Men who were sexually abused during childhood: an examination of factors that influence long-term mental health

Scott Douglas Easton

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MEN WHO WERE SEXUALLY ABUSED DURING CHILDHOOD:
AN EXAMINATION OF FACTORS THAT INFLUENCE LONG-TERM
MENTAL HEALTH

by
Scott Douglas Easton

An Abstract
Of a thesis submitted in partial fulfillment of the requirements
for the Doctor of Philosophy degree in Social Work
in the Graduate College of The University of Iowa

May 2011

Thesis Supervisor: Professor Carol A. Coohey
ABSTRACT

Men who were sexually abused during childhood (MSAC) represent a highly stigmatized, marginalized population at risk for a variety of psychological problems across the lifespan. Little research has been conducted to understand why some MSAC incur mental health problems and others do not. The purpose of this study was to identify which factors are related to mental distress among MSAC using a psychosocial trauma processing model: account-making. Using a cross-sectional design, the researcher collected data on 487 MSAC through an anonymous, online survey. Multivariate analyses for the final direct effects model revealed that high conformity to masculine norms, account-making stage, and two disclosure variables (told after one year, overall response to disclosure) were related to higher levels of mental distress. Three control variables were also related to mental distress: older age, childhood stressors, and current stressors. Posttraumatic growth moderated the relationship between abuse severity (force, penetration) and mental distress. The results of this study strengthened the knowledge base of MSAC, further developed account-making theory, and provided useful recommendations for clinical practice with this population. Future areas of research were identified.

Abstract Approved:

Thesis Supervisor

Title and Department

Date
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This is to certify that the Ph.D. thesis of

Scott Douglas Easton

has been approved by the Examining Committee for the thesis requirement for the Doctor of Philosophy degree in Social Work at the May 2011 graduation.

Thesis Committee:  
Carol A. Coohey, Thesis Supervisor  
Mercedes Bern-Klug  
Sara Sanders  
John Harvey  
William Liu  
Robert D. Baller
To the health and well-being of those affected by child sexual abuse and to those who are working to alleviate suffering and distress caused by it
…to live is to suffer, to survive is to find meaning in the suffering. If there is a purpose in life at all, there must be a purpose in suffering and in dying. But no man can tell another what this purpose is. Each must find out for himself, and must accept the responsibility that his answer prescribes.

Gordon W. Allport, preface to V. Frankl, *Man’s Search for Meaning*, 1984

…loss is the fundamental human experience that underlies many emotions, both negative and positive. Loss is also the key meaning that people associate with trauma. Dealing with loss can lead to growth experiences such as the development of the ability to reach out to help others and the courage to endure pain with hope.

I want to thank my dissertation chair, adviser, and mentor—Dr. Carol Coohey—for the innumerable hours she invested in me over the past five years. She is a brilliant scholar who strives for excellence in any project she undertakes. Her belief in me and my research topic strengthened my resolve to complete this degree and become a professor. Her persistence in challenging me to refine my ideas—over and over—improved my analytical thinking and writing skills. Through her dedication to my development, she modeled many of the traits of an ideal mentor. It is one of my career goals that one day I will be able to positively impact students in the way that Carol helped me.

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grateful I am for their willingness to share their stories. It is my highest aspiration that
this study accurately represents their voices, increases our understanding of the sexual
abuse of boys and men, and contributes to real-world, practical interventions to alleviate
pain and suffering caused by child sexual abuse. I wish each of them health and well-
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Yallah, habibtee, let’s move to Boston!
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CHAPTER 1
INTRODUCTION

Child sexual abuse (CSA) constitutes a menacing social problem. In the 1970s, activists in both the child welfare and the women’s rights movements first raised public awareness about CSA and helped legitimize it as a valid public policy issue (Finkelhor, 1984a). At that time, most discussions of CSA focused on intra-familial abuse perpetrated by parents or guardians against girls (i.e., incest). Many researchers believed that sexual abuse of boys was rare or nonexistent and estimated that the rate of female to male victims was as high as 12:1 (De Francis, 1969).

Since that time period, scholars have accumulated a great deal of evidence that boys are frequently abused. In a widely-respected study based on a nationally representative sample, Finkelhor, Hotaling, Lewis, and Smith (1990) found that approximately 27% of women and 16% of men met criteria for sexual abuse as children. In a recent national study with a geographically stratified, random sample, Briere and Elliott (2003) found that 32.3% of women and 14.2% of men reported child experiences that met criteria for sexual abuse. Dube et al. (2005) conducted one of the largest retrospective cohort studies to date (n=17,337) and found that 25% of females and 16% of males reported being sexually abused during childhood. These rates are consistent with a major review of prevalence rates from general population studies that found that, depending on the definition of CSA, between 8% and 62% of women and 3% and 29% of men were sexually abused during childhood (Fergusson & Mullen, 1999). The rates are also consistent with results from a meta-analysis conducted by Bolen and Scannapieco (1999) which found that prevalence rates ranged from 2% to 45% for females and 2% to 16% for males. Thus, although prevalence rates of CSA are considerably higher for girls than boys, “the sexual abuse of boys is common, underreported, under-recognized, and undertreated” (Holmes & Slap, 1998, p. 1860).
With the confirmation that the sexual abuse of boys represents a public health problem much larger than originally believed, there has been a corresponding increase in public awareness of the problem throughout the larger U.S. population. Some of that awareness has stemmed from national news coverage of sexual abuse scandals and the accompanying legal battles in established, mainstream organizations such as the Catholic Church and the Boys Scouts (Boyle, 1994; Fater & Mullaney, 2000). Hollywood films (e.g., *The Kite Runner*, *Mystic River*, *The Prince of Tides*, and *Sleepers*) and public disclosures by national figures and celebrities (e.g., actor Tyler Perry, Senator Scott Brown, CNN anchor Thomas Roberts, professional athletes Theoren Fleury and Greg LeMond, actors Gabriel Byrne and Tom Arnold, rock star Axl Rose) have introduced the topic to even larger audiences. More recently, Oprah Winfrey dedicated two episodes of her popular daytime television program to the topic of men who were sexually abused during childhood (Oprah Winfrey Show, 2010). By the mid-1990s, school-based CSA prevention programs were widespread (Finkelhor & Dziuba-Leatherman, 1995), and many of those programs included curriculum that stressed that *both* boys and girls can be victims (Araji, Fenton, & Straugh, 1995).

Starting in the late 1980s, there has been an increase in the number and availability of resources to assist men who were sexually abused during childhood (MSAC). Initially, a few self-help books were published such as *Victims No Longer* (Lew, 1990), *Broken Boys, Mending Men* (Grubman-Black, 1990), and *Abused Boys: The Neglected Victims of Sexual Abuse* (Hunter, 1990). Since then, numerous other books for clinicians, survivors, and supporters of survivors have been published (e.g., *Beyond Betrayal: Taking Charge of Your Life After Boyhood Sexual Abuse* (Gartner, 2005), *Recovery for Male Victims of Child Sexual Abuse* (Estrada, 1994), *The Male Survivor: The Impact of Sexual Abuse* (Mendel, 1995) along with a litany of autobiographies and personal narratives.
Additionally, national organizations have emerged that are dedicated to the prevention and treatment of sexual victimization of boys and men (e.g., National Organization on Male Sexual Victimization/MaleSurvivor, 1in6, Men Assisting Leading Educating). Several organizations specialize in serving people who were abused by priests or members of the religious clergy (e.g., Survivors Network of those Abused by Priests, SafeNet, Voices of the Faithful). Internet web sites now provide information as well as opportunities for networking, support and advocacy (e.g., www.jimhopper.com/male-ab/, www.menweb.org/sexabupg.htm, www.snapnetwork.org/). Once a hidden, silent, and seemingly invisible population, MSAC are increasingly recognized as a vulnerable group that is substantial in size and in need of recovery resources.

*Effects of CSA*

Over the past three decades, researchers have evaluated the extent of psychological injuries to children who were sexually abused. Studies have documented a litany of short-term mental health and behavioral problems associated with CSA (for reviews, see Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Browne & Finkelhor, 1986; Kendall-Tackett, Williams, & Finkelhor, 1993; Knutson, 1995; Valente, 2005). Some effects of CSA include anxiety, depression, trauma, conduct disorder, low self-esteem, sexualized behavior, substance abuse, and running away. Although not all children experience negative short-term effects (Beitchman et al., 1991; Finkelhor & Berliner, 1995; Knutson, 1995), the weight of the evidence suggests that CSA places children at risk for short-term psychopathology.

CSA can undermine the healthy development of many children through a deep psychological injury. Gonsiorek, Bera, and LeTourneau (1994) wrote that “for the majority of sexually abused children, sexual abuse is an experience in narcissistic injury” (p. 103), “…a profound blow to one’s self-esteem” (p. 103). They continued:
Sexual abuse is a wounding both by commission and omission. The abusive acts are damaging in a variety of ways (Finkelhor, 1990b; Tharinger, 1990); the failure of a perpetrating adult figure to respond in the best interests of the child and the typically confused or inadequate response from other adults to the abuse are damaging by what does not occur. The result…is a loss, in many cases drastic, of self-esteem, initiative, and legitimate entitlement. The self is prone to fragmentation, enfeeblement, and disharmony. (p. 103)

Conversely, child development researchers have found that close relationships with caring adults (both caregivers and adults outside of the family) play a critical role in fostering children’s competence, self-esteem, and resilience (Masten & Coatsworth, 1998). Because the act of CSA transgresses societal norms governing adult-child relationships and violates basic notions of safety and trust, it can cause an array of feelings in children such as betrayal, shame, guilt, confusion, and anger (Ferrara, 2002; Grubman-Black, 1990; Lew, 1990; Maltz, 1991).

Boys who are sexually abused may also feel an additional layer of stigma that can further magnify their psychological injury from CSA. For the male victim, CSA fundamentally conflicts with Western norms of masculinity, such as protecting oneself from harm, not showing one’s emotions, initiating sexual relations with others, and being heterosexual (Grubman-Black, 1990; Hunter, 1991; Hunter, 2006; Lew, 1990; Mendel, 1995). Grubman-Black (1990) explained that “‘Real men’, we are told, do and do not do certain things. The boy victims [of CSA] are made to feel inadequate and inferior, less like the expected image of a male” (p. xiv). Furthermore, because adults who sexually abuse boys are often male (Finkelhor et al., 1990; Holmes & Slap, 1998; Spataro, Moss, & Wells, 2001), boys often face shame due to internalized homophobia. Grubman-Black (1990) summarized:

Many people do not want to admit that boys are “the other victims” of sex crimes. One of the reasons for their denial is that sexual assaults are seen as fundamentally sexual acts. And as grievous as these acts are perceived regarding female victims, our society’s strong and sometimes insurmountable homophobia…contributes to a higher and thicker wall against the truth when it comes to male victims. This, in part, explains why males are less likely to tell anyone what happened; because of their shame, confusion, and even disbelief. (p. xiii)
In addition to the negative short-term effects during childhood, CSA has the potential to undermine the long-term mental health of adults who were sexually abused. Researchers have demonstrated a relationship between CSA and various psychological problems during adulthood (for reviews, see Beitchman, et al., 1992; Browne et al., 1986; Hunter, 2006; Jumper, 1995; Putnam, 2003). Findings from nationally representative studies, twin studies, and meta-analyses indicate that CSA exerts a unique and deleterious effect on the long-term mental health of adults who were abused during childhood (Andrews, Corry, Slade, Issakidis, & Swanston, 2003; Nelson et al., 2002; Molnar, Buka, & Kessler, 2001; Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999). Spataro et al. (2004) concluded:

The doubts about whether there are true associations between CSA and significant disturbances of mental health…can now be answered unequivocally in the affirmative. It is time to turn our attention to investigating those factors that mediate, and potentially ameliorate, the impact not only of sexual abuse but of the whole range of childhood adversities… (p. 420)

Although most of the existing studies are based on female respondents in early or middle adulthood (Banyard, Williams, & Siegel, 2004; Spataro et al., 2001), they nonetheless demonstrate that CSA has potentially debilitating long-term effects on adults who were abused.

Researchers are beginning to examine whether the effects of CSA continue into late life. One recent study (Draper et al., 2008) with more than 21,000 participants over 60 years of age found that those who had experienced physical or sexual abuse during childhood had a greater risk of poor physical and mental health later in life than those who were not sexually or physically abused. Draper et al. (2008) concluded that “the effects of childhood abuse appear to last a lifetime…” (p. 270) and that “further research is required to improve understanding of the pathways to health outcomes and ways to minimize the effects of childhood adversity in late life” (p. 270).
Another groundbreaking study of psychiatric patients over 50 years of age ($n=163$) found strong relationships between CSA and the level of medical illness burden, physical functioning, and pain (Talbot et al., 2009). For illness burden, the researchers found that the effects of severe CSA are roughly comparable to adding 8 years of age to the chronological age of survivors; for physical functioning and bodily pain, severe CSA was comparable to adding nearly 20 years of age. In discussing their findings, Talbot et al. (2009) concluded that “the impact of CSA is profound even into later life, and future research on the mechanisms and remediation of its effects is warranted” (Talbot et al., 2009, p. 421). Although data are limited on the effects of CSA on the mental health of older people, there is emerging support that the negative effects of CSA can last into the later stages of life.

