcomes

Despite the many mental health problems associated with childhood sexual abuse, there are few theoretical models that explain its multifaceted effects. While several models were proposed in the 1980s and 1990s when the sexual abuse literature was emerging, few of these models have been empirically tested and/or further pursued by the researchers who proposed them (for reviews, see Freeman & Morris, 2001; Holman & Stokols, 1994; Nurcombe, 2000). This problem has resulted in a fragmented theoretical landscape in the sexual abuse literature (Freeman & Morris, 2001). The following section reviews three theories that have appeared

more frequently in the literature and/or possess some empirical support, namely the traumagenics dynamic model (Finkelhor & Browne, 1985); the ecological-transactional model (Cicchetti & Lynch, 1993), and the complex trauma model (van der Kolk, 2005).

Traumagenics dynamic model. The earliest theoretical model was the traumagenics dynamic model, which suggests that there are four dynamics that impact the psychological outcomes of sexual abuse survivors: traumatic sexualisation, betrayal, powerlessness, and stigmatization (Finkelhor & Browne, 1985). Traumatic sexualisation refers to the process in which a child's sexuality is shaped in a developmentally inappropriate fashion by sexual abuse, and is influenced by the manner in which the sexual abuse was perpetrated (e.g., child receiving affection contingent on sexual acts). Sexualisation manifests in many ways as an adult, including confusion and misconceptions about sexual behaviour as well as sexual aggression. This dynamic also occurs when frightening memories and events become associated with sexual activity. The second dynamic, betrayal, occurs when children discover that a trusted individual has caused them harm. Children can experience betrayal not only at the hands of perpetrators, but also by non-offending family members who were unable or unwilling to protect them from sexual abuse. This sense of betrayal may carry over into adulthood and be manifested as dysfunctional relationships, anger, and isolation. The third dynamic, powerlessness, stems from the perpetrator's continual invasion of the child and the child's powerlessness to stop the abuse for fear of retaliation (from the perpetrator) and disbelief from family and community members. The feeling of powerlessness may not enable survivors to act in assertive ways in other relationships, thus resulting in an increased risk for revictimization. The final dynamic is stigmatization, which refers to the messages that the child receives from the perpetrator, their family, and the community about the sexual abuse experience. The dynamic of stigmatization

has implications for survivors' self-esteem, leading them to potentially feel as though they are damaged, unworthy, or inherently different than others (Finkelhor & Browne, 1985).

The traumagenics dynamic model was the earliest attempt at providing a framework for understanding the different outcomes of childhood sexual abuse. However, it generally lacks an empirical base (Freeman & Morris, 2001). Indeed, Finkelhor and Browne (1985) stated that they relied on clinical experience, rather than experimental data, to develop the model. While clinical expertise can be informative, one may wonder about the generalizability of the model when no empirical support is present (Freeman & Morris, 2001). Moreover, the model focuses almost exclusively on factors within the individual as contributing to psychological distress, and does not consider contextual factors that may precipitate the occurrence of sexual abuse and its impact on psychological outcomes (Holman & Stokols, 1994).

Ecological-transactional model. In order to account for these contextual variables, sexual abuse researchers have drawn from the broader child maltreatment literature to understand outcomes from an ecological perspective (Freeman & Morris, 2001). The ecological-transactional model (Cicchetti & Lynch, 1993) combines elements of ecological and transaction theory, and has been used to describe the diverse outcomes of sexual abuse. The model proposes that an individual's likelihood of developing psychological difficulties following sexual abuse is influenced by the interaction between individual-level factors (i.e., characteristics of the child and of the sexual abuse) and the different systems (i.e., microsystem, exosystem, macrosystem) in which the individual is embedded. The microsystem refers to the child's immediate family environment. The exosystem includes the communities and neighbourhoods in which sexually abused children and their families reside (e.g., teachers, community programs for sexual abuse survivors). The macrosystem involves cultural beliefs about childhood sexual abuse that

permeate social and family functioning. Factors that are more proximal to the child (e.g., microsystem) are believed to exert more direct effects on outcomes than distal factors (e.g., macrosystem), although risks at any system can negatively interfere with an individual's well-being. According to this model, no one processes their childhood sexual abuse in the same way, as there are an infinite number of interactions between individual-level factors and the various systems that surround the sexually abused child (Cicchetti & Lynch, 1993).

The ecological-transactional model (Cicchetti & Lynch, 1993) provides a broad and comprehensive framework for understanding the diverse outcomes of childhood sexual abuse. It has received empirical support for child and adult populations with sexual abuse histories (e.g., Campbell, Dworkin, & Cabral, 2009; Zielinski & Bradshaw, 2006), although it has yet to be tested specifically with adult males who have experienced sexual abuse. Finally, the model suggests that all systems must change in order to reduce the likelihood of childhood sexual abuse and reduce its impact, thus shifting the onus of recovery from the individual to also include families, communities, and societies.

Complex trauma model. The complex trauma model (National Child Traumatic Stress Network Task Force, 2003; van der Kolk et al., 2005) overlaps with the ecological-transactional model (Cicchetti & Lynch, 1993) in that both highlight the importance of the relationship between children and their environments. However, the complex trauma model focuses primarily on the characteristics of the individual and the child-caregiver system, with less focus on the broader influences of the neighbourhood and community. The term “complex trauma” describes both: 1) 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 (Courtois & Ford, 2009); and 2) the impact of these experiences on short- and long-term outcomes. In

terms of outcomes, the model states that complex trauma interferes with the completion of key developmental tasks, such as attachment, emotion regulation, and brain development, which underpin the 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 fundamental developmental task in early childhood is attachment, which helps the developing child begin to differentiate the emotional states and responses of both oneself and the attachment figure and modulate emotional and behavioural responses (Bowlby, 1988). Through relationships with attachment figures, children learn how to interact with the world and come to understand their value as individuals. When the child's attachment figure is a source of fear due to sexual abuse, an insecure attachment pattern may ensue (van der Kolk et al., 2005). In the context of an insecure attachment, no healthy framework for interpreting emotional states is provided, and thus, children struggle to regulate their emotional responses (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 bad and the world is a dangerous place. Thus, insecure attachments may also lead to impairments in self-esteem, sense of agency, and interpersonal relationships. Together, these difficulties with emotion regulation, self-esteem, sense of agency, and interpersonal functioning increase their risk of depression, anxiety, post-traumatic stress, and conduct disorders throughout the lifespan (National Child Traumatic Stress Network Task Force, 2003).

Chronic stress can also affect the developing brain in a number of ways (Perry, 2008; Schore, 2001). When faced with stress, the brain secretes stress hormones into the sympathetic nervous system to prepare the body to fight, flee, or freeze. When the stressor is ongoing (e.g., intrafamilial abuse), the brain may go into a chronic “hyperalert” state whereby stress hormones are continually secreted into the nervous system. Chronic secretion of stress hormones may lead to permanent changes to the limbic system, a region responsible for emotion regulation (Schore, 2001). As a result, children with histories of chronic trauma may have difficulty regulating emotions and may exhibit extreme reactions (e.g., hyperarousal, aggression) even in the absence of the original stressor (Perry, 2008). Chronic over-activation of the limbic system may also lead other regions of the brain, such as those involved with problem solving and complex thought (i.e., frontal lobes), to be under-activated and less developed (Schore, 2001). Finally, children growing up in abusive and neglectful families often do not receive the adequate array of emotional and sensory experiences that are needed to help the developing brain reach its full potential (Perry, 2008). Unless these children’s home living environments improve, these impairments they experience are likely to extend into adulthood and to compromise emotional, social, and cognitive functioning.

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). While the ecological-transactional model has empirical support, it is very broad in scope and would have involved collecting information across multiple systems (e.g., peers, communities). The complex trauma model offers a comprehensive, albeit more feasible, framework that focuses on the most influential system in determining outcomes – the child-caregiver relationship and the family system. Finally, the majority of male survivors report experiences that are consistent with the definition of complex

trauma, that is, early childhood trauma by a caregiver that is prolonged and severe (Courtois & Ford, 2009). As described in more detail in the following section, males are most likely to experience childhood sexual abuse prior to adolescence, and their sexual experiences often span several years (Dube et al., 2005; Holmes & Slap, 1998). Moreover, while male childhood sexual abuse is not always perpetrated by an attachment figure (Frias & Erviti, 2014), it often occurs alongside other types of abuse and neglect by caregivers (Gold et al., 1998). Given that it is an empirically-supported and comprehensive model that seems to account for the majority of the sexual abuse experiences of males, the complex trauma model was deemed the best-fitting model for this dissertation.

What Characterizes Childhood Sexual Abuse in Males and How Are These Characteristics Linked with Outcomes?

According to the complex trauma model, the effects of childhood severe abuse are diverse and can impact multiple domains of functioning (van der Kolk et al., 2005). Indeed, childhood sexual abuse increases the risk for many mental health difficulties in childhood and adulthood for males (Dube et al., 2005; Kendall-Tackett et al., 1993). However, not all males with sexual abuse histories exhibit negative outcomes (Kendall-Tackett et al., 1993; Marriott, Hamilton-Giachritsis, & Harrop, 2013; Rind, Tromovich, & Bauserman, 1998; Walsh, Fortier, & DiLillo, 2010). Studies on the initial outcomes of sexual abuse indicate that about a third of children do not exhibit clinical symptoms when the abuse is disclosed to parents and/or authorities (Kendall-Tackett et al., 1993). Likewise, up to 50% of sexual abuse survivors do not exhibit psychopathology when surveyed in adulthood (Marriott et al., 2013). Because there is individual variability in the responses to sexual abuse, a number of empirical efforts have been made to understand specific contextual variables that might shape the development of

psychopathology (or lack thereof) in male sexual abuse survivors. While a review of all of these factors is beyond the scope of this dissertation, the following section focuses on sexual abuse characteristics, family functioning, co-occurring child maltreatment and adversity, disclosure experiences, and coping as these variables appear most often in the sexual abuse literature (Marriott et al., 2013) and are included in Study 2.

Age of onset. With regard to the age of sexual abuse onset, research suggests that the risk is highest for boys under the age of 13 (Holmes & Slap, 1998; Romano & De Luca, 2001), with mean age of onset typically occurring between 7 and 12 years (Cammack & Hogue, 2017; Easton, 2012; Edgardh & Ormstad, 2000; Gold et al., 1998; Pereda, Abad, & Guilera, 2016). It has been suggested that sexual abuse risk may be a function of a child's physical strength relative to the perpetrator. As boys age and become physically stronger, they may become more able to ward off a perpetrator and end any sexual abuse incidents earlier (Holmes & Slap, 1998; Romano & De Luca, 2001). Studies have found no significant sex differences with respect to age of abuse onset (Briere & Elliott, 2003; Edgardh & Ormstad, 2000; Gold et al., 1998; Pereda et al., 2016).

The relationship between age of abuse onset and psychopathology is unclear. Several studies suggest that sexual abuse at a younger age is associated with greater psychological distress in adulthood (Banyard, Williams, & Siegel, 2004; Kaplow, Dodge, Amaya-Jackson, & Saxe, 2005; Zink, Klesges, Stevens, & Decker, 2009), while others report greater dysfunction in those abused during the adolescent years (Cutajar et al., 2010a; Schoedl et al., 2010; Thornberry, Ireland, & Smith, 2001). Sexual abuse in early childhood may be most harmful because it interferes with children's earliest and most basic needs for safety and protection (Molnar et al., 2001; van der Kolk et al., 2005). Moreover, as noted by the complex trauma model, younger

children undergoing rapid brain development may be more susceptible to negative environmental influences such as sexual abuse (Schoe, 2001). In contrast, Cutajar et al. (2010a) posited that older victims, especially those undergoing sexual development, will have greater awareness of the gross violation of sexual boundaries associated with sexual abuse and thus, will be more likely than their younger counterparts to develop maladaptive affective and behavioural coping strategies. It is important to note that age of onset plays only one part in a comprehensive understanding of childhood sexual abuse and likely interacts with other sexual abuse characteristics (e.g., victim-perpetrator relationship, abuse duration) to influence abuse-related outcomes (Kendall-Tackett et al., 1993).

Frequency and duration of abuse. Few studies have examined the frequency of sexual abuse in males although existing data indicate that the majority of abusive experiences are not isolated incidents (Briere & Elliott, 2003; Easton et al., 2013; Feiring, Taska, & Lewis, 1999). In a study of 487 men recruited from national U.S. organizations devoted to raising awareness of male childhood sexual abuse, 46% reported having experienced sexual abuse more than 20 times, 6% reported being abused 11-20 times, 8% reported being abused 6-10 times, 23% reported being abused 2-5 times, and a minority (17%) reported one-time abuse (Easton et al., 2013).

The mean duration of sexual abuse for males generally ranges from 2 to 4 years (Gold et al., 1998; Holmes & Slap, 1998; Tyler & Cauce, 2002), with a typical range extending from one episode to 7 years (Spiegel, 2003). While some studies have found shorter abuse duration for boys than girls (Kendall-Tackett & Simon, 1992; Zink et al., 2009), others have not found any sex differences in abuse duration (Gold et al., 1998; Tyler & Cauce, 2002). It may be that boys experience less chronic abuse because the perpetrator is more likely to be someone outside of the

family. In contrast, children who experience intra-familial sexual abuse tend to have a longer duration of abuse because of the perpetrator's sustained access and proximity to the child as well as reluctance on the part of the child and/or family to disclose the abuse (Fischer & McDonald, 1998).

There are inconsistent findings on the impact of abuse duration and frequency on later outcomes. Researchers have often used duration and frequency as indicators of abuse severity (e.g., O'Leary, Coohy, & Easton, 2010; Zink et al., 2009), with the hypothesis that more severe sexual abuse will be associated with more severe outcomes. While studies have found that longer duration and higher frequency of abuse were associated with worse outcomes, including the number and severity of psychological symptoms (Banyard et al., 2004; Easton, Renner, & O'Leary, 2013; Kendall-Tackett et al., 1993; Lopez-Castroman et al., 2013; Perez-Fuentes et al., 2013; Ruggiero, McLeer, & Dixon, 2000; Steel, Sanna, Hammond, Whipple, & Cross, 2004; Zink et al., 2009), others have found no relationship between these abuse characteristics and psychological outcomes (Calam et al., 1998; Paolucci et al., 2001). Steel et al. (2004) suggest that individuals who are abused over a long period of time may be more likely to attribute the blame for the abuse internally, whereas a one-time sexual abuse incident might be more easily attributed to chance or to the perpetrator (Steel et al., 2004). In contrast, it is possible that individuals who experience chronic and frequent abuse may, over time, be able to adapt and find helpful coping strategies than individuals exposed to an acute traumatic experience. However, this is speculative and more research with larger samples of males is needed to clarify this relationship.

Sexual acts. Turning to the types of sexual acts that comprise childhood sexual abuse, it is generally accepted that there is a gradual progression from non-contact (e.g., exposing genitals

to a child, showing pornography to a child) to contact behaviours, especially in abuse which is more chronic in nature (Berliner, 2007). Contact sexual abuse consists of the perpetrator touching the sexual parts of a child under or over the clothing, penetrating the child, or engaging in any oral-genital contact with the child (Finkelhor & Dzuiba-Leatherman, 1994). Contact sexual abuse is more intrusive and severe than non-contact forms of sexual abuse, and it represents the experiences of most male survivors. Using U.S. data on 5,501 children aged 0 to 16 years involved with child welfare, Maikovich-Fong and Jaffee (2010) found that, of the 147 male youth who were sexually abused, 30.8% of children and 53.3% of adolescents had experienced anal intercourse, penetration with an object, and/or oral-genital contact. Studies which have explored sex differences in abuse characteristics indicate that boys tend to experience more severe sexual acts (Gold et al., 1998; Soylu et al., 2016) and that they are at greater risk of anal penetration than girls (Dube et al., 2005; Negriff, Schneiderman, Smith, Schreyer, & Trickett, 2014).

Non-contact sexual abuse has not received much empirical attention but nonetheless appears to be a significant category of abuse experienced by males. Schonbucher and colleagues (2011) conducted a systematic review of 15 articles to determine the frequency of certain types of childhood sexual abusive experiences in the Swiss population. Among males, 1-15% reported non-contact sexual abuse prior to the age of 18, which included exhibitionism (3-10%), a child being forced to show his naked body or certain body parts (2.4-10%), a child being forced to view pornographic material (1-8%), a perpetrator taking photographs or films while a child was nude or engaged in a sexual act (1-3%), a child being forced to watch a perpetrator engaged in a sexual act (2%), and sexual harassment (0.4%).

Researchers have generally found that contact forms of sexual abuse, by virtue of their intrusiveness and severity, are related to greater negative short- and longer-term outcomes (Briere & Elliott, 2003; Cutajar et al., 2010a; Dube et al., 2005). For instance, sexual acts that involved penetration were related to mental health problems in both children and adults in several studies (Banyard et al., 2004; Cutajar et al., 2010a; Kendall-Tackett et al., 1993; Lopez-Castroman et al., 2013; Nelson et al., 2002). Penetrative sexual abuse has also been associated with shorter time between abuse and treatment seeking (Cutajar et al., 2010a). This may reflect a dose-response effect, in which increasing severity of sexual abuse increases the risk of psychological problems (Cutajar et al., 2010a).

Perpetrator characteristics. With regard to perpetrator sex, research indicates that the percentage of male perpetrators exceeds that of female perpetrators (Briere & Elliott, 2003; Callam et al., 1998; Cullen, Smith, Funk, & Haaf, 2000; Edgarh & Ormstad, 2000; Holmes & Slap, 1998; Maikovich-Fong & Jaffee, 2010), although some studies have found roughly equal proportions of male and female perpetrators of male childhood sexual abuse (Dube et al., 2005; Newcombe, Munoz, & Carmona, 2008). Few studies have examined the role of perpetrator sex on victim outcomes, which is likely due to the low reported frequency of female perpetration in sexually abused samples (e.g., Callam et al., 1998; Maikovich-Fong & Jaffee, 2010). Since society often paints a positive image of early sexual contact with older females, it is possible that males who experienced childhood sexual abuse by a female are less likely to label their sexual experiences as abusive (Maikovich-Fong & Jaffee, 2010; Weiss, 2010). Additionally, because females are often viewed as nurturers by society who hug, kiss, and touch their children as part of their everyday interactions, it may be easier for females to disguise sexual abuse within the context of affection or childcare activities (Hislop, 2001). It has been suggested that having a

male perpetrator may be particularly damaging for men because it raises questions about their own sexuality (Durham, 2003). For example, several clinical studies have found that adolescent males who experienced sexual abuse by a same-sex perpetrator expressed extreme shame and confusion about their experience, their sexuality, and their sexual identity (Dorahy & Clearwater, 2012; Durham, 2003).

Turning to the victim-perpetrator relationship, it has generally been established that male children are more likely to experience sexual abuse by an individual outside the family (Coohey, 2010; Cutajar et al., 2010a; Frias & Erviti, 2014; Gold et al., 1998; Holmes & Slap, 1998; Soylu et al., 2016). In a literature review of 166 studies on childhood sexual abuse, Holmes and Slap (1998) found that 54-89% of perpetrators of male children were extra-familial. Extra-familial perpetrators may include individuals who hold formal or professional relationships with the victim (e.g., teachers, coaches, Scouts leaders) or individuals with informal roles, such as family friends or neighbours (Spiegel, 2003). Although they are more likely to experience extrafamilial abuse, boys also experience rates of intrafamilial abuse that are not insubstantial. A nationally representative study of 13,440 Mexican children and adolescents found that 6.7% reported unwanted sexual experiences before the age of 18. Among those boys who reported sexual abuse, they were most likely to be abused by stepmothers (76.9%), followed by teachers (63.0%), girlfriends/boyfriends (62.3%) and uncles/aunts (56.0%; Frias & Erviti, 2014).

Intra-familial sexual abuse has been thought to be especially damaging because children rely on their family members for care and protection (O'Leary et al., 2010). This is supported by research which has found that individuals who are more closely related with their perpetrator (e.g., father) are more negatively affected by sexual abuse than individuals with a more distant relationship with their perpetrator (Edwards, Freyd, Dube, Anda, & Felitti, 2012; Kendall-

Tackett et al., 1993; O’Leary et al., 2010; Ullman, 2007; Zink et al., 2009). However, other studies have found no association between the nature of the victim-perpetrator relationship and outcomes (Callam et al., 1998; Kiser et al., 2014; Paolucci et al., 2001). These differences may be attributable to the lack of a uniform coding scheme for perpetrator closeness (Kendall-Tackett et al., 1993). Moreover, the label that a relationship is given might not truly reflect the nature of the relationship. For example, a child who experiences sexual abuse by a stepfather who has been the only father figure in the child’s life would undoubtedly have a much closer relationship to him than a child who experiences sexual abuse by a stepfather who has only recently joined the family (Yancey & Hansen, 2010). Kendall-Tackett et al (1993) recommended asking participants about their emotional closeness with the perpetrator or about the degree to which the perpetrator was responsible for caretaking rather than relying on kinship labels to determine closeness. Furthermore, perpetrators who have a close relationship with the victim often have greater access to the child, which may also impact the severity and duration of abuse (Fisher & McDonald, 1998; Yancey, Naufel, & Hansen, 2013). Thus, the victim-perpetrator relationship appears to be difficult to define and has mixed results regarding its influence on psychological functioning.

Co-occurring childhood maltreatment. Research indicates that male childhood sexual abuse often co-occurs with other forms of emotional abuse, physical abuse, neglect, and exposure to domestic violence (Dong, Anda, Dube, Giles, & Felitti, 2003; Edwards, Holden, Felitti, & Anda, 2003; Makovich-Fong & Jaffee, 2010; Perez-Fuentes et al., 2013). Childhood sexual abuse has also been associated with other childhood adversities, such as serious illness, death of a loved one, and parental substance use (Dong et al., 2003; Easton, 2012; Finkelhor et al., 2005; Finkelhor, Turner, Shattuck, & Hamby, 2013). A study of 8,629 adult members of a

U.S. healthcare centre found that 78% of those who reported childhood sexual abuse had also experienced at least one other type of childhood adversity (Dong et al., 2003). Dong et al. (2003) also found that survivors who experienced earlier onset of sexual abuse, longer abuse duration, and higher levels of penetration were significantly more likely to have suffered multiple other adverse experiences in childhood.

Physical abuse seems to be a particularly salient correlate of sexual abuse, with the proportion of males with histories of sexual abuse also experiencing physical abuse ranging from 21-72% (Dong et al., 2003; Easton, 2012; Edwards et al., 2003; MacMillan et al., 2001). Males are at greater risk for physical abuse by their sexual abuse perpetrator than females, and are more likely to be physically abused by someone other than their sexual abuse perpetrator (Gold et al., 1998). Because physical abuse is predominantly perpetrated by parents, boys might search for alternative sources of care and support from adults outside the home, thus increasing their risk of sexual abuse (Fisher & Goodwin, 2009).

Given evidence that sexual abuse tends to co-occur with other forms of childhood trauma, a number of studies have investigated the cumulative impact on survivors' long-term functioning. Sexually abused individuals who experience additional forms of victimization are at increased risk for psychopathology (Easton, 2012; Easton, 2014; Finkelhor et al., 2007; Garnefski & Diekstra, 1997; Ruggiero et al., 2000). This is likely because exposure to a number of adversities places greater demands on a child's coping resources (Finkelhor et al., 2007). Moreover, in environments characterized by multiple adversities, sexually abused individuals might have limited resources to address and end the sexual abuse, resulting in more severe and chronic victimization (Easton, 2012).

Summary. The sexual abuse experiences of men are diverse, and research is equivocal in terms of the relationship between sexual abuse characteristics and psychological outcomes. Studies addressing sexual abuse characteristics have tended to examine only one characteristic of the abuse (e.g., relationship to the perpetrator), without considering how abuse characteristics might be interrelated (e.g., abuse by a caregiver might have an earlier age of onset). Indeed, the complex trauma model suggests that there may be distinct subgroups of individuals with interrelated abuse experiences (i.e., early and prolonged sexual abuse by caregivers) who present with a unique constellation of symptoms (e.g., attachment difficulties, emotion dysregulation; van der Kolk et al., 2005). This dissertation sought to address this gap in the literature by identifying profiles of co-occurring sexual abuse characteristics among male survivors and then linking these patterns to psychological outcomes. In addition to generating profiles, the dissertation examined whether certain contextual variables (family functioning, disclosure, and coping) moderated the relationship between profiles and psychological functioning. The following sections describe the childhood families, disclosure experiences, and coping strategies of male survivors, and discuss how these variables might be associated with mental health outcomes.

What Characterizes the Families of Males with Sexual Abuse Histories?

Families of children who have experienced sexual abuse are thought to possess certain characteristics that place children at increased risk of victimization. Studies have consistently found that survivors of childhood sexual abuse are more likely to perceive their families as displaying higher levels of conflict and lower levels of cohesion and support than non-abused individuals (Kamsner & McCabe, 2000; Meyerson, Long, Miranda, & Marx, 2002; Perez-Fuentes et al., 2013). Moreover, Fitzgerald and colleagues (2008) found that children who are

forced to fulfill the sexual needs of adults are also often “parentified”, wherein they assume caregiving roles within the family. While assuming adult-roles may be protective within certain contexts (e.g., in cases of parental illness, divorce) in the short-term as it can maintain family cohesion, parentification may compromise the child’s psychological functioning in the long-term (Fitzgerald et al., 2008).

For males in particular, one-parent households have been found to be associated with childhood sexual abuse (Fontanella et al., 2000; Holmes, 2007). Holmes (2007) conducted telephone interviews with 197 men living in high-risk neighborhoods of Philadelphia to determine whether there was an association between the number of parents in the home and childhood sexual abuse (defined as oral or anal penetration before 18 years by an older adult). After controlling for socio-economic status, males who reported that they were raised in one-parent families (typically mothers) had a 2-fold greater risk of childhood sexual abuse (in particular extra-familial abuse) than boys raised in two-parent families. This may be a function of single parents often having difficulty providing the same level of supervision and monitoring as two-parent families (DiClemente et al., 2001). Boys lacking one parent might also be more susceptible to sexual abuse because of their desire to seek out attention and affection from non-parent adults (Holmes, 2007). Moreover, given the misconceptions regarding the risk of sexual abuse for boys (i.e., that it is low), single parents may be less likely to restrict the freedom of their sons, which might increase the risk of being exposed to exploitative adults (Holmes, 2007). Finally, it is possible that children of single-parent households are more vulnerable to sexual abuse due to their own characteristics (e.g., impulsivity; Turner, Finkelhor, & Ormrod, 2010), which may have been the same behaviours that contributed to difficulties in family functioning and the couple’s relationship (although these influences tend to be bi-directional in nature).

Numerous investigations have focused on the influence of the family environment on the development of psychopathology following sexual abuse (Elliott & Carnes, 2001; Hébert, Tremblay, Parent, Daigneault, & Piché, 2006; Hyman, Gold, & Cott, 2003; Kamsner & McCabe, 2000; Kendall-Tackett et al., 1993). Studies examining female sexual abuse survivors indicate that family conflict and limited family cohesion are robust predictors of psychological dysfunction (Meyerson et al., 2002; Yama, Tovey, & Fogas, 1993). A Canadian mixed-sex study of 63 children (13 boys) found that the family environment was significantly associated with emotional and behavioural symptoms following sexual abuse (Hébert et al., 2006). Even after accounting for sexual abuse characteristics, children's perceptions of their families as being high in conflict were associated with greater parent-reported externalizing behaviours (Hébert et al., 2006). It is possible that family dysfunction adversely affects the family's willingness and ability to respond to a child's disclosure (Kellogg & Menard, 2003).

How is Childhood Sexual Abuse Disclosed by Males?

Many children who experience sexual abuse do not disclose the abuse (London, Bruck, Ceci, & Shuman, 2005; O'Leary & Barber, 2008; Paine & Hansen, 2002). Studies comparing men and women have revealed that males take significantly longer to disclose and are, in fact, less likely to do so (Frias & Ervito, 2010; Hébert et al., 2009; Mohler-Kuo et al., 2014; O'Leary & Barber, 2008; Ullman & Filipas, 2005). A cross-sectional study of 296 adults (145 males) recruited from Australian sexual abuse agencies revealed that 26% of males and 64% of females disclosed around the time when the abuse occurred, with the large majority of men (73%) taking over 10 years to disclose their sexual abuse experiences (O'Leary & Barber, 2008). Few cases (<10%) of childhood sexual abuse are reported to the authorities (Easton, 2013; Frias & Ervito, 2014; Mohler-Kuo et al., 2014; Smith et al., 2000).

Certain abuse characteristics have been associated with disclosure among sexual abuse survivors. Intra-familial abuse is associated with lower rates of disclosure (LeClerc & Worthley, 2015; Smith et al., 2000; Ullman, 2007) and longer time to disclosure (Easton, 2013; Hébert et al., 2009). Children disclosing intra-familial abuse may experience a sense of disloyalty to their family and/or may fear that major family disruptions will follow disclosure (Goodman-Brown et al., 2003; Hébert et al., 2009). Disclosure is also associated with age of abuse onset, with males abused in adolescence showing the lowest rates of disclosure (Easton, 2013; Hershkowitz, Lanes, & Lamb, 2007; Goodman-Brown et al., 2003). Adolescent males may not disclose because they recognize that sexual abuse is taboo and potentially stigmatizing (Denov, 2004). Chronicity of abuse has also been found to affect disclosure in males, with males who experienced chronic abuse being less likely to disclose than males who experienced a single incident of sexual abuse (Bagley, Wood, & Young, 1994). Bagley and colleagues (1994) found that most males (58%) with chronic sexual abuse histories did not disclose because they felt partly responsible, felt ashamed, and/or did not want the perpetrator to be prosecuted. Other reasons that males do not disclose include fear of being perceived as homosexual, fear of being perceived as a potential perpetrator, fear of disbelief, fear of being blamed, and fear of bearing the responsibility of accusing the perpetrator (Bagley et al., 1994). For instance, NHL star Sheldon Kennedy, who was sexually abused in adolescence by his hockey coach, reported that he delayed disclosure until his 20's because he was "plagued by all sorts of irrational fears...My shattered emotions kept reminding me that there was something wrong with me, that I was different from everybody else" (Kennedy, 2006, pp. 40–41).

It is often assumed that the child will benefit by telling someone about the abuse (Alaggia & Kirshenbaum, 2005). However, there are mixed findings as to whether abuse disclosure is

beneficial. Several studies have shown that disclosure is associated with better short- and longer-term outcomes (Easton, 2013; Hébert et al., 2009), while others have found that disclosure is related to greater psychological distress in adulthood (O'Leary et al., 2010). Some authors have suggested that there may be psychological benefits to non-disclosure (O'Leary & Barber, 2008; Steever, Follette, & Naugle, 2001). For instance, Steever, Follette, and Naugle (2001) examined the relationship between acknowledging childhood sexual abuse and longer-term functioning in three groups of 20 undergraduate males. The sample was comprised of one group of self-identified survivors of sexual abuse, another group who did not identify themselves as survivors but would be classified this way based on conventional definitions of sexual abuse, and a third group who reported consensual sexual experiences with peers. Findings indicated that men who identified as survivors reported nearly twice the level of psychological distress than men from the other groups (Steever et al., 2001). Similarly, in a sample of prison inmates, Fondacaro, Holt, and Powell (1999) found that males who acknowledged their sexual abuse history had higher rates of PTSD and obsessive compulsive disorder compared to males who did not label their sexual experiences in childhood as abusive. These results are consistent with studies on female survivors showing that disclosure is associated with psychopathology (Glover et al., 2010; Ruggiero et al., 2004).

Social exchange theory posits that disclosure can sometimes stop the progression of sexual abuse, prevent hypervigilance around keeping the secret, and create opportunities to seek out necessary treatment (Alaggia, 2005; Vogel & Wester, 2003). On the other hand, the investigation that follows sexual abuse disclosure may lead to negative consequences, such as the individual being accused of fabricating allegations, having family members withdraw their support, and ultimately experiencing an exacerbation of psychological symptoms (Alaggia, 2005;

Smith et al., 2000). This notion is supported by research showing that disclosure by boys is often met with denial or minimization (Easton, 2013; Ullman & Filipas, 2005). Studies have shown that unsupportive or negative reactions (e.g., blaming the victim, refusing to remove perpetrator from the home) are associated with a range of psychological and health problems (Berliner, 2011; Bernard-Bonnin et al., 2009; Easton, 2013; Ullman & Filipas, 2005). In sum, it is unclear whether children benefit from abuse disclosure. It is possible that the reaction of the person to whom the child discloses is more important for psychological functioning than whether or not a child has disclosed.

How do Males Cope with Childhood Sexual Abuse?

Coping is considered an important predictor of well-being immediately following childhood sexual abuse and into adulthood (Cantón-Cortés & Cantón, 2010; Hébert et al., 2006; Marriott et al., 2013; Walsh et al., 2010; Whiffen & MacIntosh, 2005). Unfortunately, few studies have examined the coping strategies used by male survivors of sexual abuse (Walsh et al., 2010). Qualitative interviews reveal that adult male survivors often cope by suppressing thoughts related to the abuse, withdrawing from friends and family, and becoming preoccupied with seeking vengeance (Alaggia & Millington, 2008; O'Leary & Gould, 2010). Likewise, quantitative data show that adult males tend to rely on avoidant coping strategies (e.g., denial, distancing) and substances to cope with childhood sexual abuse (O'Leary, 2009; Ullman & Filipas, 2005). Male and female survivors seem to make use of similar coping strategies (Sigmon, Greene, Rohan, & Nichols, 1996), although in a cross-sectional sample of 733 college students, Ullman and Filipas (2005) found that female survivors of childhood sexual abuse were more likely to withdraw from others and try to forget the abuse. The process of coping with CSA may also evolve over time. For instance, a qualitative study of 39 Australian male survivors of

sexual abuse examined coping strategies used at the time of the abuse, as well as coping used later in life. Results indicated that while suppression of abuse-related memories and denial of the abuse were common coping strategies, there was a trend for males to use more adaptive coping strategies (e.g., reframing the abuse) later in life (O’Leary & Gould, 2010). This shift often followed a significant event, such as meeting others with similar experiences or seeking psychotherapy. Nonetheless, this finding reinforces the view that coping should be seen as a process, rather than a fixed cognitive style (O’Leary & Gould, 2010).

Coping strategies used by survivors of childhood sexual abuse have been found to influence longer-term functioning. Research has associated avoidant coping with negative psychological outcomes in male and female survivors, both initially and in the long-term (Bal, Van oost, De Bourdeaudhuij, & Crombez, 2003; Hébert et al., 2006; O’Leary, 2009; O’Leary & Gould, 2009; Runtz & Schallow, 1997). In contrast, seeking social support has been associated with better psychological outcomes following sexual abuse (Steel et al., 2004).

Summary and Objectives

Childhood sexual abuse in males has received increasing attention in the empirical literature over the past two decades. The frequency of sexual abuse experiences involving male youth is alarming, particularly when we consider that relatively few cases are reported. Childhood sexual abuse may interfere with key developmental tasks, such as attachment, emotion regulation, sense of agency, and brain development, which may lead to mental health problems including depression, anxiety, anger, aggression, substance use, and PTSD. Finally, there may be an increased risk of negative outcomes associated with certain characteristics of the abuse experience (e.g., age of abuse onset, relationship to the perpetrator) as well as the context in which the abuse occurs (e.g., family dysfunction, co-occurring maltreatment and adversity).

While research on the sexual abuse of males is emerging, there remain important gaps in our understanding. The research reviewed above has tended to rely on variable-centered analyses, such as correlations, regressions, and analyses of variance, which present an average profile for all study participants. In other words, variable-centered analyses are based on the assumption that male survivors of sexual abuse are a homogeneous group with respect, for example, to how certain variables influence outcomes (Laursen & Hoff, 2006). Although variable-centered analyses are informative, they do not capture the diversity of sexual abuse experiences for males, and consequently, individual differences may be overlooked. In contrast, person-centered analyses, 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 male survivors. The diversity of abuse experiences, when examined on an individual-male basis, may result in several broad patterns of abuse experiences and different psychological presentations.

In keeping with this notion, the overall objective of this dissertation was to use person-centered analyses to determine whether meaningful profiles of co-occurring sexual abuse characteristics could be identified among male survivors. Unfortunately, there were few measures of childhood sexual abuse with psychometric support that could be used to assess sexual abuse characteristics and generate profiles. Thus, as a first step, I collected psychometric data on a commonly-used measure of childhood sexual abuse, the Sexual Victimization Survey (SVS; Finkelhor, 1979). Once the SVS was deemed reliable and valid, it was used to collect information from male survivors about their sexual abuse experiences. Profiles were generated

based on sexual abuse characteristics. Profiles were then linked to various psychological outcomes in adulthood.