More specifically, some scholars have begun to document how CSA undermines the mental health of MSAC (for reviews, see Holmes & Slap, 1998; Spataro et al., 2001; Vander Mey, 1988). Men with histories of CSA are over-represented in clinical populations undergoing psychotherapy (Schulte et al., 1995; Roesler et al., 1994), participating in alcohol treatment programs (Windle, Windle, Scheidt, & Miller, 1995), and seeking treatment at sexually transmitted disease clinics (Bartholow & Doll, 1994). For men who were sexually abused during childhood, CSA also increases the risk for specific psychological problems such as major depressive disorder, anxiety disorders, posttraumatic stress disorder, personality disorders, and a range of other DSM-IV psychiatric illnesses (for reviews, see Holmes & Slap, 1998; Putnam, 2003; Spataro et al., 2001). In one study that controlled for many childhood stressors, 82% of men who were sexually abused during childhood reported a lifetime psychiatric disorder compared to only 51% of men who did not report a history of CSA (odds ratio 2.3, $p < .05$; Molnar et al., 2001). In another study, sexually abused men were up to ten times more likely to report suicidal ideation than men in the control group consisting of a representative community sample (O’Leary & Gould, 2009).
In addition to increasing the likelihood of long-term mental health problems, clinicians have reported that CSA often undermines other dimensions of life for adults with histories of CSA for many years. Maltz (1991) explained: “Sexual abuse is not simply an event that happened, ended and is now over. It can have an impact on every aspect of a survivor’s life—attitudes, self-image, relationships, sexuality. These are not past issues but very real and current ones” (p. 60). Researchers have also confirmed that CSA can have a negative long-term effect on different life spheres (e.g., social, sexual, interpersonal relations; Ray, 1996). MSAC are at an increased risk for other problems such as substance abuse, high-risk sexual activities, relationship problems, abusing others, re-victimization, and sexual dysfunction (for reviews, see Hunter, 2006; Loeb et al., 2002). In addition to these consequences, men with histories of CSA are 1.5 to 14 times more likely to attempt suicide than non-abused men (Holmes & Slap, 1998).

Qualitative research has strengthened our understanding of the multi-dimensional effects of CSA on men. For example, Fater and Mullaney (2000) conducted a phenomenological study to understand the lived experience of adult male survivors of clergy sexual abuse. The researchers found that survivors struggled with an ongoing deep-seated rage and a “…spiritual distress that pervaded their ‘life-being’” (p. 293). In a content analysis of autobiographical interviews with 25 MSAC, Lisak (1994) identified numerous psychological themes related to the experience of CSA: negative affective states (e.g., anger, fear, loss, guilt and shame), negative cognitive effects (e.g., negative schemas, self-blame), and difficulties with gender identity, sexuality, and interpersonal relations. Lisak (1994) concluded:

Together, these psychological themes describe a legacy of childhood abuse that permeates all of the important domains of its victims’ lives: Their beliefs and feelings about themselves and about other people, and their basic sense of connection to others. The effects of this on the lives of these men are expressed eloquently by the men themselves, and they are also manifested in the increasing evidence of lives damage, derailed or simply made more difficult by childhood abuse (e.g., Browne & Finkelhor, 1986; Lisak & Luster, 1994). (p. 544)
State of the Research

Despite improvements in our understanding of the magnitude and effects of CSA on men, large knowledge gaps still exist as scholarship remains at a relatively nascent stage. Merrill, Thomsen, Sinclair, Gold, and Milner (2001) classified CSA studies into three types: research on associations, studies on predictors, and process models. The first type of research—studies that examine the association between CSA and mental health problems—increased dramatically in the 1980s but seemed to reach a plateau in the 1990s. The second and third types of research—studies that identify factors related to poorer mental health outcomes for adults who were sexually abused—remains underdeveloped, especially for MSAC (Spataro et al., 2000). The lack of progress in this area is particularly noteworthy given that calls for research to explain variability in mental health outcomes for CSA survivors began more than a decade ago (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Finkelhor, 1998; Jumper, 1995; Kendall-Tackett et al., 1993; Sigmon, Greene, Rohan, & Nichols, 1996).

Most scholars acknowledge that CSA is associated with many long-term psychological problems (Andrews et al., 2003). However, there is some disagreement on the strength and causality of these relationships, especially for males (e.g., Rind & Tromovitch, 1997; Rind, Tromovitch, & Bauserman, 1998). Many children (up to 40%) are asymptomatic in the months following discovery of the CSA (Finkelhor et al., 1995). Furthermore, adults with CSA histories do not necessarily develop severe psychopathology (Hunter, 2006; Putnam, 2003) or suffer from interpersonal dysfunction (Colman & Widom, 2004). Thus, it is unclear which factors contribute directly or indirectly to poor mental health for MSAC in adulthood.

In preliminary studies, researchers have proposed that factors such as abuse-characteristics (e.g., duration, number of abusers, intrusiveness), childhood environment (e.g., family functioning), and individual characteristics (e.g., attribution and coping style) are related to mental health problems for this population. Other possible influences
on the mental health of MSAC (e.g., disclosure during adulthood, conformity to masculine norms, level of post-traumatic growth) have been largely unexplored. Overall, it remains unclear why some men with histories of CSA develop psychological problems in adulthood and other men do not.

The main reason for the knowledge gap on factors that influence the mental health of MSAC is the paucity of research studies on male survivors. The vast majority of studies on the effects of CSA have been conducted using samples consisting of only female respondents (Andrews et al., 2003; Banyard et al., 2004; Browne et al., 1986; Fater et al., 2000; Steever, Follette, & Naugle, 2001). Many of the literature reviews and meta-analyses are based on only a few studies with male participants (e.g., Jumper, 1995; Neumann, Houskamp, Pollock, & Briere, 1996; Rind et al., 1997).

The studies that have compared the effects of CSA on the mental health of men and women have produced mixed results. Some studies have found that women with histories of CSA report worse outcomes than men (Rind et al., 1997, 1998; Sigmon et al., 1996); other studies have found that men with histories of CSA have similar (Briere et al., 1988; Dube et al., 2005; Hunter, 1991; Jumper, 1995; Nelson et al., 2002; Young, Harford, Kinder, & Savell, 2007) or worse mental health (Boudewyn & Liem, 1995; Gold et al., 1999; Roesler et al., 1994) than women. Because it is unclear how gender impacts the mental health of adults with CSA histories, it is imprudent to generalize the findings for women to men. More research on men is clearly needed to understand how the CSA experience affects them (Boudewyn et al., 1995; Dhaliwal et al., 1996; Holmes & Slap, 1998; Spataro et. al., 2001).

Although more research is needed on the effects of CSA on men, identifying and recruiting study participants is a considerable challenge facing researchers. The topic of CSA remains a difficult one to discuss for many adults who were abused, especially for many men. Cultural and societal norms surrounding masculinity (e.g., men cannot be victims, men should be able to protect themselves at all times, and men are not
emotionally harmed by CSA) may severely restrict discussions of CSA (Grubman-Black, 1990; Lew, 1990; Hunter, 1990). In addition to the general shame often associated with being victimized, many men feel shame and self-doubt because the abuser was male (Finkelhor et al., 1990; Holmes & Slap, 1998; Spataro et al., 2001). They may fear being blamed or labeled a homosexual which may contribute to self-silencing (Banyard et al., 2004; Finkelhor, 1984). Therefore, although there is increased public awareness and understanding of sexually abused men, they remain a highly marginalized, stigmatized, and understudied group.

Purpose of the Study

The purpose of this study is to examine which factors are related to mental health problems in adulthood for MSAC. The study focuses on variables that are grouped into four domains—abuse severity, account-making, masculine norms, and posttraumatic growth (see Figure L1 for conceptual model). The possible effects of account-making (Harvey, Weber, & Orbuch, 1990), a social-psychological model for processing trauma, on men’s mental health will be examined in depth. To insure that other variables do not account for variability in mental health, demographic background variables, childhood stressors, and recent life stressors will be controlled.

The study also will examine which factors mediate or moderate relationships between several independent variables and mental health for MSAC. Specifically, this study will examine whether posttraumatic growth moderates the relationship between abuse severity and mental health (see Figure L2). The study also examines whether account-making or posttraumatic growth mediates the relationship between masculine norms and mental health (see Figure L3).

Organization of the Study

This study is organized into five chapters. Following Chapter 1, the empirical and theoretical literature related to the topic of mental health of MSAC will be reviewed in Chapter 2. In Chapter 3, Methods, the research design, data source, sampling procedure,
data collection procedures, procedures for protecting human subjects, pretesting, measures, and data analysis plan will be described. The results of the study will be presented in Chapter 4. Finally, in Chapter 5, the results will be summarized and interpreted, the study limitations will be reviewed, and the implications for research and theory, and practice will be discussed.

Throughout the study, I will use the acronym MSAC to refer to men who were sexually abused during childhood. Dhaliwal et al. (1996) first introduced this acronym in the empirical literature; however, in their work MSAC referred to “men who have been sexually abused as children” (p. 620). In the current study, I wanted to include men who experienced sexually abusive experiences as children (i.e., 0-12 years of age) and/or as adolescents (i.e., 13-18 years of age). Thus, I broadly defined childhood as the period of time from birth until 18 years of age and modified Dhaliwal et al.’s acronym by inserting the term during childhood.
CHAPTER 2
LITERATURE REVIEW

The purpose of this study was to examine which factors are related to mental health problems for MSAC (see Figure L1 for conceptual model). Many of the studies on the long-term effects of CSA have examined a wide range of psychological symptoms and problems. This study will focus on symptoms related to three mental health problems: depression, anxiety, and somatization. These problems were selected for this study because they are among the most commonly discussed sequelae of CSA, are frequently the target of clinical interventions with clients who have histories of CSA, and represent three distinct but related mental health problems.

In this chapter, research and theory related to these long-term mental health of MSAC will be reviewed. Because of the small number of studies on MSAC, relevant studies with other samples (e.g., women with CSA histories, sexually abused children) will also be included. Based on the current research and selected theory, I will propose hypotheses throughout this chapter. For a list of the hypotheses, please see Appendix A.

The chapter is divided into seven sections. In the first section, research on the relation between abuse severity (e.g., duration, frequency, physical injury) and long-term mental health outcomes will be reviewed. In the second section, a trauma processing theory (account-making; Harvey et al., 1990) will be presented and applied to MSAC. In the third section, research related to the disclosure and discussion of CSA—an integral part of account-making—will be reviewed in depth. The next section will review research on masculinity norms and their relationship to mental health. The fifth section will present research on post-traumatic growth and mental health. The sixth section will examine potential mediators and moderators of factors related to mental health for MSAC. Finally, control variables will be discussed in the last section.
Characteristics of CSA

In this section, I will review research on how aspects of the CSA experience contribute to mental health problems for MSAC. More specifically, I will critically review studies that have examined the effect of indicators of abuse severity (e.g., duration, frequency) on the mental health of survivors.

Abuse severity. A large number of empirical studies have examined predictors of mental health problems for sexually abused children. Many of these studies examined whether indicators of abuse severity are associated with short-term psychological problems. Short-term is usually defined as within a few years from the sexual abuse. Some of the factors that have been identified as contributors to short-term mental health problems include penetration, longer duration and frequency, use of force, intra-familial abuse, and a lack of maternal support (for reviews, see Beitchman et al., 1991; Browne et al, 1986; Kendall-Tackett et al., 1993). Although research on short-term outcomes is well-developed, the majority of studies had samples with girls who were sexually abused.

Researchers have identified characteristics of CSA that explain long-term mental health problems among adult women with CSA histories. In an early study with a non-clinical, student sample (n=278), Briere and Runtz (1988) measured psychological problems including anxiety and somatization using the Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Ulenhuth, & Covi, 1974). The researchers found that psychological symptoms were positively associated with duration, use of force, parental incest, completed intercourse, number of abusers, and age of the abuser. Other studies have also found an association between various abuse characteristics and mental health problems. Some of those characteristics include close relationship to the abuser (Molnar et al., 2001; Mullen & Fleming, 1998; O’Leary, Coohey, & Easton, 2010), number of abusers (Health et al., 1996; Molnar et al., 2001; O’Leary et al., 2010; Sacco & Farber, 1999), chronicity of abuse (Molnar et al., 2001), and physical injury (O’Leary et al., 2010).
Although there is much less clarity on how characteristics of CSA affect the long-term mental health of MSAC, researchers have begun to identify some of these factors. In a recent study with both women and men \( (n=172; \text{80.2\% female, 19.8\% male}) \), O’Leary et al. (2010) found that several characteristics of CSA—more than one abuser, biological relationship to abuser, physical injury—predicted a higher number of mental health symptoms during adulthood. Using multivariate analyses and a sample of 106 men \( (n=106) \) including 69 MSAC, Banyard et al. (2004) found a positive association between frequency of CSA incidents and depression as measured by a subscale of the Traumatic Symptom Inventory (Briere, 1995). In a mixed sample of 438 college students (265 women, 173 men), Boudewyn et al. (1995) found that frequency, severity, duration, and coercion were positively associated with depression scores as measured by the Beck Depression Inventory. Another study with 188 participants (168 women, 20 men) found that the use of threats or physical force were related to higher depression scores (Roesler et al., 1994). Finally, Fater and Mullaney (2000) conducted a qualitative study that demonstrated the uniquely harmful effects of CSA on the mental health of men when the abuser was a religious official or a member of the clergy.

Conversely, not all of the evidence is supportive of the association between abuse severity and mental health problems for adults with histories of CSA. Several studies found a weak relationship between severity of CSA and adult depression among adults with CSA histories (Briere et al., 1988; Dube et al., 2005; Merrill et al., 2001; Rind et al., 1998). In other studies, researchers found that several indicators of abuse severity did not explain mental health outcomes such as depression, anxiety, and somatization. Some examples of severity indicators that were not related to mental health included duration (Whiffen & Clark, 1997), frequency (O’Leary et al., 2010), and penetration or close relationship to the abuser (i.e., incest; Banyard et al., 2004). Also, the evidence for a relationship between number of abusers and mental health is equivocal (Kendall-Tackett et al., 1993). Although some studies found that people who were younger at the time of
the abuse had poorer mental health than people who were older (Banyard et al., 2004; Boudewyn et al., 1995), other studies have not found a relationship between younger age and mental health or found an association between older age at the time of the abuse and poorer mental health (Kendall-Tackett et al., 2003; O’Leary et al., 2010; Ruggiero et al., 2000).

Some research suggests that the relationship between abuse severity and mental health is more nuanced than a direct association. In a study of 5,226 female Navy recruits, Merrill, Thomsen, Sinclair, Gold, and Milner (2001) combined five indicators of abuse severity (i.e., intercourse, use of force, incest, number of abusers, and frequency of abuse) and examined its effect on psychological adjustment using the Trauma Symptom Inventory (Briere, 1995). Although the researchers found that there was a correlation between abuse severity and psychological outcomes (.23, p <.001), abuse severity was mediated by coping strategy and parental support. Merrill et al. (2001) concluded that there was strong evidence that the effect of abuse severity on long-term adjustment was mediated by the manner in which the victim coped with the abuse. Other potential mediators and moderators (of the relationship between abuse severity and mental health) include shame and attributional style (Feiring, Taska, & Lewis, 2002), stigma and self-blame (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996), and cognitive schemas (Cukor & McGinn, 2006).

Overall, there is empirical support that some indicators of abuse severity are predictors of long-term mental health problems such as depression among adults who were sexually abused during childhood. Examples of predictors include contact CSA (Andrews et al., 2003; Collings, 1995; Dinwiddie et al., 2000; Nelson et al., 2002) and penetration (Whiffen et al., 1997). Possible explanations are that contact CSA and penetration are forms of more intrusive abuse, and inflict a deeper, more long-lasting psychological injury than non-contact sexual abuse (e.g., pornographic materials, flashing). Other indicators of abuse severity (e.g., duration, frequency) have modest
empirical support. Higher frequency and longer duration of CSA, for example, may reinforce helplessness among people who are abused, thereby heightening self-blame and depression. Finally, some indicators of abuse severity (e.g., younger age at time of first abuse) have mixed or little empirical support. Regardless, most of the research on the relationships between abuse characteristics and long-term mental health has used samples of girls or women. As explained in Chapter 1, more research is needed to explore these relationships with a non-clinical sample of men.

Based on the available empirical research, I hypothesize that the following indicators of CSA severity would be associated with worse mental health for MSAC:

- Abuser was a biologically related member of the immediate family (i.e., incest)
- Abuser was a religious official (e.g., priest, nun)
- Higher frequency
- Longer duration
- Abuser used physical force
- More intrusive abuse (i.e., penetration)
- Physical injury from the CSA
- Higher number of abusers

In addition to examining these direct effects, I will describe how factors may moderate or mediate the relationship between abuse severity and mental health later in this chapter.

Account-making Theory

As discussed in the previous section, many of the studies with survivors of child sexual abuse focused on abuse severity to explain variability in mental health. To date, few studies have examined how individuals process, interpret, and create meaning from the experience of being sexually abused, especially for MSAC. Only a couple of studies have examined whether processing the abuse is related to long-term mental health for survivors. For example, if met with a supportive response, sharing one’s abuse
experience with another person can be helpful for survivors during the recovery process. A few researchers have examined the effects of disclosure on the mental health of adults who were sexually abused during childhood (Arata, 1998; Ruggiero et al., 2004; Ullman, 2007). However, most researchers narrowly defined disclosure as the act of reporting or telling another person around the time of the abuse (i.e., early disclosure during childhood).

In this section, I will present a theoretical model of processing traumatic experiences—account-making (Harvey et al., 1990)—and examine its utility in explaining long-term mental health of male survivors of CSA. In contrast to existing studies, account-making views disclosure as a multi-dimensional, interpersonal process (i.e., telling, receiving support, and discussing) that may occur across the lifespan. By embracing an expanded notion of disclosure, account-making may provide a valuable framework from which to improve our understanding of mental health for MSAC.

This section is organized into five parts. First, I will present the historical roots of account-making theory. Second, the different stages of the model will be described in detail. Third, I will review the empirical support for the account-making model for adults who have histories of sexual abuse or assault. Fourth, I will apply the general account-making model to the target population of the current study: MSAC.

Historical roots of account-making theory. Account-making is a social-psychological model that describes the adjustment process for people who have encountered a severe stressor, traumatic event or, a significant personal loss (Harvey et al., 1990). Traumatic events such as bereavement, natural disasters, or violent crimes often shatter commonly-held assumptions of normalcy (Janoff-Bulman & Berger, 2000) and increase the risk for psychological illnesses (Updegraaff & Taylor, 2000) for survivors, including depression, anxiety, and post-traumatic stress disorder. A core assumption of the account-making model is that people who have experienced potentially
traumatic events can benefit by developing *accounts* to describe, interpret, and create meaning from the event.

Researchers have defined *accounts* as “…story-like constructions of events that include explanations, descriptions …and affective reaction” (Harvey, Orbuch, Chwalisz, & Garwood, 1991, p. 516). Although some people begin developing *accounts* shortly after the event occurs, many people delay account construction until long after the event. Regardless of when account construction begins, the cognitive and affective process of refining an account often takes years to complete.

The concept of *accounts* spans several academic disciplines including sociology, cognitive psychology, communication studies, and linguistics, among other disciplines. The concept originated in the research of sociologists Scott and Lyman in the late 1960s. These scholars conceptualized *accounts* as linguistic tools used by individuals to justify or excuse actions associated with negative events (Lyman & Scott, 1970; Scott & Lyman, 1968). In the mid-1970s, Weiss (1975) applied the concept of *accounts* to the study of individuals undergoing marital separation. He found that *accounts* have the potential to help organize the lives of individuals coping with the loss of significant relationship. To understand how individuals manage blame, responsibility, and causality during relationship dissolution, other scholars incorporated attribution theory in the formation of *accounts* (Orvis, Kelly, & Butler, 1976; Harvey, Wells, & Alvarez, 1978).

More than a decade later, social-psychologists further developed the concept of *accounts* and their potential utility in helping people adjust after a traumatic event or personal loss. Harvey et al. (1990) expanded the definition of *accounts* beyond merely a set of attributions created by someone undergoing a divorce. The researchers stated, “In more recent writings, we have continued to define *accounts* as people’s explanations presented in story-like form for past actions and events that include characterizations of self and key others in plots…thus *accounts* represent more than simply collections of disparate attributions” (Harvey et al., 1990, p. 192). As a framework to understand how
individuals create meaning from traumatic events, *accounts* share common traits with other frameworks such as narratives (Gergen & Gergen, 1988), stories (Coles, 1989), and life schemas (Thompson & Janigian, 1988). As a process to create meaning from a traumatic event, account-making shares many similarities with clinical interventions such as narrative therapy (Sommers-Flanagan & Sommers-Flanagan, 2004), logotherapy (Frankl, 1984), and structured, written emotional expression (Butcher & Buckwalter, 2002).

Social-psychologists also advanced the account-making model by examining *how* people construct *accounts* after facing a wide variety of traumatic and stressful events. In addition to studying individuals coping with the termination of a relationship, researchers examined account construction by Vietnam veterans returning from combat (Harvey, Agostinelli, & Weber, 1989), older adults dealing with the death of a spouse (Weber, Harvey, & Stanley, 1987), and adults who experienced sexual assaults (Harvey et al., 1991; Orbuch, Harvey, Davis, & Merbach, 1994). *Accounts* of specific events (e.g., combat, death, rape)—sometimes termed *sub-accounts*—can later be integrated into a larger *master account* of one’s life (Harvey et al., 1991).

In addition to expanding the definition of *accounts* and applying account construction to different populations, Harvey and others (1991) emphasized the interpersonal component of account-making as a key to positive adjustment following traumatic events. Although account-making may begin as an introspective, solitary exercise, it eventually involves sharing and discussing the *account* with others. Harvey et al. (1991) introduced the term *productive confiding* and defined it as an “…interaction with other(s) that involves other’s empathic and helpful response and in turn one’s own sense of greater relief, acceptance, clarification and direction for further coping” (p. 520). The researchers examined how and when people share their experiences with others and the potential benefits from these exchanges in the recovery process.
Stages of the model. In an attempt to explain how people cope with traumatic events or severe stressors, the pioneering research of Horowitz (1986) led to the development of one of the first stress-processing models. A few years later, Harvey et al. (1990) adapted Horowitz’s original model to fit within the emerging theory of account-making. The result was a structured account-making model that consisted of seven sequential stages (see Figure L4).

In the immediate aftermath of a potentially traumatic event, the person often feels shocked, overwhelmed, or numb. The event may severely disrupt the sense of normalcy and control over the person’s life. Horowitz (1986) explained that “the person quickly processes the crude implications of the event, has an alarm reaction that interrupts ordinary activities, and expresses warning signals” (p. 241), a normal response to a shocking event. Shortly thereafter, the person may feel panic, exhaustion, hopelessness, or even despair. These reactions that occur during the outcry stage, or first stage, are precursors to the next stage: denial.

During the denial stage, the person may experience a cluster of cognitive, affective, and behavioral symptoms. Because of the intensity of the emotions surrounding the event, the person “ignores implications of threats or losses, forgets important problems, and experiences emotional numbing, withdrawal of interest in life, and behavioral constriction” (Horowitz, 1986, p. 242). The person may try to avoid thinking about the event or its impact and instead engage in escapism or isolation.

Horowitz explained:

The individual may experience a narrowing of focus and may fail to react appropriately to new stimuli, sometimes stubbornly adhering to tasks and stimuli considered important before the new and drastic changes in his life situation occurred. For example, after a nearby plane crash, the person might compulsively clean house. (1986, p. 242)

Although some denial symptoms might be adaptive in the short-term, abnormal denial is characterized by extreme avoidance of reminders of the traumatic event. Instead of coping with the severe stressor, the person resorts “…to extreme countermeasures such as
excessive drugs or thrill seeking” (Horowitz, 1986, p. 243). The period of denial varies in length from a few days to months or even years.

After the denial stage, the person may acknowledge that the event occurred and realize that it disrupted his/her sense of safety, normalcy, and continuity. In the intrusion stage of the account-making process, the person may attempt to restore a sense of equilibrium by trying to interpret and understand the event (i.e., initial account-making). However, he/she may become overpowered by the array and strength of emotions associated with recalling the event. This, in turn, can severely undermine the person’s sense of self-control and functioning. During the intrusion stage, the person may also experience repetitive, intrusive thoughts as well as other symptoms including hypervigilance, somatic problems (e.g., sweating, racing heart rate, nausea), and cognitive problems (e.g., inability to concentrate). Despite attempts to make sense of the stressful event, the person may become stuck and continue to dwell on the event without reaching new insight or understanding (i.e., obsessive review).

The working through stage of account-making represents the next step in the process. The person intensifies efforts to process the event at both the cognitive and affective levels. Because there is not a uniform account-making process, these efforts take many different forms, such as writing in a private journal, reading self-help books, and searching for support materials on the internet. More formal account-making activities may include participation in self-help groups or psychotherapy. In an attempt to understand the impact of the event on his/her life, the person may acquire new information and exchange ideas with other people during this crucial stage of the process. Account-making proponents suggest that the working through stage usually takes an extended period of time to complete (J. H. Harvey, personal communication, November 24, 2008).

In the working through stage, account-making progresses from private reflection to interpersonal exchanges. People may attempt to share the account with other people,
such as family members, partners, close friends, other survivors, or professional therapists. Several contextual factors may influence the person’s decision to disclose the account including the closeness of the relationship between the account-maker and the confidante, the account-maker’s perception of the response, and the articulateness of the account-making in sharing the account (Harvey et al., 1991).

Account-making proponents have stressed that receiving a supportive response from others “…[is] absolutely critical in influencing how successful the account maker will be in dealing with the loss experience” (Harvey, Barnett, & Rupe, 2005, p. 112). A supportive response might include belief in the person’s account, empathy, and validation. *Productive confiding* occurs when the supportive response and discussion enhances the individual’s understanding and acceptance of the traumatic event. Although proponents have not formally defined *productive confiding*, a nominal definition of productive is “yielding favorable or useful results; constructive” (American Heritage Dictionary, 2003).

Realizing that productive confiding does not always occur, Harvey later added a separate confiding step to the account-making model with bi-directional outcomes (J. H. Harvey, personal communication, November 24, 2008). If the disclosure is met with support, validation, and empathy, confiding in others can help the person progress to a later stage of the model. Alternatively, if the person receives an unhelpful response during the confiding step, then this can cause him/her to regress to an earlier stage (see Figure L5).

After successfully processing the event in the working through stage, a person then progresses to the end of the account-making process. In the completion stage he/she has fully developed and accepted a story to explain the cause and impact of the precipitating traumatic event. The *account* has been revised several times and now provides the person with an enhanced feeling of control and validation and a heightened understanding of self, others, and the world. For example, in one study of sexual assault
survivors, Harvey et al. (1991) stated that a person with a completed account places the blame for the assault on the abuser, regains the ability to trust others in close relationships, and has a restored sense of personal worth (Harvey et al., 1991). During the completion stages, the person has integrated the traumatic event into his/her life story, thereby increasing a sense of mastery over his/her past. The person can periodically discuss or review the account without experiencing extreme distress.

As a result of developing and accepting the account, the person enters the final stage of the model: identity change. This may involve changing one’s view of self from being a victim to being a survivor. While a survivor recognizes losses associated with the event, he/she has developed adequate coping skills, regained a sense of personal control, and attained a sense of self-efficacy. In addition to a restructured self-identity, successful completion of account-making can lead to improved mental and physical health.

Alternatively, if a person is unable to engage in the account-making process (or stops in the early or middle stages), he/she may develop maladaptive coping patterns (e.g., substance use), psychosomatic problems (e.g., stress, hypertension), or psychological problems (e.g., chronic grief, anxiety, depression) which may persist.

Proponents of the model admit that the length of time to progress from the traumatic event to the final stage varies greatly from person to person (J. H. Harvey, personal communication, November 24, 2008). Although the time to complete the account-making process can range from a few months to an entire lifetime, the process often takes several years for severe stressors or traumatic events.

**Empirical support.** Because it has not been tested in many studies, there is not a great deal of empirical support for the account-making model. However, some exploratory studies have found preliminary support for the viability of the account-making framework to explain mental health after potentially trauma-inducing events. A fundamental assumption of the account-making model is that emotional expression—an interpersonal process at both the affective and cognitive level—is beneficial to the
psychological well-being of the person who experiences it. This assumption is supported by the influential work of Pennebaker (1985, 1989) who found that survivors of traumatic events often experience physical and psychological benefit from sharing their stories with others. Other studies have examined account-making with various populations (e.g., veterans; Harvey et al., 1989) and found that account-making can have beneficial effects for adjustment after a traumatic experience such as war. Harvey et al. (1991) stated that “…available evidence suggests that well-developed accounts play a salutary role in providing perspective, the will to carry on, hope about the future, and closure regarding such stressors [emphasis added]” (p. 517).