Study 1: Evaluating the Psychometric Properties of a Modified Version of the Sexual Victimization Survey

Methodological Problems in Studying Childhood Sexual Abuse

Childhood sexual abuse is an important area of study given its prevalence (Dube et al., 2005) and range of immediate and long-term psychological outcomes (Chen et al., 2010; Molnar et al., 2001; Tyler, 2002). Despite the importance of conducting research in this area, there are a number of methodological problems in studying childhood sexual abuse. These include the use of retrospective reporting, defining childhood sexual abuse, and measurement issues (e.g., method of administration, limited psychometric data). The following sections briefly review issues related to the assessment of childhood sexual abuse but focus primarily on the lack of psychometric data of sexual abuse measures because this remains a significant gap in the research. I then review common measures of sexual abuse, including the SVS (Finkelhor, 1979), before introducing the study's objectives.

Retrospective reporting. Studies on childhood sexual abuse have typically relied on retrospective reports from adults (Hulme, 2004; Putnam, 2003). Several authors have stated that the quality of retrospective reporting on childhood sexual abuse is problematic due to errors in memory and perception (Hardt & Rutter, 2004; Langeland et al., 2015; London, Bruck, Wright, & Ceci, 2008). When individuals are asked to provide information years after a particular event has occurred, it is reasonable to assume that there will be some reporting errors (Shchupak, 2015). Hardt and Rutter (2004) conducted a literature review of 14 retrospective measures of adverse childhood experiences, including childhood sexual abuse. They found that adults were more likely to fail to report an experience (false negative) than to report an experience that did not occur (false positive). These results are in line with studies showing that 20-38% of

individuals with documented histories of childhood sexual abuse do not report such abuse when asked in adulthood (Goodman et al., 2003; Widom & Morris, 1997; Williams, 1994). There may also be sex differences in the retrospective reporting of childhood sexual abuse in that men with documented histories of sexual abuse are more likely to deny having experienced abuse, compared with women (Davis, 1999; Widom & Morris, 1997).

There are a number of reasons why individuals with documented histories of childhood sexual abuse may not report on this experience when asked to do so in adulthood. First, it is possible that individuals might forget that they experienced sexual abuse; however, research suggests that this is a rare occurrence (Alexander et al., 2005; Berntsen & Rubin, 2002; Widom & Morris, 1997). While individuals may forget specific details of the sexual abuse, most retain general information about the experience (Widom & Morris, 1997). Second, inconsistent reporting may reflect changes in how individuals label and interpret their early sexual experiences (Langeland et al., 2015). Given that males are often socialized to pursue sexual experiences at a young age, they may be more likely to perceive such experiences in a positive and non-abusive manner (Romano & De Luca, 2001). Similarly, individuals may misinterpret early sexually abusive experiences as consensual if they believe that they played an active role in the sexual activity (Widom & Morris, 1997). This may be particularly true for males, who are more likely than females to report sexual experiences in which they touched the perpetrator (Edgards & Ormstad, 2000). Finally, individuals may be reluctant to report sexual abuse experiences in adulthood because of shame or embarrassment; they may also believe that it was minor and/or an incident from the past that no longer has any relevance in the present (Langeland et al., 2015; Williams, 1994).

Despite the limitations of retrospective reports, there are few good alternatives (Shchupak, 2015). Although childhood sexual abuse could be examined by using corroborative information (e.g., from hospitals, police records), these methods would also likely result in underestimates given the high numbers of sexual abuse cases that are not officially reported (Mohler-Kuo et al., 2014; Smith et al., 2000). Prospective studies, which follow cohorts of children over time to determine if and when they are sexually abused and whether the abuse influences long-term outcomes, have several advantages over retrospective reports (Euser et al., 2009). For one, given that participants are typically followed from birth, prospective studies can help determine risk factors for childhood sexual abuse and other types of maltreatment. Second, prospective studies collect data at regular time intervals, thereby decreasing recall biases by participants. However, prospective studies are limited in that they are expensive and require many years to complete. Unlike prospective studies, retrospective studies make it easier to obtain large sample sizes with a range of demographic characteristics and sexual abuse experiences. As such, retrospective methods appear to be the most feasible and common way of collecting information about childhood sexual abuse (London et al., 2008; Pereda et al., 2009; Shchupak, 2015).

Operational definition of childhood sexual abuse. Another difficulty with research on childhood sexual abuse is that there is no consensus on its definition (Goldman & Padayachi, 2000; Hulme, 2004). Childhood sexual abuse is broadly defined as any situation in which a child is coerced, threatened, or forced into sexual activity by another person (Collin-Vezina, Daigneault, & Hébert, 2013). This portion of the definition is agreed upon throughout the sexual abuse literature (Shchupak, 2015). Characteristics that vary include whether childhood sexual abuse should include both contact (e.g., fondling, oral-genital contact) and non-contact (e.g.,

exhibitionism, voyeurism) behaviours as well as the age requirements of the child and/or the perpetrator. Hulme (2004) conducted a literature review of 81 studies to examine trends in the measurement of childhood sexual abuse. Over half (54%) of the studies included both contact and non-contact types of sexual behaviours in their definition of childhood sexual abuse. The studies also varied in terms of the maximum age of the child. While the largest proportion of studies included individuals under the age of 18 (30%), other studies set the maximum age requirement as young as 12 years (7%). The studies also differed in terms of the age requirement of the perpetrator. Specifically, Hulme (2004) found that the number of studies that required an age discrepancy between the child and the perpetrator was about evenly split (54%). Of these, the vast majority (89%) required that the perpetrator be at least 5 years older than the child. Researchers may stipulate an age difference between the victim and the perpetrator to avoid including consensual sexual play or exploration between peers. However, it is unclear why the 5-year difference is chosen by researchers as it has never been scientifically justified (Hulme, 2004).

The variability among definitions is clearly problematic as the results across studies may differ as a function of definition used to evaluate childhood sexual abuse (Goldman & Padayachi, 2000). For instance, the prevalence rates of studies using broad definitions (e.g., inclusive of both contact and non-contact forms of childhood sexual abuse) are undoubtedly much higher than studies using a narrow definition (Edgards & Ormstad, 2000; Goldman & Padayachi, 2000; Roosa, Reyes, Reinholtz, & Angelini, 1998; Wynkoop et al., 1995). Several solutions have been proposed to improve comparability between studies; one would be to use a definition of childhood sexual abuse that is rooted in child protective practices (Hardt & Rutter, 2004; Hulme, 2004). This may allow for easier comparisons between legal data and self-

reported research data (Hamby & Finkelhor, 2000). It may also be helpful to standardize measures of childhood sexual abuse to require a specific definition be used for that particular instrument (Hulme, 2004).

Method of administration. In addition to the definition, there is no consensus about how best to measure childhood sexual abuse. Studies have used a number of methods to examine childhood sexual abuse experiences, including pen and paper questionnaires, face-to-face or telephone interviews, and chart reviews (Hulme, 2004; Pereda et al., 2009). Empirical efforts have been made to identify the method of administration that yields the highest disclosure rates, and presumably, the most valid data on childhood sexual abuse. While interviews have a number of benefits, including rapport building and opportunities to probe ambiguous responses, pen and paper questionnaires are typically confidential and anonymous, which may increase disclosure (Hulme, 2004).

Despite these procedural differences, meta-analytic reviews have not found significant differences between interviews and self-report questionnaires in terms of the number of participants disclosing sexual abuse or the details provided (Pereda et al., 2009; Rind et al., 1998). Studies relying on chart reviews to collect information about childhood sexual abuse have typically yielded lower prevalence rates than those using interviews or self-report questionnaires (e.g., Cutajar et al., 2010a, 2010b). Factors such as the secrecy surrounding the abuse, the shame felt by the victim when discussing the events, and fear about the criminal repercussions to the perpetrator, means that very few survivors come forward to authorities. As such, chart reviews are probably an underestimation of the prevalence of sexual abuse (Goldman & Padayachi, 2000). Chart reviews are also limited in that they often do not contain the level of

detail (e.g., age of the perpetrator, duration of the abuse) that may be better captured by self-report questionnaires and interviews.

With recent technological advances, on-line assessments are increasingly becoming a popular method to collect detailed sexual abuse histories from survivors (DiLillo et al., 2006; DiLillo et al., 2010). Emerging research suggests that on-line assessments elicit more self-disclosure than other self-report methods including phone interviews and pen and paper questionnaires. A meta-analysis of 48 studies examining “socially-undesirable experiences” such as suicidality and childhood sexual abuse revealed that on-line assessments led to significantly higher disclosure rates than surveys completed by hand or over the phone (Gnambs & Kaspar, 2015). Individuals may be more likely to disclose sensitive experiences because on-line assessments allow them to answer questions in the comfort and privacy of their own home (Gnambs & Kaspar, 2015). On-line assessments can also be programmed to execute skip and branching patterns and generate data files instantly, thus eliminating the need for complex instructions which may be confusing for participants (DiLillo et al., 2006). Other studies, however, have found comparable disclosure rates of sexual abuse among on-line methods and paper questionnaires (DiLillo et al., 2006), or have found greater willingness to report sexual abuse experiences among those completing questionnaires by hand (Testa, Livingston, & VanZile-Tamsen, 2005).

Number and specificity of questions. Another methodological issue is the way in which questions about childhood sexual abuse are asked. In general, the use of broad-label questions is associated with lower prevalence rates than behaviourally-specific questions (Fricker et al., 2003; Hulme, 2004; Pereda et al., 2009; Stander, Olson, & Merrill, 2002). Fricker and colleagues (2003) randomly assigned 236 U.S. college students to receive either one label or five

behaviourally-specific questions about childhood sexual abuse. Results showed that participants were more likely to endorse behaviourally-specific questions compared to label questions. Specifically, 9% of men and 10% of women endorsed childhood sexual abuse when asked: *Before the age of 18, were you sexually abused?* whereas 39% of men and 29% of women endorsed childhood sexual abuse when asked at least one behaviourally-specific question (e.g., *Before the age of 18, did anyone, male or female, ever put their fingers or objects inside your anus or (for women) vagina when you didn't want them to?*). A similar study of 954 U.S. college students found that only 46% who reported at least one occurrence of childhood sexual abuse in response to a behaviourally-specific question also endorsed having been “sexually abused” (Craner, Martinson, Sigmon, & McGillicuddy, 2015). Research suggests that men are less likely than women to explicitly label themselves as survivors of sexual abuse (Thombs et al., 2006; Widom & Morris, 1997).

There are a number of explanations for the lower disclosure rates of childhood sexual abuse found by using broad-label questions. First, label questions require that the individual define the meaning of the term “abuse” and then determine whether his or her experiences fit within that definition (Thombs et al., 2006). Although researchers and clinicians may clearly label an experience as abusive, individuals may not label their own experiences in the same manner. For example, males who respond physiologically (e.g., ejaculation) to early sexual experiences may come to think that it was something that they desired (Holmes et al., 1997). Individuals may also want to avoid the stigma associated with the term “abuse” (Thombs et al., 2006). Finally, the use of multiple questions about specific sexual behaviours can provide retrieval cues to help access memories of early sexual experiences (Fricker et al., 2003). With

these considerations in mind, researchers generally concede that the use of behaviourally-specific questions is the best way to ask adults about childhood sexual abuse (Fricker et al., 2003).

Psychometric data. One of the biggest methodological difficulties in the sexual trauma literature is the lack of psychometric data for measures of childhood sexual abuse (Briere, 1992; Hulme, 2004; Shchupak, 2015). Shchupak (2015) conducted a literature review of 168 studies published between 2008 and 2014 in order to determine the types of measures being used to study childhood sexual abuse and the psychometric properties of these instruments. The most commonly used measures were the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1997) and the Sexual Victimization Survey (SVS; Finkelhor, 1979); these measures were used to collect information on childhood sexual abuse in 23% and 12% of studies, respectively. In terms of psychometric data, only 43 of the 168 studies (26%) reported psychometric data for their current sample (18 of which used the CTQ). Psychometric data that were collected tended to be minimal (i.e., internal consistency; Shchupak, 2015). The majority of the psychometric data that does exist is for measures that include childhood sexual abuse as a subscale (e.g., Computer Assisted Maltreatment Inventory; DiLillo et al., 2006). Other measures that do have psychometric data (albeit limited) have not often been used (e.g., Sexual Abuse Exposure Questionnaire; Ryan et al., 1992). Clearly, there is a significant gap in the literature with respect to the psychometric properties of childhood sexual abuse measures.

There are several reasons for the fact that reliability and validity data have not been collected on measures of childhood sexual abuse. First, measures of sexual abuse generally are used to dichotomize participants into those with and without sexual abuse histories. This method does not inherently lend itself to the gathering of psychometric data, given that statistics of reliability and validity often require scaled responses. Second, retrospective measures of

childhood sexual abuse are typically perceived as akin to gathering descriptive data (analogous to socio-demographic questionnaires; Hulme, 2004). Third, studies on childhood sexual abuse have tended to rely on measures that were developed over thirty years ago when the literature on this topic was just emerging. The researchers that created these classic instruments did not collect reliability and validity data because their research was largely exploratory at the time (Hulme, 2004). Finally, as previously discussed, the trauma literature has not yet reached a consensus on the definition of childhood sexual abuse, thus making it difficult to examine concurrent validity between sexual abuse measures (Briere, 1992; Shchupak, 2015).

Common Measures of Childhood Sexual Abuse

The CTQ and the SVS are the most commonly-used measures of childhood sexual abuse with limited psychometric data available (Shchupak, 2015). The following section briefly reviews these measures.

CTQ. Researchers have tended to use questionnaires that assess for multiple types of maltreatment, probably because they possess a larger psychometric base than measures assessing for childhood sexual abuse only (Shchupak, 2015). The CTQ (Bernstein & Fink, 1997) is an example of this type of measure. It is a self-report questionnaire that asks participants about five types of childhood maltreatment (including sexual abuse). Participants rate 28 items on a 5-point Likert scale. A total severity score is obtained for each type of maltreatment. The CTQ is widely considered to be a psychometrically-sound measure of childhood abuse (e.g., Forde et al., 2012; Spinhoven et al., 2014). For instance, the sexual abuse subscale of the CTQ has shown moderate concurrent validity with interview-based measures of sexual abuse ($\kappa = .58$) and 4-month test-retest reliabilities ranging from .79 to .86 (Bernstein & Fink, 1997). At face value, the CTQ would seem to be good measure for research on childhood sexual abuse. However, the

information obtained from the CTQ is very limited. For one, the sexual abuse subscale of the CTQ is comprised of only five questions that are either vague (e.g., *Someone tried to touch me in a sexual way or make me touch them*) or ask participants to identify their experiences as abusive (e.g., *I believe I was sexually abused*). Moreover, while the CTQ may be able to detect the presence of sexual abuse, it does not measure the characteristics of the abuse (e.g., relationship to the perpetrator, duration). As a result of these limitations, the CTQ is not ideal for collecting detailed information about childhood sexual abuse.

SVS. The SVS (Finkelhor, 1979) was one of the first self-report questionnaires to collect detailed information about childhood sexual abuse. The SVS asks participants to identify the sexual experiences that they had as a child from a list of 10 sexual acts (see Appendix A for the SVS). It then separates these experiences into four main questions that are divided according to the age of the child and their relationship to the perpetrator (e.g., *Now we would like you to think of sexual experiences you had after the age of twelve 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 of the four main questions, the participant can choose up to three sexual experiences. With this parameter, the participant can report on up to 12 experiences in total. For each sexual experience that the participant endorses, 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 threatened or physically forced them, and disclosure experiences. These details can help researchers distinguish sexually abusive experiences from consensual sexual experiences with peers (Finkelhor, 1979).

Despite being created over 30 years ago, the SVS remains a popular choice among researchers because its format can easily be modified (e.g., to include additional follow-up

questions), and it incorporates elements that are associated with higher disclosure rates of childhood sexual abuse (e.g., the use of behaviourally-specific questions). Also, unlike other measures (e.g., CTQ; Bernstein & Fink, 1997) which include only a few specific items (e.g., *Someone tried to make me do sexual things or watch sexual things*) and do not gather additional information beyond just the sexual acts, the SVS asks participants to provide detailed information about their sexual experiences (e.g., relationship to the perpetrator, abuse duration, disclosure experiences).

Although there are advantages to the SVS, it also possesses several limitations. First, unlike the CTQ, the SVS possesses limited psychometric data. The few studies that have examined the psychometric properties of the SVS are either limited to adult females or mixed-sex samples with relatively fewer males. For instance, Shchupak (2015) administered the SVS to 168 female undergraduate students along with a second shorter measure of childhood sexual abuse (i.e., the Russell Sexual Abuse Interview Schedule; Russell, 1986) as well as questionnaires on psychological functioning and locus of control. Results provided support for the convergent validity of the SVS. The majority of participants (92%) who reported childhood sexual abuse on the SVS also reported being sexually abused on the Russell measure. Another study by Vaillancourt-Morel and colleagues (2016) examined the relationship between childhood sexual abuse as measured by the SVS and sexual behaviours in a sample of 1,033 adults (74% female). The authors created a total severity score by summing three of the SVS indices, namely the frequency of abuse, the intrusiveness of the sexual acts, and the relationship to the perpetrator. Although the study reported an acceptable Cronbach's alpha ($\alpha = .86$), it was a modified version of the original so it is unknown whether the original instrument possessed

similar internal consistency. While these studies provide preliminary support for the psychometric base of the SVS, more research is needed with samples that also include males.

Second, the SVS asks participants to describe 12 childhood sexual experiences. While this approach increases the likelihood of capturing all sexual abuse experiences, participants may find the SVS too onerous or time-consuming to complete. Moreover, asking participants to report on all their early sexual experiences has the potential to be too overwhelming or distressing for some participants. For some participants, they may be disclosing childhood sexual abuse for the first time on the questionnaire. Participants may feel less overwhelmed, and more in control, if they are given the option to choose a few sexual experiences that they would like to discuss.

Finally, past studies have found that participants have trouble understanding the wording of the four main questions of the SVS. For instance, the types of sexual experiences that are to be included may be unclear (Shchupak, 2015). Given that studies on childhood sexual abuse are increasingly using on-line questionnaires (DiLillo et al., 2006), it is important that the SVS be straightforward and easy to follow as participants may be completing the questionnaire alone (and not in the presence of a research assistant who could clarify questions).

The current study examined the psychometric properties of the SVS. However, a modified version of the SVS was used to address the limitations of the original measure (Finkelhor, 1979; see Appendix B). While the original measure is divided into four sections (i.e., sexual experiences before/after age 12 with family/non-family member), the current study modified the SVS to allow participants to describe up to three sexually abusive experiences before the age of 16. Unlike the initial measure, the modified version was not divided into four sections. For each sexual abuse experience endorsed on the SVS, participants provided

information on the type of sexual act(s), characteristics of the perpetrator(s), age of abuse onset, duration, and disclosure experiences. Several items were re-worded in order to improve clarity (e.g., *How old were you when the sexual experience began?*). The modified SVS also asked participants to report the developmental level of the perpetrator (i.e., child, adolescent, adult, and older adult) and not the perpetrator's age as in the original SVS. This decision was based on the fact that participants may have difficulty remembering the specific age of the perpetrator, particularly for those individuals abused at younger ages or by unknown individuals. Several items from the original SVS were omitted (e.g., *Did you threaten or force the other person(s)?*) because they were seen as irrelevant in determining whether an experience constituted childhood sexual abuse. In addition, a 1-item Likert scale ranging from 1 (*very distant*) to 5 (*very close*) was added to the SVS to measure emotional closeness to each of the identified perpetrators prior to abuse onset (Schultz, Passmore, & Yoder, 2000). Please see Table 1 for a complete list of the modifications.

While the modifications to the original measure were extensive, research suggests that it is not uncommon to modify the SVS. In her review of articles published between 2008 and 2014, Shchupak (2015) found that 18 of the 20 (90%) studies that used the SVS had a modified version. Modifications ranged from minimal (e.g., adding to the list of potential perpetrators; Lutz-Zois, Phelps, & Reichle, 2011) to extensive (e.g., eliminating the four sections, having participants report on up to 10 sexual abuse experiences; Senn, Carey, & Coury-Doniger, 2012). Other studies combined items from the SVS with another measure of childhood sexual abuse

Table 1

Comparisons between the Original and Modified Versions of the SVS

Original SVS	Modified SVS
<i>Administration</i>	
Pen and paper questionnaire	On-line questionnaire
4 sections (divided by age of onset and relationship to the perpetrator); participants report on up to 3 experiences for each section (for a maximum of 12 sexual experiences)	Removal of 4 sections; participants report on up to 3 experiences in total
<i>Modified items</i>	
About how old were you at the time? —	How old were you when this sexual experience began? — years
Approximate age of the other person(s): —	Approximately how old was the other person when the sexual experience began? — Child (less than 12 years) — Adolescent (12 to 18 years) — Young adult (19 to 30 years) — Middle aged adult (31 to 59 years) — Older adult (60 years and older)
Choose up to 3 sexual experiences that you had <i>before the age of 12 with other children...</i> Relationship to the other person(s): ____ 1 for Stranger 2 for Person you knew, but not a friend 3 for Friend 4 for Niece or nephew 5 for Cousin 6 for Brother 7 for Sister Now choose up to 3 sexual experiences that you had <i>before the age of 12 with an adult (a person over 16)</i> . Relationship to the other person(s): ____ 1 for Stranger 2 for Person you knew, but not a friend 3 for Friend of yours 4 for Friend of your parents 5 for Cousin 6 for Uncle or aunt 7 for Grandparent	What was your relationship to the other person or persons? Please check off all that apply: — Stranger — Friend of yours — Friend of your parents — Father — Mother — Grandfather — Grandmother — Stepfather — Stepmother — Boyfriend — Girlfriend — Uncle — Aunt — Brother — Sister — Cousin — Neighbour — Teacher — Babysitter — Coach

8 for Brother 9 for Sister 10 for Father 11 for Stepfather 12 for Mother 13 for Stepmother Now choose up to 3 sexual experiences you had <i>after the age of 12 with a family member or relative</i>. Relationship to the other person(s): ____ 1 for Cousin 2 for Aunt or uncle 3 for Grandparent 4 for Brother or sister 5 for Parent 6 for Step-parent 7 for Guardian 8 for Close friend of a parent Finally, choose up to 3 sexual experiences that you had <i>after the age of 12, which you did not consent to</i>. Relationship to the other person(s): ____ 1 for Stranger 2 for Friend of yours 3 for Friend of your parents 4 for Cousin 5 for Aunt or uncle 6 for Brother or sister 7 for Parent 8 for Step-parent 9 for Guardian	____ Priest/religious figure ____ Other (specify:)
What happened? (Circle 1 for Yes or 0 for No for each line) a. Invitation or request to do something sexual b. Kissing and hugging in a sexual way c. Other person showing his/her sex organs to you d. You showing your sex organs to another person e. Other person fondling you in a sexual way f. You fondling another person in a sexual way	Did you experience any of the following with the other person? Please check off all those that apply. a. The person inviting or requesting that you do something sexual b. Kissing and hugging in a sexual way (like a couple might do, for example, kissing on the lips or kissing with an open mouth) c. The person showing his/her sexual parts to you d. You showing your sexual parts to the other person

g. Other person touching your sex organs h. You touching other person's sex organs i. Intercourse, but without attempting penetration j. Intercourse k. Other, please mention:	e. The other person fondling you in a sexual way and/or touching your sexual parts f. You fondling the other person in a sexual way and/or touching their sexual parts g. The other person performing oral sex on you h. You performing oral sex on the other person i. Intercourse j. Another person taking sexually suggestive or explicit photographs or videos of you k. Other, please describe:
Did the other person(s) threaten or force you? ___ Yes ___ A little ___ No	Did the other person or persons do any of the following things to you during your sexual experience? Please select all that apply. ___ Physically force you ___ Hurt you physically ___ Threaten you ___ Manipulate or trick you to participate
About how many times did you have a sexual experience with the person? ___	Approximately how many times did the sexual behavior occur? 1) Only once or twice 2) From 3-10 times 3) From 11-25 times 4) From 26-50 times 5) More than 50 times
Over how long a time did this go on? (Give number of days, months, years) ___	For approximately how long did this sexual behavior continue? ___ Child (less than 12 years) ___ Adolescent (12 to 18 years) ___ Young adult (19 to 30 years) ___ Middle aged adult (31 to 59 years) ___ Older adult (60 years and older)
Who did you tell about the experience at the time? ___ No one ___ Mother ___ Father ___ Other adult ___ Brother/sister ___ Friend	Who have you told about the sexual experience? Please select all that apply. ___ No one ___ Mother ___ Father ___ Sister ___ Brother ___ Friend ___ Teacher ___ Police

	___ Other (please specify:)
<i>Removed Items</i>	
Who started this? (Circle 1 for you and 2 for the other person)	Removed
Did you threaten or force the other person(s)? ___ Yes ___ A little ___ No	Removed
Which of these would best describe your reaction at the time of the experience? 1. Fear 2. Shock 3. Surprise 4. Interest 5. Pleasure	Removed
If mother, how did she react? (If you did not tell your mother, how do you think she would have reacted?) ___ Angry ___ Supportive	Removed
If father, how did he react? (If you did not tell your father, how do you think he would have reacted?) ___ Angry ___ Supportive	Removed
In retrospect, would you say this experience was : ___ Positive ___ Mostly positive ___ Neutral ___ Mostly negative ___ Negative	Removed
<i>Added Items</i>	
N/A	How emotionally close were you with this person (e.g., I felt “attached” to this person, I felt “connected” to this person) before the sexual experience began? 1 Very distant 2 3 4 5 Very close
N/A	Do you feel you consented to the experience? ___ Yes

	☐ No
N/A	If you did tell someone, how old were you when you first told another person about the sexual experience? ☐ years ☐ Did not disclose
N/A	The first time you told someone, if you told at all, how did that person react (check off all that apply)? ☐ Blamed you ☐ Supported you ☐ Did not believe you ☐ Ignored you ☐ Other (please describe:)
N/A	Was this experience ever reported to the police or a child welfare agency? ☐ Yes ☐ No
N/A	In your opinion, do you feel that this experience was sexual abuse? ☐ Yes ☐ No

(Young, Riggs, & Robinson, 2011). As such, my modifications to the SVS are comparable to other studies. Like past studies, I kept the spirit of the original measure by collecting detailed information (e.g., age of onset, duration, relationship to the perpetrator) about multiple childhood sexual experiences using a similar structure and wording to the SVS.

Summary and Objectives

Studies agree that childhood sexual abuse is a widespread problem with numerous potential deleterious outcomes (Dube et al., 2005; Molnar et al., 2001; Pereda et al., 2009). Despite the importance of conducting research in this area, there are numerous methodological problems. Most studies on childhood sexual abuse rely on retrospective reports, which may be subject to inaccuracies in recall and underreporting. There also is no consensus on the operational definition of childhood sexual abuse, with the majority of studies relying on

definitions that lack a scientific rationale. The research carried out to date also varies in terms of the method of administration (questionnaire, interview, on-line, or chart review) as well as the number and specificity of the questions asked about childhood sexual abuse, which can limit comparisons of results between studies. While these problems can be mitigated by using high-quality measures of childhood sexual abuse (Hardt & Rutter, 2004), few measures of sexual abuse possess information on reliability and validity (Hulme, 2004).

One of the most commonly used measures of childhood sexual abuse, the SVS, has some psychometric support but it is limited and has focused mostly on female populations (e.g., Shchupak, 2015; Vaillancourt-Morel et al., 2016). The current study adds to the existing literature by examining the reliability and validity of a modified version of the SVS among male survivors of childhood sexual abuse. The objectives of Study 1 were threefold.

First, this study examined the inter-rater reliability of the SVS by having two individuals (J. Lyons and a research assistant) independently code for the presence (or absence) of childhood sexual abuse according to participants' descriptions of childhood sexual experiences on the SVS. In line with recommendations made by Hulme (2004) and Hardt and Rutter (2004), this study used an operational definition of childhood sexual abuse that was based on the Criminal Code of Canada and child protection practices. The raters also coded for 12 abuse characteristics (i.e., age of onset, relationship to perpetrator, emotional closeness to the perpetrator, fondling, oral-genital contact, penetration, sexually explicit photographs/videos, duration, threats or physical force, multiple experiences of sexual abuse, disclosure, and reaction to disclosure).

Second, the study examined the concurrent validity of the SVS by examining its relationship to the sexual abuse subscale of the Childhood Experiences of Violence Questionnaire-Short Form (CEVQ-SF; Tanaka et al., 2012). Specifically, the percentage of

participants classified as “sexual abuse victims” on the SVS was compared to the percentage of participants classified as “sexual abuse victims” on the CEVQ-SF. The CEVQ-SF was chosen for two reasons: 1) it possesses good psychometric properties (Tanaka et al., 2012) and 2) given that the SVS has already shown good concurrent validity with another measure of childhood sexual abuse (i.e., the Russell Sexual Abuse Interview Schedule, Shchupak, 2015), the CEVQ-SF extends our understanding of the concurrent validity of the SVS to a more recent measure of childhood sexual abuse. Although it would have been useful to compare the results of the SVS to another common measure of childhood sexual abuse, the CTQ, its publisher allows students to administer the measure in its original pen and paper format only. As such, on-line adaptation of the CTQ was not possible.

Third, reliability data were gathered by way of 1-week test-retest analyses. The percentage of men who were classified as “sexual abuse victims” at the first time point were compared to the percentage of those classified as victims one week later. Finally, the consistency of each of the 12 abuse characteristics was measured across the two time points.

Hypotheses

As there are few studies that have explored the psychometric properties of the SVS, hypotheses regarding its reliability and validity were largely exploratory. Given that the study used a narrow definition of childhood sexual abuse (i.e., specific definitional criteria based on Canadian law), it was expected that inter-rater reliability would be high. It was also expected that the raters would generally agree on abuse characteristics. Turning to concurrent validity, it was hypothesized that most people who reported childhood sexual abuse on the SVS would also endorse sexual abuse on the CEVQ-SF, as previous studies have found high agreement in abuse status between the SVS and other measures of childhood sexual abuse (Shchupak, 2015).

Finally, given the salience of memories for childhood sexual abuse (Berntsen, 2002; Widom & Morris, 1997), it was hypothesized that men would report similar childhood sexual experiences at the initial time point and at the 1-week test-retest.

Method

Participants

Data collection for this on-line study began in January 2014 and lasted until September 2015. Figure 1 shows that 570 males accessed the questionnaire. Of these, 402 completed the five inclusion questions, and 356 were eligible to participate. Forty-six participants were excluded because they did not meet the study's inclusionary criteria; namely, they were female ($n = 6$), were not between the ages of 18-59 ($n = 18$), were not fluent in English ($n = 1$), or did not reside in Canada or the U.S. ($n = 21$). The age limit for participation was chosen because Study 2's primary measure of psychological functioning, the Adult Self-Report (Achenbach & Rescorla, 2003), was normed on adults aged 18-59. All participants endorsed having a sexual experience prior to the age of 16. The 356 participants who met the inclusion criteria consented to participate in the study. Of these, 302 completed the SVS. As shown in Table 1, the average age of male participants who provided data on the SVS was 39 years ($SD = 12.9$). Although participants were asked to confirm that they were between the ages of 18-59 before proceeding to the questionnaire, the age range of the participants who completed the SVS was 15-76. These participants were retained because it was unclear whether they made an error when completing the inclusionary criteria or when reporting their age. Moreover, Study 1 only relied on the SVS and CEVQ-SF, both of which do not stipulate a minimum or maximum age. Participants outside of the 18-59 age range were thus retained for Study 1.

Figure 1.

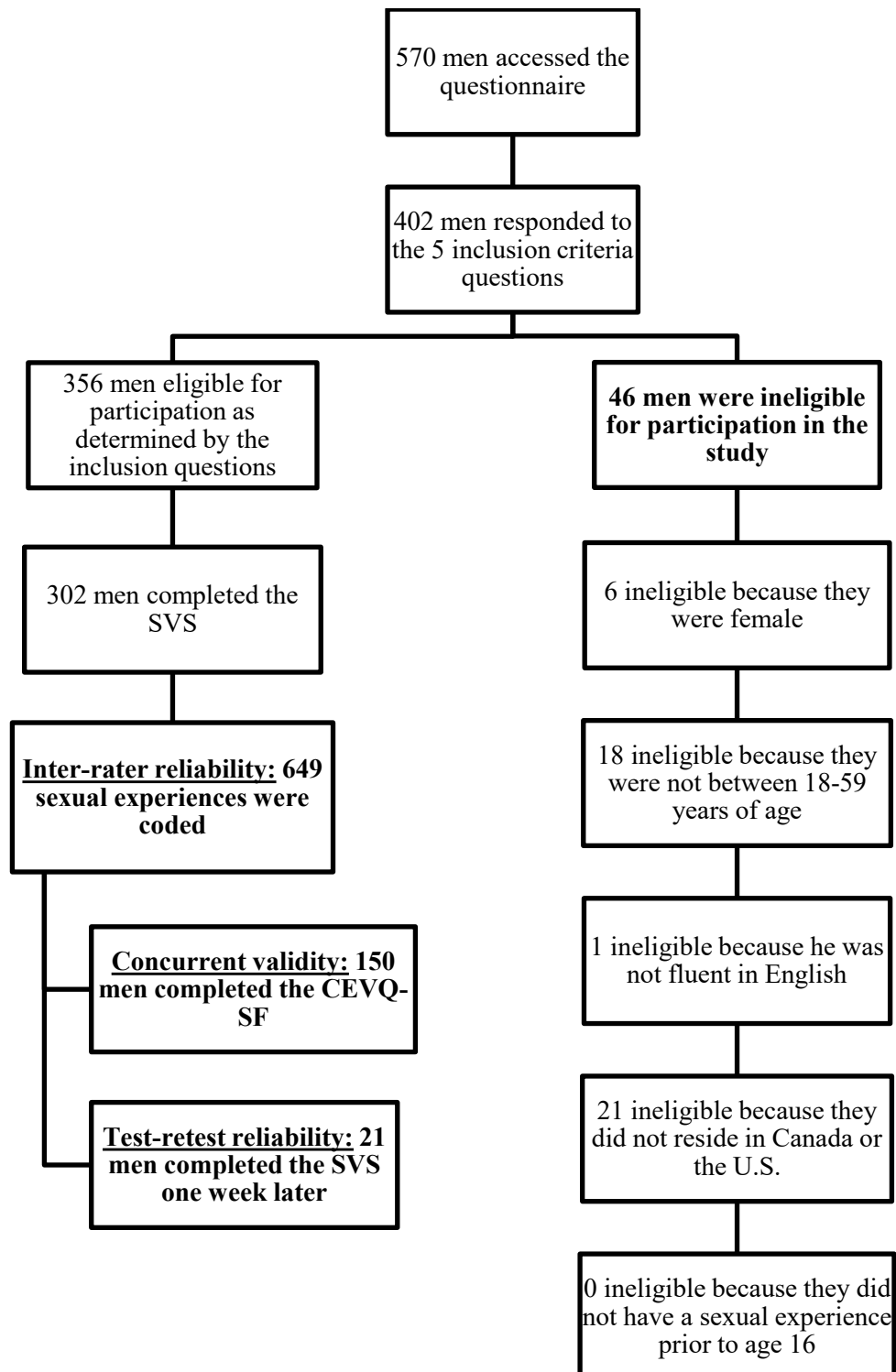
Recruitment Flow Chart for Study 1

Table 2 shows that participants were primarily U.S. residents (64.8%) and Caucasian (84.7%). Household income varied among participants; the most common ranges were between \$10,000-\$29,999 (19.0%), \$30,000-\$49,999 (17.3%), and over \$110,000 (17.3%). Similarly, there were varied levels of education, with the largest proportion (31.4%) of participants reporting that their highest educational level was high school. Finally, most males (58.9%) were employed either on a part- or full-time basis. There were no statistically significant differences between males who did and did not complete the SVS in age, Caucasian versus non-Caucasian ethnicity, income, or education. Statistical differences in employment among men who completed the SVS and those who did not could not be calculated due to small cell sizes.

Table 2

Socio-Demographics of Males Who Completed the SVS (N = 302)

	N	%	M (SD)	Range
Age	300	-	39.0 (12.9)	15-76
Country				
U.S.	193	64.8		
Canada	105	35.2	-	-
Ethnicity				
Caucasian	255	84.7		
Hispanic	12	4.0		
South Asian (e.g., Indian, Pakistani)	8	2.7		
East Asian (e.g., Chinese, Japanese)	6	2.0	-	-
Middle Eastern (e.g., Egyptian, Lebanese)	5	1.7		
Native	4	1.2		
Black	3	1.0		
Other ^a	8	2.7		
Income				
Less than \$9,999	31	10.3		
\$10,000-\$29,999	57	19.0		
\$30,000-\$49,999	52	17.3	-	-
\$50,000-\$69,999	45	15.1		
\$70,000-\$89,999	32	10.7		
\$90,000-\$109,999	31	10.3		

Over \$110,000	52	17.3		
Highest Education				
Elementary school	15	5.1		
High school	93	31.4		
College and/or trade program	42	14.2	-	-
University undergraduate degree	80	27.0		
University graduate degree	66	22.3		
Employment				
Unemployed	31	10.3		
Employed part- or full- time	177	58.9		
Going to school	22	7.3		
Going to school and employed	21	7.0	-	-
Recovering from an illness/disability	35	11.6		
Retired	14	4.6		

^a Examples included mixed race and Métis.