Few researchers have specifically evaluated the account-making model with adults who experienced child sexual abuse. In one cross-sectional study of 26 adults (25 females and 1 male) with histories of nonconsensual sex during childhood, Harvey et al. (1991) examined how levels of account-making activities (i.e., the extent to which the respondent mentioned activities such as journal-keeping, private reflection, or formal therapy in a narrative response) and timing of disclosure were related to adjustment. The researchers reported that higher levels of account-making activities were positively associated with perceptions of successful coping and supportive responses to disclosure of the sexual abuse. Also, the level of account-making was negatively associated with negative emotions about the sexual abuse experience.

Orbuch et al. (1994) conducted a similar study of 28 adults (21 females and 7 males) with histories of child sexual abuse. They evaluated how several aspects of the account-making model were related to successful coping (defined as progress towards moving beyond the abuse and effectively dealing with work and family issues), ability to develop and maintain close relationships, and emotional state in relation to the abusive experience. The respondents completed both closed and open-ended items. The researchers found that both the extent of account-making activities (i.e., the degree to which the respondent mentioned activities such as journal-keeping, private reflection, or
formal therapy in a narrative response) and the completeness of account-making (i.e., the degree to which the respondent expressed that they achieved an understanding of the abuse) were related to the dependent variables.

More specifically, the extent of account-making activities was positively correlated with successful coping and negatively associated with two other outcomes: inability to develop and maintain close relationships and negative emotional state in relation to the abusive experience. The completeness of account-making was positively correlated with successful coping and negatively correlated with inability to develop and maintain close relationships. Orbuch et al. (1994) concluded that account-making activities and confiding “…may represent invaluable acts of meaning (authors’ emphasis) in the recovery process of survivors of trauma…and may be essential to the will to recover and to other behavioral steps toward recovery” (p. 263).

By attempting to operationalize and measure parts of the account-making model, these studies (Harvey et al., 1991; Orbuch et al., 1994) greatly advanced our understanding of account-making and its relevance to adult survivors of sexual abuse. The results of the studies provided preliminary support that account-making concepts (e.g., the completeness of the account, extent of account-making efforts) may promote coping after sexual abuse. Nonetheless, the researchers acknowledged several limitations. Some of the limitations included the use of a small sample size, not controlling for gender, the possibility of self-selection sample bias, non-standardized measures, and the possibility of intervening third variables (e.g., abuse severity, personality, religious beliefs, and social support networks).

Furthermore, the central research questions for those studies focused on whether account-making activities promoted coping and overall adjustment. The studies did not examine whether account-making activities were associated with specific mental health outcomes or clinical diagnoses. More research is needed to examine the utility of the account-making in promoting the mental health of survivors of traumatic events.
Applying account-making stages to MSAC. As a general trauma processing model, account-making may offer a useful framework for understanding how boys and men deal with the experience of CSA. In the immediate aftermath of the sexual abuse during childhood (i.e., the outcry stage), the boy may feel panic, despair, or hopelessness, especially since the sexual abuse often co-occurs with emotional neglect and physical abuse (Banyard et al., 2004; Boudewyn et al., 1995; MacMillan et al., 2001; Molnar et al., 2001; Rind et al., 1997 & 1998; Roesler et al., 1994; Rosen et al., 1996; Windle et al., 1995). The boy may also feel shame from not being able to protect himself from the abuser or from being abused by another male (taboo of homosexuality).

However, boys may have other reactions in the immediate aftermath of the sexual abuse. Because of cultural norms and male socialization, many boys do not label the experience as CSA (Fondacaro, Holt, & Powell, 1999; Holmes et al., 1998; Rind et al., 1998; Widom et al., 1997). Also, abusers often emotionally manipulate their victims through psychological grooming strategies (Craven, Brown, & Gilchrist, 2006). The grooming strategies are designed to build trust and make the child believe that the abuser cares about him. As a result, the outcry stage for some boys may involve feelings of confusion or ambivalence.

The next stage of the model is the denial stage. This stage is consistent with the numbing theory of psychopathology for people who were sexually abused during childhood (Polusny & Follette, 1995). To protect himself against feelings of confusion or shame, a boy may initially minimize the experience, dissociate from it, or even deny that it occurred (for a review, see Holmes et al., 1997). In response to CSA, avoidance coping is very common during childhood for both boys and girls (Sigmon et al., 1996). Furthermore, boys have lower rates of disclosure than sexually abused girls (Boudewyn et al., 1995; Gordon, 1990; O’Leary & Barber, 2008; Roesler et al., 1994), another possible sign of denial. Denial of the CSA experience may continue well into adulthood.
As denial wanes, MSAC may enter the intrusion stage of account-making. Fater et al. (2000) explained that “...as developing awareness continues and defenses decrease, the horror of the abuse overpowers survivors whose emotions had been de-centered and blunted to avoid the emotional pain” (p. 288). In the intrusion stage, MSAC may experience fear associated with remembering the abuse, dreams, and flashbacks. Lisak (1994) wrote: “...perhaps the most common experience of fear described by the men was of fear associated with intrusions. The intrusions might be images of events which then evoked fear reactions, or they might be purely affective intrusions—unbidden and sudden experiences of raw fear and panic” (p. 532). In addition to fear, the intrusions may evoke feelings of intense anger (Fater et al., 2000; Lisak, 1994), a possible source of depression, anxiety, or suicidality.

During the next stage of account-making, the working through stage, MSAC actively attempt to understand and create meaning from the sexual abuse that occurred during childhood through various activities. Initially, a survivor might seek out resources and gather information on CSA and boys in a confidential or private manner. For example, a survivor might purchase a self-help book (e.g., Gartner, 2005) or visit an online resource on child sexual abuse (e.g., www.JimHopper.com). Another common activity in the working through stage is individual psychotherapy. For many MSAC, the presenting issue is therapy is not CSA (Easton, 2011). Often the topic of sexual abuse emerges only after a trusting, therapeutic relationship is established (Easton, 2011).

In addition to discussing the CSA in therapy, a survivor might seek out opportunities to learn about the effects of CSA by communicating with other survivors. In the past decade, there has been a proliferation of online resources that provide opportunities for survivors to talk to one another in confidential settings. National survivor organizations such as MaleSurvivor have set up discussion boards on their home page, for example, which offer a private, safe environment for survivors to meet and share experiences, offer advice, and access recovery resources. Through these activities,
survivors attempt to develop and refine their account of the child sexual abuse, and contain the negative effects from the trauma.

During the working through stage, MSAC often attempt to discuss their experience of CSA with others. Receiving a supportive response to disclosure can help a survivor advance to the later stages of account-making: completion and identity change. In these stages, the survivor begins to accept and integrate his account of the abuse into his life. The account has been revised and strengthened many times. As a result, the survivor has improved his coping skills and increased his sense of control when thinking about the abuse experience and its effects. In these stages, some MSAC decide to reach out and help others through a variety of ways (e.g., advocacy, peer support).

Based on account-making theory, I anticipate that the stage of the account-making process will be related to mental health for MSAC. More specifically, I hypothesize that participants in the early and middle stages of account-making will have higher levels of mental distress than participants in the final stages.

I also anticipate that the content of a participant’s account would be related to mental health. Previous researchers have operationally defined a completed account of a sexual assault experience as one that, among other things, names the experience as CSA and places the blame on the abuser (Harvey et al., 1991). Other researchers have measured the completeness of account-making as the degree to which a participant expresses that he/she achieved an understanding of the abuse (Orbuch et al., 1994). Although account-making proponents have used the term completed account, I will use the term well-developed account because it is not clear that survivors ever fully complete their account. In the current study, a participant with a well-developed account will report that he:

- names the experience as CSA
- places responsibility for the CSA on the abuser
recognizes the impact of CSA on various aspects of his life, and
believes that his future is not controlled by the abuse from the past.

I hypothesize that the level of account development will be negatively related to the level of mental distress.

Disclosure of CSA

In the previous section, I presented account-making theory and explicated the various stages of the account-making process. As mentioned earlier, one key component in developing an account of a traumatic experience is confiding or sharing that story with other people. Overall there is very little research on how MSAC share their story with others. Most researchers who have examined this process for CSA survivors have narrowly defined disclosure as the act of reporting or telling another person around the time of the abuse (i.e., early disclosure during childhood). In contrast, account-making theory posits that disclosure is an interpersonal process that involves not only telling or reporting during childhood, but also discussing and receiving feedback from others at any point across the lifespan.

In this section, I will review empirical and clinical literature on disclosure and relate it to account-making theory. First, I will discuss rates of disclosure of CSA. Second, I will examine barriers to disclosure for MSAC. Third, research on the effects of disclosure on mental health will be reviewed. Finally, based on the account-making theory and the empirical and clinical literature, I will present several hypotheses on the effects of disclosure on the mental health of MSAC.

Disclosure rates. Delayed disclosure and avoidance coping are common behaviors among both sexually abused boys and girls (Alaggia, 2005; Bell & Belicki, 1998; Hershkowitz, Lanes, & Lamb, 2007; Lamb & Edgar-Smith, 1994; Leitenberg, Greenwald, & Cado, 1992; Sigmon et al., 1996; Ullman & Filipas, 2005; Weingarten & Cobb, 1995). However, there is evidence for significant gender differences regarding rates of early disclosure. Using a subsample of the 1985 Los Angeles Times national poll,
Gordon (1990) analyzed gender differences in the nature and context of CSA for 585 men and women who reported histories of CSA. Retrospective phone interviews elicited disparate rates of early disclosure based on gender. Although 67.9% of sexually abused women reported that they told someone about the abuse around the time of the abuse (or shortly thereafter), the percentage of sexually abused men who told someone around the time of the abused was only 53.4% ($p=.001$).

Other retrospective studies of adults with histories of CSA have found even larger gender differences in rates of early disclosure. For example, O’Leary and Barber (2008) evaluated disclosure patterns in a non-clinical sample of 296 adults with CSA histories (151 women, 145 men). Only 26% of male respondents (compared to 63.6% of female respondents) told someone at or around the time of the sexual abuse ($x^2=40.28, p<.001$). Roesler et al. (1994) found that among a clinical sample of 188 adults who were sexually abused as children (168 women, 20 men), 62.3% of the women remembered having told someone about the sexual abuse as a child. The corresponding percentage for men was only 31.3% ($x^2, p<.02$). In a similar study with a college sample, Boudewyn et al. (1995) found that a lower percentage of men reported that they told someone about the sexual abuse as a child than women (18% v. 41%, $x^2=3.62, p<.05$). These findings are consistent with a major review of studies on the sexual abuse of boys which found that early disclosure rates ranged between 10% and 33% (Holmes et al., 1998).

Researchers have found that the lower rates of disclosure for sexually abused boys may continue into adulthood. Many MSAC struggle with the confiding step of account-making and delay disclosure well into adulthood or do not disclose at all (Finkelhor et al., 1990; Holmes et al., 1998; O’Leary & Barber, 2008; Sigmon et al., 1996; Spataro et al., 2001). In a national survey, Finkelhor et al. (1990) found that approximately 42% of adults with CSA histories reported that they disclosed the sexual abuse within one year of its occurrence. Although the rates for disclosure within one year of the sexual abuse were nearly identical for men and women, a higher percentage of men reported that they never
told someone about the abuse in their lifetime (42% v. 33%). In a small study (n=78; 59 women, 19 men) with a high concentration of incest cases, male respondents reported that they kept the sexual abuse a secret for an average of 26.8 years compared to 19.5 years for female respondents (Sigmon et al., 1996). More recently, O’Leary and Barber (2008) found that men took significantly longer to discuss CSA in adulthood than women. Of the men in their study, 44.9% indicated that it took more than 20 years to discuss the experience with someone else. Finally, Ullman & Filipas (2005) examined disclosure in a convenience sample of 733 college students and found that the rates of ever disclosing the abuse were lower for male survivors of CSA than for female survivors (45.8% v. 70.6%, $x^2=5.29, p<.019$). Overall the available data suggest that sexually abused boys disclose less frequently than sexually abused girls, and that these patterns continue into adulthood.

*Barriers to disclosure.* Several barriers may explain the lower rates of early disclosure for sexually abused boys and disclosure during adulthood for MSAC. In a review of factors that influence whether children disclose sexual abuse, Paine and Hansen (2002) classified motivational barriers to early disclosure into three categories: concerns relating to the self, concerns related to family and loved ones, and concerns related to the abuser. Concerns relating to the self included negative feelings (e.g., shame, self-blame, guilt) which can impair disclosure. A sexual abuse survivor may also have concerns about the reaction of family and friends. He may fear not being believed, not being taken seriously, or even blamed when telling someone else about the experience. Finally, due to ambivalent and confusing feelings towards the abuser, a child may actually maintain secrecy to protect the abuser from negative repercussions (Paine & Hansen, 2002).

Although many of the motivational barriers to early disclosure are similar for sexually abused boys and girls, sexually abused boys may experience unique barriers as well. A primary barrier is based on general beliefs and myths of CSA and boys. Examples of these beliefs include: 1) sexual abuse of boys is rare or non-existent, 2) boys
should be able to protect themselves from problems such as CSA, 3) early sexual experiences (including contact between an adult and a boy) are normative male sexual exploration, 4) sexually abusive experiences don’t cause emotional harm to boys, 5) the experience of physiological pleasure by the boy indicates that the sexual interaction was consensual, and 6) early childhood experiences, even sexual abuse, don’t cause long-term harm in adulthood for men (Grubman-Black, 1990; Holmes et al., 1997; Hunter, 1990; Lew, 1990; Paine & Hansen, 2002). Additionally, the experience of CSA violates well-established gender norms and expectations for boys and men in American culture (which will be discussed in more depth later in this chapter). If internalized by the male survivor, these norms and beliefs may inhibit him from disclosing the abuse or seeking help.

When held by caretakers or adults in positions of authority, these beliefs constitute external barriers to disclosure for sexually abused boys and MSAC. During childhood, for example, parents may be less vigilant in monitoring or detecting problems following victimization for boys (Spataro et al., 2001). Officials (e.g., child protection workers, law enforcement officers) often subscribe to beliefs that minimize the prevalence or negative effects of CSA of men (Spataro et al., 2001). These beliefs make officials less likely to substantiate cases of sexual abuse involving boys (Dersch & Munsch, 1999) or provide services to male survivors and their families (Agar & Read, 2002; Holmes & Slap, 1998). Clinicians may also have biases that impede the identification, assessment, and treatment of CSA in male clients (Holmes & Offen, 1996; Lab, Feigenbaum, & De Silva, 2000, Spataro et al., 2001). In a literature review of research on barriers to help-seeking for MSAC, Holmes et al. (1997) concluded that clinicians are less likely to assess male clients for child sexual abuse than female clients and may be less likely to believe or support male clients who disclose CSA. These institutional barriers may thwart disclosure of CSA for boys and MSAC.
Another barrier to disclosure of CSA for men is based on the attribution or labeling process. Many men who meet objective criteria for CSA do not label or consider the experience as abusive (Fondacaro et al., 1999; Holmes & Slap, 1998; Holmes et al., 1997; Rind et al., 1998; Widom et al., 1997) but are nonetheless at risk for a wide range of negative clinical outcomes (Holmes & Slap, 1998). For example, in a recent study of 298 men recruited to participate in telephone interviews, Holmes (2008) found that of the 43 participants who met objective criteria for CSA, 35% of them did not define the experience as CSA. Some of the reasons that MSAC do not label the experience as sexual abuse include: they are not familiar with legal definitions of sexual abuse, they believe that their participation signified consent, they believe that physiological responsiveness or pleasure meant that the experience was not abusive, or they minimize the experience due to embarrassment, shame, or conflict with internalized masculine gender norms.

Preliminary research indicates that gender differences exist in perceiving and labeling CSA. In a small sample of men and women who met objective criteria for CSA, only 16% of the male respondents considered the experience to be sexual abuse compared to 64% of the female respondents (Widom et al., 1997). The researchers speculated that the gender differences could be due to inadequate measurement techniques, but they also could be due to “…early socialization experiences in which men learn to view such behaviors as non-predatory and non-abusive” (Widom et al., 1997, p. 42). This explanation is supported by other research which suggests that there are significant gender differences in attributions of responsibility, perceptions of blame, and labeling for CSA (Smith, Fromuth, & Morris, 1997; Wellman, 1993).

The heightened stigma and shame from having an abuser who is of the same gender constitute another barrier to disclosure for MSAC. Although research has demonstrated that older females (i.e., both adolescents and adults) sexually abuse boys at rates much higher than previously believed (Hunter, 2006, Spataro et al., 2001), adult
men are the perpetrators in the vast majority of sexual abuse cases involving boys (Finkelhor et al., 1990; Holmes et al, 1998; Spataro et al., 2001). Even though most offenders self-identify as heterosexual (Holmes et al., 1998), the sexual contact between an adult male and a boy represent severe transgressions of the male norm of heterosexuality. Because the male socialization process denigrates both victimhood and homosexuality (Heath et al., 1996; Mahalik et al., 2003; Spataro et al., 2001), sexually abused boys and MSAC may experience a compounded sense of shame and a heightened stigma due to homophobia (Holmes et al., 1997).

Qualitative researchers have found that being abused by a male adult can jumpstart a process of intense introspection full of identity confusion, self-blame, and shame, and, consequently, alienation from others (Lisak, 1994). Researchers who have examined the grooming process (i.e., the process whereby an abuser prepares and gains access to a potential target) have found that abusers attempt to shift responsibility for the sexual abuse to the child and use a variety of strategies to ensure secrecy and prevent disclosure (Craven et al., 2006). One of the strategies is to remind the boy of the potential consequences of disclosure (i.e., being labeled a homosexual). As a result, pervasive fears such as not being believed (Banyard et al., 2004) or being labeled a homosexual (Finkelhor, 1984b) may thwart disclosure for sexually abused boys and MSAC.

In one of the first studies of the disclosure process for MSAC, Sorsoli, Kia-Keating, and Grossman (2008) conducted an exploratory, qualitative study with 16 participants using semi-structured interviews. This important study was part of a larger research project on the resilience of MSAC and yielded valuable insights that advanced understanding of barriers to disclosure. More specifically, the researchers classified disclosure barriers into three domains: personal (e.g., lack of cognitive awareness, emotional readiness, emotional safety), relational (e.g., fear of negative repercussions, relational disruptions, isolation), and sociocultural (e.g., taboo). The researchers found
that these barriers exist not only during childhood, but often continue into adulthood and throughout the lifespan for MSAC.

Another qualitative study examined factors that impede or promote disclosure of CSA with 30 adult survivors (Alaggia, 2005). Through in-depth interviews with 19 female and 11 male survivors of CSA, Alaggia (2005) found that MSAC reported several unique barriers based on fears of being viewed as a homosexual, being viewed as a victim, and becoming an abuser themselves. She concluded that “for men, being sexually abused by a male evokes unique conflicts about their sexuality and sexual orientation. Men are strongly affected by prevailing attitudes about masculinity and what it means to be a man in a patriarchal, heterosexist society” (p. 464).

The net effect of these barriers to disclosure is that sexually abused boys and MSAC may perceive that the costs of disclosure are too high (Hunter, 2001) and outweigh the potential benefits of seeking social support (Holmes et al., 1997). They may minimize and/or guard the secret of CSA, a process called silencing (O’Leary & Barber, 2008). The silencing often begins in childhood, continues into adulthood, and represents a second form of victimization (i.e., self-victimization; Gold et al., 1999). Gold et al. (1999) summarized: “Their own victimization...may be perceived by them as evidence of not being masculine. Consequently, there may be powerful disincentives for men to acknowledge CSA histories by entering therapy for the long-term sequelae of childhood molestation” (p. 689). Many MSAC guard their secret well into adulthood, even when they are in considerable psychological distress (Lew, 1990). Thus, silencing serves as a primary impediment to seeking social support or help from others.

*Effects of disclosure.* Many of the sexual abuse prevention programs encourage children to disclose instances of sexual exploitation to a trusted adult (Davis & Gidycz, 2000). An underlying assumption of this approach is that early disclosure is inherently helpful to the well-being of the abused child (Alaggia & Kirshenbaum, 2005; Paine & Hansen, 2002). The rationale is that telling another person may increase the probability
that the abuse will end because of intervention by an adult (e.g., family member, teacher, child protective worker, law enforcement officer). Also, early disclosure to a trusted adult may lead to treatment services (e.g., counseling, family support services), if needed. Numerous theories of CSA stress the importance of seeking social support through disclosure (for reviews of theories that stress social support, see Morrissette, 1999, and Ullman, 2003).

Some research studies support the proposition that early disclosure is helpful to the mental health of sexually abused children. For example, in a nationally representative study of adolescents, Broman-Fulks et al. (2007) conducted a sub-analysis of adolescents who reported being sexually abused \(n=321\); 251 girls, 70 boys). The researchers found that respondents who disclosed their abuse within 1 month had a reduced risk of depression and delinquency (but not PTSD or substance abuse problems). In that study, disclosure to mothers was associated with a reduced risk of PTSD and delinquency.

Finkelhor (1990) reviewed three studies that examined symptomatology in the months following disclosure of CSA for abused children. In all of the studies, there was a decrease in many (but not all) of the symptoms (e.g., fear, trauma, emotional disturbances, behavioral problems) in the months following disclosure and assessment (Finkelhor, 1990).

However, the data are highly equivocal on whether early disclosure is beneficial to the short-term mental health of children and adolescents who were sexually abused. In many cases, disclosure of CSA does not terminate the abuse or end the child’s distress (Jonzon & Lindblad, 2004; Palmer, Brown, Rae-Grant, & Loughlin, 1999). In one study of adult incest survivors, over half of the participants reported that their abuse continued for a year or more following disclosure to a parent (Roesler & Wind, 1994). This finding may be due to the phenomena of dead-end disclosures (i.e., a disclosure that is not reported to the authorities; Malloy & Lyon, 2006). Malloy and Lyon (2006) examined factors that led to recantation of the abuse by the child in a sample of 257 substantiated
cases of CSA. They found that in 58.8% of the cases, the response of the non-offending caregiver to disclosure was non-supportive (e.g., didn’t believe child, blamed child, forced the child to leave the home) and that children made dead-end disclosures to their mothers in almost one-third (32%) of the cases. In another study, Sas and Cunningham (1995) found that 60% of children who made a dead-end disclosure to a parent reported that the abuse re-occurred.

Other research has confirmed that many children are simply not believed when they disclose (Berliner & Conte, 1995; Gomes-Schwartz, Horowitz, & Cardarelli, 1990). Furthermore, children who purposely disclose often receive less support and treatment and report greater anxiety and coping difficulties than those who accidentally disclose (i.e., discovered by an adult; Nagel, Noll, Putnam, & Trickett, 1997). In one study, childhood disclosure was associated with more physical abuse and violence (Jonzon & Lindblad, 2004). Finally, another study found that many adolescents who disclosed CSA actually reported greater psychological distress than their counterparts who did not disclose (Feiring, Taska, & Lewis, 2002).

Many factors affect whether early disclosure is helpful. One of the most important factors appears to be the quality of response that the survivor receives. In their traumagenic dynamics model, for example, Finkelhor and Browne (1988) emphasized that a positive response to disclosure is essential in containing the negative effects of CSA.

Account-making proponents have similarly stressed that a helpful, empathetic response to disclosure is one of the keys to positive adjustment following a traumatic event. Harvey, Barnett, and Rupe (2005) wrote that receiving a positive response “…[is] absolutely critical in influencing how successful the account maker will be in dealing with the loss experience” (p. 112). When a child receives a non-supportive, non-believing, or even hostile response, this can add to the shame and trauma surrounding the
sexual and contribute to mental health problems (Feiring et al., 2002). Account-making efforts may be severely impaired or delayed for years or decades.

Conversely, receiving a positive, supportive response to disclosure may promote better short-term mental health. A substantial body of research has confirmed a positive relationship between level of parental support and the child’s emotional and behavioral adjustment following CSA (for reviews, see Elliot & Carnes, 2001; Spaccarelli, 1994). In particular, researchers have identified maternal protection and support important factors associated with better mental health in sexually abused children (Broman-Fulks et al., 2007; Kendall-Tackett et al., 1993; Lovett, 2004). Some of the characteristics of a helpful maternal response include believing the child, providing affective support, and taking behavioral action (Alaggia, 2002). These characteristics of a supportive maternal response—belief, support, and protection—have also been included in frameworks and models by other researchers investigating child sexual abuse (e.g., Coohey, 2006; Everson, Hunter, Runyan, Edelsohn, & Coulter, 1989; Morrison & Clavenna-Valleroy, 1998). Overall, receiving a supportive response to early disclosure may promote account-making and adjustment.

In recent years, a few studies have examined how early disclosure of CSA affects the long-term mental health of survivors. A study of 733 college students (71% female, 29% male) found that delayed disclosure, negative reactions to disclosure, and self-blame at the time of CSA were related to PTSD symptoms in adulthood (Ullman, 2007). In a study based on a nationally representative sample of adult women (n=3220), Ruggiero et al. (2004) examined the effects of disclosure on the mental health of female survivors of severe CSA (i.e., childhood rape). The researchers found that delaying disclosure for more than 1 month (versus never disclosing or disclosing within 1 month) was associated with more PTSD symptoms. Arata (1998) conducted a retrospective study of 204 female adults and found that early disclosure was associated with fewer PTSD symptoms (i.e., intrusive thoughts and avoidance behavior), but was not related to overall functioning.
Sigmon et al. (1996) examined the effect of coping style on mental health during adulthood (e.g., trauma symptoms, depression, anxiety) for 78 CSA survivors (59 women, 19 men). The researchers concluded that avoidance coping during childhood (and, by extension, non-disclosure) may temporarily serve as a protective factor for the abuse survivors. However, avoidant coping was associated with more psychological symptoms in adulthood (Sigmon et al., 1996). Although preliminary, the available evidence suggests that early disclosure may be related to improved long-term mental health for adults who were sexually abused during childhood.

In addition to the timing of the disclosure, the level of support received after disclosure may influence the long-term mental health of CSA survivors. In an exploratory study of 26 adults who experienced nonconsensual sex in childhood (25 women, 1 man), Harvey et al. (1991) examined the effect of account-making on long-term adjustment. Among other things, they found that early confiding (i.e., disclosure of CSA within 1 year of the abuse) that was met with a helpful response by the confidante was associated with successful coping. In a similar study of account-making among 28 adult CSA survivors (21 women, 7 men), Orbuch et al. (1994) found that the perceived supportiveness of the confidante’s response to disclosure was positively correlated with successful coping and negatively associated with two other outcomes: inability to develop and maintain close relationships and negative emotional state in relation to the abusive experience.

Beyond merely telling someone about the abuse, only a few studies have examined the effect of discussing the abuse in-depth on mental health (Lamb & Edgar-Smith, 1994; Paine & Hansen, 2002). The findings indicate that discussing earlier reduces the severity of long-term mental health symptoms. In one of the only studies that simultaneously examined both telling and discussing, O’Leary et al. (2010) conducted a secondary analysis based on interviews with 172 Australian adults (80.2% female, 19.8% male) who reported being sexually abused during childhood. Using hierarchical
regression analysis, the researchers found that adults who told someone about the abuse at the time it occurred and those who waited longer than 1 year to discuss their abuse in-depth had more mental health symptoms. The findings challenged the assumption that early disclosure (i.e., telling) leads to positive outcomes, but supported the notion that timely discussion of CSA can help to minimize its potentially detrimental effects.

Very little research has been conducted on disclosure of CSA across the lifespan and its effect on the mental health for adult survivors of CSA, especially for MSAC (Ullman, 2003). Although there is a dearth of empirical work in this area, many therapeutic models assert that disclosure and discussion of traumatic events can be helpful (e.g., Pennebaker, 1997; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Among MSAC, survivors who remain silent about the sexual abuse during adulthood may feel isolated, conflicted, and powerless.