Data collection for concurrent validity and test-retest reliability began in January 2015. One hundred and fifty men completed the CEVQ-SF in addition to the SVS. For the test-retest analyses, there were 21 men who completed the SVS initially and then again approximately one week later ($M = 8.4$ days, $SD = 2.1$, range = 7-15).

Measures

Participants completed a socio-demographics questionnaire (Appendix C), the modified SVS (Appendix B), and one question from the CEVQ-SF (Appendix D).

SVS. As described, a modified version of the SVS was used to collect information about the childhood sexual experiences of participants. Males reported on a maximum of three sexual experiences. 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 current study defined childhood sexual abuse as any contact or non-contact sexual experience

occurring before the age of 16 years with an individual in a relative position of authority, trust, or dependency (e.g. with a 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). Consensual sexual experiences occurring between the ages of 14-15 years with individuals less than five years older as well as sexual experiences occurring between the ages of 12-13 years with individuals less than 2 years older and with whom there was no relationship of authority, trust, or dependency, were not considered childhood sexual abuse.

While some experiences were easy to identify as sexually abusive (e.g., sexual acts between children and adults), sexual experiences with peers required decision making. Sexual exploration and sexual play are considered natural and healthy processes that occur before and during puberty (Cavanaugh-Johnson, 1999). As such, it can be difficult to decide when the sexual behaviour is typical and when it is abusive. According to Rich (1999), normative (or expected) 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. With these criteria in mind, sexual experiences with peers were only considered sexually abusive if: a) the participant endorsed extensive sexual acts that are beyond what we might consider explorative for their age (e.g., intercourse prior to age 12); b) if the participant reported that physical harm, violence, or threats were used as methods of coercion, and c) if the participant did not consent to the experience. For example, if a participant endorsed several incidents of fondling occurring at age 10 with another child (i.e., individual aged 6 to 12), but he did not experience physical harm, violence, or threat and he reported that it was consensual, the experience was not coded as childhood sexual abuse.

When multiple sexual abuse experiences were reported, decision making for coding became more difficult. Past studies have tended to code only the most severe experience (Bennett, Hughes, & Luke, 2000; Hulme & Agrawal, 2004; Shchupak, 2015). Although this method simplifies analyses, it does not account for the potentially significant impact of other sexual abuse experiences. For instance, an individual may consider a one-time incident of rape in adolescence to be more traumatic than chronic fondling by a family member at a young age. As such, when participants endorsed more than one sexual experience, their data across multiple experiences were examined and coded for each abuse characteristic based on the response that indicated the greatest severity. For example, if a participant endorsed three sexually abusive experiences, two of which were perpetrated by individuals outside the family and one of which was perpetrated by a family member, the “relationship to the perpetrator” variable was coded as “both” to capture the greatest severity, namely that the participant had perpetrators that were both related and unrelated to him. As another example, a participant may have indicated having experienced two separate incidents of sexual abuse, one of which began during early childhood and one of which began in adolescence. In this case, the “age of onset” variable was coded as early childhood because it reflected the greatest severity. For the remaining variables, greater perceived emotional closeness to the perpetrator, greater physical invasiveness of the sexual act(s), longer duration, presence of threats and/or physical force, multiple experiences, and disclosure met with a negative reaction were considered more severe. The abuse characteristics were coded the same way at both the initial and test-retest time points, namely:

(a) Age of abuse onset: continuous variable coded as age in years.

(b) Duration of abuse: continuous variable coded as one day or a few days (1); over a period of a few weeks (2); over a period of a few months (3); over a period of a few years (4); and over a period of many years (5).

(c) Relationship to the perpetrator: categorical variable coded as extrafamilial (0); intrafamilial (1); or both (2). Intrafamilial perpetrators included biological, step, and foster family members (e.g., father, uncle, stepbrother). Extrafamilial perpetrators included individuals outside of the immediate or extended family (e.g., friend, neighbour, teacher, coach). The relationship to the perpetrator was coded as “both” if the participant endorsed multiple abuse experiences with both intrafamilial and extrafamilial perpetrators.

(d) Emotional closeness to the perpetrator: continuous variable coded from 1 (*very close*) to 5 (*very distant*).

(e) Fondling: dichotomous variable coded as 0 if participants did not endorse being fondled and/or fondling the perpetrator, or 1 if they endorsed this sexual activity.

(f) Oral-genital contact: dichotomous variable coded as 0 if participants did not endorse oral-genital contact, or 1 if they endorsed this sexual activity.

(g) Penetration: dichotomous variable coded as 0 if participants did not endorse being penetrated (e.g., with an object, or penis), or 1 if they endorsed this sexual activity.

(h) Sexually explicit photographs/videos: dichotomous variable coded as 0 if participants did not endorse that the perpetrator took sexually explicit photographs and/or videos of them, or a code of 1 if they endorsed this sexual activity.

(i) Threats or physical force: dichotomous variable coded as 0 if participants endorsed being physically forced, threatened, and/or being hurt physically during the sexual experience, or a code of 1 if they did not endorse these experiences.

(j) Multiple experiences: dichotomous variable coded as 0 if participants endorsed one sexual abuse experience, or a code of 1 if they endorsed multiple sexual abuse experiences.

(k) Disclosure: dichotomous variable coded as 0 if participants have not previously disclosed their sexual abuse experience prior to completing the study, or a code of 1 if participants had disclosed.

(l) Reaction to disclosure: if participants had disclosed their sexual abuse experience, they were asked to describe the response they received when they first told. This variable was coded as 0 if participants had received a supportive response, or a code of 1 if participants received a negative response (e.g., were blamed, ignored) to disclosure.

CEVQ-SF. One item from the CEVQ-SF was used to assess for childhood sexual abuse (i.e., *Before age 16, when you were growing up, did anyone ever do any of the following things when you didn't want them to: touch the private parts of your body or make you touch their private parts, threaten, or try to have sex with you or sexually force themselves on you*).

Participants who responded “no” were coded as “not abused” while participants who endorsed this item were coded as sexually abused. The total CEVQ-SF has been shown to possess good internal consistency and moderate-to-good 2-week test-retest reliability (Tanaka et al., 2012).

The sexual abuse subscale of the CEVQ-SF has also shown substantial agreement with the sexual abuse subscale of the CTQ ($\kappa = .69$), thereby supporting its concurrent validity (Tanaka et al., 2012).

Procedure

Data for Study 1 and Study 2 were collected simultaneously as one larger research project. The research project was reviewed and approved by the Office of Research Ethics and Integrity at the University of Ottawa (see Appendix E for a copy of the ethics approval).

Participants were recruited via websites offering information and resources for sexually abused men, such as 1in6.ca, 1in6.org, and The Men's Project website at themensproject.ca (note that The Men's Project closed in 2015 due to government funding cuts, and has since reopened under the name "Men and Healing" at menandhealing.ca). Individuals at these organizations agreed to post study notices, which explained the purpose of the study, outlined eligibility criteria and participation requirements, and provided the study web-link and phone number for the primary investigator (see Appendix F for the study notice). As way to express appreciation for their participation, males were invited to enter a draw for one of four \$50 Visa gift cards.

Interested individuals logged onto fluidsurveys.com using the web-link provided to them on the study notice. Prior to beginning the study, eligibility criteria were assessed. In order to participate in the study, individuals had to: (a) be male; (b) be between the ages of 18-59; (c) be fluent in English; (d) currently reside in Canada or the United States; and (e) have had a sexual experience before the age of 16. If participants answered "no" to any of the eligibility criteria, they were forwarded to a webpage thanking them for their interest and explaining that they were not eligible for the study. As for eligible participants, consent was obtained. Specifically, participants were provided with an on-line consent form (see Appendix G) following which they were asked to click a button indicating that they read and understood the form and that they agreed to participate in the study. To ensure anonymity, no identifiable information is collected from participants (e.g., IP address), and cookies were not installed on their computers. A limitation to this Internet design is that it prevented participants from closing the study's webpage and returning to it at a later point. To provide more flexibility in time completion, participants were given eight hours to complete the study before the web-link timed out.

Participants were informed prior to the beginning of the study of the 8-hour time frame and of the fact that the study could not be retrieved after closing the webpage.

The on-line questionnaire took approximately 40-50 minutes to complete. Participants were able to terminate the study at any time. A window opened when participants either terminated or completed the study. Participants were provided with a relaxation exercise (see Appendix H) and a list of mental health resources that they could contact should they feel any discomfort as a result of study participation (see Appendix I). At the end of the questionnaire, men were given the option to be re-contacted in one week to participate in a second study that was anticipated to take 10-15 minutes to complete. If they were interested, they were asked to enter a 4-digit code (i.e., their initials, and last two years of birth). Participants then clicked “Next” to be forwarded to a new window, and having no way at this point to link participants to their response in the study, they were asked to provide their email address. Contact information was forwarded to an email account created for study purposes. Approximately one week later, the primary investigator emailed participants with a web-link, which asked them to complete another consent form (see Appendix J), re-enter the same code, and complete a second SVS. Regardless of whether they expressed interest in the second study, all participants were forwarded to the exit page where they could enter their email address to be entered into the draw. The primary investigator checked the email addresses at the end of the recruitment process, once all data had been downloaded into an SPSS data file.

Data Analysis

SPSS 23.0 was used to analyze the data. In assessing the inter-rater reliability of the SVS, the data were purely descriptive and are presented in frequencies. Cohen’s kappa statistic (κ) was used to evaluate agreement in abuse status between the SVS and the CEVQ-SF. Power

was calculated using G*Power 3.0. While G*Power cannot calculate power for kappa, it can accommodate chi-square, 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 sample of 150, there was adequate statistical power to detect a large effect using a .05 alpha level.

Kappa values were also used to examine the agreement in abuse status and categorical abuse characteristics (i.e., relationship to the perpetrator, fondling, oral-genital contact, penetration, sexually explicit photographs/videos, threats or physical force, multiple experiences, disclosure, and reaction to disclosure) between the initial and 1-week test-retest time points. For continuous abuse characteristics (i.e., age of onset, emotional closeness to the perpetrator, and duration), Pearson correlation coefficients were used. In terms of calculating power, the test-retest reliability of the SVS has not been previously investigated so it was difficult to decide which effect size to use for the power calculation. However, studies that have investigated the test-retest of other sexual abuse measures, such as the Computer Assisted Inventory (DiLillo et al., 2006; 2010) and the CSA Frequency Scale (Hulme, 2007), cite substantial kappa values ($\kappa = .70$) and correlation coefficients of .92-.94. As such, I expected that the SVS would show similar rates, particularly since the time gap between administrations was only one week. To detect a large effect with a sample of 21 men and a .05 alpha level, the power was low. Although statistical power was limited, this sample size is consistent with other studies investigating the test-retest reliability of sexual abuse measures (DiLillo et al., 2006; 2010; Hulme, 2007).

Results

Objective 1: What is the Inter-Rater Reliability of the Modified Version of the SVS?

On average, males provided information on 2.1 sexual experiences ($SD = .85$). Ninety-one men (30.1%) reported on one sexual experience, 79 (26.2%) reported on two sexual experiences, and 132 (43.7%) reported on three sexual experiences. As mentioned, two research assistants separately coded each sexual experience to determine whether it met criteria for childhood sexual abuse. Agreement on abuse status on the SVS was high; the raters agreed on the abuse status of 602 of the 649 sexual experiences (92.7%). Disagreements were resolved by Dr. E. Romano. Two hundred and eighty-two men (93.3%) reported at least one sexual experience that met criteria for childhood sexual abuse.

Raters also coded abuse characteristics for the men who were sexually abused. For men who reported multiple experiences, the abuse characteristics were coded according to the response that indicated the greatest severity. Agreement between the two raters on abuse characteristics ranged from 92.9-99.3%. Fondling had the highest rate of agreement, and reaction to disclosure had the lowest rate of agreement. Please see Table 3 for detailed information on inter-rater reliability.

Objective 2: What is the Concurrent Validity of the Modified Version of the SVS?

To examine concurrent validity, participants' responses on the CEVQ-SF were compared to their abuse status on the SVS. In general, more men were coded as sexually abused on the SVS than the CEVQ-SF (137 versus 120). As shown in Table 4, among the 120 men who endorsed CSA on the CEVQ-SF, 117 men (98%) were also coded as sexually abused on the SVS. Three men (2%) indicated that they were abused on the CEVQ-SF but were not coded as such on the SVS. Among the 137 men who were coded as abused on the SVS, 117 (85%) endorsed CSA on the CEVQ-SF, whereas 20 (15%) did not endorse CSA. The kappa value between both measures was .39, indicating fair concurrent validity (Landis & Koch, 1977).

Table 3

Inter-rater Reliability on Abuse Status and Characteristics from the SVS

	Inter-rater Reliability
Sexual experience 1 (abuse/not abuse)	96.0%
Sexual experience 2 (abuse/not abuse)	92.0%
Sexual experience 3 (abuse/not abuse)	88.6%
Age of onset	97.5%
Duration	98.9%
Relationship to the perpetrator	96.8%
Emotional closeness to the perpetrator	96.8%
Fondling	99.3%
Oral-genital contact	96.8%
Penetration	98.6%
Sexually explicit photographs/videos	98.6%
Use of threats and/or physical force	97.9%
Multiple experiences	94.7%
Disclosure	98.5%
Reaction to disclosure	92.9%

Table 4

Chi-Square of the SVS and the CEVQ-SF

		Sexual Abuse (SVS)		
Sexual Abuse (CEVQ-SF)		No	Yes	Total
	No	10	20	30
	Yes	3	117	120
	Total	13	137	150

In order to explore the discrepancies between the SVS and the CEVQ-SF, I examined whether the 20 men who were coded as abused on the SVS but who did not endorse CSA on the CEVQ-SF differed from men who were in agreement on both measures as a function of their abuse characteristics. Independent samples t-tests were used for continuous abuse characteristics (i.e., age of onset, emotional closeness to the perpetrator, and duration) and chi-squares were used for categorical characteristics (i.e., relationship to the perpetrator, fondling, oral-genital contact, penetration, sexually explicit photographs/videos, threats or physical force, and multiple sexual experiences). Results showed that men who did not endorse abuse on the CEVQ-SF but who endorsed abuse on the SVS were significantly less likely to experience CSA involving threats or physical force than men who were in agreement on both measures (15% compared to 56%; $\chi^2(1) = 11.72, p = .001$; OR = .15, 95% CI [.04, .44]). All remaining abuse characteristics were not significantly different between the two groups. I could not perform t-tests and chi-squares for the men who reported abuse on the CEVQ-SF but not the SVS given that the sample size was too small for statistical comparisons.

As another exploratory measure, I examined how participants responded to the question: *In your own opinion, do you feel that this experience was sexual abuse?* This question appears after each sexual experience on the SVS. Of the 20 participants who reported that they were not abused on the CEVQ-SF but were coded as abused on the SVS, the majority ($n = 12$; 60%) said that they felt at least one of their experiences constituted CSA. Among the three men who reported abuse on the CEVQ-SF but not the SVS, two said that they felt that at least one experience on the SVS was CSA. One participant was coded as not abused on the SVS because he was missing key details of the sexual experience (i.e., age of onset, type of sexual act(s)) that made it difficult to discern whether the experience was abusive. The second participant reported

experiences that were clearly abusive (i.e., gang rape) but which occurred at age 16, which is outside of the age limit of CSA in the Canadian Criminal Code. As such, this experience was not coded as CSA.

Objective 3: What is the Test-Retest Reliability of the Modified Version of the SVS?

Twenty-one participants completed the SVS initially and again one week later to examine test-retest reliability. Two research assistants coded 39 sexual experiences as abusive or not abusive according to the Canadian Criminal Code's definition of CSA. Agreement between the coders was 100%. The kappa value was 1.00 indicating perfect agreement on abuse status between both time points.

A total of 18 men were coded as abused at the initial and test-retest time points. To further examine the consistency across both time points, each abuse characteristic was examined separately. Inter-rater reliability ranged from 88% (i.e., multiple experiences) to 100% (i.e., age of onset, relationship to the perpetrator, emotional closeness to the perpetrator, duration, threats or physical force). Table 5 presents test-retest agreement on abuse characteristics at the initial and test-retest time points. As shown, the kappa values (for dichotomous and categorical variables) and correlation coefficients (for continuous variables) reflected fair to outstanding agreement, ranging from .38 (reaction to disclosure) to 1.00 (relationship to the perpetrator, penetration, sexually explicit photographs/videos, and threats or physical force).

Table 5

Test-Retest Agreement in Abuse Characteristics across Initial and Test-Retest Administrations of the SVS (N = 18)

	Time 1	Time 2	κ / r
Age of onset (M, SD)	8.24 (3.26)	8.08 (2.75)	.78**
Duration (M, SD)	3.28 (1.41)	3.06 (1.63)	.92**
Perpetrator			
Extrafamilial	50.0%	50.0%	1.00***
Intrafamilial	22.2%	22.2%	
Both	27.8%	27.8%	
Emotional closeness (M, SD)	3.50 (1.29)	3.33 (1.50)	.91**
Fondling	81.0%	85.7%	.89***
Oral-genital contact	50.0%	55.6%	.89***
Penetration	55.6%	55.6%	1.00***
Sexually explicit photographs/videos	27.8%	27.8%	1.00***
Threats or physical force	77.8%	77.8%	1.00***
Multiple experiences	50.0%	55.6%	.89***
Disclosed	88.9%	66.7%	.61**
Negative reaction to disclosure	37.5%	23.8%	.38

Note. Cohen's kappa was used for dichotomous and categorical variables, Pearson's r was used for continuous variables.

* $p < .05$; ** $p < .01$; *** $p < .001$

Discussion

A large gap in the literature is the lack of psychometric data for measures of childhood sexual abuse (Briere, 1992; Hulme, 2004). This study added to the literature by examining the reliability and validity of a modified version of the SVS (Finkelhor, 1979). While several studies have explored the psychometric properties of the SVS among females (e.g., Henderson et al.,

2009; Shchupak, 2015), this is the first study to examine its psychometric properties among male survivors of childhood sexual abuse. The objectives of the study were to examine the inter-rater reliability, concurrent validity, and test-retest reliability of the SVS.

Objective 1: What is the Inter-Rater Reliability of the Modified Version of the SVS?

In terms of the first objective, the current study found high rates of inter-rater reliability for the SVS. This is consistent with my hypothesis. Specifically, raters agreed on abuse status (i.e., abused vs. not-abused) for 93% of the sexual experiences reported by participants.

Although the SVS is designed to be coded for abuse status by researchers, this is the first study to report inter-rater reliability for this measure. The high rate of agreement is likely due to the detailed information obtained by the SVS, as well as the study's use of a very specific definition of childhood sexual abuse. While previous studies have used definitions that are specific but lack a scientific rationale (Hulme, 2004), the current study based its definition of childhood sexual abuse on the Criminal Code of Canada (*Criminal Code*, 1985; Department of Justice, 2004) and child protection laws (Trocmé et al., 2010). Given that the SVS collects comprehensive details about the sexual experience, the raters easily located key variables (e.g., age of onset, perpetrator's use of threat and/or physical force, whether it was consensual), that could help them determine whether an experience constituted childhood sexual abuse. Coding became difficult when participants reported sexual experiences with peers. Although the study stipulated guidelines for how to code sexual experiences with other children, it was difficult to discern whether some experiences were normative or abusive. For instance, several participants reported consensual childhood sexual experiences with other children (e.g., friends, siblings) that included sexual acts that may be considered beyond explorative, such as oral-genital contact and penetration. A conservative approach was taken in these cases, and these experiences were

coded as non-abusive because they did not appear to be coercive or exploitative. These ambiguous responses highlight the importance of relying on a clear definition of childhood sexual abuse and using multiple coders to help distinguish abusive experiences from normative childhood experiences.

For participants who experienced sexual abuse, inter-rater reliability was calculated for abuse characteristics. While previous studies have tended to only examine the most severe sexual experience (Bennett et al., 2000; Hulme & Agrawal, 2004; Shchupak, 2015), the current study coded each abuse characteristic according to the response that indicated the greatest severity. Inter-rater reliability was high, ranging from 93-99%. Dichotomous variables (e.g., fondling, penetration) tended to have higher inter-rater agreement than open-ended variables (e.g., age of onset). Reaction to abuse disclosure had the lowest rate of inter-rater reliability. Participants often described experiences that were not listed in the response options. For example, several participants reported that the person they disclosed to was “neutral” or “didn’t care”. It was difficult for raters to discern whether these reactions were supportive or negative. In order to make this question easier to code, it may be beneficial for future studies to ask participants whether telling someone made them feel better or worse overall with several categories ranging from much worse to much better (e.g., Ullman & Filipas, 2005). Nonetheless, these results provide support for the inter-rater reliability of the SVS.

Objective 2: What is the Concurrent Validity of the Modified Version of the SVS?

The second objective was to compare the SVS to another retrospective measure of childhood sexual abuse, the CEVQ-SF, in order to generate concurrent validity data. In line with our hypotheses, these instruments showed strong consistency (85%) in identifying childhood sexual abuse. This figure is slightly lower than the agreement rate found between the SVS and

the Russell Sexual Abuse Interview Schedule (92%; Shchupak, 2015). Despite the high rate of agreement in abuse status, the measures provided discrepant classifications in 15% of cases. The SVS classified more participants as sexually abused than the CEVQ-SF (91% vs. 80%). There are a number of explanations for this finding.

First, unlike the CEVQ-SF which is a dichotomous self-report item, the SVS is more detailed and requires that researchers objectively code each sexual experience for childhood sexual abuse according to pre-defined criteria. Thus, the SVS may be better at identifying those men who were sexually abused but who may have quickly skimmed over the one item of the CEVQ-SF and/or were unsure how to answer it.

Second, exploratory analyses revealed that men who reported abuse on the SVS but not the CEVQ-SF were less likely to have experienced threats and/or physical force as part of their sexual experience (15%) than men who were in agreement on both measures (56%). This may be due to the wording of the CEVQ-SF (i.e., *Did anyone ever do any of the following things when you didn't want them to...threaten, or try to have sex with you or sexually force themselves on you?*), which asks participants to recall sexual experiences that were threatening and/or physically forceful. This is problematic because the majority of men who experience sexual abuse are abused by an individual known to them (Holmes & Slap, 1998; Paine & Hansen, 2001). They may have been “groomed” by the perpetrator (e.g., the perpetrator first developed a relationship of trust prior to hurting them) so that threats or physical force were not needed. As such, men who were not threatened or forced during the experience may not endorse abuse on the CEVQ-SF but may still believe that they were sexually abused. Indeed, additional analyses revealed that the majority of men (60%) reported that at least one of their experiences constituted childhood sexual abuse on the SVS.

The wording on the CEVQ-SF is also troublesome because it suggests that early sexual experiences are only abusive if the child did not want them to happen. Given that males often respond physiologically to childhood sexual abuse (Holmes et al., 1997), they may have mixed feelings about whether it was something that they desired (Romano & De Luca, 2001). In sum, these findings provide support for the concurrent validity of the SVS. Moreover, the SVS appears to be more sensitive in detecting childhood sexual abuse than the CEVQ-SF.

Objective 3: What is the Test-Retest Reliability of the Modified Version of the SVS?

Consistent with our hypotheses, all participants who reported being sexually abused (or not) at the initial time point reported the same one week later. This resulted in perfect test-retest reliability in abuse status. Among those classified as sexually abused, reports about the characteristics of these experiences, including the age of onset, duration, sexual act(s), relationship to the perpetrator, experiences of threats and/or physical force, and multiple experiences of sexual abuse, were largely consistent over time. Given that males' sexual abuse characteristics were nearly identical at both time points, it is likely that they were reporting on the same sexual abuse experiences. Disclosure and reaction to disclosure showed the greatest variability between time points, with kappa values in the substantial and fair range, respectively (Landis & Koch, 1977). It is possible that males are unsure what constitutes disclosure. To some, disclosure might mean having an explicit conversation about their sexual abuse experiences with a loved one, whereas others may consider disclosure to include casually mentioning their sexual experiences in conversation. In addition, for participants who disclosed to many people, they may have difficulty remembering whom they first told and what reaction it elicited.

It is important to note that the current study used a modified version of the SVS. Unfortunately, it can be difficult to compare the psychometric properties of modified instruments to other studies that have used the original questionnaire (e.g., Henderson et al., 2009; Shchupak, 2015). However, there were several important reasons for these modifications, which may also apply to future studies investigating childhood sexual abuse.

Given that the SVS was part of a larger questionnaire package that could take up to 50 minutes to complete, it was shortened so that participants reported on up to three sexual experiences in total. It is possible that capping the data collection at three might not have captured the full extent of experiences. However, it may be that this is not a frequent occurrence. For example, males report an average of 1.9 sexual abuse experiences (Briere & Elliott, 2003). Moreover, examining the data for the 302 participants who completed the SVS, a mean of 2.1 sexual experiences was reported. A little over half (56%) reported on one or two experiences. Some participants may have simply chosen not to report on additional experiences, but this limitation cuts across all self-report data in terms of how participants choose to respond to items. Second, participants may be confused by the wording of the four main questions on the original SVS (Shchupak, 2015). Given that participants completed the study in their homes, it was important for the items on the SVS to be clear and easy to follow. As such, the current study eliminated the four questions and re-worded several items on the original questionnaire. Moreover, the original SVS asks men to report on up to 12 sexual experiences in childhood, which can be overwhelming and emotionally triggering (particularly for men who are disclosing for the first time). Thus, it made sense to reduce the number of sexual experiences on the SVS and also include crisis lines and relaxation exercises at the bottom of each page of the survey.

Future studies aiming to administer the SVS anonymously and/or on-line might consider using the current study's modified SVS and methodology.

Research and Clinical Implications

In considering the research implications of this study, researchers should consider their goals when using retrospective measures of childhood sexual abuse. The modified SVS used in the current study is a valid and reliable tool for classifying adults into abused and non-abused groups and collecting detailed abuse histories, but it is a long questionnaire which can be onerous for participants to complete. If knowing the specific details of the abuse is not important, then brief measures like the CEVQ-SF may be desirable. However, as our findings illustrate, the CEVQ-SF may be more susceptible to false negatives, especially for participants who did not experience threat and/or physical force as part of their experience.

With recent technological advances, researchers are now using on-line questionnaires to collect sensitive information from participants (DiLillo et al., 2006). On-line administration has many advantages, both on the part of the participant (e.g., ability to complete the questionnaire in the comfort of their home) as well as researchers (e.g., collecting data nation-wide; DiLillo et al., 2006). In using an on-line questionnaire, this study was able to recruit 282 male survivors of childhood sexual abuse from the U.S. and Canada. On-line administrations may mitigate reporting errors, as participants may be more likely to disclose childhood sexual abuse because they perceive the on-line format to be more confidential than pen and paper questionnaires or interviews (DiLillo et al., 2006). With increasing numbers of survey websites, more studies will be administering sexual abuse instruments on-line. Future studies may consider clarifying which format is associated with higher disclosure rates of childhood sexual abuse. It may also be

helpful to compare the emotional impact of completing sexual abuse pen and paper questionnaires, interviews, and on-line questionnaires (DiLillo et al., 2006).

The SVS is among the most commonly-used measures of childhood sexual abuse (Shchupak, 2015), likely because it is easily modified and collects detailed information about abuse experiences. From a clinical standpoint, mental health practitioners may consider using the SVS (or modified versions of the SVS with psychometric support) to assess for history of childhood sexual abuse and abuse characteristics. Specific information collected by the SVS may be used to identify adults at increased risk for psychological difficulties, and may also inform interventions for this population.

Limitations

There were several limitations to the current study. First, the study used a modified version of the SVS. As such, the psychometric data generated by this study's modified version may not be generalizable to studies using the original measure (Shchupak, 2015). Future studies examining the psychometric data of the SVS may benefit from using the modified version to corroborate the results of the current study. Second, data was collected from males seeking support for childhood sexual abuse, and may not be applicable to the general population. Third, study's power for the test-retest analyses was limited, although my sample size was similar to other studies examining the test-retest of sexual abuse instruments (e.g., DiLillo et al., 2006; Hulme, 2007). Test-retest reliability was limited to one week, and as a result, there may have been practice effects. Re-administering the SVS at a longer temporal interval (e.g., one month) may help to clarify whether participants' responses are accurately reflecting their sexual experiences or if participants are simply remembering their initial answers to the SVS. Finally, although the CEVQ-SF possesses psychometric support (Tanaka et al., 2012), it is a retrospective

self-report instrument. Thus, there is the need for future research to examine the validity of the SVS using corroborative information, such as hospital or child welfare records.

Summary

This study is an important contribution to the sexual abuse literature. Studies often use measures of childhood sexual abuse with few or unknown psychometric properties (Hulme, 2004). When studies use a variety of measures, it is not always clear whether these results can be compared when there is no psychometric information available comparing these measures (Shchupak, 2015). The current study found support for the inter-rater reliability, concurrent validity, and test-retest reliability of a modified version of a commonly-used measure of childhood sexual abuse, the SVS. The high rates of reliability and validity are likely associated with the study's use of a clear operational definition of childhood sexual abuse to determine abuse status as well as modifications to the initial measure to make it easier to follow and less onerous to complete. Although these findings represent a key step in the measurement of childhood sexual abuse, more work is needed to identify measures with empirical support in order to increase our confidence in the reported prevalence/frequency rates and outcomes of childhood sexual abuse.

Link between Study 1 and Study 2

The first study established the reliability and validity of a modified version of the SVS. The second study contributes to our understanding of the experiences of male survivors in a more applied way by creating profiles on the basis of sexual abuse characteristics (using the SVS) among male survivors and then linking these profiles to psychological outcomes in adulthood. Both studies highlight the need for evidence-based assessment and treatment of male survivors of childhood sexual abuse.

Study 2: The Relationship between Childhood Sexual Abuse Profiles and Adult Psychological Functioning

Sexual Abuse Profiles

The sexual abuse experiences of males are diverse, ranging from a single episode of exhibitionism to penetration involving a stranger or a family member (Holmes & Slap, 1998; Romano & De Luca, 2001). Despite the diversity of these experiences, survivors are often lumped together in statistical analyses that are more centred on variables, such as characteristics of the sexual abuse (Hébert, Parent, Daigneault, & Tourigny, 2006). However, it is unlikely that all sexual abuse survivors have similar abuse experiences and/or respond to sexual abuse in the same way. As such, there have been attempts in the research literature to examine the heterogeneity in childhood sexual abuse experiences using person-centered approaches, such as cluster analysis or latent profile analysis, which classify individuals into groups or profiles on the basis of similarities on a set of selected variables (Hair, Anderson, Tatham, & Black, 1998).

For Study 2, a review of the literature was conducted to identify studies published since 1985 that had created profiles of sexual abuse experiences for either child or adult samples. This cut-off was chosen because few studies focused specifically on childhood sexual abuse prior to 1985, and those studies that did typically relied on small sample sizes and poor methodology (Kendall-Tackett et al., 1993). As shown in Table 6, six studies were found and none generated profiles with adult males. The studies were conducted in the U.S. and Australia, with a focus on adult females ($n = 4$), female children ($n = 1$), or female and male children ($n = 1$). The number of profiles identified across these studies ranged from 3-8, with each profile containing 5-55% of the study's sample. It is difficult to directly compare profiles across these studies because of the variation in the abuse characteristics that were examined. For example, the adult female survivor

profiles identified by Watson and Halford (2010) were based on four sexual abuse characteristics, namely severity of abuse, identity of the perpetrator, use of coercion, and disclosure experiences. In contrast, Bennett et al. (2000) examined profiles of adult female survivors using eight dichotomously-coded abuse characteristics, namely incestuous offender, victim-perpetrator age difference less than 5 years, exhibitionism, clothed fondling, unclothed fondling, any form of penetration, multiple incidents, and use of threat or force. Despite the methodological variability across studies, there is a general trend for profiles of adult females and children to differ according to the victim-perpetrator relationship and/or the severity of sexual acts (Alexander & Shaeffer, 1994; Bennett et al., 2000; Hulme & Agrawal, 2004; McCrae et al., 2006; Watson & Halford, 2010). For instance, Bennett et al. (2000) identified adult female profiles according to intrafamilial and extrafamilial abuse, and they labeled each profile according to the severity of the sexual act(s).