Other researchers have challenged the belief that extensive emotional expression is beneficial for all trauma survivors. Ullman (2003), for example, wrote that “real-life disclosures of stigmatized traumas like sexual assault may well only be therapeutic if the person one tells reacts in a supportive or at least neutral manner” (p. 95). Furthermore, McNulty and Wardle (1994) contended that for a substantial minority of adult survivors of CSA, disclosure during adulthood may actually *heighten* psychological distress. The combination of remembering traumatic material and receiving a hostile or rejecting response can severely disrupt a survivor’s social networks and lead to a downward spiral (McNulty & Wardle, 1994). Although account-making theory assumes that emotional expression can be beneficial to a trauma survivor, it incorporates the reaction of others to disclosure during the confiding steps.

In one of the few studies on social reactions to disclosure of CSA in both childhood and adulthood, Ullman and Filipas (2005) examined predictors of PTSD among 733 college students (71% female) who reported being sexually abused during childhood (22.8% of the original sample). The researchers found that the extent and
timing of the disclosure were related to current PTSD symptom severity. More specifically, the level of detail provided in the disclosure was negatively related to PTSD symptoms for both men and women. Furthermore, women who delayed disclosure had greater PTSD symptom severity than women who told sooner. There was not a relationship between the length of time to disclose and PTSD symptom severity for men. The researchers also found that both negative social reactions to disclosure and maladaptive coping were associated with more symptoms. The researchers concluded that although disclosure has the potential to be helpful, it can undermine a survivor’s mental health if it is met with a negative response.

A second study examined aspects of adult disclosure of CSA and its effect on mental health. Lamb and Smith (1994) conducted phone interviews with 60 participants (48 women, 12 men) who responded to an advertisement for survivors of CSA. The researchers found that the number of disclosures (in childhood, adulthood or combined) were not related to adult functioning as measured by the BSI. Interestingly, the number of positive disclosures (i.e., receiving a helpful response) was also not related to adult functioning. Furthermore, in both childhood and adulthood disclosures, more direct disclosures were associated with less helpful responses. The researchers concluded that “…repeated telling may not have the purported healing effects about which we have heard so much” (p. 323), but acknowledged that the convenience sample may have been biased (i.e., disproportionate number in the clinical range of the BSI; inadequate variation). They also stated that they were only able to measure a “few obvious aspects of disclosure” (p. 323), and that other characteristics of disclosure may help explain mental health among CSA survivors.

A third study indirectly investigated the effect of disclosure on mental health for MSAC. Using a clinical sample of 147 Australian men who were sexually abused during childhood, O’Leary (2009) examined how coping strategies were related to psychological functioning as measured by the 28-item General Health Questionnaire (GHQ), a
standardized instrument that assesses somatic symptoms, anxiety, social dysfunction, and severe depression (Goldberg & Williams, 1988). One coping strategy that was related to better functioning was seeking instrumental social support. This finding indicates that actively disclosing and discussing the abuse with individuals capable of providing tangible support may be critical in promoting a survivor’s mental health. O’Leary (2009) also found that negative coping strategies such as behavioral disengagement increased the odds of a clinical classification on the GHQ. However, the use of emotional support increased the odds of being classified with PTSD, a counter-intuitive finding. O’Leary (2009) speculated that this finding may be because MSAC received an inadequate to disclosure.

Hypotheses related to disclosure. Based on the empirical work and theoretical models, in the current study I propose eight hypotheses related to disclosure and discussion of CSA. First, I anticipate that telling someone about the sexual abuse within a relatively short time will be related to better long-term mental health. More specifically, I hypothesize that MSAC who did not tell someone within 1 year of the abuse (or who never told) will have higher scores for mental distress than MSAC who told within 1 year of the abuse.

Second, receiving a supportive response is an important part of productive confiding in account-making theory (Harvey et al., 1991). The results from exploratory studies indicate that a supportive response is related to improved coping and adjustment (Harvey et al., 1991; Orbuch et al., 1994). Because the response to first disclosure can influence subsequent account-making activities, I hypothesize that MSAC who did not receive a very helpful response to first disclosure will have higher scores for mental distress than MSAC who received a very helpful response to first disclosure.

Aside from the response to first disclosure, researchers have also examined the effect of specific aspects of the response to disclosure on mental health. There is growing evidence that being believed, supported, and protected by someone during childhood is
important to mental health for survivors of CSA. These characteristics of responses to disclosure fit well with the concept of productive confiding in account-making theory. Therefore, I hypothesize that the level of support to disclosure during childhood (i.e., being believed, supported, protected, and encouraged by someone in childhood) will be negatively related to the level of mental distress.

Fourth, beyond telling someone about the abuse, account-making theory posits that discussing the abuse in-depth can assist an individual in processing a traumatic event. Thus, I hypothesize that MSAC who have never had an in-depth discussion about the sexual abuse will have a higher level of mental distress than MSAC who have had an in-depth discussion. Because discussing and processing the abuse occurs at various points in the lifespan, the timing of the initial discussion may be important. A few exploratory studies have examined the effect of discussing abuse on mental health and found that discussing the abuse within a relatively short period of time was related to fewer mental health symptoms (O’Leary et al., 2010) and better coping and adjustment (Harvey et al., 1991). In the current study, I hypothesize that the number of years until the abuse was discussed will be positively related to the level of mental distress.

In addition to the hypotheses related to early disclosure and discussion of CSA, I will examine three hypotheses related to disclosure during adulthood. All three examined different aspects of productive confiding from account-making theory. First, I hypothesize that the level of support during adulthood (i.e., being believed, supported, protected, and encouraged) will be negatively related to the level of mental distress. Second, I hypothesize that MSAC who report that the overall response to telling during their lifetime was not “very helpful” (or who never told) will have higher scores for mental distress than MSAC who report that the overall response to telling was “very helpful”. Third, I expect that the perceived degree of helpfulness of in-depth discussions will be related to mental health. I hypothesize that MSAC who report that their most helpful discussant was not “very helpful” (or who never discussed) will have higher
scores for mental distress than MSAC who report that their most helpful discussant was “very helpful.”

Conformity to Masculine Norms

Traditional masculinity. In addition to abuse severity, disclosure and discussion of CSA, and account-making, this study will examine how conformity to masculine norms impacts the mental health of MSAC. To understand how masculine norms are established, Mahalik (2000) proposed a model of masculinity in an address at the annual conference of the American Psychological Association. He posited that dominant, powerful groups in society shape gender standards and expectations, and communicate them through descriptive, cohesive norms (Mahalik et al., 2003). Traditional masculinity is composed of a set of norms including an emphasis on winning, an ethos of self-reliance, and the importance of being productive. According to Mahalik (2000), a variety of individual and group factors (e.g., racial identity, socio-economic status, personal history) filter these expectations and affect the extent to which an individual conforms (or does not conform) to the dominant gender role norms. Additionally, there are costs and benefits at both the personal and the interpersonal levels at each level of conformity to masculine norms.

To assess the degree to which a person adheres to traditional masculine norms, Mahalik (2000) developed an instrument, the Conformity to Masculine Norms Inventory (CMNI). The 94-item inventory produces scores on eleven subscales: winning, emotional control, risk-taking, violence, power over women, dominance, playboy, self-reliance, primacy of work, disdain of homosexuals, and pursuit of status. The total conformity score falls on a continuum ranging from extreme conformity to extreme nonconformity. Although the psychometric properties of the assessment are still being established, preliminary data suggest that it has strong internal consistency, good differential validity, convergent validity with established measures, and high test-retest reliability (Mahalik et al., 2003).
Mahalik et al. (2003) identified three comparative advantages of the CMNI instrument over other instruments of masculinity. The researchers explained that existing measures conceptualize and measure masculinity using one-dimensional, global indices. The CMNI has many subscales and includes a broader range of norms than other measures. A second advantage is that the CMNI assesses masculinity not only at the cognitive level, but also at the affective and behavioral levels. Many of the existing measures examine masculinity on only one of those levels. Finally, many of the existing measures focus on gender stress and conflict, thereby pathologizing masculinity (Mahalik et al., 2003). The CMNI measures both conformity on a continuum and is based on the proposition that neither conformity nor non-conformity is universally detrimental. In fact, the researchers contend that any level of conformity can be adaptive and functional for specific situations.

In addition to providing researchers with an improved method of analyzing normative masculinity, the CMNI provides mental health practitioners with a tool for exploring factors associated with psychological symptoms. For example, tests of convergent validity have demonstrated that three subscales (i.e., self-reliance, dominance, violence) as well as the overall conformity score predict global psychological distress as measured by the Brief Symptom Inventory (Mahalik et al., 2003). Other subscales of masculine norms were associated with depression, somatization, hostility, and anxiety. Thus, strict adherence to traditional masculine norms is associated with mental health problems in the general population.

Despite its clinical utility, Mahalik et al. (2003) issued a few cautions in the application of the CMNI. First, it would be unwise to draw sweeping conclusions (e.g., conformity to male gender norms is only associated with adverse outcomes). Conformity can have many off-setting benefits (e.g., career advancement or group acceptance) and non-conformity can also have high costs (e.g., social rejection). Second, although the 11 factors were tested through factor analysis and successfully differentiated groups of men
and women, the list is far from exhaustive. Because masculinity is a socially constructed concept, Mahalik et al. (2003) acknowledged that masculinity could vary significantly among different sub-cultures and sub-populations.

**CSA and traditional masculinity.** Researchers have used the CMNI to measure conformity to masculine norms in the general population of men (Mahalik, Levi-Minzi, & Walker, 2007) as well as several sub-populations such as men with spinal cord injuries (Schopp, Good, Mazurek, Barker & Stucky, 2007), Asian men (Liu & Iwamoto, 2007), gay men (Kimmel, 2004), and men in therapy (Mahalik, Talmadge, Locke, & Scott, 2005). However, the instrument has never been used to assess conformity among MSAC (J. R. Mahalik, personal communication, October 15, 2008). Nonetheless, research has demonstrated that the experience of CSA can profoundly impact the masculine identity of MSAC by causing identity confusion, self-blame, and shame (Holmes & Slap, 1998; Hunter, 1991; Lisak, 1994; Nasjleti, 1980).

Some MSAC struggle with their masculine identity because the CSA experience violates many well-established, socially sanctioned gender norms and expectations in American culture. For example, there is a prevailing belief that to be masculine, a man needs to be a self-reliant, dominant individual that defeats opponents in competitive situations (Mahalik et al., 2003). A corollary of this belief is that being a victim is wholly un-masculine a man should not be a dependent, submissive individual who cannot defend and protect himself (Briere, 1996; Lisak, 1993).

Another masculine norm is that men should be sexually proactive and seek partners for heterosexual experiences (Mahalik et al., 2003). Because of the prevalence of homophobia, deviance from heterosexual experiences (whether consensual or coercive) is highly discouraged and heavily sanctioned. For sexually abused boys, the majority of abusers are men (Finkelhor et al., 1990; Holmes et al., 1998; Spataro et al., 2001). Because the male socialization process denigrates both victimhood and homosexuality (Heath et al., 1996; Mahalik et al., 2003; Spataro et al., 2001), having an
abuser who is a man may heighten feelings of stigma and shame. Additionally, if he tells someone about the sexual abuse, a boy may fear that he will not be believed (Banyard et al., 2004) or will be labeled a homosexual (Finkelhor, 1984b).

The belief that boys are not emotionally damaged from adverse childhood experiences such as CSA (Grubman-Black, 1990; Holmes et al., 1996; Lew, 1990; Hunter, 1990) is another masculine norm. Generally, boys are expected to quickly recover from potentially trauma-inducing experiences. Furthermore, in cases where a boy is sexually abused by an older woman, many people minimize the consequences of the sexual abuse, consider it to be a normal part of the developmental process or view it as a positive initiation into manhood (Spataro et al., 2001). As a result, these beliefs may cause boys to deny that they were abused or harmed from the CSA.

Finally, a prevailing masculine norm is that men should maintain tight control over their emotions and restrict emotional expression (Mahalik et al., 2003). This norm is especially important for emotions related to loss, injury or disability. Thus, even if a boy felt that he was harmed from being sexually abused or realized later in life that the sexual abuse caused emotional damage, masculine norms may discourage him from acknowledging or discussing the sexual abuse with others.

In addition to internalized masculine norms, there are external actors who may reinforce masculine norms, thereby magnifying the internal conflict between CSA and traditional masculinity for sexually abused boys. Institutional agents (e.g., law enforcement, child protective service) who subscribe to cultural beliefs may minimize the prevalence or negative effects of CSA for boys (Spataro et al., 2001). One survivor described the lack of resources and support for male victims:

For women, you just call your local 800 rape line and you’ve got everything from a place to stay, food, money. They take care of your bills and your kids and everything else. I can call up and plead all I want, I can’t get a cup of coffee. And that is like one of the biggest, most frustrating things in the world for me. (Lisak, 1994, p. 531)
Furthermore, parents or caregivers who traditional masculine norms may also impede recovery for sexually abused boys. Because of the lack of awareness of male sexual victimization, parents may be less vigilant in monitoring or detecting problems following victimization for sexually abused boys (Spataro et al., 2001).

The lack of awareness of male sexual victimization can extend into clinical work with MSAC. Researchers have found that some mental health professionals have gender biases that can impede the identification, assessment, and treatment of CSA in male clients (Holmes et al., 1996; Lab et al., 2000). Because men often engage in therapy for problems other than CSA (Steever et al., 2001), clinicians are less likely to question them about the possibility of a history of CSA than women (Spataro et al., 2001).

**Hegemonic masculinity.** The experience of CSA clashes with many gender norms in our society and may create an internal conflict regarding gender identity for MSAC (Holmes et al., 1998; Hunter, 1991; Lisak, 1994; Nasjleti, 1980). Rather than attempting to understand, address, and reconcile the internal conflict over masculinity, some MSAC adopt a different approach: hegemonic masculinity or hyper-masculinity (Dorais, 2002; Lisak, 1994). In these cases, sexually abused men guard the secret of being sexually abused through behaviors designed to prove or reassert their masculinity according to stereotypical norms (i.e., excessive conformity). Hunter (1991) referred to this phenomenon as a “...proclivity for the emergence of masculine-proving behaviors...” (p. 206).

The construct of hegemonic masculinity may explain many of the behavioral outcomes associated with CSA for men. For example, researchers have found that CSA is associated with sexual promiscuity, high-risk sexual practices, and even offending behaviors for MSAC (Bartholow et al., 1994; Holmes et al., 1998; Meston, Heiman, & Trapnell, 1999). These behaviors may reflect a desire to demonstrate masculine norms such as dominance, superiority over women, and heterosexuality. For example,
substance abuse may be a form of self-medication or numbing (Hussey, Strom & Singer, 1992; Polusny, & Follette, 1995) that is largely driven by a heightened degree of risk-taking and emotional control, two norms measured in Mahalik’s inventory. Qualitative research has identified a typology of coping responses including a conformist strategy where the MSAC covers insecurities, fears, and painful memories by creating a persona of an average, normal guy (Dorais, 2002). The quest to simultaneously deny the CSA experience and conform to male norms may result in extreme scores on the CMNI. Extreme conformity, in turn, may be a significant pathway to subsequent psychopathology, but it has not yet been investigated by researchers using standardized measures. Based on the concept of hegemonic masculinity, I propose that MSAC who report high conformity to masculine norms will have higher levels of mental distress than MSAC who do not report high conformity.

Posttraumatic Growth (PTG)

Definition and measurement of PTG. There is a well-established literature on the psychological problems that are associated with severe stressors or traumatic events such as CSA. However, since the late 1980s and early 1990s, scholars have begun to examine whether some people who are exposed to potentially trauma-inducing events may perceive that some good has emerged from the experience (Tedeschi & Calhoun, 1996). The term PTG has been defined as “...positive psychological change experiences as a result of the struggle with highly challenging life circumstances” (Tedeschi & Calhoun, 2004, p. 1). Researchers in this field use terms such as trauma, crisis, and highly stressful events as roughly synonymous experiences that describe “...sets of circumstances that represent significant challenges to the adaptive resources of the individual, and that represent significant challenges to individuals’ ways of understanding the world and their place in it (Janoff-Bulman, 1992)” (Tedeschi et al., 2004, p. 1).

To further define the concept of PTG, Tedeschi et al. (1996) proposed that PTG is comprised of three areas of perceived benefits: perceived changes in self, a changed sense
of relationships to others, and a changed philosophy of life. Some people who are exposed to traumatic events may experience emotional growth and a newfound confidence in their capacity to handle difficult situations. Other people may improve and deepen their connection to family members and friends. As a result of the severe stressor or potentially trauma-inducing event, a person may be more emotionally expressive, willing to self-disclose, and likely to accept help and support from others. Finally, Tedeschi et al. (1996) contended that some people find a new appreciation for life after struggling to find meaning from the stressors or event.

One manifestation of PTG is when a stressful or traumatic event motivates survivors to explore ways of helping others. Staub and Vollhardt (2008) suggested that psychological changes that result from coping with trauma may facilitate caring for others, a phenomenon that they call *altruism born of suffering*. For example, a group of mothers whose children were killed in drunken driving accidents formed the organization called Mothers Against Drunk Driving (MADD). Many MADD members turned the death of their child into efforts to help others through prevention campaigns and support services for other grieving parents.

Although there are similarities between perceived benefits (i.e., PTG) and the creation of meaning from traumatic events (i.e., account-making), researchers have found that they are distinct processes. In research with data from the Stanford Bereavement Project, Davis and Nolen-Hoeksema (2001) found that “whether the bereaved family member was able to find benefit in the loss was not significantly associated with his or her ability to make sense of it” and that “…making sense of the death does not seem to aid one in deriving benefit” (p. 735). Unlike the process of finding meaning from a loss, the researchers found that finding benefit had little to do with characteristics of the traumatic event and more to do with the survivor’s personality traits.

*Uses of PTG in research.* Although the notion that good can arise from suffering dates back to early civilizations (Tedeschi et al., 2004), the term PTG has recently been
incorporated into research in a variety of ways. Researchers have used PTG as an outcome variable with various populations. In these studies, the researchers identified factors that contribute to PTG. Some examples of these studies include research with persons exposed to terrorism on television (Park, Aldwin, Fenster, & Snyder, 2008), bereaved college students (Ho, Chu, & Yiu, 2008; Taku, Calhoun, Cann & Tedeschi, 2008), persons who lost a family member due to industrial accidents (Davis, Wohl, & Verberg, 2007), children of divorced parents (Harvey, 2008), and HIV caregivers (Cadell, 2007).

Other researchers have explored whether PTG predicts mental health. In populations ranging from Arabs and Jews who witnessed acts of terrorism to adult female survivors of sexual assault, researchers have examined whether PTG is related to PTSD (Hall et al., 2008; Hobfoll et al., 2008), stress (Anderson, & Lopez-Baez, 2008), and general distress and well-being (Frazier & Berman, 2008). Although some researchers have found that PTG is associated with lower levels of psychological problems, other researchers have not found support for this relationship or have found that PTG may be associated with more mental health problems. In a review of the empirical literature on PTG, Tedeschi et al. (2004) concluded: “The available data suggest that experiencing higher levels of posttraumatic growth is correlated with, and perhaps may result in, reduced levels of psychological distress, but not always” (p. 13).

Finally, some studies have explored whether PTG operates as a third variable (i.e., moderator or mediator) between variables and mental health (e.g., Morrill et al., 2008). In an exploratory study of psychological adjustment in 172 adult cancer survivors, Park et al. (2008) examined whether creating meaning from the experience of cancer mediated the relationship between meaning-making activities and psychological adjustment. Created meaning was conceptualized as an outcome of that process, and included PTG, increased life meaningfulness, and perceived discrepancy of cancer with a just-world belief. Both cross-sectional and longitudinal models indicated that meaning-making
activities were related to better adjustment through the concept of created meanings of the cancer experience. Although this study combined creating meaning and finding benefits, the findings nonetheless lend preliminary support that PTG indirectly promotes the mental health for survivors of traumatic life events such as the diagnosis and treatment of cancer.

The research base on PTG has increased dramatically in the past decade and the concept has been applied to a growing number of populations. The literature search for this study, however, did not produce any results indicating that a standardized, validated measure of PTG has been applied to MSAC in any research studies to date. One study (O’Leary, 2009), however, measured positive reinterpretation and growth among a clinical sample of 147 men with histories of CSA using a subscale of a coping style inventory (Carver, Scheier, & Weintraub, 1989). O’Leary (2009) found that positive coping strategies (e.g., positive reinterpretation and growth, instrument social support) reduced the odds of a clinical classification based on somatic symptoms, anxiety, social dysfunction, and severe depression. However, O’Leary (2009) pointed out that future research is needed to more fully understand how coping strategies such as positive reinterpretation and growth relate to other concepts such as social support.

In the current study, deriving benefits (e.g., sense of self, relationships with others, philosophy of life) from surviving child sexual abuse may improve a sense of self-efficacy and control for MSAC. As a result of feeling more effective in their daily lives or when they remember the sexual abuse, MSAC who perceived benefits from the sexual abuse may have better mental health. Thus, I hypothesize that the level of PTG will be negatively related to the level of mental distress for MSAC.

**Moderator and Mediator Variables**

In this section, I will discuss the moderating and mediating effects of third variables on relationships in the general model. Baron and Kenny (1986) offered a useful definition of a moderating variable: “In general terms, a moderator is a qualitative (e.g.,
sex, race, class) or quantitative (e.g., level of reward) variable that affects the direction and/or strength of the relation between an independent or predictor variable and a dependent or criterion variable” (p. 1174). They continued: “In the more familiar analysis of variance (ANOVA) terms, a basic moderator effect can be represented as an interaction between a focal independent variable and a factor that specifies the appropriate conditions for its operation” (Baron et al., 1986, p. 1174). Although there may be significant direct effects of both the predictor and the moderator variable on the outcome, these effects are not “directly related conceptually to testing the moderator hypothesis” (Baron et al., 1986, p. 1174).

Earlier in this chapter, I hypothesized that various indicators of CSA severity will be associated with more mental distress in the general model. However, the relationship between abuse severity and mental distress may vary depending on the level of PTG. For example, among MSAC who report that their sexual abuse involved physical injury, men who experienced lower PTG will have more mental distress than those who experienced higher PTG. Thus, I hypothesize that PTG will moderate the relationship between abuse severity indicators and mental health for MSAC (see Figure L2).

According to Keith (2006), “the term mediation means the same thing as an indirect effect” (p. 168). Baron et al. (1986) further clarified the difference between a mediator and a moderator variable: “In general, a given variable may be said to function as a mediator to the extent that it accounts for the relations between the predictor and the criterion…Whereas moderator variables specify when certain effects will hold, mediators speak to how or why such effects occur” (p. 1176). In a three-variable system, there is a causal relationship between the independent variable and the dependent variable, between the mediator variable and the dependent variable, and also between the independent variable and the mediator variable. Baron et al. (1986) outlined the necessary requisites of a mediator variable:
A variable functions as a mediator when it meets the following conditions: (a) variations in levels of the independent variable significantly account for variations in the presumed mediator (i.e., Path $a$), (b) variations in the mediator significantly account for variations in the dependent variable (i.e., Path $b$), and (c) when Paths $a$ and $b$ are controlled, a previously significant relation between the independent and dependent variables is no longer significant, with the strongest demonstration of mediation occurring when Path $c$ is zero. (p. 1176)

Earlier in this chapter, I proposed that high conformity to masculine norms will be positively related to mental distress and that account development will be negatively related to mental distress. However, I am also proposing that the level of account-making (i.e., account development) will mediate the relationship between conformity to masculine norms and mental health for MSAC (see Figure L3). Participants who report high conformity to masculine norms may be less likely to progress through account-making or develop their account of the sexual abuse than participants who do not report high conformity to masculine norms. Furthermore, the level of account development may be negatively related to mental distress. Thus, conformity to masculine norms may impact mental health indirectly through account development.

Similarly, I hypothesize that the level of PTG will mediate the relationship between conformity to masculine norms and mental health for MSAC. Participants who report high conformity to masculine may be less likely to experience PTG than participants who do not report high conformity to masculine norms. Additionally, PTG may be negatively related to mental distress for MSAC. Therefore, conformity to masculine norms may impact mental health indirectly through PTG.

**Control Variables**

This study will examine the effect of variables in four domains (abuse severity, account-making, masculinity, and PTG) on mental distress for MSAC. To better understand the effect of variables within each of those domains, demographic (e.g., race) and socioeconomic variables (e.g., income, education) variables that are known to have an effect on mental health will be controlled. Membership in a survivor organization will also be controlled. In this section, I will review the literature on four other control
variables that will be included in the model: age, recent stressors, childhood stressors, and age at first abuse.

Age. Although the knowledge base on the short-term effects of CSA on children is well-established, researchers are just beginning to explore how early childhood experiences such as CSA may affect the long-term mental health of adults. Most of the research on the long-term effects of CSA has included participants in early adulthood. Very few studies have included adults over the age of 50 years.

Draper et al.’s (2008) pioneering study, detailed earlier in this chapter, included 21,000 older adults aged 60 and above. Multivariate analyses indicated that participants with a history of either physical or sexual abuse in childhood had a greater risk of poor physical or mental health than those who did not report such a history. Furthermore, those who reported both types of abuse also had an even higher risk of poor physical or mental health. As one of the first studies of its kind, this study demonstrated that the negative effects of physical and sexual abuse can last throughout the lifespan.

In another groundbreaking study, Talbot et al. (2009) examined the relationship between CSA and long-term outcomes such as illness burden, physical functioning, and bodily pain in a sample of 163 psychiatric patients over 50 years of age. The researchers collected data through multiple sources: self-report measures, chart reviews, and clinician ratings. The researchers found that compared to those who were not abused during childhood, participants who reported a history of severe CSA had higher cumulative medical illness burden, worse physical functioning, and greater bodily pain. For illness burden, the effect of severe CSA was roughly comparable to adding 8 years to the chronological age of survivors. For physical functioning and bodily pain, severe CSA was comparable to adding nearly 20 years of age. In discussing their findings, Talbot et al. (2009) concluded that “the impact of CSA is profound even into later life, and future research on the mechanisms and remediation of its effects is warranted” (Talbot et al., 2009, p. 421).
These two studies (Draper et al., 2008; Talbot et al., 2009) demonstrated the potential for CSA to have long-lasting adverse effects. Nonetheless, very little is known about the nature of the relationship between age and mental health for adults with CSA histories. In a recent study of predictors of mental health problems in 172 adults who were sexually abused as children (80.2% female, 19.8% male), O’Leary et al. (2010) found that several abuse characteristics and disclosure variables were related to a greater number of mental health symptoms. An unexpected finding, however, was that participants in their 30s and 40s reported more mental health symptoms than participants in their 20s or those who were over 50 years of age.

In interpreting the results related to age differences, O’Leary et al. (2010) speculated that adults in their 20s may deny or minimize the CSA, but that mental health symptoms may worsen for adults as they age and then dissipate later in life. This interpretation implies that there is a developmental process for adults with CSA histories. Alternatively, the researchers speculated that some of the age differences may be due to a cohort or generational effect. Younger participants may have benefited from improved prevention and treatment efforts. Because of the cross-sectional design of the study, O’Leary et al. (2010) were unable to determine if the age results were due to a developmental process, a cohort effect, or some other explanation.

Because of the paucity of research on the relationship between age and mental health among adults with CSA histories, it is uncertain whether age has a positive or negative effect on mental health of MSAC. Thus, for the current study, the effects of age will be controlled.

Recent stressors. In evaluating which factors contribute to mental health problems for MSAC, it is important to consider whether factors such as recent life events may explain some of the variability in psychological problems. Some of those events could include sudden physical illness (e.g., heart attack, stroke), chronic physical illness (e.g., cancer, dementia), financial problems (e.g., loss of job, bankruptcy), or relationship
problems (e.g., divorce). However, few studies have specifically examined the effect of recent stressors on the mental health for adults with histories of CSA. Using a clinical sample of 176 adults (91 men; 76 women), Whiffen et al. (1997) hypothesized that one type of recent life stressor—victimization during adulthood—would mediate the relationship between CSA and depression scores. The researchers did not support for this relationship. In another study that examined recent stressors, Horwitz et al. (2001) found that lifetime events such as unemployment, money problems, homelessness, divorce/separation, death of a parent, and others were highly correlated with CSA and independently contributed to higher rates of lifetime dysthymia and anti-social personality disorder for men.