Table 6

Summary of Studies Identifying Profiles on the Basis of Sexual Abuse Characteristics

Study, country	Sample	Measure, rater	Clustering variables	Number and description of profiles	Correlates of profiles
Alexander & Schaeffer (1994) U.S.	81 females aged 19-62 years recruited from the community (M = 36 years)	Interview about childhood sexual abuse	Age of onset of sexual abuse	1 (44%) – Onset in mid-childhood (M = 8 years), primarily fondling, shortest duration (M = 4 years), least physically coercive methods (primarily psychological coercion and verbal prohibitions), fewer perpetrators (M = 2), less physical abuse from fathers than clusters 2 & 3, less physical abuse by mothers than cluster 3, families were less conflictual than clusters 2 & 3, and families were less controlling than cluster 3	Depression: N.S.
		Family Environment Scale, self-report	Duration of sexual abuse		Current distress: N.S.
		Conflict Tactics Scales, self-report	Number of sexual abuse perpetrators		Posttraumatic stress: N.S.
		Beck Depression Inventory, self-report	Degree of coercion		Schizoid traits: 3 > 1, 2
			Most severe sexual act	2 (46%) – Onset in early-mid childhood (M = 7 years), more than half experienced penetration, moderate duration (8 years), primarily verbal threats, fewer perpetrators (M = 2), more physical abuse by fathers than cluster 1, less physical abuse by mothers than cluster 3, families were more conflictual than cluster 1	Avoidant traits: 3 > 1, 2
			Family conflict		Borderline personality traits: 3 > 1, 2
		Symptom Checklist-10, self-report	Family control		
			Family cohesion		Self-defeating traits: 3 > 1, 2
		Impact of Events Scale, self-report	Physical abuse by father		
		Million Clinical Multiaxial Inventory-II, self-report	Physical abuse by mother		Dissociation: 3 > 1, 2
				3 (10%) – Onset in toddlerhood (M = 4 years), more than half	

		Dissociative Experiences Scale, self-report		experienced penetration, longest duration (M = 12 years), highest degree of coercion, more physical abuse from fathers and mothers than clusters 1 & 2, more familial conflict and control than 1 & 2	
Bennett, Hughes, & Luke (2000) U.S.	124 female students, aged 18-57 years (M = 26 years)	Sexual Victimization Survey, self-report	Familial status of perpetrator (intrafamilial, extrafamilial)	<u>Intrafamilial:</u> 1 (10%) - Least Severe Incest: clothed fondling by an older family member, occurring more than once in half the cases, little threat or force 2 (19%) - Severe Incest: multiple incidents of unclothed fondling by older family member, threat or force in half the cases 3 (11%) - Very Severe Incest: intercourse by older family member, multiple incidents, threat or force in half the cases	Family adaptability and cohesion: 4 > 3 Family health: 4 > 3 6 > 3 Current distress: 7 > 5, 6 Impact of the abuse: 2 > 1, 4 3 > 4, 5, 6 7 > 4, 5, 6 8 > 4, 5, 6
		Family Adaptability and Cohesion Scales, self-report	Age difference between victim and perpetrator less than 5 years (yes/no)		
		Family of Origin Scale, self-report	Exhibitionism (yes/no)		Retrospective reaction to abuse: N.S.
		Brief Symptom Inventory, self-report	Clothed fondling (yes/no)		
		Impact of sexually abusive incidents, self-report	Unclothed fondling (yes/no)	<u>Extrafamilial:</u> 4 (10%) - Exhibitionism: single incident of exhibitionism by older perpetrator, no force or threat 5 (12%) - Least Severe Extrafamilial: single incident of	
		Retrospective reaction to experiences, self-report	Intercourse (yes/no)		
			Multiple incidents (yes/no)		
			Force or threat (yes/no)		

clothed fondling by older perpetrator, 33% reported force or threat

6 (13%) - Severe Extrafamilial: single incidents of unclothed fondling by older perpetrator, often involving threat or force

7 (13%) - Very Severe Extrafamilial: Forceful and threatening intercourse by peer perpetrators, typically single incidents

8 (12%) - Inappropriate Relationships: Chronic intercourse with older perpetrator, no threat or force

Hulme & Agrawal (2004) U.S.	130 female family practice patients, aged 21-49 years (M = 35 years)	Questionnaire on Childhood Sexual Abuse, self-report	Non-contact sexual activity (yes/no)	<u>Intrafamilial:</u>	Emotional abuse:
		CSA-Symptom Inventory, self-report	Contact sexual activity, without penetration (yes/no)	1 (9%) - Contact intrafamilial without force or threat, occurred more than once, age difference greater than 5 years in half the cases	1 = 42% 2 = 71% 3 = 40% 4 = 59% 5 = 33% 6 = 20% 7 = 58%
		Center for Epidemiologic Depression Scale, self-report	Vaginal or anal penetration (yes/no)	2 (16%) - Contact intrafamilial with use of force or threat, typically occurred more than once, age difference greater than 5 years in half the cases	Physical abuse: 1 = 8% 2 = 43% 3 = 13%
			Familial status of perpetrator (intrafamilial/extrafa		

		Number of visits to primary care provider over 2-year period, chart review	milial) Force or threat (yes/no) Multiple incidents of SA (yes/no) Age difference between victim and abuser less than 5 years (yes/no)	3 (12%) - Penetration intrafamilial without use of force or threat, occurred more than once, older perpetrators 4 (25%) - Penetration intrafamilial with use of force or threat, occurred more than once, older perpetrators <u>Extrafamilial:</u> 5 (5%) - Non-contact extrafamilial without force or threat, single occurrence, older perpetrators 6 (23%) - Contact extrafamilial without force or threat, single occurrence, older perpetrators 7 (9%) - Penetration extrafamilial with force or threat, typically occurred more than once, age difference greater than 5 years in half the cases	4 = 44% 5 = 33% 6 = 7% 7 = 25% Physical and psychosocial symptomatology: 4 > 6 Depression: 4 > 6 Health care utilization: N.S.
McCrae, Chapman, & Christ (2006) U.S.	409 females and 144 males involved with child welfare, aged 3-14 years (M =	Maltreatment Classification System, child welfare worker Composite International Diagnostic	Abuse duration (days) Severity (less severe abuse, fondling, masturbation, digital penetration, oral copulation,	<u>Ages 3-7:</u> 1 (29%) - Normative: single incident of less severe abuse by non-related perpetrator, low incidence of other maltreatment 2 (26%) - Intimate partner	<u>Ages 3-7:</u> Behaviour problems: 2 > 1, 3, 4 5 > 1, 3, 4 Internalizing: 2 > 1, 4

9 years)	Interview-Short Form, caregiver	intercourse)	violence/Mental Illness: Less severe abuse over short duration by parent or unrelated perpetrator, high incidence of intimate partner violence and parental mental illness	Externalizing: 2 > 1 5 > 1, 4
	Conflict Tactics Scale-I, caregiver	Parent perpetrator (yes/no)		
	Child Behavior Checklist, caregiver	Relative perpetrator (yes/no)	3 (16%) - Severe chronic: Severe abuse over a long duration, related and unrelated perpetrators, half the cases also witnessed intimate partner violence	<u>Ages 8-11:</u> Internalizing: 3 > 1
	Trauma Symptom Checklist for Children, children aged 7 and older	Co-occurring maltreatment (yes/no)		Externalizing: 4 > 1, 2, 3, 5
	Children's Depression Inventory, children aged 6 and older	Prior reports to child welfare (yes/no)	4 (16%) - Severe moderate: Severe abuse with moderate duration by unrelated perpetrator, prior reports to child welfare	Post-traumatic stress: 4 > 1, 2, 3, 5
	Services and case characteristics, child welfare worker	Low social support (yes/no)		Depression: 3 > 2 4 > 2
		Parental substance use (yes/no)	5 (13%) – Boys: Moderately severe abuse over short duration by unrelated perpetrator, majority have prior reports and parental mental illness	<u>Ages 12-14:</u> Internalizing: 4 > 2 5 > 2
		Parental mental illness (yes/no)		
		Intimate partner violence (yes/no)	<u>Ages 8-11:</u> 1 (54%) - Normative: Less severe, typically single incident by related/unrelated perpetrators 2 (22%) - Severe moderate: Severe abuse over moderate duration by unrelated perpetrator, high incidence of multi-type	Externalizing: 2 > 1 4 > 3 5 > 1, 2, 3, 4 Post-traumatic stress: 2 > 1

maltreatment and prior reports	5 > 2, 4
3 (14%) - Severe all: Severe abuse over long duration by a parent figure, high incidence of multi-type maltreatment, intimate partner violence, and parental mental illness	Depression: 4 > 3 5 > 1, 2, 3, 4

4 (10%) - Chronic relative: Severe abuse over long duration by a non-parental relative, prior reports to child welfare, low incidence of parental mental illness, intimate partner violence, and substance use

Ages 12-14:

1 (45%) Normative: Less severe abuse over a short duration by related and unrelated perpetrators, high incidence of intimate partner violence

2 (26%) - Severe chronic: Severe abuse with long duration by related and unrelated perpetrators, about half reported parental mental illness

3 (12%) - Severe all: Severe abuse with moderate duration by an unrelated perpetrator, multiple family problems

4 (9%) - Mental Illness/Priors:
Moderately severe abuse over a short duration by an unrelated perpetrator, high incidence of parental mental illness and prior reports to child welfare

5 (8%) - Boys: Moderately severe abuse over a long duration by a parent figure, high incidence of multi-type maltreatment, prior reports to child welfare, parental mental illness

Trickett, Noll, Reiffman, & Putnam (2001) U.S.	<u>At initial time point:</u>	<u>At initial time point:</u>	Age of onset (years)	1 (30%) - Abuse by multiple perpetrators (none were biological fathers) over a short period, use of physical violence	<u>At initial time point:</u>
	78 SA girls, aged 6-16 years (M = 11 years), involved with child welfare	Caseworker Abuse History Questionnaire, child welfare worker	Duration of abuse (months)	2 (44%) - Abuse by a non-biological father figure or other relative, short duration, low physical violence	Delinquent/misbehaving: 1 > 2, CG 3 > 1, 2, CG
	76 matched-controls (CG) aged 6-16 (M = 11 years) recruited through	Child Behavior Checklist, caregiver Child Depression Inventory, self-report State-Trait	Primary perpetrator identity (primary father, other father figure, other relative)	3 (26%) - Abuse by primary father over long period, beginning at a young age, half reported physical violence	Immaturity/bizarre behaviour: 1 > CG 3 > 2, CG
			Severity of abuse (count variable ranging from 1-6)		Aggressiveness/bullying: 1 > CG 3 > 2, CG
			Multiple perpetrators (yes/no)		Depressed/withdrawn: 1 > CG 3 > 1, 2, CG

community advertising	Anxiety Scale, self-report	Physical violence (count variable ranging from 1-3)	Physical problems: 3 > CG
<u>At 7 year follow up:</u>	Self-perception Profile for Children, self- report		Depression: 3 > 1, 2, CG
76 SA girls, aged 13-23 (M = 19 years)	Childhood Dissociation Checklist, caregiver		Trait anxiety: 3 > CG
70 matched- controls (CG) aged 13-23 (M =18 years)	<u>At 7 year follow up:</u>		Dissociation: 1 > 2, CG 3 > 2, CG
	Adapted Child Depression Inventory, self- report		<u>At 7 year follow up:</u>
	State-Trait Anxiety Scale, self-report		Delinquent/misbehaving: N.S.
	Youth Self Report, self- report		Immaturity/bizarre behaviour: 3 > CG
	Perceived Competence Scale for Adolescents, self-		Aggressiveness/bullying: 3 > 1, CG
			Depressed/withdrawn: 3 > CG
			Physical problems: N.S.
			Depression:

		report			N.S.
		Adolescent Dissociative Experiences Scale, self-report			Trait Anxiety: N.S. Dissociation: 2 > CG 3 > CG
Watson & Halford (2010) Australia	569 women, aged 18 to 41 (M = 30 years), randomly selected from voting registry	The Early Sexual Experiences Checklist, self- report Family Environment Scale, self-report Parental Conflict Tactics Scale, self-report Childhood Trauma Questionnaire, self-report Abbreviated Dyadic Adjustment Scale, self-report	Victim-perpetrator relationship (intrafamilial, extrafamilial, unknown) Severity of the sexual act (non- contact, contact without penetration, vaginal penetration) Use of psychological coercion (# of coercive behaviours) Abuse disclosure (yes/no; if yes, level of support received)	1 (55%) - Intrafamilial, early onset, invasive, coercive, and chronic, less than half had disclosed but received unsupportive reactions 2 (31%) - Extrafamilial, older age of onset, moderate physical invasiveness, often coercive, multiple incidents in half the cases, half the participants had disclosed and received moderate support 3 (14%) - Stranger, older age of onset, low levels of physical invasiveness and coercion, typically a single incident, the majority of women had disclosed and received high levels of support	Family functioning: 1 < 2, 3 Interparental aggression: N.S. Physical abuse: 1 > 2, 3 Physical neglect: 1 > 2, 3 Relationship satisfaction: 1 < 2, 3 Sexual satisfaction: N.S.

Note. M = mean; > = higher than the other profiles; < = lower than the other profiles; N.S. = no significant difference among profiles; SA = sexual abuse.

Childhood Sexual Abuse Profiles and Co-occurring Maltreatment and Adversity

Despite findings showing that childhood sexual abuse typically co-occurs with other types of maltreatment and adversity (Dong et al., 2013; Perez-Fuentes et al., 2013), few researchers have examined the relationship between sexual abuse (be it characteristics or profiles) and exposure to other childhood adversities. Table 6 presents findings from three studies (two with adult females and one with children) that did examine this relationship (Hulme & Agrawal, 2004; McCrae et al., 2006; Watson & Halford, 2010). These findings generally indicate that profiles depicting chronic intrafamilial sexual abuse are associated with higher rates of co-occurring child maltreatment and adversity (Hulme & Agrawal, 2004; McCrae et al., 2006; Watson & Halford, 2010). Hulme and Agrawal (2004) sampled 130 female patients from a family practice setting in the U.S. who reported either contact or non-contact sexual abuse before the age of 17. Findings indicated that intrafamilial sexual abuse profiles characterized by physical force or threat had the highest rates of childhood physical abuse (profiles 2 and 4). Emotional abuse was also common across all intrafamilial profiles, but it was particularly high for those women who experienced force or threat as part of their sexual abuse experience, regardless of whether or not the perpetrator was a family member (profiles 2, 4, and 7).

There are a number of explanations for these findings. First, it is possible that the presence of emotional and/or physical abuse in the home predisposes an individual to certain types of sexual abuse (Hulme & Agrawal, 2004). For example, children who are emotionally and/or physically abused by caregivers might search for alternative sources of care and support from adults in the extended family or outside the home, thereby increasing their risk of being exploited and victimized (Fisher & Goodwin, 2009). In the context of an unsafe family environment, children may be afraid to disclose childhood sexual abuse (Alaggia &

Kirshenbaum, 2005), thus allowing the sexual abuse to continue and gradually include more physically forceful acts. Second, intrafamilial sexual abuse may increase a child's risk of being emotionally and/or physically abused. For instance, perpetrators may resort to physical violence and emotional abusive tactics (e.g., blaming the child) to prevent children from disclosing sexual abuse to non-offending family members (Hershkowitz et al., 2007). Moreover, because intrafamilial sexual abuse is associated with greater externalizing problems in childhood (Hébert et al., 2006), family members may become physically and/or emotionally abusive as a way to manage their child's abuse-related behaviours. Given that Hulme and Agrawal's (2004) study was cross-sectional, it is unclear whether these patterns of sexual abuse preceded or followed other types of child maltreatment. Nonetheless, these findings suggest that severe intrafamilial sexual abuse often occurs within the context of a broader maltreating family environment.

McCrae et al. (2006) generated profiles on the basis of sexual abuse characteristics as well as other maltreatment and adversity experiences in U.S. child welfare-involved children aged 3-14 years. Five profiles were identified among 3-7 year olds; four profiles were identified among 8-11 year olds; and five profiles were identified among 12-14 year olds. Profiles that were generated for older children tended to show distinct perpetrators (e.g., parent figure, other relative, unknown perpetrator), while the profiles for younger children were comprised of both related and unrelated perpetrators. Results indicated that, regardless of age, those profiles characterized by less severe sexual abuse (i.e., a one-time fondling by an unrelated adult) did not occur alongside other maltreatment or adversity experiences (e.g., parental substance use, parental mental illness). In contrast, profiles characterized by more severe sexual abuse (i.e., penetration by related and/or unrelated perpetrators over a long duration) did not show any consistent patterns with regard to other maltreatment or adversity experiences. It is possible that

the relatively large number of variables used in the cluster analysis blurred the results of McCrae et al.'s (2006) study. For instance, the results may have been clearer if the authors had included only the sexual abuse characteristics into the clustering solution and then compared the frequencies of other adversities across the profiles. Nonetheless, the results do appear to suggest that children who experience more severe sexual abuse have a greater chance of also experiencing other types of maltreatment and adversities in childhood.

Sexual Abuse Profiles and Psychological Outcomes

The few studies that have generated profiles on the basis of sexual abuse characteristics have also examined how these profiles differ with regard to psychological outcomes. Table 6 shows that profiles characterized by chronic and severe (i.e., penetration) by a family member is often linked with worse immediate and longer-term psychological outcomes than other profiles, for both adult females and children (Alexander & Schaeffer, 1994; Hulme & Agrawal, 2004; McCrae et al., 2006; Trickett et al., 2001; Watson & Halford, 2010). For instance, Trickett et al. (2001) linked the profiles of 154 6-16 year old girls who experienced intrafamilial sexual abuse with their psychological functioning, according to the caregiver-completed Child Behavior Checklist (Achenbach, 1991). Girls who were classified into the "incest" profile depicting early onset sexual abuse by a biological father for a prolonged period of time (profile 3) had significantly higher externalizing and internalizing behaviour scores than girls who experienced abuse by other family members (profiles 1 and 2). When girls were re-assessed 7 years later, those in the "incest" profile continued to show the greatest behavioural problems relative to the other profiles. These findings are in line with the complex trauma model that stipulates early and chronic abuse by a caregiver to have wide-ranging effects on a variety of developmental tasks, including attachment, emotion regulation, and brain development. When these key

developmental tasks are disrupted by childhood sexual abuse, internalizing and externalizing problems may ensue (National Child Traumatic Stress Network Task Force, 2003; van der Kolk et al., 2005).

Contextual Variables

In addition to sexual abuse characteristics, certain contextual variables might also contribute to the variability in psychological outcomes among survivors of childhood sexual abuse. In the current study, I focused on present-day coping, childhood family functioning, and abuse disclosure experiences because these variables have been included in previous person-centered studies (Alexander & Schaeffer, 1994; Hulme & Agrawal, 2004; McCrae et al., 2006; Trickett et al., 2001; Watson & Halford, 2010) and because they have been conceptualized as mediators and/or moderators of sexual abuse-related outcomes in the larger sexual abuse literature (Luster & Small, 1997; Walsh et al., 2010; Whiffen & MacIntosh, 2005). Mediators are conceptualized as being produced by the independent variable (e.g., sexual abuse), and, in turn, causally related to the dependent variable (e.g., psychological outcomes; Shadish & Sweeney, 1991). For instance, childhood sexual abuse may negatively impact individuals' ability to access and use social supports, which may then contribute to psychological difficulties, such as depression (Whiffen & MacIntosh, 2005). Moderators, in contrast, are variables that affect the direction and/or strength of the relationship between the independent and dependent variables, either by increasing or decreasing the presence or expression of the dependent variable (Baron & Kenny, 1986). For instance, social support could also amplify or diminish the impact of sexual abuse on psychological functioning. Ideally, mediation and moderation are demonstrated over time by way of longitudinal analyses (Baron & Kenny, 1986). However, mediation and moderation in the sexual abuse literature are often tested with cross-sectional

studies, which make it difficult to determine the direction of the effects (Walsh et al., 2010; Whiffen & MacIntosh, 2005). With this limitation in mind, the following sections review how present-day coping, past family functioning, and abuse disclosure experiences influence the relationship between childhood sexual abuse and adult psychological functioning.

Present-day coping. Coping has been proposed as both a mediator and moderator of the relationship between childhood sexual abuse and adult functioning (Cantón-Cortés & Cantón, 2010; Fortier et al., 2009; Merrill et al., 2003; Walsh et al., 2010; Whiffen & MacIntosh, 2005). More specifically, sexual abuse during childhood seems to engender a certain type of coping, which in turn contributes to long-term functioning (mediation), and the long-term effects of childhood sexual abuse also vary as a function of coping (moderation; Whiffen & MacIntosh, 2005). Research has primarily focused on avoidant coping in adulthood (Walsh et al., 2010; Whiffen & MacIntosh, 2005). Studies have shown that present-day avoidant coping is more common among adult survivors of childhood sexual abuse than survivors of other stressful events (e.g., motor vehicle accident, death of loved one; Bal et al., 2003; Cantón-Cortés & Cantón, 2010). Avoidant coping also appears more common among survivors of intrafamilial rather than extrafamilial sexual abuse (Cantón-Cortés & Cantón, 2010; Rosenthal, Hall, Palm, Batten, & Follette, 2005). In a Spanish sample of 138 adult female undergraduates reporting childhood sexual abuse, Cantón-Cortés and Cantón (2010) found that there was a stronger relationship between present-day avoidant coping and trauma symptoms for survivors of intrafamilial sexual abuse than those with histories of extrafamilial abuse. The relationship between avoidant coping and trauma symptoms was also stronger when the sexual abuse represented a chronic rather than an isolated event (Canton-Cortez & Canton, 2010).

There are several explanations for these findings. First, individuals with histories of chronic and/or intrafamilial sexual abuse may be more inclined to distance themselves from memories and reminders of abuse due to the shame, guilt, and stigma associated with these types of experiences (Rosenthal et al., 2005). Second, given that intrafamilial sexual abuse often occurs alongside other types of maltreatment and adversity (Hulme & Agrawal, 2004; Watson & Halford, 2010), children may struggle to find an adult who could help them stop the sexual abuse. In an environment with little support, children may attempt to cope on their own by avoiding thoughts, sensations, and situations related to the abuse. In the short-term, avoidance may be adaptive because it minimizes feelings of distress (Walsh et al., 2007), but in the long-term, it impedes the processing of abuse memories and the extinction of fear responses to abuse reminders, thereby maintaining anxiety (Keane & Barlow, 2002; Steel et al., 2004). Indeed, greater use of present-day avoidant coping has repeatedly been associated with increased psychological difficulties in adulthood, such as more depression, PTSD symptoms, and overall symptomatology (Fortier et al., 2009; Merrill et al., 2003; Walsh et al., 2010).

Only one person-centered study has examined the relationship between coping and psychological outcomes. In a Quebec sample of 123 7-13 year olds (110 girls, 13 boys) with sexual abuse histories, Hébert and colleagues (2006) identified four profiles based on psychological functioning. Profiles ranged from resilience to severe adaptation difficulties. Results indicated that sexual abuse characteristics, such as duration, victim-perpetrator relationship, and severity of the sexual act(s), did not distinguish the “resilient” group from the “severe distress” group. However, resilient children were significantly less likely to use avoidant coping (e.g., distancing, internalizing distress) than children in the other groups, according to the Self-Report Coping Scale (Causey & Dubow, 1992). These results are in line with other studies

with adults (mostly female) showing the detrimental impact of avoidant coping (Littleton et al., 2007).

Childhood family functioning. When studies have considered childhood family dysfunction in their analyses of abuse-related impacts, it is often included as a control variable in analyses of covariance (Briere & Elliott, 1993; DiLillo, 2001; Whiffen & MacIntosh, 2005). Researchers have urged caution in simply controlling for past family functioning as it is often confounded with sexual abuse variables, which may lead to erroneous conclusions about the effects of both sexual abuse and family variables (Briere & Elliott, 1993; DiLillo, 2001). Instead, it may be helpful to use alternative statistical techniques (such as multiple regression or structural equation modeling) to determine whether sexual abuse and family variables independently predict long-term outcomes (Briere, 1992). Such analyses could also examine whether sexual abuse and family-of-origin functioning interact to produce certain outcomes (Briere, 1992; DiLillo, 2001).

Studies indicate that high conflict and low cohesion in the family-of-origin are associated with numerous deleterious outcomes among adult survivors of childhood sexual abuse, including depression, anxiety, social isolation, and general psychological distress (Easton et al., 2010; Elliott & Carnes, 2001; Hyman, Gold, & Cott, 2003; Messman-Moore & Brown, 2004; Meyerson et al., 2002; Whiffen & MacIntosh, 2005; Yama et al., 1993). Dysfunctional family environments may not only contribute to an increased risk of childhood sexual abuse (Fisher & Goodwin, 2009), but they may also interfere with caregivers' ability to offer children the support necessary to recover from sexual abuse (Gold, 2000; Hébert, Lavoie, & Blais, 2014). It can also be speculated that cohesive families that talk openly about their problems may detect sexual abuse sooner, thus allowing for earlier intervention and recovery.

Despite ample evidence of the independent effects of childhood family functioning on psychological outcomes, it has only received limited attention in the sexual abuse literature as a moderator (Hillberg et al., 2011; Yancey & Hansen, 2010). Limited studies are mixed as to whether family functioning during childhood moderates the relationship between childhood sexual abuse and psychological outcomes. While several studies have found that low levels of family conflict and high levels of family support decrease the risk of psychopathology more for individuals with sexual abuse histories than non-abused individuals (Luster & Small, 1997; Yama et al., 1993), other studies have failed to detect a moderating effect (Merrill et al., 2001; Nash et al., 1993; Ray & Jackson, 1997). However, these studies have been limited to high school students and female undergraduates who are generally well functioning (Luster & Small, 1997; Ray & Jackson, 1997; Yama et al., 1993). As such, more research is needed with heterogeneous samples of sexual abuse survivors (particularly males). It would also be important to examine interactions between specific sexual abuse characteristics (e.g., duration, age of onset) and family-of-origin functioning, as such interactions would aid in predicting which survivors will be most (or least) adversely affected and subsequently, in tailoring intervention efforts to meet individuals' specific needs.

None of the person-centered studies in Table 6 examined the relationship between childhood sexual abuse profiles and family functioning during childhood in predicting outcomes. However, three of the studies that focused on adult females investigated how sexual abuse profiles differed with respect to family functioning in childhood (Alexander & Schaeffer, 1994; Bennett et al., 2000; Watson & Halford, 2010). Findings indicated that childhood family dysfunction was common among individuals across all sexual abuse profiles, although it was particularly evident for those in profiles characterized by severe intrafamilial abuse (Alexander

& Schaeffer, 1994; Bennett et al., 2000; Watson & Halford, 2010). These findings are in line with research showing that severe intrafamilial abuse tends to occur within a broadly dysfunctional family environment in which rigid patriarchal roles, family violence, and social isolation are common (Alaggia & Kirshenbaum, 2005).

Disclosure experiences. Another important contextual variable that may influence long-term outcomes are disclosure experiences. Several studies have shown that disclosure of childhood sexual abuse is associated with better initial and longer-term outcomes (Arata, 1998; Hébert et al., 2009; Ullman & Filipas, 2005), while others have found that disclosure is related to greater adult psychological distress (Feiring, Taska, & Lewis, 2002; Jonzon & Lindbald, 2004; O’Leary et al., 2010). The effect of disclosure may depend on the quality of the response that is received (O’Leary et al., 2010). Disclosure that is met with a dismissive, unsupportive, or disbelieving response may be traumatic in itself and may exacerbate feelings of shame (Feiring et al., 2002; O’Leary et al., 2010) whereas supportive reactions (e.g., validating distress, placing responsibility on the perpetrator) may reduce feelings of shame and powerlessness, thereby improving mental health (O’Leary, 2010).

Few studies have investigated whether disclosure moderates the relationship between childhood sexual abuse and long-term outcomes (Easton et al., 2011; O’Leary et al., 2010). In an Australian sample of 172 adults (35 males) with histories of childhood sexual abuse, O’Leary et al. (2010) examined whether disclosure within one year of the abuse (yes/no) interacted with physically injurious sexual abuse (yes/no) to predict self-reported psychopathology. The interactions were not significant, which the authors attributed to small cell frequencies. However, the study also relied on a scale that was designed specifically for the study, and its lack of validation may have also contributed to the non-significant finding. Another Australian study

(Easton et al., 2011) found that disclosure (yes/no) moderated the relationship between age of abuse onset and sexual concerns in adulthood. In a U.S. sample of 165 adults (32 males) who were sexually abused as children, results indicated that, among participants who disclosed their abuse, those who were older when the abuse began were 14 times more likely to report being afraid of sex and 8 times more likely to have problems with touching than individuals who were younger at abuse onset (Easton et al., 2011). The researchers speculated that children who experience sexual abuse at older ages and who disclose may be more likely to be blamed for not preventing or stopping the abuse. These negative reactions to disclosure may increase the individual's sense of shame and guilt, which could then be carried into their adult sexual relationships (Easton et al., 2011). Clearly, more research is needed to clarify whether both the presence of disclosure and the reaction to disclosure moderate the relationship between childhood sexual abuse psychological outcomes.

Among the studies in Table 6, only one examined abuse disclosure, but it was included as a clustering variable (Watson & Halford, 2010). In Watson and Halford's (2010) study of 569 Australian women retrospectively reporting on their childhood sexual abuse experiences, three profiles were identified on the basis of the victim-perpetrator relationship, the extent of coercion used in perpetrating the abuse, the physical intrusiveness of the sexual activity, and whether the abuse had been disclosed to others. Results indicated that the profile characterized by coercive and invasive sexual abuse by a family member had the lowest rates of disclosure (profile 1). Among those women who did disclose, reactions were found to be largely unsupportive. While Watson and Halford did not include a measure of psychological functioning in their study, their findings indicated that the profile associated with lower rates of disclosure and greater

unsupportive reactions (profile 1) was associated with lower marital dissatisfaction, relative to women who disclosed and received supportive reactions (profile 3).

Summary and Objectives

The relatively few studies that have used a person-centered approach with sexually abused adult females and children have indicated that childhood sexual abuse is indeed a heterogeneous phenomenon. In addition, distinct profiles varying according to sexual abuse characteristics have been linked with different psychological presentations. Specifically, individuals (both children and adult females) who experience chronic and penetrative abuse by family members appear to display the greatest psychological distress. Contextual variables may also help to explain and/or influence the strength of the relationship between childhood sexual abuse and psychological functioning. These variables may include present-day avoidant coping, childhood family dysfunction, and non-disclosure (or disclosure met with a negative reaction).

The study of childhood sexual abuse profiles, as well as the relationship between profiles and psychological functioning, is limited and has focused exclusively on populations of adult females and children (primarily girls). As such, Study 2 extended this research to adult males with childhood sexual abuse histories by addressing four research objectives using a retrospective design. The first objective was to identify profiles of men based on characteristics of their sexual abuse experiences. I focused on characteristics that have been examined in adult females and children, including duration, relationship to the perpetrator, age of onset, use of force or threat, multiple experiences, and the type of sexual act(s). Profiles also included the individual's perceived emotional closeness to the perpetrator, as Kendall-Tackett et al. (1993) suggested that the emotional connection between the victim and perpetrator may be better linked to outcomes than the actual type of relationship (e.g., parent, cousin).

Given that childhood sexual abuse often co-occurs with other types of childhood maltreatment and adversities (Dong et al., 2003; Perez-Fuentes et al., 2013), the second objective was to examine how various profiles were associated with other maltreatment and non-maltreatment adverse experiences (e.g., parental substance use, bullying). Turning to the third objective, male childhood sexual abuse has been associated with numerous longer-term outcomes (Dube et al., 2005; Maikovich-Fong & Jaffe, 2010; Paolucci et al., 2001), although these studies have not necessarily taken into account adverse experiences that tend to co-occur with sexual abuse. As such, I examined the link between childhood sexual abuse profiles and psychological functioning (i.e., internalizing and externalizing behaviours, trauma symptoms, and substance use) while also controlling for the potential influence of other experiences of child maltreatment and adversity.

Despite the growing number of person-centered studies linking sexual abuse profiles to later functioning, little empirical attention has been paid to contextual variables that may moderate these effects. When these contextual variables have been included in person-centered studies, they are either examined descriptively (Alexander & Schaeffer, 1994; Bennett et al., 2000) or were included as variables in the clustering solution (Hébert et al., 2006; Watson & Halford, 2010). Thus, the fourth objective was to add to the person-centered literature by examining how present-day avoidant coping, childhood family functioning, and disclosure moderated the relationship between sexual abuse profiles and psychological outcomes (i.e., internalizing and externalizing problems, substance use, and trauma symptoms). Although present-day avoidant coping and childhood family functioning have been conceptualized as both mediators and moderators of childhood sexual abuse and psychological outcomes (Walsh et al., 2010; Whiffen & MacIntosh, 2005), I focused on these variables as potential moderators. The

definition of a mediator requires that it be a consequence of sexual abuse and therefore develop after the abuse has occurred (Kraemer, Stice, Kazdin, Offord, & Kupfer, 2001). However, it is unclear whether avoidant coping develops in response to sexual abuse, or whether an individual's general tendency to avoid distressing thoughts and situations precedes the onset of any adverse or traumatic events. Likewise, sexual abuse may disrupt family relationships, or sexual abuse may occur within an already dysfunctional family (Briere, 1992). Without knowing the direction of the effects, these variables may be better construed as moderators (Whiffen & MacIntosh, 2005).

Hypotheses

Objective 1. Given the absence of research on childhood sexual abuse profiles for adult males, it was difficult to generate specific hypotheses with regard to the number and types of profiles that would be identified in the current study. Nonetheless, based on past research with adult females and children (e.g., Bennett et al., 2000; Trickett et al., 2001), it was hypothesized that at least two profiles reflecting differential patterns of victimization would be identified. Specifically, I expected that profiles would differ in terms of relatedness to the perpetrator and severity of the sexual act(s).

Objective 2. In line with past research (Hulme & Agrawal, 2004; Watson & Halford, 2010), it was hypothesized that those profiles characterized by intrafamilial sexual abuse would be associated with the presence of emotional abuse, physical abuse, neglect, and exposure to intimate partner violence. I also expected that individuals in more severe profiles would have experienced greater non-victimization adversities.

Objective 3. As shown in previous person-centered studies (e.g., Bennett et al., 2000; Hulme & Agrawal, 2004), it was hypothesized that those profiles which captured more severe

sexual abuse (i.e., earlier age of onset, longer duration, intrafamilial perpetrators, greater victim-perpetrator emotional closeness, use of force or threat, and multiple sexual abuse experiences) would be associated with greater internalizing and externalizing behaviours, trauma symptoms, and substance use. Given that abuse characteristics (e.g., sexual acts, relationship with perpetrator) appear to be associated with psychological outcomes even after controlling for other adverse childhood experiences (Cantón-Cortés & Cantón, 2010; Dube et al., 2005), it was expected that the relationship between profiles and internalizing and externalizing behaviours, trauma symptoms, and substance use would remain statistically significant even with the inclusion of co-occurring childhood maltreatment and adversity.

Objective 4. It was hypothesized that individuals within the various profiles would vary in their levels of internalizing and externalizing problems, trauma symptoms, and substance use, depending on their use of present-day avoidant coping, childhood family functioning, and whether they had disclosed the abuse. Past research has found that there is a stronger relationship between present-day avoidant coping and psychological symptoms for individuals with histories of chronic intrafamilial abuse than those with less severe sexual abuse histories (Cantón-Cortés & Cantón, 2010). As such, it was expected that greater use of present-day avoidant coping would be associated with greater internalizing and externalizing problems, trauma symptoms, and substance use among men in the profiles characterized by more severe sexual abuse. I did not have any specific hypotheses around the moderating role of past family functioning as research findings have been mixed. Likewise, research is equivocal with regards to the benefits of disclosure (Feiring et al., 2002; O’Leary et al., 2010). Thus, there were no specific hypotheses with regards to how disclosure might reduce or exacerbate psychological difficulties as a function of profile membership.

Method

Participants

Table 7 indicates that participants ranged in age from 17 to 61 years, with an average age of 39.3 years ($SD = 12.6$). Although the study initially stipulated that participants must be between the ages of 18 to 59, I retained the one individual who was 17 years old and the two individuals who were 61 years old because it was unclear whether they had made an error when filling out the inclusionary criteria or when they were typing their age. While the study's outcome questionnaire, the ASR, is normed on adults aged 18 to 59 (Achenbach & Rescorla, 2003), the authors note that there is flexibility for individuals approaching the age cut-offs.

The sample consisted primarily of U.S. residents (64.8%) and Caucasians (86.0%). All household incomes before taxes were represented in the current study, with the most common ranges falling between \$10,000 and \$29,999 (20.0%), \$30,000 and \$49,999 (16.7%), and over \$110,000 (16.7%). In terms of education, the majority of participants reported completing post-secondary studies (62.2%), and the majority of males were employed part- or full-time (61%).

Measures

Data were collected using a questionnaire package consisting of socio-demographic questions, the SVS (Finkelhor, 1979), the Adverse Childhood Experiences questionnaire (ACE; Felitti & Anda, 1997), the non-victimization adversity subscale of the Childhood Trauma and Adversity Scale (Turner, Finkelhor, & Ormrod, 2006), the Family Relationships Index (FRI; Holahan & Moos, 1981), the How I Deal With Things Scale (HIDWT; Burt & Katz, 1987), the Post-Traumatic Stress Disorder Checklist- Specific Version (PCL-S; Weathers et al., 1993), and the ASR (Achenbach & Rescorla, 2003).

Table 7

Socio-Demographics of Males Included in the Latent Profile Analysis (N = 215)

	N	%	M (SD)	Range
Age	214	-	39.3 (12.6)	17-61
Country				
U.S.	138	64.8		
Canada	75	35.2	-	-
Ethnicity				
Caucasian	185	86.0		
Hispanic	7	3.3		
South Asian (e.g., Indian, Pakistani)	6	2.8		
Middle Eastern (e.g., Egyptian, Lebanese)	4	1.9	-	-
East Asian (e.g., Chinese, Japanese)	3	1.4		
Native	3	1.4		
Black	2	.9		
Other ^a	5	2.3		
Income				
Less than \$9,999	26	11.6		
\$10,000-\$29,999	43	20.0		
\$30,000-\$49,999	36	16.7		
\$50,000-\$69,999	29	13.5	-	-
\$70,000-\$89,999	27	12.6		
\$90,000-\$109,999	19	8.8		
Over \$110,000	36	16.7		
Highest Education				
Elementary school	12	5.7		
High school	68	32.1		
College and/or trade program	32	15.1	-	-
University undergraduate degree	55	25.9		
University graduate degree	45	21.2		
Employment				
Unemployed	22	10.3		
Employed part- or full-time	130	61.0		
Going to school	15	7.1	-	-
Going to school and employed	15	7.1		
Recovering from an	24	11.3		

illness/disability

Retired

7

3.2

^a Examples included mixed race and Métis.

Childhood sexual abuse. Detailed information about childhood sexual abuse was collected using a modified version of the SVS (Finkelhor, 1979; Appendix B). A detailed description of the SVS, as well as its psychometric properties, can be found in Study 1. As described in Study 1, the current study defined childhood sexual abuse according to the Criminal Code of Canada and child protection laws. Specifically, it was defined as any sexual experience occurring before the age of 16 years with an individual in a relative position of authority, trust, or dependency, or exploitative sexual activity (*Criminal Code*, 1985; Department of Justice, 2014). As in Study 1, abuse characteristics were coded in the following manner:

- (a) Age of abuse onset: continuous variable coded as age in years.
- (b) Duration of abuse: continuous variable coded as one day or a few days (1); over a period of a few weeks (2); over a period of a few months (3); over a period of a few years (4); and over a period of many years (5).
- (c) Relationship to the perpetrator: categorical variable coded as extrafamilial (0); intrafamilial (1); or both (2).
- (d) Emotional closeness to the perpetrator: continuous variable coded from 1 (*very distant*) to 5 (*very close*).
- (e) Fondling: dichotomous variable coded as 0 (absence of fondling) or 1 (presence of fondling)
- (f) Oral-genital contact: dichotomous variable coded as 0 (absence of oral-genital contact) or 1 (presence of oral-genital contact).
- (g) Penetration: dichotomous variable coded as 0 (absence of penetration) or 1 (presence of penetration).

(h) Sexually explicit photographs/videos: dichotomous variable coded as 0 (the participant was not photographed or videotaped as part of their sexual abuse experience) or 1 if they endorsed these experiences.

(i) Threats of or use of physical force: dichotomous variable coded as 0 (absence of threats of harm or physical force) or 1 if they endorsed these experiences.

(j) Multiple experiences: dichotomous variable coded as 0 if only one sexual abuse experience was endorsed or a code of 1 if multiple sexual abuse experiences were endorsed.

Other types of childhood maltreatment. An adapted version of the questionnaire developed by the ACE study (Felitti & Anda, 1997; see Appendix K) assessed other types of childhood maltreatment before the age of 16. The ACE study was initially developed by the Kaiser Health Plan in the U.S. to examine the relationship between childhood maltreatment and well-being in approximately 17,000 adults (Felitti & Anda, 1997). Eleven items assessed four types of childhood maltreatment, namely emotional abuse, physical abuse, neglect, and exposure to intimate partner violence. Although the original measure also assessed childhood sexual abuse, this subscale was excluded in the current study because participants already provided a detailed account of their sexual abuse experiences through the SVS. In addition, while the ACE study assesses father-to-mother intimate partner violence, it does not take into account experiences of mother-to-father violence. As such, three items using the same wording as the original intimate partner violence items, but replacing “mother” with “father” and vice versa, were added to the questionnaire to assess exposure to mother-perpetrated intimate partner violence. Therefore, the current study used 14 items in total to assess childhood maltreatment. Participants responded yes (1) or no (0) to each item. Items were summed to create a total score, with emotional abuse ranging from 0-2, physical abuse ranging from 0-2, neglect ranging from

0-4, and exposure to intimate partner violence ranging from 0-6. Subscale scores were dichotomized so that a score of 0 was coded as *Absent* (0), and all other scores were coded as *Present* (1).

Childhood non-victimization adversity. The 15-item non-victimization adversity subscale of the Childhood Trauma and Adversity Scale (Turner, Finkelhor, & Ormrod, 2006; see Appendix L) examined non-maltreatment adversities such as parent imprisonment, natural disasters, serious illness, and parental substance use. Any specific adversity which was reported to have occurred at least once in the participant's lifetime was coded as 1, and items were summed so scores ranged from 0-15. Higher scores indicated greater childhood non-victimization adversity.

Present-day avoidant coping. The avoidance subscale of the HIDWT scale (Burt & Katz, 1987; Appendix M) assessed participants' current coping with regard to their childhood sexual abuse experiences. The HIDWT scale was originally developed to examine the coping strategies of adult victims of sexual assault but has since been used with survivors of childhood sexual abuse (Cantón-Cortés & Cantón, 2010; Merrill et al., 2003). Individuals were asked to recall a significant sexual experience from their childhood and answer 5 statements about how they deal with this experience now (e.g., *I try to forget that the experience ever happened*; Appendix M). Items were rated on a 5-point Likert scale ranging from 1 (*never*) to 5 (*usually*). Items were summed to create a subscale score ranging from 5-25, with higher scores indicating greater use of avoidant coping. The avoidance subscale has been shown to possess acceptable Cronbach's alpha with female survivors of childhood sexual abuse ($\alpha > .80$; Merrill et al., 2003). In the current study, internal consistency was questionable ($\alpha = .64$).

Childhood family functioning. The Family Relationships Index (FRI; Holahan & Moos, 1981; see Appendix N), which is derived from the FES (Moos & Moos, 1986), included 27 true-false items that assessed participants' perception of their family environment while growing up. The FRI is a widely-used measure in family environment research (Charamlampous, Kokkinos, & Panayiotou, 2013) and is reported to have good construct validity (Hoge et al., 1989) and moderate to high internal consistency (Galea, 2010; Holahan & Moos, 1981; Moos & Moos, 1994). Three subscales make up the FRI, namely Conflict, Cohesion, and Expressiveness. Moos and Moos (1986) define family conflict as the amount of open aggression and anger in the family (e.g., *We fought a lot in our family*), family cohesion as the degree to which family members are concerned about and supportive of one another (e.g., *Family members really helped and supported one another*), and expressiveness as the extent to which family members are encouraged to express their feelings directly (e.g., *We said anything we wanted to around home*). A total family relationships score was computed by summing the number of true responses on the cohesion and expressiveness subscales and the number of false responses on the conflict subscale. Scores ranged from 0-27, with higher scores indicating healthier familial relationships. The current study found excellent internal consistency for the total scale ($\alpha = .90$).

Disclosure experiences. The SVS (Finkelhor, 1979) assessed disclosure experiences. The disclosure variable was dichotomously coded so that disclosure was coded as 1, and non-disclosure was coded as 0. If a participant reported multiple sexual abuse experiences, one of which was disclosed, they were coded as having disclosed (1).

Participants were also asked to indicate the type of response they received when they first disclosed the abuse (e.g., supported, ignored). Responses were coded as either supportive (0) or non-supportive (1). When participants reported that they had disclosed multiple sexual abuse

experiences, the disclosure variable was coded according to whether they had ever received a non-supportive reaction. For example, if a participant disclosed multiple sexual abuse experiences, two of which were met with supportive responses and one in which he was blamed for the abuse, his response was coded as non-supportive (1).

Psychological functioning. The ASR (Achenbach & Rescorla, 2003) is a self-report measure of behavioural difficulties in individuals aged 18-59 years. Individuals responded to 126 statements using a 3-point Likert scale, ranging from 0 (*not true*) to 2 (*very true or often true*; refer to Appendix O). Items were grouped according to internalizing and externalizing behaviour problems. The internalizing subscale contained 39 items related to anxious/depressed behaviour, withdrawn behaviour, and somatic complaints (e.g., *I feel that no one loves me*). The externalizing subscale contained 35 items related to aggression, rule-breaking behaviour, and intrusiveness (e.g., *I do things that may cause me trouble with the law*). Internalizing scores can range from 0-78, while externalizing scores can range from 0-70 (Achenbach & Rescorla, 2003). Higher scores indicate more problematic behaviour. Finally, the last three items of the ASR assesses how many times per day individuals used tobacco, were drunk, and/or used drugs in the past 6 months. Tobacco, alcohol, and drug items were summed to create a total substance use score, with higher scores indicating greater substance use (Achenbach & Rescorla, 2003).

The ASR has been shown to possess excellent psychometric properties (Achenbach & Rescorla, 2003). One-week test-retest coefficients range from .89 for the externalizing subscale to .96 for substance use. Internal consistency is also high, with alpha coefficients in the high .80's and .90's for the internalizing and externalizing subscales, respectively (Achenbach & Rescorla, 2003). Moreover, scores on the ASR are strongly correlated with scores on the Symptom Checklist-90-Revised (Derogatis, 1994) with most correlations >.70, which supports

the construct validity of the ASR (Achenbach & Rescorla, 2003). In the current study, the internal consistencies for both the internalizing and externalizing scales were excellent ($\alpha = .93$ and $\alpha = .91$, respectively).

Trauma symptoms. The PCL-S (Weathers et al., 1993) is a 17-item measure of current PTSD symptoms, based closely on the DSM-IV diagnostic criteria (see Appendix P). The PCL-S is answered in reference to a specific traumatic event. Individuals were asked to recall their most significant childhood sexual experience and to indicate the degree to which they have been bothered by a particular symptom in the past month (e.g., *feeling very upset when something reminded you of the sexual experience*) along a scale from 1 (*not at all*) to 5 (*extremely*). Responses were summed to create a total symptom severity score ranging from 17-85, with higher scores indicating greater PTSD severity.

Although self-report measures should not be used to make a formal diagnosis of PTSD, the PCL-S has been shown to have good diagnostic utility. While studies have not yet studied the diagnostic properties of the PCL-S for sexual abuse survivors, a cut-off score of 44 has been shown to indicate a probable diagnosis of PTSD for survivors of motor vehicle accidents (Blanchard et al., 1996; Weathers et al., 1993). The PCL-S has demonstrated strong psychometric properties. Internal consistency is reported to be high across several studies, ranging from .94 (Blanchard et al., 1996) to .97 (Weathers et al., 1993). One-week test-retest reliability has been reported to be .88 (Ruggiero, Del Ben, Scotti, & Rabalais, 2003). In the current study, internal consistency was excellent ($\alpha = .94$).

Procedure

Data for Study 1 and Study 2 were collected simultaneously. As described in Study 1, men were recruited from January 2014 to September 2015 from websites in North America

offering support for childhood sexual abuse. In order to participate in the study, individuals had to: (a) be male; (b) be between the ages of 18-59; (c) be fluent in English; (d) currently reside in Canada or the U.S.; and (e) have had a sexual experience before the age of 16. Participants completed an anonymous, online questionnaire about their sexual abuse experience(s), other experiences of childhood maltreatment and adversity, coping, childhood family functioning, and their current psychological functioning. Out of the 302 men who completed the questionnaire, 282 reported experiences consistent with the study's definition of childhood sexual abuse. Once participants with significant missing data were deleted from the dataset, the final sample was 215. Please see the following section for detailed information about missing data.

Data Analysis

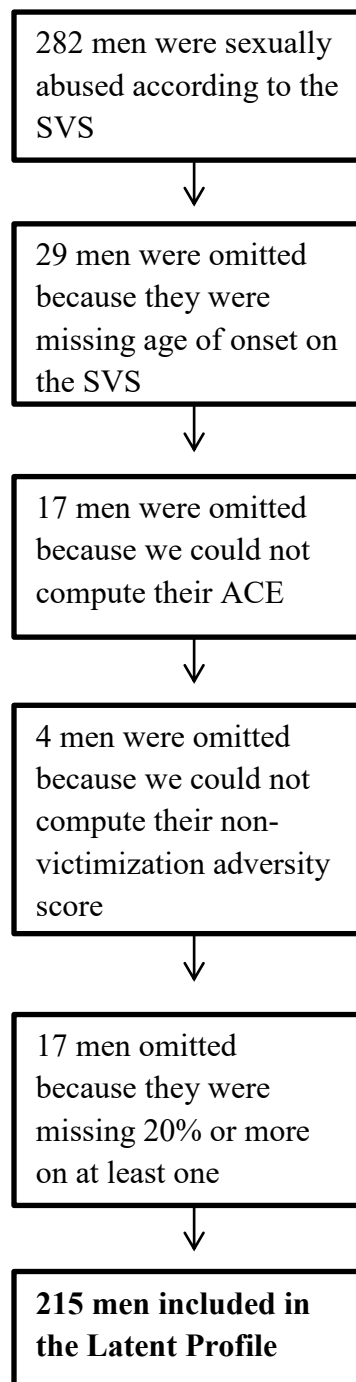
Profiles were generated using Mplus version 7.3 (Muthén & Muthén, 1998-2011). All remaining data analyses were carried out using the Statistical Package for the Social Sciences (SPSS) computer program (version 23.0 for Windows). Given that this was the first study that makes use of person-centered analyses with male survivors, alpha levels were not adjusted according to the number of comparisons. The significance level for all analyses was set at $p < .05$.

Missing data. Prior to analyses, the independent and dependent variables were examined for missing values. Figure 2 indicates that 282 men reported experiences consistent with the study's definition of childhood sexual abuse on the SVS. Of these, 29 men were missing data on the age of abuse onset variable. Given that Mplus is unable to handle missing data on the indicator variables, these men were dropped from the analyses. Next, the ACE questionnaire was examined for missing data. As described, the ACE questionnaire uses dichotomous yes/no questions to assess the presence or absence of different types of childhood maltreatment. If a

participant endorsed at least one item on one of the subscales, then that type of maltreatment was coded as present. However, for participants who responded to only a few items of a subscale and responses indicated the absence of that type of maltreatment, I could not assume that they did not experience that type of abuse. For example, if a participant endorsed the first item on the physical abuse subscale (i.e., *Before the age of 16, did a parent or other individual in the household often push, grab or throw something at you?*) but missed the second item on the physical abuse subscale (i.e., ... *did a parent or other individual in the household hit you so hard that you had marks or were injured?*), then he was retained in the dataset and physical abuse was coded as present. However, if he did not endorse the first item, and missed the second item, then he was omitted from the analyses. Seventeen men were omitted from the analyses due to missing data on the ACE questionnaire.

The non-victimization adversity scale is similar to the ACE questionnaire in that participants report the presence (or absence) of different childhood adversities. Ten participants were missing 1 or 2 items on the scale, while four participants did not have any data on the scale. In order to retain the 10 participants who were missing only 1 or 2 items of the scale, a mean percentage was computed. Specifically, the total number of items that a participant responded to was divided by the number of adversities that they endorsed. For instance, if a participant had data for 13 of the 15 experiences and endorsed 8 adversities, then his score would be 61.5%. If a participant completed all 15 items and endorsed 2 adversities, then his score would be 13.3%. The four participants who were missing all data on the non-victimization adversity scale were omitted from the analyses.

Figure 2.

Sample Flow Chart for Study 2

*4 participants were missing 20% or more of their data on the HIDWT; 3 participants were missing 20% or more data on the FRI; 7 participants were missing 20% or more data on the PCL-S; 13 participants were missing 20% or more data on the ASR. Some participants were missing more than 20% of their data on multiple questionnaires.

The rate of missing data among the remaining independent and dependent variables (i.e., the disclosure variable from the SVS, the HIDWT, the FRI, the PCL-S, and the ASR) was 4.8%. Researchers generally discourage imputation techniques for participants who are missing more than 5% of their overall data (Tabachnick & Fidell, 2007) or those with 20% or more missing items on a scale (Bono et al., 2007; Mazza, Enders, & Ruelman, 2015). All participants had complete data on the SVS's disclosure variable. Four participants were missing 20% or more items on the HIDWT scale (at least 1 of the 5 items); 3 participants were missing 20% or more items on the FRI (at least 6 of the 29 items); 7 participants were missing 20% or more items on the PCL-S (at least 3 of the 17 items); and 13 participants were missing 20% or more items on the ASR problem behaviours scale (at least 17 of the 85 items). The substance use subscale of the ASR had the highest rate of missing data; 28 people (12%) were missing at least one item. Given that the substance use scale only contains 3 items, missing one or more of the substance use items easily exceeded the 20% cut-off. In addition, although the substance use scale sets response parameters (e.g., *How many days were you drunk in the past 6 months?*), participants tended to provide responses that were difficult to code (e.g., *every weekend*). In light of these limitations, the substance use scale was dropped from the analyses.

In all, 17 men were deleted from the analyses because they were missing 20% or more of their data on at least one of the scales. This resulted in a final sample of 215 men (see Figure 2). There were no statistically significant differences between those who dropped out after the SVS and those with complete data with regards to age, Caucasian versus non-Caucasian ethnicity, income, and employment. The rate of missing data in the final sample was low (0.6%). A little MCAR's test revealed that the data were missing completely at random ($\chi^2 = 8041.85$, $df = 8033$, $p = .50$). 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).

After imputation, variables were examined for univariate and multivariate outliers. One univariate outlier on the non-victimization adversity scale was identified due to a participant's high standardized score ($z > 3.29$; Tabachnick & Fidell, 2007); his raw score was bootstrapped to the value of the next highest score on the scale (Tabachnick & Fidell, 2007). When the standardized scores were computed again, this value ceased to be an outlier. There were no multivariate outliers according to the Mahalanobis distance ($p < .001$).

The dataset was checked for normality using skewness and kurtosis values in SPSS. Variables with a skewness or kurtosis value of 3.29 or above were considered skewed (Tabachnick & Fidell, 2007). Past family functioning and the externalizing subscale of the ASR were positively skewed, with values of 4.48 and 3.63 respectively. Square root transformations successfully corrected the normality of these variables. 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 were normal.

Results

Objective 1: Based on Abuse Characteristics, how Many Profiles can be Identified in a Sample of Male Sexual Abuse Survivors?

Latent profile analysis (LPA) was used to identify profiles on the basis of ten abuse characteristics, namely: 1) age of onset; 2) duration; 3) relationship to the perpetrator; 4) emotional closeness to the perpetrator; 5) fondling; 6) oral/genital contact; 7) penetration; 8) sexually explicit photographs/videos; 9) threats of or use of physical force; and 10) multiple

experiences of sexual abuse. Although past research has tended to use cluster analysis to form profiles on the basis of abuse characteristics (e.g., Bennett et al., 2000; Hulme & Agrawal, 2004), one study used LPA to identify three distinct profiles of female survivors of childhood sexual abuse (Watson & Halford, 2010). LPA has advantages over cluster analysis. First, LPA can accommodate different types of data, including dichotomous, categorical, and continuous variables (Hagenaars & McCutcheon, 2002). In addition, LPA provides statistical fit indices, making the determination of the number of classes more systematic than cluster analysis (Hagenaars & McCutcheon, 2002).

There are no straightforward guidelines with regard to the minimum required sample size for LPA (Dziak, Lanza, & Tan, 2014). Generally, it is not recommended that LPA be conducted with samples smaller than 100 (Wurptz, 2012). However, the number of indicators can compensate for low sample size. For instance, a simulation study by Wurptz (2012) showed that samples as small as 100 resulted in reliable 3-profile models with 6 to 12 indicators. With samples of 200, 9 to 12 indicators would be a minimum recommendation (Wurptz, 2012). Another simulation study (Dziak et al., 2014) found that a minimum of 142 participants was required in order to detect a 2-profile solution with 10 indicators and with power set at .80. In order to detect 3 profiles with 10 indicators, with power set at .80, a minimum of 229 participants appear to be needed (Dziak et al., 2014). The current study collected complete data from 215 men, suggesting that there was adequate statistical power to detect a 2- or 3-profile model.

Latent profiles were sequentially run to obtain model fit statistics for a range of profiles, although it was anticipated that three profiles would provide the best fit based on prior research with adult female survivors of sexual abuse that used LPA (Watson & Halford, 2010). The Bayesian Information Criteria (BIC; Schwarz, 1978), the bootstrap likelihood ratio test (BLRT;

Nylund, Asparouhov, & Muthén, 2007), and the Entropy criterion were used to determine the optimal number of profiles. The average posterior probabilities were also examined to determine statistical fit.

The model that yields the lowest BIC value indicates the best fitting model (Schwarz, 1978). Entropy is an index that examines the accuracy of classifying individuals into their respective profiles, with higher values (i.e., closer to 1.0) indicating a better-fitting solution. For the BLRT, a low p-value ($p < .05$) indicates that the current model has a better fit than the model with one less profile (Nylund et al., 2007). While previous studies have used the Lo-Mendell Rubin likelihood criterion (Lo, Mendell, & Rubin, 2001) to examine improvements in fit with the inclusion of additional profiles, recent simulation studies suggest that the BLRT is the best indicator of fit for sample sizes of 200 or more (Nylund et al., 2007). Average posterior probabilities refer to the average probability of being in one latent profile compared to the other latent profiles, with higher values (nearing 1.0) indicating better fit.

Latent Profile Analysis. Table 8 presents the BIC, Entropy, and BLRT values for the latent profiles that were tested. The plausibility of 1- through 6-profile solutions was tested. Profiles were run until the BIC values began to increase and the BLRT tests were no longer significant. Results indicated that the 2-profile solution was superior to the 1-profile solution, as evidenced by the significant BLRT value. Despite the better Entropy value of the 2-profile solution, the 3-profile solution provided a better fit based on the lower BIC value. The 3-profile solution also had a lower BIC value than the 4-, 5-, 6-profile solutions. The 3-profile solution had a statistically significant BLRT value, meaning that the 3-profile solution provided a significantly better fit than 2-profile solution. Moreover, the BLRT values for the 4-, 5-, and 6-profile solutions were non-significant, indicating that they failed to produce a better fit than the

3-profile solution. The 3-profile model yielded excellent average posterior probabilities (see Table 8) ranging from .90 to .95, suggesting successful profile identification. While the average posterior probabilities for the 4- and 5-profile solutions were also high (ranging from .90 to .96, and .82 to .96, respectively), the 4- and 5-profile solutions resulted in fewer men in each profile and greater variability between the smallest and largest profiles. For example, the smallest profile for the 4-profile solution was 22 (10.2% of the sample), while the largest profile consisted of 88 men (41.0% of the sample). Similarly, the 5-profile solution resulted in a two very small profiles of 35 and 21 men (16.3% and 9.8% of the sample). When included in statistical analyses, these small profiles may not have had large enough cell frequencies to detect differences. There was a more even divide in the number of men in each profile in the 3-profile solution, ranging from 56 to 88 men (26.1% to 40.9% of the sample). Given that the 3-profile solution had the lowest BIC value, a significant BLRT value, excellent average posterior probabilities, and that there were enough men in each profile to be able to detect differences among groups, the 3-profile solution was deemed the best-fitting model.

Table 8.

Model Fit Indices and Average Posterior Probabilities for the 1-, 2-, 3-, 4-, 5-, and 6-Profile Solutions (N = 215)

Fit Statistics	Profile 1	Profile 2	Profile 3	Profile 4	Profile 5	Profile 6
BIC	4,566.51	4,472.98	4,456.90	4,487.83	4,523.32	4,558.96
Entropy		.87	.85	.85	.82	.81
BLRT test		-2,245.66	-2,166.67	-2,126.41	-2,109.65	-2,071.76
BLRT p-value		.00	.00	.02	0.08	1.00
Average Posterior Probabilities						
Two Profile						
Model	1.	2.				
1. n = 62 (28.8%)	.94	.06				
2. n = 153 (71.2%)	.03	.97				
Three Profile						
Model	1.	2.	3.			
1. n = 56 (26.1%)	.97	.02	.01			
2. n = 71 (33.0%)	.02	.95	.03			
3. n = 88 (40.9%)	.00	.10	.90			
Four Profile						
Model	1.	2.	3.	4.		
1. n = 34 (15.8%)	.91	.08	.00	.01		
2. n = 22 (10.2%)	.06	.92	.00	.02		
3. n = 88 (41.0%)	.00	.01	.90	.09		
4. n = 71 (33.0%)	.01	.01	.02	.96		
Five Profile						
Model	1.	2.	3.	4.	5.	
1. n = 35 (16.3%)	.90	.10	.00	.00	.00	
2. n = 21 (9.8%)	.04	.96	.00	.00	.00	

3. n = 46 (21.3%)	.00	.00	.80	.14	.06	
4. n = 52 (24.2%)	.00	.00	.06	.90	.04	
5. n = 61 (28.4%)	.00	.00	.04	.06	.90	
Six Profile						
Model	1.	2.	3.	4.	5.	6.
1. n = 37 (17.2%)	.90	.00	.04	.00	.02	.04
2. n = 22 (10.2%)	.00	.93	.00	.06	.01	.00
3. n = 34 (15.9%)	.08	.00	.82	.00	.03	.07
4. n = 34 (15.9%)	.00	.09	.00	.91	.00	.00
5. n = 47 (21.8%)	.03	.00	.05	.00	.85	.07
6. n = 41 (19.0%)	.05	.00	.04	.00	.09	.82

Note. BIC = Bayesian Information Criterion; BLRT test = Bootstrapped Likelihood Ratio Test.

To further investigate differences in abuse characteristics between profiles, one-way analyses of variance (ANOVAs) were run between profiles and continuous variables (i.e., age of onset, duration, and emotional closeness to perpetrator), while chi-squares were run between profiles and categorical variables (i.e., relationship to the perpetrator, sexual acts, use of physical force/threat, and multiple experiences). Partial eta squared (η^2) and Cramer's Φ measured effect sizes for ANOVAs and chi-squares, respectively. Effect sizes of .01 were considered small, .06 were considered medium, and .14 were considered large for partial eta squared (η^2), while effect sizes of .10, .30, and .50 served as small, medium, and large benchmarks for Cramer's Φ (Cohen, 1988). Tukey HSD and standardized residuals (with values exceeding 1.96 indicating significant differences) were used to examine post-hoc comparisons.

As shown in Table 9, sexual abuse characteristics varied as a function of profile membership. There were statistically significant differences among profiles with respect to duration ($F(2, 212) = 371.28, p < .001$, partial $\eta^2 = .78$, 95% CIs [.73, .81]), age of onset ($F(2, 212) = 9.68, p < .001$, partial $\eta^2 = .08$, 95% CIs [.02, .16]), relationship to the perpetrator ($\chi^2(4) = 71.98, p < .001$, Cramer's $\Phi = .41$, 95% CIs [.34, .49]), and emotional closeness to the perpetrator ($F(2, 212) = 16.89, p < .001$, partial $\eta^2 = .14$, 95% CIs [.06, .22]). In terms of sexual acts, profiles differed on fondling ($\chi^2(2) = 9.31, p = .01$, Cramer's $\Phi = .21$, 95% CIs [.08, .36]), oral-genital contact ($\chi^2(2) = 9.79, p = .007$, Cramer's $\Phi = .22$, 95% CIs [.09, .35]), penetration ($\chi^2(2) = 20.38, p < .001$, Cramer's $\Phi = .22$, 95% CIs [.19, .44]), and having been photographed or videotaped as part of the sexual abuse experience ($\chi^2(2) = 9.36, p = .009$, Cramer's $\Phi = .21$, 95% CIs [.11, .33]). Fisher's exact test was used to examine the relationship among profiles and multiple experiences of sexual abuse, as one of the cells had a count of 0. Results revealed significant differences among profiles with respect to multiple abuse experiences (Fisher's exact test (2) = 168.51, $p < .001$, Cramer's $\Phi = .79$, 95% CIs [.73, .85]). There were small effects for fondling, oral-genital contact, penetration, and having been photographed/videotaped as part of the sexual abuse experience. Age of onset showed a medium effect. Duration, relationship to the perpetrator, emotional closeness to the perpetrator, and multiple sexual abuse experiences displayed large effects. There were no significant differences among profiles with respect to perpetrators' use of threats and/or physical force. Given that profiles appeared to gradually increase in severity, they were appropriately labeled Severe (1), More Severe (2), and Most Severe (3). Profiles are described below.

Table 9

Abuse Characteristics of the 3-Profile Solution (N = 215)

	Profile 1 Severe (n = 56)	Profile 2 More Severe (n = 71)	Profile 3 Most Severe (n = 88)	<i>F</i>	Partial η^2	χ^2	Cramer's Φ	CIs	Comparisons between profiles
Duration ^a (M, SD)	1.27 (.45)	3.82 (.70)	4.22 (.73)	371.28***	.78	-	-	.73, .81	2 > 1 3 > 1, 2
Age of onset (M, SD)	8.58 (3.59)	8.87 (3.32)	6.80 (2.84)	9.68***	.08	-	-	.02, .16	3 < 1, 2
Perpetrator									
Extrafamilial	73.2%	70.4%	30.7%			71.98***	.41	.34, .49	3 < 1, 2
Intrafamilial	14.3%	25.4%	9.1%	-	-				2 > 1, 3
Both	12.5%	4.2%	60.2%						3 > 1, 2
Emotional closeness ^b (M, SD)	2.66 (1.27)	3.34 (1.38)	3.90 (1.12)	16.89***	.14	-	-	.06, .22	2 > 1 3 > 1, 2
Fondling	85.7%	95.8%	97.7%	-	-	9.31*	.21	.08, .36	1 < 2, 3
Oral-genital contact	53.6%	67.6%	78.4%	-	-	9.79**	.22	.09, .35	1 < 2, 3
Penetration	30.4%	39.4%	65.9%	-	-	20.38***	.31	.19, .44	3 > 1, 2

Sexually explicit photographs/videos	7.1%	16.9%	27.3%	-	-	9.36**	.21	.11, .33	3 > 1, 2
Threats or physical force	50.0%	59.2%	67.0%	-	-	4.18	.14	.05, .29	-
Multiple experiences ^c	41.1%	9.9%	100%	-	-	168.51***	.79	.73, .85	2 < 1, 3 3 > 1, 2

Note. CIs = 95% confidence intervals.

^a 1 = Happened one day or a few days, 2 = Happened over a period of a few weeks, 3 = Happened over a period of a few months, 4 = Happened over a period of a few years, 5 = Happened over a period of many years.

^b = Range = 1-5.

^c = Comparisons based on Fisher's exact test.

* $p < .05$; * $p < .01$; *** $p < .001$

Severe (1) profile. The smallest profile consisted of 56 men (26.1%) with sexual abuse, which began at a mean age of 8.58 years and lasted for 1 to 2 days. The majority (73.2%) of men in the Severe (1) profile were abused by perpetrators outside of the family. Compared to men in the other two profiles, participants in the Severe (1) profile were significantly less close with their perpetrators prior to the onset of the abuse ($M = 2.66$, range = 1-5). Men in the Severe (1) profile were significantly less likely to report fondling and oral-genital contact than men from the other profiles, although they still experienced these sexual acts at substantial rates (85.7% and 53.6%, respectively). With regards to other sexual acts, 30.4% reported penetration, and 7.1% reported that photographs/videos were taken of the sexual abuse experience. There was an even divide in the number of men who were (and were not) threatened and/or physically forced into the childhood sexual experience. Finally, males in the Severe (1) profile were significantly less likely to report multiple sexual abuse experiences than men in the Most Severe (3) profile, with the majority (59.9%) reporting that this was their only sexual abuse experience.

More Severe (2) profile. The second largest profile consisted of 71 men (33.0%) who reported sexual abuse that began in mid-childhood ($M = 8.87$ years). Compared to men in the Severe (1) profile, men in the More Severe profile (2) reported longer abuse duration, with a mean duration of few months to a few years. The majority of men in the More Severe (2) profile were abused by individuals outside the family (70.4%), although they were significantly more likely to be abused by a family member (25.4%) than men in the Severe (1) and Most Severe (3) profiles (14.3% and 9.1% respectively). Men in this profile were also significantly closer with their perpetrators ($M = 3.34$, range = 1-5) than men in the Severe (1) profile. Nearly all men reported fondling (95.8%), followed by oral-genital contact (67.6%), penetration (39.4%), and having their sexual experience photographed or videotaped (16.9%). The majority of men in this

profile (59.2%) reported that they were threatened and/or physically forced into the childhood sexual experience. This profile was also significantly less likely to report multiple experiences of sexual abuse than men in the other profiles; for most men (90.1%), this was their only sexual experience.

Most Severe (3) profile. The largest profile consisted of 88 men (40.9%). Compared to men in the Severe (1) and More Severe (2) profiles, participants in this profile tended to report the most severe childhood sexual abuse experiences. They experienced abuse that began significantly earlier ($M = 6.80$ years) than men in the Severe (1) and More Severe (2) profiles. The Most Severe (3) profile also reported significantly longer abuse duration than the other two profiles, with most (81.8%) reporting that the abuse lasted at least a few years. Compared to the other profiles, men in the Most Severe (3) profile were more likely to be abused by perpetrators both within and outside their families (60.2%). They were also significantly closer to their perpetrators before the abuse started ($M = 3.90$, range = 1-5) than men in the other profiles. The vast majority of participants in this profile reported experiences of fondling (97.7%) and oral-genital contact (78.4%). Compared to men in the other profiles, men in the Most Severe (3) profile were significantly more likely to experience penetration (65.9%) and to be photographed or videotaped as part of their sexual abuse experience (27.3%). The majority (67.0%) were threatened and/or physically forced by their perpetrators. Men in the Most Severe (3) profile were significantly more likely to report multiple sexual abuse experiences than men in the other profiles; all men in the Most Severe (3) profile reported more than one sexual abuse experience.

Objective 2: How are Childhood Sexual Abuse Profiles Associated with Other Childhood Maltreatment and Non-Victimization Adverse Experiences?

A chi-squared test for independence was used to identify if and how childhood sexual abuse profiles were associated with the occurrence of other forms of childhood maltreatment. The other forms were: 1) emotional abuse; 2) physical abuse; 3) neglect; and 4) exposure to intimate partner violence. Cramer's Φ was used as a measure of effect size. Effect sizes of .10 were considered small, .30 medium, and .50 large (Cohen, 1992). Based on past studies (Hulme & Agrawal, 2004), I expected a medium effect. G*Power 3.0 revealed that there was a 98.2% chance of detecting a medium effect using a chi-squared analysis with a total sample of 215 participants and three profiles at a .05 alpha level.

A one-way ANOVA examined whether the mean percentage of non-victimization adversities differed across profiles. Effect size was measured using partial eta squared (η^2). Effect sizes of .01 were considered small, .06 were considered medium, and .14 were considered large (Cohen, 1988). It was difficult to estimate an effect size for the power calculation, as there have been no other person-centered studies that have investigated the relationship between profiles and non-victimization adversities. As such, I took a conservative approach and estimated power based on a small effect size. According to G*Power, there was only a 23.7% probability of detecting a small effect using an ANOVA with a sample of 215 participants and three profiles with a .05 alpha level.

Table 10

Co-occurring Child Maltreatment and Non-Victimization Adversity among Profiles (N = 215)

	Profile 1 Severe (n = 56)	Profile 2 More Severe (n = 71)	Profile 3 Most Severe (n = 88)	χ^2	Cramer's Φ	F	Partial η^2	CI's	Comparisons between profiles
Emotional abuse	60.7%	56.3%	79.5%	10.91**	.23	-	-	.11, .36	3 > 1, 2
Physical abuse	51.8%	62.0%	73.9%	7.48*	.19		-	.07, .33	3 > 1, 2
Neglect	66.1%	70.4%	73.9%	1.01	.07	-	-	.02, .22	-
Exposure to IPV	25.0%	23.9%	29.5%	.72	.06	-	-	.02, .20	-
Mean % of non- victimization adversities	26.5%	27.6%	34.5%	-	-	5.27**	.05	.01, .11	2 > 1 3 > 1, 2

Note. CIs = 95% confidence intervals.

IPV = intimate partner violence.

* $p < .05$; * $p < .01$; *** $p < .001$

Table 10 indicates the presence of other types of maltreatment and non-victimization adversities across childhood sexual abuse profiles. Results indicated that there were significant differences in the rates of emotional abuse between profiles ($\chi^2(2) = 10.91, p = .004$, Cramer's $\Phi = .23$, 95% CIs [.11, .36]), which resulted in a small effect. Post-hoc standardized residuals indicated that men in the Most Severe (3) profile reported significantly higher rates of emotional abuse (79.5%) than men in the Severe (1) and More Severe (2) profiles (60.7% and 56.3%, respectively). There were also significant differences among profiles with respect to physical abuse ($\chi^2(2) = 7.48, p = .02$, Cramer's $\Phi = .19$, 95% CIs [.07, .33]), which equated to a small effect. Men in the Most Severe (3) group were significantly more likely to have experienced physical abuse (73.9%) than men in the Severe (51.8%) and More Severe profiles (62.0%). There were no statistically significant differences across profiles with respect to neglect or exposure to intimate partner violence. However, binomial distributions revealed that there were significantly more neglected (70.6%) than non-neglected males (29.4%; $p < .001$) in the total sample, and significantly fewer males who witnessed intimate partner violence (73.5%) than males who did not witness intimate partner violence (26.5%; $p < .001$). These findings may explain why the chi-squared tests were not significant as there most likely was not enough variance in the frequencies of these variables to detect differences (Tabachnick & Fidell, 2007).

Results also indicated a significant effect of the mean percentage of non-victimization adversities across the profiles ($F(2, 212) = 5.37, p = .006$, partial $\eta^2 = .05$, 95% CIs [.01, .11]), which equated to a small effect size. Tukey HSD tests indicated that men in the Most Severe (3) profile experienced a significantly greater mean percentage of non-victimization adversities (34.5%) than men in the Severe (26.5%) and More Severe (27.6%) profiles. The more commonly-reported childhood adversities by men in the Most Severe (3) profile were as follows:

being teased for their appearance (80.7%); living with family members who argued or yelled at each other all the time (75.9%); having someone close to them die (62.5%); having a family member who drank or used drugs so often that it caused problems (46.0%), and having a primary caregiver lose their job and/or be unable to find work (38.6%).

Objective 3: What is the Link Between Childhood Sexual Abuse Profiles and Psychological Functioning While Controlling for the Potential Influence of Other Experiences of Child Maltreatment and Adversity?

Objective 4: Do Present-Day Avoidant Coping, Childhood Family Functioning, and Disclosure Moderate the Relationship Between Childhood Sexual Abuse Profiles and Psychological Outcomes?

Objectives 3 and 4 were addressed simultaneously using hierarchical linear regression modelling. Three regressions were run for each predicted variable (i.e., internalizing problems, externalizing problems, and trauma symptoms). The first block contained the control variables (i.e., emotional abuse, physical abuse, neglect, exposure to intimate partner violence, and non-victimization adversity). The second block contained the profiles. The third block contained the potential moderators, namely present-day avoidant coping, childhood family functioning, and disclosure (yes/no). The final block contained the interactions between profiles and moderating variables. To examine whether profiles were significantly associated with the predicted variables above and beyond other child maltreatment and adversity (objective 3), block 2 was examined. To examine whether there were independent and moderating effects of present-day avoidant coping, childhood family functioning, and disclosure (objective 4), blocks 3 and 4 were examined. Assumptions of multiple regression were tested prior to running analyses (Tabachnick & Fidell, 2007). Standardized betas, unstandardized betas, and 95% confidence

intervals were presented in tables and text. Part correlations squared (sr^2) were examined to assess the unique contribution and effect size of each significant variable. Effect sizes of .02 were considered small, .15 medium, and .35 large (Cohen, 1992). Significant predictors were highlighted in the tables to make them easier to locate.

Given that multiple regression does not handle categorical data, the profiles were dummy coded into two sets. The full sample ($N = 215$) was retained in each set. In the first set, the Severe (1) profile was used as the reference category to capture differences between the Severe (1) and More Severe (2) profiles, as well as between the Severe (1) and Most Severe (3) profiles. In order to capture differences between the More Severe (2) and Most Severe (3) profile, the More Severe (2) profile was used as the reference category in a second set. Each set of dummy coded variables was entered into the regression at a time. As there were four dummy coded profile variables (i.e., two dummy coded variables with Severe (1) as the reference group, and two dummy coded variables with More Severe (2) as the reference group) and three potential moderating variables, there were 12 interactions in total.

In terms of statistical power, the rule of thumb for multiple regressions is that the sample size should be eight times the number of independent variables plus 50 (Green, 1991). With 24 independent variables (i.e., five control variables, four dummy coded profile variables, three potential moderators, and 12 interactions), a sample of 242 would be required. As the regression was conducted with only 215 men, statistical power was borderline (Green, 1991). However, according to G*Power, with a sample of 215 and 24 predictor variables, there was still a 99.9% chance of detecting a medium effect, which is what has been found in past person-centered studies (Hulme & Agrawal, 2004).

Table 11 presents the means and standard deviations of the predicted variables across the three profiles. As shown, internalizing scores were mid-range, while externalizing scores were on the lower end of the scale. PCL scores were also mid-range. Results from each regression are presented below.

Table 11

Means and Standard Deviations on Predicted Variables by Profile (N = 215)

	Range	Total Sample (n = 215)	Profile 1 Severe (n = 56)	Profile 2 More Severe (n = 71)	Profile 3 Most Severe (n = 88)
Internalizing Problems	0-78	36.13 (15.05)	30.73 (15.03)	37.11 (16.17)	38.78 (13.30)
Externalizing Problems	0-70	18.62 (11.20)	16.73 (10.83)	19.33 (11.12)	19.25 (11.47)
Trauma Symptoms	17-85	52.73 (16.73)	46.02 (18.22)	51.76 (16.74)	57.77 (14.07)

Internalizing problems. Tables 12A and 12B show the regression results for internalizing problems. Table 12A presents the findings from the first set of dummy coded variables using the Severe (1) profile as the reference group. Table 12B presents the findings from the second set using the More Severe (2) profile as the reference group. The values in both tables are identical, with the exception of the comparisons between the More Severe (2) and Most Severe (3) profiles. Block 1, which contained the control variables (childhood maltreatment and non-victimization adversity) explained 8.0% of the variance in internalizing problems ($R^2(5, 209) = .08, p = .004$). The inclusion of profiles in Block 2 explained an additional 3.2% of the variance ($R^2(2, 207) = .11, p = .03$). Compared to men in the Severe (1)

profile, men in the More Severe (2) profile ($\beta = .20$, $B = 6.22$, $p = .02$, 95% CIs [1.08, 11.35], $sr^2 = .02$) and Most Severe (3) profile ($\beta = .21$, $B = 6.29$, $p = .01$, 95% CIs [1.28, 11.29], $sr^2 = .03$) reported significantly more internalizing problems. The More Severe (2) and Most Severe (3) profile accounted for 2.4% and 2.6% of the variance in internalizing problems, which equated to small effects. Table 12B indicates that there were no significant differences between men in the More Severe (2) and Most Severe (3) profile with respect to internalizing problems.

Block 3 in Tables 12A and 12B, which include present-day avoidant coping, childhood family functioning, and disclosure, explained an additional 16.9% of the variance in internalizing problems ($R^2(3, 204) = .28$, $p < .001$). Compared to the Severe (1) profile, the More Severe (2) profile continued to predict internalizing problems, even after accounting for other types of child maltreatment and adversity, present-day avoidant coping, childhood family functioning, and disclosure ($\beta = .16$, $B = 5.11$, $p = .03$, 95% CIs [.44, 9.78], $sr^2 = .02$), and accounted for 1.6% of the variance in internalizing problems, which equated to a small effect. Greater present-day use of avoidant coping ($\beta = .39$, $B = 1.32$, $p < .001$, 95% CIs [.91, 1.73], $sr^2 = .14$) and worse childhood family functioning ($\beta = -.21$, $B = -2.82$, $p = .02$, 95% CIs [-5.08, -.56], $sr^2 = .02$) were associated with more internalizing problems. These variables accounted for 13.9% (medium effect) and 2.1% (small effect) of the variance in internalizing problems, respectively. There was no statistically significant relationship between disclosure (yes/no) and internalizing problems. Block 4, which contained the interactions between profiles and the potential moderators, had no statistically significant findings. However, present-day avoidant coping continued to predict internalizing problems ($\beta = .32$, $B = 1.10$, $p = .003$, 95% CIs [.38, 1.82], $sr^2 = .03$), explaining 3.0% of its variance (small effect).

Table 12A.

Hierarchical Regression for Predictors of Internalizing Problems with Severe (1) Profile as the Reference Category (N = 215)

Variables	Coefficients		CIs	<i>t</i>	<i>sr</i> ²	<i>R</i> ²
	β (S)	B (U)				
Block 1						.08
Control variables	-	-	-	-	-	
Block 2						.11
Control variables	-	-	-	-	-	
More Severe (2) profile^a	.20*	6.22	1.08, 11.35	2.39	.02	
Most Severe (3) profile^a	.21*	6.29	1.28, 11.29	2.48	.03	
Block 3						.28
Control variables	-	-	-	-	-	
More Severe (2) profile^a	.16*	5.11	.44, 9.78	2.16	.02	
Most Severe (3) profile ^a	.14	4.23	-.39, 8.84	1.82	.01	
Avoidant coping	.39***	1.32	.91, 1.73	6.31	.14	
Family functioning^b	-.21*	-2.82	-5.08, -.56	-2.46	.02	
Disclosure	2.58	4.18	-.89, 9.26	1.62	.01	
Block 4						.32
Control variables	-	-	-	-	-	
More Severe (2) profile ^a	.03	1.03	-23.62, 25.67	.08	.00	

Most Severe (3) profile ^a	.23	6.93	-17.39, 31.26	.56	.00
Avoidant coping	.32**	1.10	.38, 1.82	2.96	.03
Family functioning ^b	-.18	-2.50	-5.79, .78	-1.50	.00
Disclosure	.11	4.71	-3.43, 12.85	1.14	.00
More Severe (2) profile ^a x Avoidant coping	.36	.72	-.34, 1.77	1.34	.00
Most Severe (3) profile ^a x Avoidant coping	-.06	-.11	-1.09, .88	-.22	.00
More Severe (2) profile ^a x Family functioning ^b	-.29	-2.95	-7.16, 1.26	-1.38	.00
Most Severe (3) profile ^a x Family functioning ^b	.14	1.38	-2.64, 5.40	.68	.00
More Severe (2) profile ^a x Disclosure	.07	2.18	-9.38, 13.73	.37	.00
Most Severe (3) profile ^a x Disclosure	-.15	-4.56	-18.13, 9.00	-.66	.00

Note. ^a Reference group is the Severe (1) profile; ^b = Square-root transformation.

Control variables = presence of emotional abuse, physical abuse, neglect, exposure to intimate partner violence, and mean percentage of non-victimization adversities.

CIs = 95% confidence intervals.

Table 12B.

Hierarchical Regression for Predictors of Internalizing Problems with More Severe (2) Profile as the Reference Category (N = 215)

Variables	Coefficients		CIs	<i>t</i>	<i>sr</i> ²	<i>R</i> ²
	β (S)	B (U)				
Block 1						.08
Control variables	-	-	-	-	-	
Block 2						.11
Control variables	-	-	-	-	-	
Most Severe (3) profile ^a	.01	.07	-4.61, 4.75	.03	.00	
Block 3						.28
Control variables	-	-	-	-	-	
Most Severe (3) profile ^a	-.03	-.88	-5.17, 3.40	-.41	.00	
Avoidant coping	.39***	1.32	.91, 1.73	6.31	.14	
Family functioning^b	-.21*	-2.82	-5.08, -.56	-2.46	.02	
Disclosure	2.58	4.18	-.89, 9.26	1.62	.01	
Block 4						.32
Control variables	-	-	-	-	-	
Most Severe (3) profile ^a	.19	5.91	-19.25, 31.06	.46	.00	
Avoidant coping	.32**	1.10	.38, 1.82	2.96	.03	
Family functioning ^b	-.18	-2.50	-5.79, .78	-1.50	.00	

Disclosure	.10	4.18	-.89, 9.26	1.62	.01
Most Severe (3) profile ^a x Avoidant coping	-.46	-.83	-1.84, .19	-1.60	.00
Most Severe (3) profile ^a x Family functioning ^b	.43	4.33	.24, 8.42	2.09	.01
Most Severe (3) profile ^a x Disclosure	-.22	-6.74	-20.29, 6.81	-.98	.00

Note. ^a Reference group is the More Severe (2) profile; ^b = Square-root transformation.

Control variables = presence of emotional abuse, physical abuse, neglect, exposure to intimate partner violence, and mean percentage of non-victimization adversities.

CIs = 95% confidence intervals.

Externalizing problems. As described above, the externalizing subscale was positively skewed, so regressions were run using its square root transformation as the dependent variable. Tables 13A and 13B present the regression findings for externalizing problems, with the Severe (1) and More Severe (2) profiles used as the reference categories. As shown, the control variables (child maltreatment and non-victimization adversity) explained 7.5% of the variance in externalizing problems ($R^2 = .08$, $df = 5$, 209 , $p = .006$). There were no statistically significant findings when the profiles were entered in Block 2.

The addition of present-day avoidant coping, childhood family functioning, and disclosure in Block 3 explained an additional 8.9% of the variance in externalizing problems ($R^2 = .17$, $df = 3$, 204 , $p < .001$). Greater present-day use of avoidant coping ($\beta = .22$, $B = .07$, $p = .001$, 95% CIs $[.03, .11]$, $sr^2 = .04$), worse childhood family functioning ($\beta = -.19$, $B = -.24$, $p = .03$, 95% CIs $[-.47, -.02]$, $sr^2 = .02$), and disclosure of the abuse ($\beta = .17$, $B = .65$, $p = .01$, 95% CIs $[.14, 1.15]$, $sr^2 = .03$) were associated with more externalizing problems. The effect sizes for these variables were small, and explained 4.3%, 1.8%, and 2.5% of the variance in externalizing problems, respectively.

The interactions between profiles and the potential moderating variables in Block 4 were not statistically significant. Childhood family functioning and disclosure no longer had a main effect on externalizing problems when the interactions were included in the model. Avoidant coping, however, continued to predict externalizing problems ($\beta = .29$, $B = .09$, $p = .01$, 95% CIs $[.02, .17]$, $sr^2 = .03$) in Block 4. Avoidant coping uniquely predicted 2.5% of the variance in externalizing problems, which equates to a small effect.

Table 13A.

Hierarchical Regression for Predictors of Externalizing Problems with Severe (1) Profile as the Reference Category (N = 215)

Variables	Coefficients		CIs	<i>t</i>	<i>sr</i> ²	<i>R</i> ²
	β (S)	B (U)				
Block 1						
Control variables	-	-	-	-	-	.08
Block 2						
Control variables	-	-	-	-	-	.08
More Severe (2) profile ^a	.10	.30	-.19, .78	1.21	.00	
Most Severe (3) profile ^a	.05	.14	-.33, .61	.59	.00	
Block 3						
Control variables	-	-	-	-	-	.17
More Severe (2) profile ^a	.07	.20	-.26, .67	.85	.00	
Most Severe (3) profile ^a	-.01	-.03	-.49, .43	-.12	.00	
Avoidant coping	.22**	.07	.03, .11	3.27	.04	
Family functioning^b	-.19*	-.24	-.47, -.02	-2.14	.02	
Disclosure	.17*	.65	.14, 1.15	2.52	.03	
Block 4						
Control variables	-	-	-	-	-	.20
More Severe (2) profile ^a	.41	1.20	-1.28, 3.68	.96	.00	

Most Severe (3) profile ^a	.45	1.26	-1.18, 3.71	1.02	.00
Avoidant coping	.29*	.09	.02, .17	2.50	.03
Family functioning ^b	-.07	-.10	-.43, .24	-.57	.00
Disclosure	.16	.61	.21, 1.43	1.48	.00
More Severe (2) profile ^a x Avoidant coping	.02	.00	-.10, .11	.06	.00
Most Severe (3) profile ^a x Avoidant coping	-.42	.07	.17, .03	-1.38	.00
More Severe (2) profile ^a x Family functioning ^b	-.41	.39	-.81, .04	-1.79	.00
Most Severe (3) profile ^a x Family functioning ^b	-.04	-.05	-.45, .36	-.21	.00
More Severe (2) profile ^a x Disclosure	.03	.08	-1.07, 1.25	.14	.00
Most Severe (3) profile ^a x Disclosure	-.01	-.02	-1.38, 1.35	-.03	.00

Note. ^a Reference group is the Severe (1) profile; ^b = Square-root transformation.

Control variables = presence of emotional abuse, physical abuse, neglect, exposure to intimate partner violence, and mean percentage of non-victimization adversities.

CIs = 95% confidence intervals.

Table 13B.

Hierarchical Regression for Predictors of Externalizing Problems with More Severe (2) Profile as the Reference Category (N = 215)

Variables	Coefficients		CIs	<i>t</i>	<i>sr</i> ²	<i>R</i> ²
	β (S)	B (U)				
Block 1						
Control variables	-	-	-	-	-	.08
Block 2						
Control variables	-	-	-	-	-	.08
Most Severe (3) profile ^a	-.06	-.16	-.60, .29	.96	.00	
Block 3						
Control variables	-	-	-	-	-	.17
Most Severe (3) profile ^a	.45	1.26	-1.18, 3.71	1.02	.00	
Avoidant coping	.22**	.07	.03, .11	3.27	.04	
Family functioning^b	-.19*	-.24	-.47, -.02	-2.14	.02	
Disclosure	.17*	.65	.14, 1.15	2.52	.03	
Block 4						.20
Control variables	-	-	-	-	-	
Most Severe (3) profile ^a	.02	.06	-2.46, 2.60	.05	.00	
Avoidant coping	.29*	.09	.02, .17	2.50	.03	
Family functioning ^b	-.07	-.10	-.43, .24	-.57	.00	

Disclosure	.16	.61	.21, 1.43	1.48	.00
Most Severe (3) profile ^a x Avoidant coping	-.44	.07	-.18, .03	-1.40	.00
Most Severe (3) profile ^a x Family functioning ^b	.37	.34	-.07, .75	1.64	.00
Most Severe (3) profile ^a x Disclosure	-.04	-.10	-1.46, 1.26	-.15	.00

Note. ^a Reference group is the More Severe (2) profile; ^b = Square-root transformation.

Control variables = presence of emotional abuse, physical abuse, neglect, exposure to intimate partner violence, and mean percentage of non-victimization adversities.

CIs = 95% confidence intervals.

In order to further explore the relationship between disclosure and externalizing problems, I ran an ANOVA with response to disclosure (supportive versus non-supportive) as the independent variable and externalizing problems as the dependent variable. The ANOVA was not significant. This indicates that there was no statistically significant relationship between externalizing problems and response to abuse disclosure.

Trauma symptoms. Tables 14A and 14B present the regression analyses for predictors of trauma symptoms. The control variables (childhood maltreatment and non-victimization adversity) in Block 1 accounted for 13.3% of the variance in trauma symptoms ($R^2 = .13$, $df = 5$, 209 , $p < .001$). The inclusion of profiles to Block 2 accounted for an additional 4.8% of the variance in trauma symptoms ($R^2 = .18$, $df = 2$, 207 , $p = .003$). Using the Severe (1) profile as a reference group, men in the Most Severe (3) profile reported significantly more trauma symptoms ($\beta = .28$, $B = 9.42$, $p = .001$, 95% CIs [4.08, 14.77], $sr^2 = .05$). This profile accounted for 4.7% of the variance in trauma symptoms (small effect). There were no significant differences between men in the Severe (1) and More Severe (2) profiles with respect to trauma symptoms. The More Severe (2) profile was then used as the reference category (see Table 14B). There were also no significant differences in trauma symptoms between men in the More Severe (2) and Most Severe (3) profiles.

Table 14A.

Hierarchical Regression for Predictors of Trauma Symptoms with Severe (1) Profile as the Reference Category (N = 215)

Variables	Coefficients		CIs	<i>t</i>	<i>sr</i> ²	<i>R</i> ²
	β (S)	B (U)				
Block 1						
Control variables	-	-	-	-	-	.13
Block 2						
Control variables	-	-	-	-	-	.18
More Severe (2) profile ^a	.15	5.34	-.15, 10.82	1.92	.01	
Most Severe (3) profile^a	.28**	9.42	4.08, 14.77	3.47	.05	
Block 3						
Control variables	-	-	-	-	-	.45
More Severe (2) profile ^a	.12	4.07	-.49, 8.64	1.76	.00	
Most Severe (3) profile^a	.19**	6.51	2.00, 11.02	2.85	.01	
Avoidant coping	.51***	1.95	1.55, 2.34	9.53	.25	
Family functioning ^b	-.11	-1.62	-3.83, .58	-1.45	.00	
Disclosure	.12*	5.76	.80, 10.73	2.29	.01	
Block 4						.47
Control variables	-	-	-	-	-	
More Severe (2) profile ^a	.24	8.50	-15.64, 32.63	.69	.00	

Most Severe (3) profile^a	.73*	24.62	.80, 48.44	2.04	.01
Avoidant coping	.56***	2.12	1.41, 2.83	5.90	.09
Family functioning ^b	-.03	-.51	-3.74, 2.72	-.31	.00
Disclosure	.15	6.91	-1.06, 14.88	1.71	.00
More Severe (2) profile ^a x Avoidant coping	.11	.24	-.80, 1.27	.45	.00
Most Severe (3) profile ^a x Avoidant coping	-.36	-.72	-1.68, .25	-1.47	.00
More Severe (2) profile ^a x Family functioning ^b	-.28	-3.11	-7.23, 1.02	-1.49	.00
Most Severe (3) profile ^a x Family functioning ^b	-.01	-.06	-4.00, 3.89	-.03	.00
More Severe (2) profile ^a x Disclosure	.03	1.16	-10.16, 12.47	.20	.00
Most Severe (3) profile ^a x Disclosure	-.20	-6.88	-20.17, 6.40	-1.02	.00

Note. ^a Reference group is the Severe (1) profile; ^b = Square-root transformation.

Control variables = presence of emotional abuse, physical abuse, neglect, exposure to intimate partner violence, and mean percentage of non-victimization adversities.

CIs = 95% confidence intervals.

Table 14B.

Hierarchical Regression for Predictors of Trauma Symptoms with More Severe (2) Profile as the Reference Category (N = 215)

Variables	Coefficients		CIs	<i>t</i>	<i>sr</i> ²	<i>R</i> ²
	β (S)	B (U)				
Block 1						
Control variables	-	-	-	-	-	.13
Block 2						
Control variables	-	-	-	-	-	.18
Most Severe (3) profile ^a	.12	4.08	-.92, 9.09	1.61	.01	
Block 3						
Control variables	-	-	-	-	-	.45
Most Severe (3) profile ^a	.07	2.44	-1.75, 6.62	1.15	.00	
Avoidant coping	.51***	1.95	1.55, 2.34	9.53	.25	
Family functioning ^b	-.11	-1.62	-3.83, .58	-1.45	.00	
Disclosure	.12*	5.76	.80, 10.73	2.29	.01	
Block 4						
Control variables	-	-	-	-	-	.47
Most Severe (3) profile ^a	.48	16.13	-8.51, 40.76	1.29	.00	
Avoidant coping	.56***	2.12	1.41, 2.83	5.90	.09	
Family functioning ^b	-.03	-.51	-3.74, 2.72	-.31	.00	

Disclosure	.15	6.91	-1.06, 14.88	1.71	.00
Most Severe (3) profile ^a x Avoidant coping	-.48	-.95	-1.95, .05	-1.88	.01
Most Severe (3) profile ^a x Family functioning ^b	.27	3.05	-.96, 7.06	1.50	.00
Most Severe (3) profile ^a x Disclosure	-.23	-8.04	-21.31, 5.23	-1.20	.00

Note. ^a Reference group is the More Severe (2) profile; ^b = Square-root transformation.

Control variables = presence of emotional abuse, physical abuse, neglect, exposure to intimate partner violence, and mean percentage of non-victimization adversities.

CIs = 95% confidence intervals.

Block 3 in Tables 14A and 14B, which included present-day avoidant coping, childhood family functioning, and disclosure, explained an additional 26.4% of the variance in trauma symptoms ($R^2 = .45$, $df = 3$, 204 , $p < .001$). Using more avoidant coping ($\beta = .51$, $B = 1.95$, $p < .001$, 95% CIs $[1.55, 2.35]$, $sr^2 = .25$) and having disclosed the childhood sexual abuse ($\beta = .12$, $B = 5.76$, $p = .02$, 95% CIs $[-.80, 10.73]$, $sr^2 = .01$) were associated with more trauma symptoms. Present-day avoidant coping accounted for 24.7% of the variance in trauma symptoms, which equates to a medium effect, while disclosure displayed a small effect, as it accounted for just 1.4% of the variance in trauma symptoms.

Block 4, which contained the interactions between profiles and the potential moderators, was not significant in predicting trauma symptoms. However, compared to the Severe (1) profile, the Most Severe (3) profile ($\beta = .73$, $B = 24.62$, $p = .04$, 95% CIs $[-.80, 48.44]$, $sr^2 = .01$) as well as greater present-day use of avoidant coping ($\beta = .56$, $B = 2.12$, $p < .001$, 95% CIs $[1.41, 2.83]$, $sr^2 = .09$) continued to predict trauma symptoms, and accounted for 1.1% and 9.3% of the variance in the dependent variable, respectively (small effects). As was done with externalizing problems, I ran an ANOVA between response to disclosure (supportive versus non-supportive) and trauma symptoms. The relationship between response to disclosure and trauma symptoms was not significant.

Discussion

The current study had four objectives. The first was to identify profiles based on the childhood sexual abuse characteristics of males. The second objective was to examine how profiles were associated with other childhood maltreatment and non-victimization adversity. Third, the study examined how profiles differed with respect to internalizing problems, externalizing problems, and trauma symptoms, while also accounting for the potential influence

of other experiences of child maltreatment and adversity. Finally, the study examined whether present-day avoidant coping, childhood family functioning, and disclosure (yes/no) moderated the relationship between sexual abuse profiles and psychological functioning. To my knowledge, this was the first study to examine the heterogeneity of sexual abuse experiences among male survivors, with only six studies examining the sexual abuse profiles of children and adult female survivors. As such, the analyses were mainly exploratory.

Objective 1: Based on Abuse Characteristics, how Many Profiles can be Identified in a Sample of Male Sexual Abuse Survivors?

Results were in line with my hypotheses in that three distinct profiles were identified. The smallest profile (26.1%) consisted of men who experienced 1 to 2 instances of fondling and/or oral-genital contact with unknown extrafamilial perpetrators in mid-childhood. The next largest profile (33.0%) consisted of men whose sexual abuse also began in mid-childhood, but it tended to be more severe in that they experienced abuse over several months or years by perpetrators with whom they were relatively close. The largest profile (40.9%) consisted of men with very severe experiences. These men experienced sexual abuse beginning in early childhood. The abuse involved more invasive sexual acts by trusted individuals both within and outside the family.

It is difficult to directly compare the current study's findings with previous studies on adult female and child survivors of sexual abuse due to methodological differences. While the current study included abuse characteristics similar to those included in Bennett et al. (2000) as well as Hulme and Agrawal (2004), I also included other abuse characteristics (i.e., age of onset, duration, emotional closeness to the perpetrator) because they are often included as predictors of long-term functioning in the sexual abuse literature (Dube et al., 2005; Kendall-Tackett et al.,

1993). In addition, unlike most previous person-centered studies that have used cluster analysis to generate subgroups of survivors of childhood sexual abuse (Alexander & Schaeffer, 1994; Bennett et al., 2000; Hébert et al., 2006; Hulme & Agrawal, 2004; Trickett et al., 2001), the current study used LPA because it accommodates different types of data and is more reliable than cluster analysis (Hagenaars & McCutcheon, 2002).

Perhaps the most comparable person-centered study is Watson and Halford (2010), which also used LPA with adult female survivors and included similar, albeit fewer, abuse characteristics (i.e., age of onset, relationship to the perpetrator, sexual acts, and disclosure experiences). As in the current study, Watson and Halford (2010) identified three profiles with increasing severity. Although Watson and Halford (2010) labeled profiles according to participants' relationship to the perpetrator (i.e., family member, friend, stranger), the current study used broader labels (i.e., Severe, More Severe, and Most Severe) to account for all abuse characteristics included in the analyses.

There are differences between the profiles identified in Watson and Halford (2010) and in the current study. The largest profile (54.4%) identified by Watson and Halford (2010) depicted "friend" abuse that occurred in pre-adolescence. Most cases involved the perpetrator touching the females' genitals or other body parts. This differs from the largest profile (40.9%) identified in the current study, which depicted very severe sexual abuse that began in early childhood, was perpetrated by both individuals inside and outside of the family, and involved penetration for the majority of men. It is possible that males are abused at younger ages than females, although research has generally been equivocal on this matter (Briere & Elliott, 2003; Fontanella et al., 2000). These findings are consistent with studies showing significantly higher rates of penetration among male than female survivors (Dube et al., 2005) but inconsistent with studies

showing that girls are more likely to be abused by family members, whereas boys are typically abused by individuals outside of the family (Coohey, 2010; Gold et al., 1998; Holmes & Slap, 1998). Given that males in the current study were recruited from websites offering support for sexual abuse, they may have been more symptomatic than individuals contacted from the Australian national voting registry (as is the case in Watson and Halford's study). As a result, the abuse characteristics of males in the current study may be more similar to those of a clinical sample than male survivors in the community.

Most abuse characteristics (i.e., duration, age of onset, relationship to the perpetrator, emotional closeness to the perpetrator, and sexual acts) in the current study showed increasing severity from the Severe (1) profile to the Most Severe (3) profile. However, perpetrators' use of threats and/or physical force, as well as multiple experiences of sexual abuse, did not show as clear a pattern among profiles. Surprisingly, there were no differences among profiles with regards to threats and/or physical force. I anticipated that men in the Most Severe (3) profile would report more threats and/or physical force by virtue of their more severe abuse experiences. It is possible that the perpetrators of men in the Most Severe (3) profile used alternative tactics to gain compliance, such that threats and physical force were not needed. For instance, men in this profile reported that they were very close with their perpetrators prior to abuse onset. This relationship might reflect their perpetrator's efforts to "groom" the child, whereby they gradually developed a trusting relationship before persuading the child to engage in sexual acts (McAlinden, 2006). Research has also indicated that threats and/or physical force increase as victims age, because boys become physically stronger and are better able to fend off their perpetrator (Holmes & Slap, 1998). Thus, it might be expected that men in the Severe (1) and More Severe (2) profiles, who were older at the onset of abuse, would report higher levels of

threat/physical force than men in the Most Severe (3) profile. However, given that the abuse characteristics were coded according to the most severe sexual experience, the age of onset reported by men in the Most Severe (3) profile reflects only their earliest abuse experience, and all men in the Most Severe (3) profile reported more than one sexual abuse experience. While they may not have been threatened and/or physically forced into sexual acts as young children, they may have experienced threats and/or physical violence by perpetrators later in childhood. Nonetheless, the high rates of threats and/or physical force across all three profiles (50-67%) suggest that this is a common strategy used by perpetrators of boys.

Another surprising finding was that men in the More Severe (2) profile reported a low rate of abuse by different perpetrators (9.9%). Given that they generally reported more severe sexual experiences than men in the Severe (1) profile, it was expected that they would also be more likely to report multiple abuse experiences. These findings suggest there are two distinct types of male sexual abuse that begin in mid-childhood, one which consists of a 1- or 2-time fondling by an unknown extrafamilial perpetrator (Severe profile) and another in which boys experience more severe sexual acts over a long period by an extrafamilial perpetrator with whom they are reasonably close (More Severe). Although not tested in this study, it is possible that the perpetrators of men in the More Severe (2) profile included individuals who had sustained access to the child (e.g., babysitter, coach), whereas the perpetrators of men in the Severe profile may have included individuals with whom they did not have a formal or professional relationship (e.g., neighbours, strangers).

Objective 2: How are Childhood Sexual Abuse Profiles Associated with Other Childhood Maltreatment and Non-Victimization Adverse Experiences?

The second hypothesis that profiles characterized by intrafamilial sexual abuse would be associated with the presence of emotional abuse, physical abuse, neglect, and exposure to intimate partner violence was partially confirmed. Males in the Most Severe (3) profile were significantly more likely to have experienced emotional and physical abuse as well as greater non-victimization adversities, compared to men in the Severe (1) and More Severe (2) profiles. These results are consistent with profile studies of adult females and children (Alexander & Schaeffer, 1994; Hulme & Agrawal, 2004; Watson & Halford, 2010) which indicate that profiles characterized by more severe sexual abuse also have higher rates of emotional and physical abuse. There are a number of explanations for these findings. It is possible that emotional and physical abuse precede sexual abuse (Hulme & Agrawal, 2004). For instance, children with abusive caregivers might seek out caring adults outside the home, thereby increasing their risk of being exploited (Fisher & Goodwin, 2009). Children may also have difficulty disclosing sexual abuse in the context of an abusive family environment (Alaggia & Krishenbaum, 2005), thus allowing the sexual abuse to continue and increase in severity. It is also possible that sexual abuse precedes emotional and physical abuse, as caregivers may resort to emotionally abusive and physically violent discipline to manage their child's trauma-related behaviours (Hébert et al., 2006). Finally, intrafamilial perpetrators may use emotionally and physically abusive tactics to keep the child from disclosing to non-offending family members (Hershkowitz et al., 2007).

Although the current study is the first person-centered examination of the relationship between sexual abuse profiles and non-victimization adversities, past variable-centered studies have found a strong dose-response relationship between severity of sexual abuse (e.g., earlier age of onset, longer duration) and the number of childhood adversities (Dong et al., 2003). Men in the Most Severe (3) profile may have grown up in the most chaotic and dysfunctional family

environments which were themselves abusive and/or did not adequately protect children from harm. Even in those cases in which males in the Most Severe (3) profile were not sexually abused by a family member (30.7%), research indicates that sexual abuse perpetrators target children from families with obvious vulnerabilities (e.g., marital discord, peer victimization; McAlinden, 2006). In line with this research, the most common non-victimization adversity reported by men in the Most Severe (3) profile was frequently being teased for their appearance during childhood. Children who are isolated and rejected by peers may be more vulnerable targets to sexual abuse perpetrators (Olson et al., 2007). Unfortunately, given the retrospective nature of the study, the question of whether types of maltreatment and adversities actually predispose a child to certain forms of sexual abuse cannot be answered.

Objective 3: What is the Link Between Childhood Sexual Abuse Profiles and Psychological Functioning While Controlling for the Potential Influence of Other Experiences of Child Maltreatment and Adversity?

The study's third hypothesis that men who experienced more severe patterns of childhood sexual abuse would report greater psychological difficulties, after controlling for other childhood maltreatment and adverse experiences, was partially supported. In line with person-centered studies with children and adult females with sexual abuse histories (Hulme & Agrawal, 2004; McCrae et al., 2006; Trickett et al., 2001), the current study found that: 1) men in the More Severe (2) profile reported significantly greater internalizing difficulties than men in the Severe (1) profile; 2) men in the Most Severe (3) profile displayed significantly more internalizing problems than men in the Severe (1) profile; and 3) men in the Most Severe (3) profile displayed significantly more trauma symptoms than men in the More Severe profile (2).

The relationship between profiles and psychological outcomes can be understood from a complex trauma perspective (National Child Traumatic Stress Network Task Force, 2003; van der Kolk et al., 2005). Chronic childhood sexual abuse which begins at an early age (as was the case for men in the Most Severe profile) impacts critical periods of brain development that are linked with foundational developmental processes such as attachment and emotion regulation (Schore, 2001). Failure to attain these foundational competencies increases the likelihood of subsequent psychological difficulties (National Child Traumatic Stress Network Task Force, 2003; van der Kolk et al., 2005). Thus, the timing, chronicity, and nature of the sexual abuse experience (e.g., whether it is perpetrated by an attachment figure) are critical in helping shape later psychological outcomes (National Child Traumatic Stress Network Task Force, 2003; van der Kolk et al., 2005). Given that men in the Severe (1) and More Severe (2) profiles experienced childhood sexual abuse at older ages, for a shorter duration, and by unknown individuals, it is possible that they were more likely able to attain these key developmental processes and thereby experience fewer negative effects than males in the Most Severe (3) profile. Men in the Severe (1) and More Severe (2) profiles may also exhibit fewer internalizing problems and trauma symptoms by virtue of their lower rates of exposure to other types of child maltreatment and adversity.

It is important to note, however, that internalizing problems and trauma symptoms were high regardless of profile. Men in the Severe (1), More Severe (2), and Most Severe (3) profiles reported mean internalizing scores of 30.7, 37.1, and 38.8, respectively, which are triple that of normative samples of males aged 36-59 ($M = 9.3$; Achenbach & Rescorla, 2003). Likewise, the mean trauma symptom scores were 46.0 (Severe profile), 51.8 (More Severe profile), and 57.8 (Most Severe profile), all of which exceed the measure's diagnostic cut-off of 44 for PTSD

(Blanchard et al., 1996). Although person-centered studies have shown that there are subgroups of children who show little distress following childhood sexual abuse (Hébert et al., 2006; McCrae et al., 2006), the current findings suggest that the majority of male survivors exhibit significant internalizing problems and trauma symptoms. Some individuals may exhibit “sleeper effects” in which they show few problems initially, followed by increased psychopathology over time (Putnam, 2003). Given that the majority of males in the sample experienced multiple types of maltreatment, the cumulative impact of these experiences may have placed increasingly greater demands on coping resources, thus increasing their risk of psychological distress. However, these results are based on a sample of males who are seeking support for their sexual experiences. As such, it would be expected that their distress would be higher than non-support seeking males.

In contrast to previous person-centered studies with mixed-sex children (McCrae et al., 2006), profiles from the current study were unrelated to externalizing problems. While children with more severe sexual experiences may exhibit more externalizing problems initially, it is possible that these problems decrease with age as children acquire increasing control over aggressive behaviours and begin to recognize the social consequences of such behaviour. In other words, there may be differential effects of sexual abuse profiles on outcomes depending on the developmental period of the sample. It is also possible that there were no distinctions between the profiles in externalizing problems because the data were drawn from the community, a setting in which externalizing problems may simply not be as common. There may, for example, be more variability in externalizing problems among male survivors recruited from forensic and/or clinical settings. Surprisingly, however, the current study found rates of externalizing problems that were more than double those of normative samples of males ($M =$

18.6 for the total sample compared to $M = 8.0$ for normative males aged 36-59), suggesting that externalizing problems remain high even into adulthood. Since the majority of males in the sample also experienced physical abuse and/or were physically forced or threatened as part of their sexual abuse experience, exposure to such violence may have encouraged them to adopt violent values and aggressive behaviours (Lynch & Cicchetti, 1998). It is also possible that male survivors engage in aggressive behaviours (e.g., yelling, threatening) due to a perceived need to protect themselves from others (Lewis et al., 2007).

Objective 4: Do Present-Day Avoidant Coping, Childhood Family Functioning, and Disclosure Moderate the Relationship Between Childhood Sexual Abuse Profiles and Psychological Outcomes?

The study's fourth hypothesis that present-day avoidant coping, childhood family functioning, and disclosure would moderate the relationship between profiles and psychological outcomes was not supported. This is in contrast to previous variable-centered studies (Cantón-Cortés & Cantón, 2010; Easton et al., 2011) showing that these contextual variables interact with abuse characteristics to produce certain outcomes. The interactions in the current study may not have been significant because they were competing with a number of variables in the regression model (Tabachnick & Fidell, 2007). Although the potential moderators could have been examined individually, it would have resulted in an additional 18 regressions (both sets of dummy coded profile variables x one of the three potential moderating variables, for each of the three dependent variables). Bonferroni corrections were not applied in the current study because it was the first person-centered study with male survivors of childhood sexual abuse, and I was more concerned with committing a Type II (i.e., retaining a false null hypothesis) than Type I error (i.e., rejecting a true null hypothesis). The addition of 18 analyses would have increased

the likelihood of committing a Type I error (Tabachnick & Fidell, 2007). As such, I chose a more conservative approach by including all three moderators together in the regression analyses. More research with larger samples of male survivors is needed in order to determine whether avoidant coping, childhood family functioning, and disclosure place individuals at greater risk of psychological difficulties depending on their profile membership.

Although the contextual variables were not significant as moderators, several main effects were found. In line with Hébert et al. (2006), greater use of abuse-related avoidance coping was significantly associated with more internalizing problems, externalizing problems, and trauma symptoms. These relationships held even after accounting for the profiles, as well as other child maltreatment and adversity. These findings are consistent with numerous studies highlighting the detrimental impact of avoidance coping (Bal et al., 2003; O’Leary, 2009; Steel et al., 2004). Avoidance coping might be adaptive in the short-term because it prevents the child from overwhelming feelings of anxiety and fear. In the long-term, however, avoidant coping impedes emotional processing of the trauma and maintains anxiety (Steel et al., 2004).

In line with numerous studies (e.g., Easton et al., 2010; Messman-Moore & Brown, 2004; Whiffen & MacIntosh, 2005), childhood family dysfunction was associated with more internalizing and externalizing problems, as well as trauma symptoms, in adulthood. There are numerous explanations for these findings. As noted by Hébert et al. (2014), family dysfunction may adversely affect the family’s ability to respond to a child’s disclosure of sexual abuse and provide the emotional support necessary for recovery. Second, children often model their parents’ behaviour. Sexually abused children growing up in families in which vulnerable emotions are not talked about openly may be more likely to internalize their distress, whereas children from families marked by conflict and aggression may be more likely to cope through

externalizing behaviours (e.g., threatening others; Repetti et al., 2002). Finally, if the childhood family environment is unable to provide relief or respite from the stress of sexual abuse, the brain may remain in a constant state of flight, fight, or freeze, leading to permanent changes to the brain regions responsible for emotion regulation (Schore, 2001).

Having disclosed the sexual abuse was associated with more externalizing problems and trauma symptoms. These findings are consistent with studies (Feiring et al., 2004; O’Leary et al., 2010) showing that disclosure is associated with greater psychological distress in adulthood. It has been proposed that the quality of the response that is received might explain the relationship between disclosure and psychological outcomes (O’Leary et al., 2010). This may be particularly true for males because their disclosures are often met with denial and minimization (Ullman & Filipas, 2005). However, response to disclosure (supportive versus non-supportive) did not predict externalizing problems and trauma symptoms in the current study. This non-significant result may be due to the way in which the reaction to disclosure variable was coded. Namely, reaction to disclosure was coded as “negative” if they had ever received a negative response to their disclosure. As such, a participant may have received several supportive responses and one negative one, and still be coded as “negative”. The reaction to disclosure variable was coded in this manner to be consistent with the coding of the other abuse characteristics (i.e., coding according to the most severe response). While it is possible that the positive responses to disclosure might wipe out the effects of the negative responses, the reverse might also be true. Anecdotally, we might assume that males would be more affected by negative responses than positive ones due to the highly stigmatized and sensitive nature of their abuse experiences. Given that the sexual abuse literature is divided with regards to the benefits of disclosure (Hébert et al., 2009; O’Leary et al., 2010; Ullman & Filipas,

2005), additional research is needed. It may also be helpful to investigate other variables related to the disclosure, such as the number of years taken to disclose as it might explain the relationship between disclosure and long-term outcomes (Easton et al., 2013).

Effect size. While there were several statistically significant relationships identified in the current study, their effect sizes were small. Once other types of child maltreatment and adversity were taken into account, profiles only accounted for 3% of the variance in internalizing symptoms and 5% of the variance in trauma symptoms. Childhood family functioning and disclosure also displayed small effects on the predicted variables. These findings are not altogether surprising when we consider that these childhood experiences occurred over 25 years ago for most men in the current sample. More recent experiences might exert bigger effects on current psychological functioning. Indeed, present-day avoidant coping explained 14% of the variance in internalizing problems and 25% of the variance in trauma symptoms.

The current study found smaller effect sizes for profiles and contextual variables than previous person-centered studies with female survivors of childhood sexual abuse (Hulme & Agarwal, 2004; Trickett et al., 2001). The lower effect size might be attributable to the broad-band measures of psychological functioning that were used in the current study (i.e., internalizing and externalizing difficulties). It is possible that these variables would display larger effects with trauma-specific measures. Alternatively, it could simply be the case that the predictor variables included in the study are not as relevant for male survivors as they are for female survivors.

While the effects of the predictor variables were small, they can still have significant clinical implications (Briere & Elliott, 2003). For example, public health efforts have historically targeted risk factors with small effect sizes, such as the impact of smoking on

pregnancy (Castles, Adams, Melvin, Kelsch, & Boulton, 1999) and the effect of calcium consumption on bone mass (Bushman & Anderson, 2001). As such, the small effects found in the current study should not be dismissed as trivial.

Research and Clinical Implications

This study contributed to the sexual abuse literature in a number of ways. First, I extended the study of sexual abuse profiles to males, which is a population that has received relatively little empirical attention. While the current study focused on characteristics that have been examined in prior person-centered studies with adult females and children, I also included additional relevant characteristics, such as the emotional closeness between the child and the perpetrator as well as multiple sexual abuse experiences. Moreover, while previous person-centered studies (e.g., Bennett et al., 2000; Hulme & Agrawal, 2004) have tended to only include the most severe sexual abuse experience in the formation of profiles, the current study examined all experiences of sexual abuse and coded each characteristic according to the response that indicated the greatest severity.

Findings indicated that the abuse experiences of male survivors are heterogeneous. Even though all males in the current sample reported sexual abuse experiences that are severe, there were clear differences in the chronicity, relationship to the perpetrator, and the invasiveness of sexual acts. Abuse experiences ranged from a few instances of fondling to invasive sexual abuse spanning many years. The study's results also showed that profiles varied in their experiences of other types of child maltreatment and adversity as well as in their associations with various adult psychological outcomes. These findings, paired with emerging person-centered studies on adult females and children (Alexander & Schaeffer, 1994; Bennett et al., 2000; Hulme & Agrawal, 2004; McCrae et al., 2006; Trickett et al., 2001; Watson & Halford, 2010), highlight the

importance of taking a person-centered approach to studying survivors of childhood sexual abuse. While my analyses were mostly exploratory, additional studies with larger samples of male survivors are recommended to validate the profiles and their clinical presentations.

From a clinical perspective, this study contributes to informing the service needs of male survivors of childhood sexual abuse. At a fundamental level, this study demonstrates that not all experiences of sexual abuse are alike. Even within a narrowly-defined sample of males seeking support for childhood sexual abuse, experiences varied greatly. Given the heterogeneity of abuse experiences and outcomes, no single type of intervention is likely to be effective for all sexually abused men. Tailoring interventions to distinct profiles will likely enhance potential benefits. For example, men presenting with sexual abuse that closely matches the Most Severe (3) profile will likely require interventions that focus on developing emotion regulation, which may not be fully developed due to their early abuse experiences (National Child Traumatic Stress Network Task Force, 2003). Given that these men would have had early and repeated disruptions in their attachment relationships, they might also benefit from interventions aimed at developing and maintaining interpersonal relationships. Skills Training in Affective and Interpersonal Regulation (Levitt & Cloitre, 2005), an evidence-based skills-focused treatment developed to provide social and emotion management skills for individuals with PTSD related to childhood sexual abuse, may be particularly helpful for men in the Most Severe (3) profile. Moreover, given that men in the Most Severe (3) profile were highly symptomatic, they 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, emotionally process their trauma, and reconnect to supportive family members and community organizations.

In contrast, men in the Severe (1) and More Severe (2) profiles would likely require less intensive treatment. Given that their sexual abuse experiences were acute (i.e., 1 to 2 times), men in the Severe (1) profile may benefit from trauma-focused interventions aimed at reducing symptoms stemming from one-time traumas (e.g., Prolonged Exposure; Foa, Hembree, & Rothbaum, 2007). As they reported fewer internalizing problems and trauma symptoms than men in the other profiles, their treatment would likely be shorter-term than men in the More Severe (2) and Most Severe (3) profiles. Men in the More Severe (2) profile were abused over a long period of time by a single extrafamilial perpetrator with whom they were reasonably close. As such, they may benefit from therapy aimed at resolving attachment disruptions and regaining trust in others. Men in the More Severe (2) profile might be good candidates for group psychotherapy for male survivors, because it would help them regain the capacity to develop and maintain relationships with other men and challenge beliefs about male childhood sexual abuse. In light of their less severe internalizing problems, men in the More Severe (2) profile may be better able to tolerate group psychotherapy than men in the Most Severe (3) profile. It is recommended that future studies investigate how profiles differ with respect to other outcomes (e.g., substance use), which may inform the development of tailored treatment plans.

Findings also suggest that clinicians need to go beyond sexual abuse-related variables for purposes of treatment planning. In line with the larger sexual abuse literature, this study found that the family environment at the time of the abuse, which may or may not have changed over the years, is associated with adult psychological symptoms. Thus, 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), as it may provide information about their male client's current distress. It may be also helpful for

clinicians treating sexually abused boys to integrate family members to reduce the likelihood of developing long-term difficulties.

In terms of coping, the study highlighted the negative impact of avoidant coping on trauma symptoms. Several evidence-based treatments for trauma (e.g., Prolonged Exposure, cognitive behavioural therapy) aim to reduce abuse-related avoidant coping through graded exposure to feared memories, thoughts, and situations related to the traumatic experience (Chard, 2005; Foa et al., 2007). The current results suggest that interventions focused on reducing abuse-related avoidance would be useful for male survivors of childhood sexual abuse. Unfortunately, the current study did not possess enough statistical power to explore the relationship between adult psychological outcomes and other types of coping as measured by the HIDWT scale (Burt & Katz, 1987). In addition to reducing avoidance coping strategies, it may be helpful to promote problem-solving and expressive coping strategies (e.g., assertiveness, expressing and working through difficult emotions; Marriott et al., 2013). For instance, recent studies suggest that male survivors 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, Lyons, & Romano, 2018; Romano, Lyons, & St. John, 2015). Additional studies investigating coping strategies and skills that promote resilience among male survivors may provide useful avenues for trauma-focused interventions.

Limitations

The findings from the study should be considered in the context of several limitations. First, the sample was comprised of males (primarily Caucasian) seeking help for childhood sexual abuse and generally experiencing high psychological distress, which may affect the results and generalizability of the findings. For instance, it is unclear whether similar profiles

would emerge if the study was conducted with non-support seeking males with sexual abuse histories, or with clinical or forensic male populations. More research should be conducted with larger and more diverse samples of male survivors of childhood sexual abuse. Second, the statistical power for the regressions was in the borderline range (Green, 1991), which likely limited the number of significant findings. Third, given that this study was one of only a few that have generated profiles on the basis of sexual abuse characteristics (and the first to do so with male survivors), it was considered exploratory and no Bonferroni corrections were applied. While doing so reduced the likelihood of committing Type II errors (i.e., failing to detect meaningful differences in the data), it increased the likelihood of committing Type I errors. Fourth, the measure of substance use had to be dropped from the analyses due to significant missing data. It would be useful for future studies to examine how male profiles differ with respect to substance use, as research indicates that alcohol use among male survivors is of particular concern (Garnefski & Arends, 1998). Finally, the study was cross-sectional. Thus, causal relationships between childhood sexual abuse profiles, contextual variables, and psychological distress could not be established. Despite these limitations, the current study was an important first step to disentangling the heterogeneity of sexual abuse experiences of male survivors.

Summary

This study extended previous research showing that childhood sexual abuse is a heterogeneous phenomenon. In line with previous person-centered studies with women (Watson & Halford, 2010), the current study identified three distinct profiles of men with sexual abuse histories. Profiles varied according to the severity of abuse experiences, as well as with co-occurring child maltreatment and adversity. Profiles also differed in their clinical presentations.

Namely, as profiles increased in severity, so did the severity of internalizing problems and posttraumatic stress. Results indicated that current use of avoidance coping and childhood family dysfunction predicted internalizing and externalizing problems, as well as trauma symptoms. Having disclosed the abuse was associated with more externalizing problems and trauma symptoms. These findings highlight the importance of thoroughly assessing the details of sexual abuse experiences and tailoring interventions accordingly. Future studies should consider replicating the current study with larger samples of male survivors.

General Discussion

Research suggests that the sexual abuse of boys is far more common than initially believed (Dube et al., 2005). However, pervasive social stereotypes often associate masculinity with invulnerability and with the idea that boys are not victims (Romano & De Luca, 2014). 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 male survivors. The objective of Study 1 was to examine the reliability and validity of a modified version of the Sexual Victimization Survey (SVS), a widely-used measure of childhood sexual abuse. The SVS was then used in Study 2 to generate profiles of male survivors of childhood sexual abuse on the basis of their sexual abuse characteristics and to link profiles to adult psychological outcomes. Given that sexual abuse often occurs within a broadly dysfunctional home environment, I also examined how males across profiles differed in their experiences of other child maltreatment and adversity and how contextual variables (present-day avoidant coping, childhood family dysfunction, and disclosure) influenced psychological outcomes. Male survivors were recruited from January 2014 to September 2015 from websites in North America offering support to this population. Men completed an anonymous, online questionnaire about their sexual abuse experiences, co-occurring child maltreatment and adversity, current coping, family functioning while growing up, and current psychological functioning.

Major Findings

With regards to the SVS psychometric data, Study 1 found high rates of inter-rater reliability. Raters agreed on the abuse status (i.e., abused versus not-abused) for 92.7% of the

sexual experiences reported by participants. Inter-rater reliability was also high (92.9-99.3%) across the 12 abuse characteristics. There was strong concurrent validity between the SVS and another measure of childhood sexual abuse, the Childhood Experiences of Victimization Questionnaire – Short Form (CEVQ-SF). Namely, among those men who were coded as sexually abused on the SVS, 85.4% also endorsed childhood sexual abuse on the CEVQ-SF. Finally, all participants who reported being sexually abused at the initial time point reported the same one week later, thus resulting in perfect test-retest reliability. The results of Study 1, paired with emerging studies on the psychometric properties of the SVS (Shchupak, 2015), suggest that it is a reliable and valid measure of childhood sexual abuse.

Based on the Study 1 findings, I could be confident in my use of the SVS to generate profiles of male survivors in Study 2. Consistent with person-centered studies of adult female survivors (Watson & Halford, 2010), three profiles were identified, with abuse experiences ranging from Severe (26.1%) to More Severe (33.0%) to Most Severe (40.9%). Profiles differed in their experiences of other types of maltreatment and adversity. Specifically, males in the Most Severe profile were more likely to have also experienced emotional and physical abuse as well as a greater number of non-victimization adversities, relative to men in the other profiles. Compared to the Severe (1) profile, men in the More Severe (2) profile reported more internalizing problems. Relative to the other two profiles, males in the Most Severe profile reported more internalizing problems and trauma symptoms. The results did not support present-day avoidant coping, past family functioning, or disclosure as moderators of profiles and adult psychological functioning, likely because there was limited statistical power and there were too many predictors in the regression model. However, greater present-day use of avoidant coping was associated with more internalizing and externalizing problems and trauma symptoms, while

childhood family dysfunction was associated with greater internalizing and externalizing problems and having disclosed the abuse was associated with greater externalizing problems and trauma symptoms. In sum, these results indicate that the sexual abuse experiences of males are diverse, and the various constellations of abuse experiences correspond to different levels of internalizing problems and trauma symptoms in adulthood.

Theoretical Applications

The dissertation was 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 childhood sexual abuse (e.g., the Traumagenic Dynamics Model, Finkelhor & Browne, 1985), there has been little empirical research to evaluate them and they do not account for the range of abusive experiences and symptoms observed in sexual abuse survivors (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 disrupts the successful attainment of key developmental tasks, such as attachment, emotion regulation, and brain development, which in turn affect emotional, social, and cognitive functioning (van der Kolk et al., 2005). Findings from the dissertation can be construed as support for the complex trauma model. Men who experienced early and prolonged childhood sexual abuse (in addition to other types of maltreatment and adversity) by individuals within and outside the family exhibited more psychological difficulties than men who were sexually abused once or twice by an individual outside of the family. Given that the complex trauma model has a growing evidence base and accounts for the broad range of experiences and difficulties exhibited

by survivors of childhood maltreatment, future studies with survivors of childhood sexual abuse may consider adopting the complex trauma model as a theoretical framework. Person-centered statistical approaches (such as latent profile analysis) may be particularly useful in testing the complex trauma theory because they can capture the complexity of individual traumatic experiences and assess the impact of different constellations of trauma.

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 was limited in that it only focused on different aspects of psychological functioning. However, Study 2 indicated that, in addition to reporting more trauma symptoms, males with severe sexual abuse histories also reported more depression, anxiety, and somatization. This suggests that the trauma literature should move beyond looking only at PTSD as an outcome of early childhood maltreatment (van der Kolk et al., 2005). As this dissertation suggests, males with very severe sexual abuse histories also have a tendency to internalize their distress. Additional studies are needed to clarify how males with complex trauma histories function across other domains of functioning (e.g., interpersonal, cognitive).

Research Applications

The dissertation has several research applications. First and perhaps most importantly, there are significant gaps in our understanding of the abuse experiences and outcomes of male survivors of childhood sexual abuse. The sexual abuse literature has tended to rely exclusively on females or mixed-sex samples with relatively fewer males (Chen et al., 2010). The lack of research on males may be due to the relatively lower occurrence of childhood sexual abuse in males relative to females, as well as societal beliefs that equate masculinity with invulnerability

and non-victimhood (Alaggia, 2005; Romano & De Luca, 2001). However, existing (albeit limited) research indicates that there are serious psychological repercussions associated with male childhood sexual abuse. For instance, several studies have suggested that the level of symptomatology experienced by male survivors is comparable, if not even greater, than that of female survivors (Garnefski & Arends, 1998; Ullman & Filipas, 2005). Likewise, this dissertation indicated that, regardless of profile membership, the internalizing scores of male survivors on the Adult Self Report (Achenbach & Rescorla, 2003) were triple that of normed samples of adult males, and their scores on a measure of trauma symptoms exceeded the diagnostic cut-off for PTSD. As researchers, clinicians, and policy makers, we cannot simply afford to ignore this population. While this dissertation adds to the growing body of research of male childhood sexual abuse, more research with male survivors is needed to understand the experiences, risk factors, and psychological needs of this under-studied population.

Second, in order to understand the occurrence and consequences of male childhood sexual abuse, there needs to be consensus on its definition and measurement. As noted in Study 1, there is no consensus in the literature about how to define childhood sexual abuse. Definitions vary with regards to the upper age limit of the child, the type of sexual abuse activity, and the victim-perpetrator age difference, making it difficult to generalize findings across studies (Hulme, 2004). Another limitation to the sexual abuse literature is that studies often rely on measures of childhood sexual abuse with little or no psychometric data (Shchupak, 2015). Study 1, which examined the psychometric properties of a modified version of the SVS, represents an important step in this regard. Suggestions were also provided in Study 1 to help researchers make informed decisions about which instruments and definitions to choose, particularly when working with male survivors who are less likely than females to disclose childhood sexual abuse.

However, more studies are needed to corroborate the validity and reliability of the SVS and/or other measures of child sexual abuse (e.g., the Computer Assisted Maltreatment Inventory, DiLillo et al., 2010) and to determine how best to define childhood sexual abuse.

Third, it is becoming clear that sexual abuse often occurs alongside other forms of maltreatment and adversity (Dong et al., 2003). However, the trauma literature has tended to focus on single types of abuse without considering the effects of co-occurring maltreatment and adversity (Finkelhor et al., 2007). While it can be useful to distinguish between the different types of childhood maltreatment in order to understand them more thoroughly, it can also create the misleading impression that there is a strong demarcation between the different types of child maltreatment or that they occur in isolation (Price-Robertson, Higgins, & Vassallo, 2013). For instance, if researchers only measure sexual abuse, they cannot be sure that the relationships they find with long-term outcomes are not actually the effect of other types of maltreatment experiences that tend to co-occur with sexual abuse. Indeed, in the current dissertation, the rates of emotional and physical abuse, neglect, and non-maltreatment adversity were high across all three profiles of childhood sexual abuse. Co-occurring maltreatment and adversity explained a significant proportion of the variance in internalizing and externalizing problems, as well as in trauma symptoms. These findings, in conjunction with emerging studies (Babchishin & Romano, 2014; Finkelhor et al., 2009), suggest that researchers investigating childhood sexual abuse should take into account the effects of other victimization experiences.

Practical Applications

The dissertation has clinical implications for both the assessment and treatment of childhood sexual abuse. In terms of assessment, research indicates that clinicians rarely assess for childhood sexual abuse, 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 childhood sexual abuse with male clients, due to beliefs that sexual abuse does not occur in men or that they are not as affected by it as female clients (Alaggia & Millington, 2008). This highlights the need for clinicians to learn how to ask about sexual abuse and respond therapeutically. Indeed, as highlighted in Study 1, the way in which we ask about childhood sexual abuse can affect the likelihood that an individual will report abuse. 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. Findings from Study 2 might help clinicians gain a deeper understanding of the consequences of male childhood sexual abuse, which may increase their comfort and skill in responding to sexual abuse disclosures from men. For instance, men disclosing sexual abuse may benefit from having their clinicians provide psycho-education about different patterns of sexual abuse experiences and discuss common reactions to trauma (e.g., internalizing problems, trauma symptoms). The bottom line is that if clients are not asked about childhood sexual abuse, their experiences 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) adult male survivors of childhood sexual abuse experience serious psychological difficulties which likely require psychological services; and 2) a “one size fits all” approach may not be conducive to treating

male survivors. There are a number of empirically-supported treatments for childhood sexual abuse, including cognitive-behavioural therapy, eye movement desensitization reprocessing, and Skills Training in Affective and Interpersonal Regulation (Levitt & Cloitre, 2005; Wilen, Littell, & Salanti, 2012). Unfortunately, relatively few of the treatments described in the literature have been empirically validated for male survivors (Taylor & Harvey, 2010). Given the differences in gender socialization processes, male survivors may require different interventions than female survivors. For example, it may be therapeutic for male clients to confront male norms that associate victimization with femininity and suggest that early sexual activity is “initiation” rather than “abuse” (Weiss, 2010). In addition, as Study 2 highlights, males will likely require different treatment depending on their abuse histories. Whereas males with a one- or two-time sexual touching by an individual outside of the family may benefit from a short-term therapy that helps them challenge their trauma-related beliefs and coping behaviours, males who grew up in a chronically abusive family environment will likely require more intensive treatment to promote healthier attachments and emotion regulation.

The dissertation also has preventative implications that extend beyond the field of mental health. Front line workers (e.g., teachers, physicians) play a critical role in the prevention of childhood sexual abuse. Considering their frequent contact with children and their awareness of typical child behaviour, they are in critical positions to detect and report suspected childhood sexual abuse to child protection agencies (Cerezo & Ponz-Salvador, 2004; Flaherty et al., 2008). As such, front line workers should be aware of the risk factors that increase the likelihood of childhood sexual abuse (e.g., co-occurring maltreatment, family dysfunction), as well as the behavioural (e.g., sexual problems, nightmares) and physical (e.g., bruising) markers that may indicate that a child is experiencing sexual abuse. At a general level, results from this

dissertation may serve as a reminder to frontline workers that boys are also at risk for sexual abuse and trauma-related outcomes. As such, frontline workers should monitor childhood sexual abuse in both girls and boys.

The dissertation also has policy implications, particularly with respect to the legal definition of childhood sexual abuse. At present, the Criminal Code of Canada defines childhood sexual abuse as sexual activity occurring before the age of 16 with a person in an individual in a relative position of authority, trust, or dependency, or sexual activity that exploits the younger person. Sexual experiences that occur between the ages of 14-15 years with individuals less than five years older, as well as sexual experiences occurring between the ages of 12-13 years with individuals less than 2 years older and with whom there is no relationship of authority, trust, or dependency, are not considered childhood sexual abuse based on the Criminal Code (*Criminal Code*, 1985). Presumably, these age criteria were chosen to exclude normal sex play and exploration (Cavanaugh-Johnson, 1999). While sexual activity between children is often thought to be harmless, research indicates that some child-to-child sexual experiences may actually be as detrimental to psychological functioning as adult-to-child sexual experiences (Shaw, 2000). However, child-to-child sexual experiences are less clear cut than adult-to-child sexual experiences, because there is often no coercion or harm, and individuals may feel that they participated in the sexual act(s) voluntarily (Carlson, Maciol, & Schneider, 2006).

In the current dissertation, a number of men reported consensual sexual activity (e.g., oral-genital contact, penetration) that spanned several years with siblings who were very close in age. In order to distinguish child-to-child sexual abuse from normal sexual exploration, it may be helpful to determine whether the sexual acts constitute age-appropriate sexual behaviour. For instance, Stop It Now!, an American organization aimed at preventing childhood sexual abuse,

generated a handout aimed at educating the public about common versus uncommon sexual experiences according to the child's developmental level (Stop It Now!, 2016). Nonetheless, what is clear is that the "one size fits all" approach in the Criminal Code is likely to exclude cases of child-to-child sexual abuse. The Criminal Code may consider cutting the age differences between victims and perpetrators and instead, identifying child-perpetrated sexual abuse on a case-by-case basis according to: 1) whether the sexual act is more extensive than what is developmentally appropriate (Stop It Now!, 2016); 2) whether the sexual act involves coercion, harm, or physical force; and 3) whether it is consensual.

Conclusion

In sum, male survivors of childhood sexual abuse are an under-studied and under-served population. This two-study dissertation adds to the limited research on male childhood sexual abuse. Findings indicate that the sexual abuse experiences of males are diverse, ranging from several instances of extrafamilial abuse to early, chronic abuse by individuals both within and outside the family. Psychological difficulties are highly prevalent among male survivors, with those reporting early and prolonged sexual abuse (in addition to co-occurring child maltreatment and adversity) exhibiting worse psychological outcomes. Future study requires better methods of assessing and defining childhood sexual abuse, greater emphasis on person-centered statistical analyses, greater consideration of the broader effects of abuse that extend beyond psychological outcomes, and examination of co-occurring child maltreatment and contextual factors that are associated with the presence (or lack of) psychopathology. Such studies can then guide the development of prevention and intervention efforts that are focused and specific to male survivors.

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APPENDIX A

Sexual Victimization Survey

It is now generally realized that most people have sexual experiences as children and while they are still growing up. Some of these are with friends and playmates, and some with relatives and family members. Some are very upsetting and painful, and some are not. Some influence people's later lives and sexual experiences, and some are practically forgotten. Although these are often important events, very little is actually known about them. We would like you to try to remember the sexual experiences you had while growing up. By "sexual," we mean a broad range of things, anything from playing "doctor" to sexual intercourse—in fact, anything that might have seemed "sexual" to you.

Did you have any of the following experiences *before the age of 12 (6th grade)* (circle any that apply)?

- a. An invitation or request to do something sexual.
- b. Kissing and hugging in a sexual way.
- c. Another person showing his/ her sex organs to you.
- d. You showing your sex organs to another person.
- e. Another person fondling you in a sexual way.
- f. You fondling another person in a sexual way.
- g. Another person touching your sex organs.
- h. You touching another person's sex organs.
- i. Intercourse, but without attempting penetration.
- j. Intercourse
- k. Other: _____

Choose up to 3 sexual experiences that you had *before the age of 12 with other children*. These could have included friends, strangers, brothers, sisters, and cousins. Pick the 3 most important to you and answer the following questions about each experience. Please note: the questions to be answered are on the following 2 pages. If no such experience, Check the box and Go to page _____

	Experience 1	Experience 2	Experience 3
1. About how old were you at the time?			
2. Approximate age of the other person(s):			
3. Sex of the other person(s): 1 for male 2 for female			
4. Relationship to the other person(s): 1 for Stranger 2 for Person you knew, but not friend 3 for Friend 4 for Niece or nephew 5 for Cousin			

6 for Brother			
7 for Sister			

What happened? (Circle 1 for Yes or 0 for No for each line.)

	Experience 1	Experience 2	Experience 3
a. An invitation or request to do something sexual	1 0	1 0	1 0
b. Kissing and hugging in a sexual way	1 0	1 0	1 0
c. Other person showing his/her sex organs to you	1 0	1 0	1 0
d. You showing your sex organs to other person	1 0	1 0	1 0
e. Other person fondling you in a sexual way	1 0	1 0	1 0
f. You fondling other person in a sexual way	1 0	1 0	1 0
g. Other person touching your sex organs	1 0	1 0	1 0
h. You touching other person's sex organs	1 0	1 0	1 0
i. Intercourse, but without attempting penetration	1 0	1 0	1 0
j. Intercourse	1 0	1 0	1 0
k. Other: please mention	1 0	1 0	1 0

Who started this? (Circle 1 for you or 2 for Other Person.)

Experience 1: 1 2
 Experience 2: 1 2
 Experience 3: 1 2

Did other person(s) threaten or force you?

Experience 1: Yes A little No
 Experience 2: Yes A little No
 Experience 3: Yes A little No

8. Did you threaten or force other person(s)?

Experience 1: Yes A little No
 Experience 2: Yes A little No
 Experience 3: Yes A little No

About how many times did you have a sexual experience with this person?

Experience 1: _____
 Experience 2: _____
 Experience 3: _____

Over how long a time did this go on? (Give number of days, months, years.)

Experience 1: _____

Experience 2: _____

Experience 3: _____

Which of these would best describe your reaction at the time of the experience?

1. Fear 2. Shock 3. Surprise 4. Interest 5. Pleasure

Experience 1: 1 2 3 4 5

Experience 2: 1 2 3 4 5

Experience 3: 1 2 3 4 5

Who did you tell about this experience at the time?

	Experience 1	Experience 2	Experience 3
No one			
Mother			
Father			
Other adult			
Brother/sister			
Friend			

If mother, how did she react? (If you did not tell your mother, how do you think she would have reacted?)

	Experience 1				Experience 2				Experience 3			
Angry	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all
Supportive	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all

If father, how did he react? (If you did not tell your father, how do you think he would have reacted?)

	Experience 1				Experience 2				Experience 3			
Angry	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all
Supportive	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all

In retrospect, would you say this **experience was**:

Experience 1: Positive Mostly positive Neutral Mostly negative Negative

Experience 2: Positive Mostly positive Neutral Mostly negative Negative

Experience 3: Positive Mostly Neutral Mostly Negative
 positive negative

Now choose up to 3 sexual experiences that you had *before the age of 12 with an adult (a person over 16)*. These could have included strangers, friends, or family members like cousins, aunts, uncles, brothers, sisters, mother, or father. Pick the 3 most important to you and answer the following questions about each experience. If no such experience, Check the box and Go to page ____

	Experience 1	Experience 2	Experience 3
1. About how old were you at the time?			
2. Approximate age of the other person(s):			
3. Sex of the other person(s): 1 for male 2 for female			
4. Relationship to the other person(s): 1 for stranger 2 for a person you knew, but not a friend 3 for a friend of yours 4 for a friend of your parents 5 for a cousin 6 for an uncle or aunt 7 for a grandparent 8 for a brother 9 for a sister 10 for a father 11 for a stepfather 12 for a mother 13 for a stepmother			

What happened? (Circle 1 for Yes or 0 for No for each line.)

	Experience 1	Experience 2	Experience 3
a. An invitation or request to do something sexual	1 0	1 0	1 0
b. Kissing and hugging in a sexual way	1 0	1 0	1 0
c. Other person showing his/her sex organs to you	1 0	1 0	1 0
d. You showing your sex organs to other person	1 0	1 0	1 0
e. Other person fondling you in a sexual way	1 0	1 0	1 0
f. You fondling other person in a sexual way	1 0	1 0	1 0
g. Other person touching your sex organs	1 0	1 0	1 0
h. You touching other person's sex organs	1 0	1 0	1 0

i. Intercourse, but without attempting penetration	1 0	1 0	1 0
j. Intercourse	1 0	1 0	1 0
k. Other: please mention	1 0	1 0	1 0

Who started this? (Circle 1 for you or 2 for Other Person.)

Experience 1: 1 2
 Experience 2: 1 2
 Experience 3: 1 2

Did other person(s) threaten or force you?

Experience 1: Yes A little No
 Experience 2: Yes A little No
 Experience 3: Yes A little No

8. Did you threaten or force other person(s)?

Experience 1: Yes A little No
 Experience 2: Yes A little No
 Experience 3: Yes A little No

About how many times did you have a sexual experience with this person?

Experience 1: _____
 Experience 2: _____
 Experience 3: _____

Over how long a time did this go on? (Give number of days, months, years.)

Experience 1: _____
 Experience 2: _____
 Experience 3: _____

Which of these would best describe your reaction at the time of the experience?

1. Fear 2. Shock 3. Surprise 4. Interest 5. Pleasure

Experience 1: 1 2 3 4 5
 Experience 2: 1 2 3 4 5
 Experience 3: 1 2 3 4 5

Who did you tell about this experience at the time?

	Experience 1	Experience 2	Experience 3
No one			
Mother			

Father			
Other adult			
Brother/sister			
Friend			

If mother, how did she react? (If you did not tell your mother, how do you think she would have reacted?)

	Experience 1				Experience 2				Experience 3			
Angry	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all
Supportive	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all

If father, how did he react? (If you did not tell your father, how do you think he would have reacted?)

	Experience 1				Experience 2				Experience 3			
Angry	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all
Supportive	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all

In retrospect, would you say this **experience was:**

Experience 1:	Positive	Mostly positive	Neutral	Mostly negative	Negative
Experience 2:	Positive	Mostly positive	Neutral	Mostly negative	Negative
Experience 3:	Positive	Mostly positive	Neutral	Mostly negative	Negative

Now choose up to 3 sexual experiences you had *after the age of 12 with a family member or relative*. These could have included cousins, uncles, aunts, including cousins, uncles, aunts, brothers, sisters, grandparents, mother or father, or a guardian or close friend of a parent. (If this relationship was described in a previous section, do not repeat it). Pick the 3 most important to you and answer the following questions about each experience. If no such experience, Check the box and Go to page ____

	Experience 1	Experience 2	Experience 3
1. About how old were you at the time?			
2. Approximate age of the other person(s):			
3. Sex of the other person(s): 1 for male 2 for female			

4. Relationship to the other person(s): 1 for a cousin 2 for an aunt or uncle 3 for a grandparent 4 for a brother or sister 5 for a parent 6 for a step-parent 7 for a guardian 8 for a close friend of a parent			
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What happened? (Circle 1 for Yes or 0 for No for each line.)

	Experience 1	Experience 2	Experience 3
a. An invitation or request to do something sexual	1 0	1 0	1 0
b. Kissing and hugging in a sexual way	1 0	1 0	1 0
c. Other person showing his/her sex organs to you	1 0	1 0	1 0
d. You showing your sex organs to other person	1 0	1 0	1 0
e. Other person fondling you in a sexual way	1 0	1 0	1 0
f. You fondling other person in a sexual way	1 0	1 0	1 0
g. Other person touching your sex organs	1 0	1 0	1 0
h. You touching other person's sex organs	1 0	1 0	1 0
i. Intercourse, but without attempting penetration	1 0	1 0	1 0
j. Intercourse	1 0	1 0	1 0
k. Other: please mention	1 0	1 0	1 0

Who started this? (Circle 1 for you or 2 for Other Person.)

Experience 1: 1 2
Experience 2: 1 2
Experience 3: 1 2

Did other person(s) threaten or force you?

Experience 1: Yes A little No
Experience 2: Yes A little No
Experience 3: Yes A little No

8. Did you threaten or force other person(s)?

Experience 1: Yes A little No
Experience 2: Yes A little No

Experience 3: Yes A little No

About how many times did you have a sexual experience with this person?

Experience 1: _____

Experience 2: _____

Experience 3: _____

Over how long a time did this go on? (Give number of days, months, years.)

Experience 1: _____

Experience 2: _____

Experience 3: _____

Which of these would best describe your reaction at the time of the experience?

1. Fear 2. Shock 3. Surprise 4. Interest 5. Pleasure

Experience 1: 1 2 3 4 5

Experience 2: 1 2 3 4 5

Experience 3: 1 2 3 4 5

Who did you tell about this experience at the time?

	Experience 1	Experience 2	Experience 3
No one			
Mother			
Father			
Other adult			
Brother/sister			
Friend			

If mother, how did she react? (If you did not tell your mother, how do you think she would have reacted?)

	Experience 1				Experience 2				Experience 3			
Angry	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all
Supportive	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all

If father, how did he react? (If you did not tell your father, how do you think he would have reacted?)

	Experience 1				Experience 2				Experience 3			
Angry	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all
Supportive	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all

In retrospect, would you say this **experience was:**

Experience 1:	Positive	Mostly positive	Neutral	Mostly negative	Negative
Experience 2:	Positive	Mostly positive	Neutral	Mostly negative	Negative
Experience 3:	Positive	Mostly positive	Neutral	Mostly negative	Negative

Finally, choose up to 3 sexual experiences that you had *after the age of 12, which you did not consent to*. That is, a sexual experience which was forced on you, or done against your will, or which you didn't want to happen. (Once again, do not repeat describing a relationship you described earlier.) Pick the 3 most important to you and answer the following questions about each experience. If no such experience, Check the box and Go to page ____

	Experience 1	Experience 2	Experience 3
1. About how old were you at the time?			
2. Approximate age of the other person(s):			
3. Sex of the other person(s): 1 for male 2 for female			
4. Relationship to the other person(s): 1 a stranger 2 a friend of yours 3 a friend of your parents 4 a cousin 5 an aunt or uncle 6 a brother or sister 7 a parent 8 a step-parent 9 a guardian			

What happened? (Circle 1 for Yes or 0 for No for each line.)

	Experience 1	Experience 2	Experience 3
a. An invitation or request to do something sexual	1 0	1 0	1 0
b. Kissing and hugging in a sexual way	1 0	1 0	1 0
c. Other person showing his/her sex organs to you	1 0	1 0	1 0
d. You showing your sex organs to other person	1 0	1 0	1 0

e. Other person fondling you in a sexual way	1 0	1 0	1 0
f. You fondling other person in a sexual way	1 0	1 0	1 0
g. Other person touching your sex organs	1 0	1 0	1 0
h. You touching other person's sex organs	1 0	1 0	1 0
i. Intercourse, but without attempting penetration	1 0	1 0	1 0
j. Intercourse	1 0	1 0	1 0
k. Other: please mention	1 0	1 0	1 0

Who started this? (Circle 1 for you or 2 for Other Person.)

Experience 1: 1 2
 Experience 2: 1 2
 Experience 3: 1 2

Did other person(s) threaten or force you?

Experience 1: Yes A little No
 Experience 2: Yes A little No
 Experience 3: Yes A little No

8. Did you threaten or force other person(s)?

Experience 1: Yes A little No
 Experience 2: Yes A little No
 Experience 3: Yes A little No

About how many times did you have a sexual experience with this person?

Experience 1: _____
 Experience 2: _____
 Experience 3: _____

Over how long a time did this go on? (Give number of days, months, years.)

Experience 1: _____
 Experience 2: _____
 Experience 3: _____

Which of these would best describe your reaction at the time of the experience?

1. Fear 2. Shock 3. Surprise 4. Interest 5. Pleasure

Experience 1: 1 2 3 4 5
 Experience 2: 1 2 3 4 5
 Experience 3: 1 2 3 4 5

Who did you tell about this experience at the time?

	Experience 1	Experience 2	Experience 3
No one			
Mother			
Father			
Other adult			
Brother/sister			
Friend			

If mother, how did she react? (If you did not tell your mother, how do you think she would have reacted?)

	Experience 1				Experience 2				Experience 3			
Angry	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all
Supportive	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all

If father, how did he react? (If you did not tell your father, how do you think he would have reacted?)

	Experience 1				Experience 2				Experience 3			
Angry	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all
Supportive	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all	Very	Mildly	A little	Not at all

In retrospect, would you say this **experience was**:

Experience 1:	Positive	Mostly positive	Neutral	Mostly negative	Negative
Experience 2:	Positive	Mostly positive	Neutral	Mostly negative	Negative
Experience 3:	Positive	Mostly positive	Neutral	Mostly negative	Negative

APPENDIX B

Modified Sexual Victimization Survey

It is now generally recognized that many individuals have sexual experiences as children and adolescents while they are growing up. Some of these are with friends and playmates while others are with family members, acquaintances, and strangers. Some are very upsetting and painful while others are not. Some influence individuals' later lives while others are practically forgotten. Although these are often important events, very little is actually known about them.

We would like you to try to remember any sexual experiences you had while growing up. By "sexual", we mean a broad range of things, anything from playing "doctor" to sexual intercourse – in fact, anything that might have seemed sexual to you.

Did you have any of the following experiences **before the age of 16**?

Please select all that apply.

- 1) An invitation or request to do something sexual.
- 2) Kissing and hugging in a sexual way (like a couple might do, for example, kissing on the lips or kissing with an open mouth).
- 3) Another person showing his/her sexual parts to you.
- 4) You showing your sexual parts to another person.
- 5) Another person fondling you in a sexual way and/or touching your sexual parts.
- 6) You fondling another person in a sexual way and/or touching another person's sexual parts.
- 7) Another person performing oral sex on you.
- 8) You performing oral sex on another person.
- 9) Intercourse
- 10) Another person taking sexually suggestive or explicit photographs or videos of you.
- 11) Other, please describe:

If you endorsed any of the previous experiences, please continue to answer the following items. If you did not endorse any of these experiences, please click here to exit the study.

How many different people did you have sexual experiences with before the age of 16? ____

Please complete the following questions for **each sexual experience before the age of 16**. If you had multiple sexual experiences with the same person, please count it as one experience.

Experience 1

Thinking about one of your **sexual experiences before the age of 16...**

What was the sex of the other person? If this sexual experience included multiple people, please specify how many males and how many females.

____ Male

____ Female

___ This experience included multiple people (please specify: ___ males, ___ females)

Did you experience any of the following with the other person? Please check off all those that apply.

- ___ The other person inviting or requesting that you do something sexual.
- ___ Kissing and hugging in a sexual way (like a couple might do, for example, kissing on the lips or kissing with an open mouth).
- ___ The person showing his/her sexual parts to you.
- ___ You showing your sexual parts to the other person.
- ___ The other person fondling you in a sexual way and/or touching your sexual parts.
- ___ You fondling the other person in a sexual way and/or touching their sexual parts.
- ___ The other person performing oral sex on you.
- ___ You performing oral sex on the other person.
- ___ Intercourse
- ___ 10) Another person taking sexually suggestive or explicit photographs or videos of you.
- 11) Other, please describe:

What was your relationship to the other person or persons? Please check off all that apply.

- ___ Stranger
- ___ Friend of yours
- ___ Friend of your parents
- ___ Father
- ___ Mother
- ___ Grandfather
- ___ Grandmother
- ___ Stepfather
- ___ Stepmother
- ___ Boyfriend
- ___ Girlfriend
- ___ Uncle
- ___ Aunt
- ___ Brother
- ___ Sister
- ___ Cousin
- ___ Neighbour
- ___ Teacher
- ___ Babysitter
- ___ Coach
- ___ Priest/Religious Figure
- ___ Other (specify: ___)

How emotionally close were you with this person (e.g., I felt “attached” to this person, I felt “connected” to this person) **before** the sexual experience began?

- | | | | | |
|------|---|---|---------|------------|
| 1 | 2 | 3 | 4 | 5 |
| Very | | | distant | Very close |

How old were you when this sexual experience began?

___ years

Approximately how old was the other person when the sexual experience began?

___ Child (less than 12 years)

___ Adolescent (12 to 18 years)

___ Young adult (19 to 30 years)

___ Middle aged adult (31 to 59 years)

___ Older adult (60 years and older)

For approximately how long did this sexual behaviour continue?

a) Happened one day or a few days

b) Happened over a period of a few weeks

c) Happened over a period of a few months

d) Happened over a period of a few years

e) Happened over a period of many years

Approximately how many times did the sexual behaviour occur?

a) Only once or twice

b) From 3-10 times

c) From 11-25 times

d) From 26-50 times

e) More than 50 times

Did the other person or persons do any of the following things to you during your sexual experience? Please select all that apply.

___ Physically force you

___ Hurt you physically

___ Threaten you

___ Manipulate or trick you to participate

Do you feel you consented to the experience? Y N

Who have you told about the sexual experience? Please select all that apply.

___ No one

___ Mother

___ Father

___ Sister

___ Brother

___ Friend

___ Teacher

___ Police

___ Other (specify) _____

If you did tell someone, approximately how old were you when you first told another person about the sexual experience?

___ years
___ Did not disclose

The first time you told someone, if you told at all, how did that person react (check off all that apply)?

___ Blamed you
___ Supported you
___ Did not believe you
___ Ignored you
___ Other (describe: _____)

Was this experience ever reported to the police or to a child welfare agency?

___ Yes
___ No

In your own opinion, do you feel that this experience was sexual abuse?

a) Yes
b) No

Experience 2

Thinking about **another sexual experience before the age of 16...**

If you did not have another sexual experience, please leave the following questions blank and click "Next" to proceed to the next questionnaire.

What was the sex of the other person? If this sexual experience included multiple people, please specify how many males and how many females.

___ Male
___ Female
___ This experience included multiple people (please specify: ___ males, ___ females)

Did you experience any of the following with the other person? Please check off all those that apply.

___ The other person inviting or requesting that you do something sexual.
___ Kissing and hugging in a sexual way (like a couple might do, for example, kissing on the lips or kissing with an open mouth).
___ The person showing his/her sexual parts to you.
___ You showing your sexual parts to the other person.
___ The other person fondling you in a sexual way and/or touching your sexual parts.
___ You fondling the other person in a sexual way and/or touching their sexual parts.
___ The other person performing oral sex on you.
___ You performing oral sex on the other person.
___ Intercourse
___ 10) Another person taking sexually suggestive or explicit photographs or videos of you.
___ 11) Other, please describe:

What was your relationship to the other person or persons? Please check off all that apply.

- ☐ Stranger
- ☐ Friend of yours
- ☐ Friend of your parents
- ☐ Father
- ☐ Mother
- ☐ Grandfather
- ☐ Grandmother
- ☐ Stepfather
- ☐ Stepmother
- ☐ Boyfriend
- ☐ Girlfriend
- ☐ Uncle
- ☐ Aunt
- ☐ Brother
- ☐ Sister
- ☐ Cousin
- ☐ Neighbour
- ☐ Teacher
- ☐ Babysitter
- ☐ Coach
- ☐ Priest/Religious Figure
- ☐ Other (specify:)

How emotionally close were you with this person (e.g., I felt “attached” to this person, I felt “connected” to this person) before the sexual experience began?

- | | | | | |
|------|---|---|---------|------------|
| 1 | 2 | 3 | 4 | 5 |
| Very | | | distant | Very close |

How old were you when this sexual experience began?

years

Approximately how old was the other person when the sexual experience began?

- ☐ Child (less than 12 years)
- ☐ Adolescent (12 to 18 years)
- ☐ Young adult (19 to 30 years)
- ☐ Middle aged adult (31 to 59 years)
- ☐ Older adult (60 years and older)

For approximately how long did this sexual behaviour continue?

- a) Happened one day or a few days
- b) Happened over a period of a few weeks
- c) Happened over a period of a few months
- d) Happened over a period of a few years
- e) Happened over a period of many years

Approximately how many times did the sexual behaviour occur?

- a) Only once or twice
- b) From 3-10 times
- c) From 11-25 times
- d) From 26-50 times
- e) More than 50 times

Did the other person or persons do any of the following things to you during your sexual experience? Please select all that apply.

- ☐ Physically force you
- ☐ Hurt you physically
- ☐ Threaten you
- ☐ Manipulate or trick you to participate

Do you feel you consented to the experience? Y N

Who have you told about the sexual experience? Please select all that apply.

- ☐ No one
- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Friend
- ☐ Teacher
- ☐ Police
- ☐ Other (specify) _____

If you did tell someone, approximately how old were you when you first told another person about the sexual experience?

- ☐ _____ years
- ☐ Did not disclose

The first time you told someone, if you told at all, how did that person react (check off all that apply)?

- ☐ Blamed you
- ☐ Supported you
- ☐ Did not believe you
- ☐ Ignored you
- ☐ Other (describe: _____)

Was this experience ever reported to the police or to a child welfare agency?

- ☐ Yes
- ☐ No

Experience 3

Thinking about **another sexual experience before the age of 16**. If you did not have another sexual experience, please leave the following questions blank and click “Next” to proceed to the next questionnaire.

What was the sex of the other person? If this sexual experience included multiple people, please specify how many males and how many females.

☐ Male

☐ Female

☐ This experience included multiple people (please specify: males, females)

Did you experience any of the following with the other person? Please check off all those that apply.

☐ The other person inviting or requesting that you do something sexual.

☐ Kissing and hugging in a sexual way (like a couple might do, for example, kissing on the lips or kissing with an open mouth).

☐ The person showing his/her sexual parts to you.

☐ You showing your sexual parts to the other person.

☐ The other person fondling you in a sexual way and/or touching your sexual parts.

☐ You fondling the other person in a sexual way and/or touching their sexual parts.

☐ The other person performing oral sex on you.

☐ You performing oral sex on the other person.

☐ Intercourse

☐ 10) Another person taking sexually suggestive or explicit photographs or videos of you.

☐ 11) Other, please describe:

What was your relationship to the other person or persons? Please check off all that apply.

☐ Stranger

☐ Friend of yours

☐ Friend of your parents

☐ Father

☐ Mother

☐ Grandfather

☐ Grandmother

☐ Stepfather

☐ Stepmother

☐ Boyfriend

☐ Girlfriend

☐ Uncle

☐ Aunt

☐ Brother

☐ Sister

☐ Cousin

☐ Neighbour

☐ Teacher

☐ Babysitter

☐ Coach

____ Priest/Religious Figure
____ Other (specify:____)

How emotionally close were you with this person (e.g., I felt “attached” to this person, I felt “connected” to this person) before the sexual experience began?

1	2	3	4	5
Very			distant	Very close

How old were you when this sexual experience began?
 ____ years

Approximately how old was the other person when the sexual experience began?

___ Child (less than 12 years)
 ___ Adolescent (12 to 18 years)
 ___ Young adult (19 to 30 years)
 ___ Middle aged adult (31 to 59 years)
 ___ Older adult (60 years and older)

For approximately how long did this sexual behaviour continue?

- a) Happened one day or a few days
- b) Happened over a period of a few weeks
- c) Happened over a period of a few months
- d) Happened over a period of a few years
- e) Happened over a period of many years

Approximately how many times did the sexual behaviour occur?

- a) Only once or twice
- b) From 3-10 times
- c) From 11-25 times
- d) From 26-50 times
- e) More than 50 times

Did the other person or persons do any of the following things to you during your sexual experience? Please select all that apply.

- Physically force you
- Hurt you physically
- Threaten you
- Manipulate or trick you to participate

Do you feel you consented to the experience? Y N

Who have you told about the sexual experience? Please select all that apply.

☐ No one
☐ Mother
☐ Father
☐ Sister

- ☐ Brother
- ☐ Friend
- ☐ Teacher
- ☐ Police
- ☐ Other (specify) _____

If you did tell someone, approximately how old were you when you first told another person about the sexual experience?

- ☐ _____ years
- ☐ Did not disclose

The first time you told someone, if you told at all, how did that person react (check off all that apply)?

- ☐ Blamed you
- ☐ Supported you
- ☐ Did not believe you
- ☐ Ignored you
- ☐ Other (describe: _____)

Was this experience ever reported to the police or to a child welfare agency?

- ☐ Yes
- ☐ No

In your own opinion, do you feel that this experience was sexual abuse?

- a) Yes
- b) No

APPENDIX C

Socio-Demographic Questionnaire

Please answer the following questions by clicking or entering the answer that seems most appropriate for you.

1. What is your sex?

☐ Male

☐ Female

2. What is your age? _____

3. How many people **currently** live in your household. This could be partners, parents, and children, for example.

☐ One

☐ Two

☐ Three

☐ Four

☐ Five

☐ Six

☐ Seven

☐ Eight

☐ Nine

☐ 10 or more

4. What is your predominant ethnic background?

☐ Caucasian

☐ Black

☐ Native

☐ East Asian (e.g., Chinese, Japanese, Korean)

☐ South Asian (e.g., Indian, Pakistani, Sri Lankan)

☐ Middle Eastern (e.g., Egyptian, Iranian, Afghan)

☐ Hispanic

☐ Other (describe: _____)

5. In what country are you currently living?

Canada ☐

United States ☐

6. If you are currently living in Canada, please indicate the province or territory in which you reside.

☐ Alberta

☐ British Columbia

☐ Manitoba

☐ New Brunswick

- ☐ Newfoundland and Labrador
☐ Northwest Territories
☐ Nova Scotia
☐ Nunavut
☐ Ontario
☐ Prince Edward Island
☐ Quebec
☐ Saskatchewan
☐ Yukon
☐ I live in the United States.

7. If you are currently living in the United States, please indicate the state in which you reside.

- | | | |
|--------------------------------------|---|---|
| ☐ Alabama | ☐ Massachusetts | ☐ South Dakota |
| ☐ Alaska | ☐ Michigan | ☐ Tennessee |
| ☐ Arizona | ☐ Minnesota | ☐ Utah |
| ☐ Arkansas | ☐ Mississippi | ☐ Vermont |
| ☐ California | ☐ Missouri | ☐ Virginia |
| ☐ Colorado | ☐ Montana | ☐ Washington |
| ☐ Connecticut | ☐ Nebraska | ☐ West Virginia |
| ☐ Delaware | ☐ Nevada | ☐ Wisconsin |
| ☐ Florida | ☐ New Hampshire | ☐ Wyoming |
| ☐ Georgia | ☐ New Jersey | ☐ I live in Canada |
| ☐ Hawaii | ☐ New Mexico | |
| ☐ Idaho | ☐ New York | |
| ☐ Illinois | ☐ North Carolina | |
| ☐ Indiana | ☐ North Dakota | |
| ☐ Iowa | ☐ Ohio | |
| ☐ Kansas | ☐ Oklahoma | |
| ☐ Kentucky | ☐ Oregon | |
| ☐ Louisiana | ☐ Pennsylvania | |
| ☐ Maine | ☐ Rhode Island | |
| ☐ Maryland | ☐ South Carolina | |

6. What is your highest level of education?

- ☐ Completed elementary school
☐ Completed high school
☐ Completed trade program or college/CEGEP
☐ Completed university undergraduate program
☐ Completed university graduate program
☐ Other (describe: _____)

7. In which of the following groups does your income fall prior to income tax? If you are living alone or with non-family members, please answer according to your personal income. If you are living with your own family, please answer according to the total household income.

- ☐ Less than \$9,999

- ☐ \$10,000-\$29,999
- ☐ \$30,000-\$49,999
- ☐ \$50,000-\$69,999
- ☐ \$70,000-\$89,999
- ☐ \$90,000-\$109,999
- ☐ Over \$110,000

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

- ☐ Not employed outside the home
- ☐ Employed outside the home (part- or full-time basis)
- ☐ Going to school
- ☐ Going to school and employed outside the home
- ☐ Recovering from illness or disability
- ☐ Retired
- ☐ Other, please specify:

The following questions ask you to think about the **family you grew up with**. If you lived with different families, think of the one **you lived with the longest**.

10. For **most** of the time before you were 16 years old, which best describes your family?

- ☐ Lived with both biological parents
- ☐ Lived with biological mother only
- ☐ Lived with biological father only
- ☐ Lived with one biological parent and either step-parent or common-law partner
- ☐ Lived in different foster homes with non-family
- ☐ Lived in different homes with family members (e.g., grandparents, aunts, uncles)
- ☐ Lived in a group home
- ☐ Other (describe: _____)

11. How many children were in your family while growing up (including yourself)? If you have lived in different homes or there were different children living in your family at different times, think about the number of children that were in your family for the **longest** time before you were 16 years old (including yourself).

- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four
- ☐ Five
- ☐ Six
- ☐ Seven
- ☐ Eight
- ☐ Nine
- ☐ 10 or more

APPENDIX D

Sexual abuse subscale of the Childhood Experiences of Violence Questionnaire – Short-Form

Before age 16, when you were growing up, did anyone ever do any of the following things when you didn't want them to: touch the private parts of your body or make you touch their private parts, threaten, or try to have sex with you or sexually force themselves on you?

___ Yes

___ No

APPENDIX E

Ethics Approval

File Number: H12-13-07

Date (mm/dd/yyyy): 08/06/2014



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>
Elisa	Romano	Social Sciences / Psychology	Supervisor
Jennifer	Lyons	Social Sciences / Psychology	Student Researcher
Elizabeth	St. John	Social Sciences / Psychology	Co-investigator

File Number: H12-13-07**Type of Project:** Independent Student Project**Title:** Male Childhood Sexual Abuse: How do Abuse Characteristics Contribute to Psychological Functioning in Adulthood

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
01/16/2014	01/15/2015	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

APPENDIX F

Study Notice



uOttawa

**Are you a male between the ages of 18 and 59?
Did you have any sexual experiences in childhood or adolescence?**

If so, you may be eligible to participate in an on-line research study being conducted at the University of Ottawa. Early sexual experiences among males have only recently begun to receive the attention they deserve. Your participation in this study will help us better understand the impact that sexual experiences during childhood or adolescence can have on males.

By participating in the study, you will be entered in a draw for
one of four \$50 Visa gift cards.

What does participation involve?

- Anonymously answer a series of questions that take approximately 40-50 minutes to complete
- The study is available on-line and can be completed from any computer, in the convenience of your home or office
- Please note that the study is only available in English and to those living in Canada or the United States

Interested?

- Log on to: <http://fluidsurveys.com/s/male-childhood-sexual-experiences/>

Questions?

- Contact Jennifer Lyons from The Children's Well-Being Lab at the University of Ottawa: **(613) 562-5800**

APPENDIX G

Consent Form for Initial Time Point

Principal Investigators:

Jennifer Lyons, B.A., Ph.D. Candidate
Elisa Romano, Ph.D.
School of Psychology
University of Ottawa
Phone:
E-mail:

**Task to be completed:**

This study is being conducted under the supervision of Dr. Elisa Romano from the School of Psychology at the University of Ottawa. The goal of this study is to understand the childhood experiences of males, including sexual abuse and other types of maltreatment and adversity. We are also interested in better understanding how these experiences are related to psychological functioning in adulthood. Should you decide to participate, you will be invited to complete a questionnaire which will take approximately 40-50 minutes. Given the length and the sensitive nature of the questions, it is possible that some participants may require additional time to complete the questionnaire. The questionnaire is available on-line and can be completed from any computer at a place of your choice. Once you begin the questionnaire, it should be noted that it will not be possible to close the study's webpage and return to it at a later point. However, you will be allocated an 8-hour time-frame to complete the questionnaire.

At the end of the questionnaire, you will have the option to leave your email address if you are interested in being contacted about a second research study. The goal of the second study is to collect reliability data on a measure of childhood sexual experiences. If you leave your email address, a research assistant will contact you within one week to complete a 10-15 minute questionnaire about your sexual experiences in childhood and adolescence. You will also be asked to enter a unique 4-digit code (i.e., your initials, and last two years of birth) which will be used to link your responses at both time points. If you do not want to participate in the second study, answer "No, I am not interested" and proceed to the draw page.

Anonymity and confidentiality:

Be assured that no identifiable information will be gathered. Your answers are strictly confidential and no one will be informed of your answers. Only Dr. Romano and Jennifer Lyons will have access to the data, which will be kept for 10 years on a password-protected computer in Dr. Romano's laboratory. Data from the study will be analyzed and presented at a group level so that there will not be presentation of individual results.

Rights and responsibilities:

The study can be completed in a quiet place at a time that is convenient for you. We would really appreciate your honesty in responding to the questions. You are free to refuse to participate or to withdraw from the study at any time without penalty. Any data completed prior to withdrawing from the questionnaire will be included in the study. Once you complete the questionnaire, or, if you do not complete the entire study, when you select the “exit study” option, you will be invited to be entered for a draw for one of four \$50 Visa gift cards. If you choose to enter your name for the draw, you will be forwarded to a different window and will be required to enter your email address. Please note that your e-mail address cannot be linked to the answers you have provided during the study.

Potential inconveniences and resources:

Some of the questions are sensitive in nature in that they ask about difficult experiences that may have happened to you as a child, such as experiencing maltreatment, adversity, and family conflict. The study also includes questions related to your current psychological functioning. As such, it is possible that you may experience some emotional distress and may feel like you are reliving some of these distressing childhood experiences. The on-line study provides a link to a list of resources, such as telephone distress lines, as well as relaxation exercises at the bottom of each page. Please do not hesitate to contact these resources or participate in these exercises should you feel distressed. Any data that you have completed up until that point will be retained, and you will have the option to return to the questionnaire.

Compensation:

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Upon completion of the study, four names will be randomly selected among those who have entered and those participants' whose names are drawn will be informed by email. If a participant cannot be reached within 14 days from the date of the draw, another name will be randomly selected and contacted and so on until the prize has been awarded. The odds of winning a prize will depend on the number of eligible entries received. The prize must be accepted as awarded or forfeited and cannot be redeemed for cash.

The name and email address that you provide when you enter the draw is collected for the purposes of contacting you if your name is selected in the draw. Your name and the contact information you have provided will be kept confidential and then destroyed once the prizes have been awarded. We reserve the right to cancel the draw or cancel the awarding of the prize if the integrity of the draw or the research or the confidentiality of participants is compromised. The draw is governed by the applicable laws of Canada.

Data storage and use:

Data from this study are being collected as part of a research project that could become part of Jennifer Lyons' doctoral thesis. Data will be used for research purposes only in that they will be presented at psychology conferences and published in scientific journals. Your data will be stored electronically on a password-protected computer in Dr. Romano's laboratory. Results from this study will be analyzed and disseminated in group form meaning that no individual results will be presented. Data from this study will be kept for 10 years, after which point they will be deleted. Only Dr. Romano and Jennifer Lyons will have access to the data.

Additional information:

Should you have any questions or require additional information, please contact the Protocol Officer for Ethics in Research, Office of Research Ethics and Integrity, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON, K1N 6N5; Tel.: (613) 562-5387; E-mail: ethics@uottawa.ca. Any questions about the current study may be addressed to Jennifer Lyons.

Informed consent:

If you understand all the statements above and freely consent to participate in the study, click on the button below which will direct you to the study. Participants should print a copy of the consent form to keep for their personal records. If you understand all the statements above and do not want to participate in the study, answer "No" to the question below and close this web page. If you have any questions before deciding whether or not you would like to participate, please contact Mrs. Jennifer Lyons at The Children's Well-Being Lab at 613-562-5800.

Do you wish to participate?

☐ No

☐ Yes

APPENDIX H

Relaxation Exercise

It is common to feel nervous and frightened when we remember scary things that happened to us in the past. If you find that you are becoming distressed during this questionnaire, please feel free to try some of these exercises.

Breathe calmly and slowly. Put your hand on the area above your belly button, and feel it go up and expand as you breathe in and then come in as you breathe out. Try counting to 5 as you breathe in and then 5 as you breathe out. Breathe in deeply through your nose and out through your mouth. Repeat a reassuring word to yourself on each breath in for example, a favourite colour or a soothing word such as “safe” or “easy”.

Bring your attention to the present moment, by focusing on your 5 senses:

Smell – Notice any smells in the room that you are in. Name them specifically if you can. Do you smell more than one thing? What is causing the smells? Do you have a scented lotion that makes you feel calm and relaxed that you can rub on yourself?

Sight – Look at individual objects around you – for example, your keys, your clothing, the computer screen, the walls, or an object outside your window. How many different colours can you name in your room or outside?

Touch - Touch individual objects around you – for example, your keys, your clothing, a table, the walls. Notice textures, colours, materials, weight, temperature. Compare the different objects you touch: Is one colder? Lighter? Heavier?

Sound - What do you hear in your room? Or what can you hear outside? What song is on the radio or your iPod? Do you recognize it? What is the quietest sound in the room that you can make out?

Taste – Eat or drink something, and focus on its flavour. Is it sweet, salty, sour? Do you have a favourite taste that reminds you of good times in the present?

How are you feeling now? Are you feeling calm and safe?

If so, you may want to try returning to the questionnaire. If not, take some more time to go through these exercises until you feel ready to return to the questionnaire.

APPENDIX I

Crisis Lines

If you are experiencing emotional distress as a result of having participated in the study or think you would benefit from resources, please feel free to contact any of the following resources.

CANADIAN TELEPHONE CRISIS LINESAlberta

Mental Health Help Line: 1-877-303-2642
St. Paul & District Crisis Centre: (780) 645-5195 or 1-800-263-3045
Distress Line of Southwestern Alberta: (403) 327-7905 or 1-888-787-2880
Distress Centre Calgary: (403) 266-4357

British Columbia

Canadian Mental Health Association Crisis Line: 1-888-353-2273
Crisis Centre for Northern BC: 1-888-565-1214
Vancouver Island Crisis Society: 1-888-494-3888
Province-Wide British Columbia Crisis Line: 1-800-SUICIDE (1-800-784-2433)

Manitoba

Klinic Community Health Centre: (204) 786-8686 or 1-888-322-3019
Manitoba Suicide Line: 1-877-435-7170
Mobile Crisis Unit: 1-888-379-7699
Mental Health Crisis Service: 1-888-310-4593

New Brunswick

New Brunswick Help Crisis Line: (506) 859-HELP (859-4357)
Chimo Helpline: 1-800-667-5005

Newfoundland and Labrador

Mental Health Crisis Centre: (709) 737-4668 or 1-888-737-4668

Northwest Territories

Northwest Territories Help Line: 1-800-661-0844
Kids Help Phone: 1-800-668-6868

Nova Scotia

Mental Health Mobile Crisis Team: 1-888-429-8167
Eastern Regional Help Line: 1-800-957-9995

Nunavut

Nenavuat Kamatsiaqtut Help Line: (867) 979-3333 or 1-800-265-3333

Ontario

Mental Health Crisis Line: (613) 722-6914 or 1-866-996-0991
 Mental Health Service Information Ontario: 1-866-531-2600
 Ontario Crisis Intervention Centre: 1-888-757-7766
 Ottawa Distress Centre: (613) 238-3311 or (613) 722-6914
 Tel-Aide Outaouais: (613) 741-6433

Prince Edward Island

Island Helpline: 1-800-218-2885

Québec

Centre de prévention du suicide de Québec: 1-866-APPELLE (1-866-277-3553)
 Tel-Aide Outaouais: (613) 741-6433
 Centre d'aide 24-7: (819) 595-9999
 Suicide Action Montréal: (514) 723-4000 or 1-866-277-3553

Saskatchewan

Mobile Crisis Service (Saskatoon): (306) 933-6200
 North East Crisis Intervention Centre: (306) 752-9455 or 1-800-611-6349
 Hudson Bay & District Crisis Centre: (306) 865-3064 or 1-866-865-7274
 Prince Albert Mobile Crisis Unit: (306) 764-1011
 Regina Mobile Crisis Services: (306) 525-5333

Yukon

Kaushee's Place Crisis Line: (867) 668-5733

AMERICAN TELEPHONE CRISIS LINES

National Suicide Prevention Hotline 1-800-273-8255
 Rape, Abuse, and Incest National Network 1-800-656-4673
 National Domestic Violence/Abuse Hotline 1-800-799-7233
 National Alliance on Mental Illness 1-800-950-6264
 Drug & Alcohol Treatment Hotline 1-800-662-4357

If you have any questions about the study you completed, please contact:

Jennifer Lyons, B.A., Ph.D. Candidate. Phone: (613) 562-5800
 Elisa Romano, Ph.D., C.Psych. Phone: (613) 562-5800

APPENDIX J

Consent Form for Test-Retest

Principal Investigators:

Jennifer Lyons, B.A., Ph.D. Candidate
Elisa Romano, Ph.D.
School of Psychology
University of Ottawa
Phone:
E-mail:

**Task to be completed:**

This study is being conducted under the supervision of Dr. Elisa Romano from the School of Psychology at the University of Ottawa. The goal of this study is to collect reliability information on the measure of childhood sexual experiences used in the study that you completed approximately one week ago. Should you decide to participate, you will be invited to complete again the 10-15 minute questionnaire about your sexual experiences in childhood and adolescence. You will also be asked to enter a unique 4-digit code (i.e., your initials and the last two years of birth) which will be used to link your responses at both time points. The questionnaire is available on-line and can be completed from any computer at a place of your choice. Once you begin the questionnaire, it should be noted that it will not be possible to close the study's webpage and return to it at a later point. However, you will be allocated an 8-hour time-frame to complete the questionnaire.

Anonymity and confidentiality:

Be assured that no identifiable information will be gathered. The information that you provide will be coded so that your identity is protected. For example, your name would not be placed on any of the documents, but instead a code will be used. Your answers are strictly confidential and no one will be informed of your answers. Only Dr. Romano and Jennifer Lyons will have access to the data, which will be kept for 10 years on a password-protected computer in Dr. Romano's laboratory. Data from the study will be analyzed and presented at a group level so that there will not be presentation of individual results.

Rights and responsibilities:

The study can be completed in a quiet place at a time that is convenient for you. We would really appreciate your honesty in responding to the questions. You are free to refuse to participate or to withdraw from the study at any time without penalty. Any data completed prior to withdrawing from the questionnaire will be included in the study. Once you complete the questionnaire, or, if you do not complete the entire study, when you select the "exit study" option, you will be invited to be entered for a draw for one of four \$50 Visa gift cards. If you choose to enter your name for

the draw, you will be forwarded to a different window and will be required to enter your email address. Please note that your e-mail address cannot be linked to the answers you have provided during the study.

Potential inconveniences and resources:

Some of the questions are sensitive in nature in that they ask about difficult experiences that may have happened to you as a child. As such, it is possible that you may experience some emotional distress and may feel like you are reliving some of these distressing childhood experiences. The on-line study provides a link to a list of resources, such as telephone distress lines, as well as relaxation exercises at the bottom of each page. Please do not hesitate to contact these resources or participate in these exercises should you feel distressed. Any data that you have completed up until that point will be retained, and you will have the option to return to the questionnaire.

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Data storage and use:

Data from this study are being collected as part of a research project that is part of Jennifer Lyons' doctoral thesis. Data will be used for research purposes only in that they will be presented in Mrs. Lyons' thesis manuscript, at psychology conferences, and published in scientific journals. Your data will be stored electronically on a password-protected computer in Dr. Romano's laboratory. Results from this study will be analyzed and disseminated in group form meaning that no individual results will be presented. Data from this study will be kept for 10 years, after which point they will be deleted. Only Dr. Romano and Jennifer Lyons will have access to the data.

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Do you wish to participate?

☐ No

☐ Yes

APPENDIX K

Adverse Childhood Experiences Questionnaire

We would like to ask about some other things that may have happened to you as a child or adolescent, **before the age of 16**.

Did a parent or another individual in the household often swear at you, insult you, put you down, or humiliate you?

☐ Yes

☐ No

Did a parent or another individual in the household often act in a way that made you afraid that you might be physically hurt?

☐ Yes

☐ No

Did a parent or another individual in the household often push, grab, or throw something at you?

☐ Yes

☐ No

Did a parent or another individual in the household **ever** hit you so hard that you had marks or were injured?

☐ Yes

☐ No

Did you often feel that no one in your family loved you or thought you were important or special?

☐ Yes

☐ No

Did you often feel that your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes

☐ No

Did you often feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect you?

☐ Yes

☐ No

Did you often feel that your parents (biological, step, or other caregivers) were too drunk or high to take care of you or take you to the doctor if you needed it?

☐ Yes

☐ No

Was your mother (biological, step, or other female caregiver) often pushed, grabbed, slapped, or had something thrown at her?

☐ Yes

☐ No

Was your mother (biological, step, or other female caregiver) sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

☐ Yes

☐ No

Was your mother (biological, step, or other female caregiver) ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

☐ Yes

☐ No

Was your father (biological, step, or other male caregiver) often pushed, grabbed, slapped, or had something thrown at him?

☐ Yes

☐ No

Was your father (biological, step, or other male caregiver) sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

☐ Yes

☐ No

Was your father (biological, step, or other male caregiver) ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

☐ Yes

☐ No

APPENDIX L

Non-victimization Adversity Scale

When you were a child or teenager, before the age of 16....

Were you ever in a very bad fire, explosion, flood, tornado, hurricane, earthquake or other disaster?

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? This would be a time that you were very hurt and needed to spend a long time in the hospital.

Did you ever have a very bad illness where you had to be in the hospital for many days? This could be a time when you were so sick that you had to be in the hospital a lot?

Y N

Did someone you were really close to ever have a very bad accident where he or she had to be in the hospital for many days? This would be someone important to you, like a parent, brother or sister, or best friend.

Did someone you were really close to ever have very bad illness where he or she had to be in the hospital a lot? Again, this would be someone important to you, like a parent, brother or sister, or best friend.

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? Y N

Did you ever have to do a school year over again? Y N

Was there ever a time when your mother, father, or primary caregiver lost a job or couldn't find work? Y N

Were you ever sent away or taken away from your family for any reason?

Y N

Was there ever a time when either of your parents (biological, step, or other primary caregivers) ever have to go to a prison? Y N

Did you ever see a dead body in someone's house, or the street, or somewhere in your neighborhood (other than at a funeral)?

Was there ever a time that a family member drank or used drugs so often that it caused problems? Y N

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? Y N

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?

Y

N

Did anyone ever close to you ever die?

Y

N

APPENDIX M

Avoidance subscale of the How I Deal With Things Scale

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Most of the time
- 5 = Usually

1. I avoid people, places, or situations that remind me of the experience.
2. I try to forget that the experience ever happened.
3. I try to ignore all thoughts and feelings about the experience.
4. I tell myself and/or others that I am determined not to let the experience ruin my life or make me a victim forever, and that I am not going to let it defeat me emotionally.
5. I keep busy and try to distract myself from being bothered by the experience.

APPENDIX N

Family Relationships Index

The Family Relationships Index is a copyrighted questionnaire. Please contact Mind Garden at mindgarden.com for the measure.

APPENDIX O

Adult Self-Report

The Adult Self-Report is a copyrighted questionnaire. Please contact the Achenbach System of Empirically Based Assessments at aseba.org for the measure.

APPENDIX P

Post-Traumatic Stress Disorder Checklist (PCL) - Specific Version

Below is a list of problems and complaints that people sometimes have in response to sexual experiences in childhood or adolescence. If you had more than one sexual experience, please choose the experience that seems most significant to you now. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by the problem **in the past (month/2 weeks)**.

Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1. Repeated, disturbing memories, thoughts, or images of the sexual experience?					
2. Repeated, disturbing dreams of the sexual experience?					
3. Suddenly acting or feeling as if the sexual experience were happening again (as if you were reliving it)?					
4. Feeling very upset when something reminded you of the sexual experience?					
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the sexual experience?					
6. Avoid thinking about or talking about the sexual experience or avoid having feelings related to it?					
7. Avoid activities or situations because they remind you of the sexual experience?					
8. Trouble remembering important parts of the sexual experience?					
9. Loss of interest in things that you used to enjoy?					
10. Feeling distant or cut off from other people?					
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?					

12. Feeling as if your future will somehow be cut short?					
13. Trouble falling or staying asleep?					
14. Feeling irritable or having angry outbursts?					
15. Having difficulty concentrating?					
16. Being “super alert” or watchful on guard?					
17. Feeling jumpy or easily startled?					