Boudewyn et al. (1995) examined the relative contribution of CSA, other childhood stressors (e.g., death of a family member, separation/divorce, physical/emotional abuse) and recent stressors (e.g., serious illness, separation/divorce) in explaining depression and self-destructive behaviors in adulthood for a college sample of 173 men and 265 women. The researchers found that CSA explained 7% to 13% of the variance in the outcomes and was “the strongest and most consistent predictor of adult depression and self-destructiveness” (p. 456). However, the combination of CSA and other childhood stressors explained 9% to 18% of the outcomes. After adding recent stressors during adulthood, Boudewyn et al. (1995) were then able to explain 14% to 29% of the mental health outcomes. The researchers concluded:

Clearly, researchers doing cross-sectional research on the long-term effects of CSA must continue to struggle with the challenge of discriminating abuse-specific from abuse-concurrent, abuse-antecedent (Briere, 1992), and postabuse events. While preliminary, our analyses suggest that the occurrence of certain life stressors is more frequent among individuals with histories of CSA. (Boudewyn et al., 1995, p. 456)

Although there is not a substantial amount of research in this area, it is plausible that recent stressors may be related to the mental health of MSAC. For this reason, I will control for the level of recent life stressors for participants in this study.
Childhood stressors. Researchers have begun to examine whether environmental factors during childhood (i.e., stressors) are related to long-term mental health problems for adults with histories of CSA. It is important to consider the role of other childhood stressors because “…sexual abuse does not occur in a vacuum; it occurs in a childhood context that more often than not includes other forms of maltreatment, other traumas, and various degrees of family dysfunction, disruption, and deprivation” (Finkelhor, 1998, p. 1865). This section reviews research related to other childhood stressors.

Epidemiological research has documented that a large percentage of children experience different types of direct and indirect victimization. In a recent study that used a nationally representative sample (n=4549), Finkelhor, Turner, Ormrod, and Hamby (2009) examined the prevalence of direct and indirect victimization in several categories: sexual victimization (e.g., assault, rape, harassment), maltreatment (e.g., physical abuse, neglect), violence (e.g., family assault, assault in community, bullying), and property victimization (e.g., robbery, vandalism). They found that 60.6% of the participants had experienced (or witnessed) at least one type of victimization in the previous year, 38.7% had been exposed to two or more types of victimizations, and 10.9% had been exposed to five or more types of victimization. Finkelhor et al. (2009) concluded that American children experience high levels and multiple forms of victimization, that exposure to victimization accumulates over the length of childhood, and that other researchers need to consider multiple forms of victimization rather than focusing exclusively on the effects of one type of violence.

In the literature on the effects of childhood stressors on mental health, a frequently cited stressor is other forms of child maltreatment. Co-morbid forms of maltreatment (e.g., emotional abuse, physical abuse) are common and have an additive negative effect on psychological outcomes (Banyard et al., 2004; Boudewyn et al., 1995; MacMillan et al., 2001; Molnar et al., 2001; Rind & Tromovitch, 1997; Rind et al., 1998; Roesler et al., 1994; Rosen & Martin, 1996; Windle et al., 1995). When it co-occurs with
CSA, physical abuse can reinforce helplessness and compliance, thus exacerbating the negative psychological effects of CSA.

Edwards, Holden, Felitti, and Anda (2003) examined the effect of multiple forms of child maltreatment on adult mental health with a large sample \((n = 8667; 54\% \text{ female; } 46\% \text{ male})\). In their literature review, the researchers summarized findings from 10 prevalence studies of child abuse from the 1990s and found that multiple forms of child maltreatment were common. The findings from their own study demonstrated a dose-response relationship between the number of maltreatment types and mental health outcomes such as depression and anxiety levels (Edwards et al., 2003). Similar to Finkelhor et al. (2009), Edwards et al. (2003) urged other researchers to examine co-occurring forms of abuse rather than focusing on a single form of maltreatment.

In a recent pioneering study, Draper et al. (2008) examined the independent and cumulative effects of both sexual and physical abuse into later life. Because the study included 21,000 participants aged 60 and above \((58.7\% \text{ female, } 41.3\% \text{ male})\), it was one of the first to examine the relationship between these forms of abuse and both mental and physical health outcomes in late life. Multivariate analyses indicated that a history of either physical or sexual abuse in childhood increased the risk of poor physical and mental health. Furthermore, a history of both types of abuse increased the risk even further for poor physical or mental health. The researchers concluded that “…the effects of childhood abuse appear to last a lifetime” (Draper et al., 2008, p. 270), but that more research is needed in this area.

More specifically, researchers have demonstrated that physical abuse frequently co-occurs with CSA for boys (Edwards et al., 2003; Finkelhor et al., 1990; Holmes et al., 1998). The combination of CSA and physical abuse appears to have an especially deleterious effect on long-term psychological health. Among MSAC, the co-occurrence of physical and sexual abuse during childhood is associated with higher depression scores than either type of abuse alone (Health et al., 1996; MacMillan et al., 2001; Rosen et al.,
1996; Whiffen et al., 1997; Windle et al., 1995). Other researchers have found that the influence of physical abuse on adult depression is more nuanced. For example, Banyard et al. (2004) did not find a statistically significant relationship between physical abuse and depression among sexually abused respondents but did find such a relationship for severe physical abuse (i.e., abuse resulting in injury) and depression.

In addition to co-occurring forms of abuse, researchers have identified other contextual variables that are highly associated with CSA. Some of those variables include a one-parent family structure, parental substance abuse, parental unemployment, parental criminal behavior, and domestic violence (Holmes & Slap, 1998; Hurwitz, Widom, McLaughlin, & White, 2001; Hunter, 2006; Putnam, 2003). Although some researchers examined the relationship between these variables and CSA individually, other researchers have examined them as a constellation or syndrome through the use of an index.

In an important study, Molnar et al. (2001) analyzed retrospective reports of CSA and a range of psychiatric disorders in a large nationally representative sample of 5877 adults (2921 females, 2945 males) from the 1990 National Comorbidity Survey (NCOS). The researchers examined more than 19 different types of childhood adversities and combined them into seven adversity clusters: mother’s verbal or physical abuse toward the child, father’s verbal or physical abuse toward the child, parents’ verbal or physical abuse of each other, mother’s psychopathology, father’s psychopathology, mother’s substance abuse problems and antisocial behavior, and father’s substance abuse problems and antisocial behavior. Their results indicated that all of the adversity clusters were associated with CSA for both men and women.

Other researchers have established that childhood stressors (other than CSA) are associated with mental health problems for adults with CSA histories. For example, parental substance use (Lisak, 1994; Nelson et al., 2002; Windle et al., 1995) and poverty (Hurwitz et al., 2001) have been associated with mental health problems for adults with
histories of CSA. In another study, Banyard et al. (2004) found that injury by a caregiver and other traumas during childhood (e.g., violent crime, serious accident) were associated with CSA for men and explained higher levels of mental health symptoms including depression and anxiety. A meta-analysis found that family functioning during childhood (i.e., level of conflict, support, number of parents) explained a considerable amount of variance in adult psychological outcomes of participants with histories of CSA (Rind et al., 1998).

Some researchers have proposed that childhood stressors such as family functioning explain more variance in long-term mental health than CSA and contend that the long-term effects of CSA are overstated (e.g., Rind et al., 1998). Most of the research, however, does not support that claim. In fact, most of the research provides support for the relationship between CSA and adverse long-term outcomes. For example, after controlling for 19 different types of childhood adversities, Molnar et al. (2001) found “...a strong, independent, and statistically significant relationship between CSA and the majority of mood, anxiety, and substance disorders” examined in the study (p. 787). Nonetheless, childhood stressors that co-occur with CSA may undermine a child’s development and independently contribute to long-term mental health problems for MSAC. Thus, I will control for a set of childhood stressors for participants in the current study.

*Age first abused.* One variable related to abuse characteristics—the age that the child was first sexually abused—has frequently been included in models that attempt to explain mental health for CSA survivors. Some researchers have found that age at first abuse is negatively related to mental health problems. Children who were younger at the time they were first abused were more likely to report anxiety (Banyard et al., 2004) or attempt suicide (Boundewyn & Liem, 1995), for example, than children who were older at the time that they were first abused. Some clinical researchers theorized that sexual abuse can inflict a narcissistic injury to a child in the form of a profound blow to his/her
self-esteem (Gonsiorek, Bera, & Letourneau, 1994). When this occurs early in the child’s life, it can severely undermine subsequent developmental processes and growth. Also, compared to older children, younger children may have fewer resources and be less equipped to label the experience as abuse, report the abuse, seek support, and avoid revictimization.

However, not all researchers found this relationship between age first abused and mental health outcomes (Ruggiero, McLeer, & Dixon, 2000). In another study, Easton, Coohey, and O’Leary (2010) found that older age at first abuse increased the odds of emotional and evaluative problems in psychosexual functioning for adults who were sexually abused during childhood. The researchers suggested that the sexual abuse may more negatively affect children who are older because they are more likely to understand the implications of the abuse, comprehend the social norms that were violated, and experience negative emotions such as guilt, shame or fear. In their review of empirical research on CSA, Kendall-Tackett, Williams, and Finkelhor (1993) concluded that there is considerable ambiguity regarding the role of age in explaining psychological adjustment following CSA. Because the empirical research is inconclusive, I will control for the effect of age at first abuse during modeling.

In the next chapter, the Methods, I will present details on how the study was carried out.
CHAPTER 3
METHODS

Research Design

This study used a cross-sectional survey design with purposive sampling from three national organizations to collect data from 487 men who were sexually abused during childhood. Participants completed an electronic, internet-based survey that was administered through WebSurveyor under the license of the Instructional Technology Services department at the University of Iowa (see Appendix B for a copy of the survey). Data were collected during an 8-week time period (April 23-June 18, 2010).

Several data collection methods were initially considered. Although it would have been desirable to conduct a national survey of MSAC using a representative sample obtained through probabilistic sampling techniques, it was not economically feasible. Prevalence rates of CSA for adult men in the general population vary considerably due to factors such as the definition of CSA used by the researcher. Several national studies based on representative community samples placed the prevalence rate of CSA for men in the general population at approximately 16% (Briere & Elliott, 2003; Dube et al., 2005; Finkelhor et al., 1990). To generate enough MSAC participants to test the hypotheses in the current study, a national probability sample with thousands of men would have been needed. Conducting this type of study would have required a large staff, considerable financial resources, and a great deal of time. Resource constraints prohibited this approach.

Alternatively, some researchers have conducted studies with probability sampling using official administrative records from government agencies such as child protective services (CPS). This approach was not used due to the inherent limitations of administrative records and feasibility issues. First, many states did not start collecting data on cases of child sexual abuse until after the mid-1970s. Using existing lists from government agencies would have excluded men aged 50 and above, thereby making it
impossible to examine the relationship between age and mental health problems. Second, due to lawsuits and concerns about privacy, many states expunge CSA records after a certain period of time and will not provide a list of names of those who were abused. As a result, CPS lists are missing a large proportion of cases or are unavailable. Third, administrative records include only cases of CSA that have been reported to and confirmed by government authorities. Most cases of CSA, especially those involving intra-familial abuse, are never reported to officials (Finkelhor, 1984a). Furthermore, there are numerous reporting barriers unique to boys such as internalized homophobia (Spataro et al., 2001). Thus, a comprehensive, national list of sexually abused men over the age of 18 does not exist, and lists from state agencies have significant limitations that would have undermined some of the central aims of the current study. Even if such a list was available, the current study did not have sufficient resources to track down individuals on the list to identify potential participants.

A third approach to the study of MSAC would have been to use an existing dataset that was drawn from a nationally representative sample. One example of a national dataset is the National Survey of Midlife Development in the United States (MIDUS; Brim et al., 1996). Although some of the national datasets include items to measure whether the participant was sexually abused during childhood, most datasets do not include measures on other concepts that are central to the model proposed in this study (e.g., disclosure, masculinity, post-traumatic growth). Therefore, this study included survey items related to the central concepts in the model that are missing from national datasets.

The target population for this study—men over 18 years of age who were sexually abused during childhood—is a very difficult group to access for research purposes. Due to a variety of reasons including cultural norms surrounding masculinity, adult men with sexual abuse histories often do not disclose such information or self-identify as survivors (Finkelhor et al., 1990; Grubman-Black, 1990; Lew, 1990; Hunter, 1990; O’Leary et al.,
The stigma associated with CSA for men is another reason MSAC remain isolated and reluctant to participate in research (Grubman-Black, 1990; Hunter, 1991; Lew, 1990; Mendel, 1995). Because of the considerable difficulties in recruiting research participants, MSAC remain a highly understudied group (Holmes et al., 1998; Spataro et al., 2001).

The research design—a cross-sectional study using a purposive sample through an internet-based survey—had many benefits. First, it provided a unique research opportunity to reach a hidden, understudied population. The anonymous internet-based survey provided a high degree of privacy, confidentiality, and convenience to participants. Second, the research design allowed the researcher to collect a relatively large sample within a relatively short timeframe and with limited resources and minimal burden on participants. The size of the sample was adequate to examine hypotheses and also contribute to theory development. Third, this design was an improvement over many of the previous studies on this population that relied on very small, clinical or college-aged samples that have limited generalizability.

Data Source

Participants for this study were recruited from three national organizations: The Survivors Network of those Abused by Priests (SNAP), MaleSurvivor, and 1in6. Founded in 1989, SNAP is the nation’s oldest, largest, and most active support group for adults sexually abused by religious authority figures such as priests, ministers, rabbis, and nuns (SNAP, 2010a). Operating independently of all churches, SNAP is a non-profit organization with the dual mission of supporting survivors of clergy abuse in personal healing and “by pursuing justice and institutional change by holding individual perpetrators responsible and the church accountable” (SNAP, 2010b).

With a national office in Chicago, Illinois, SNAP has organized an extensive network with active local branches in more than 40 states. Although the organization was created primarily in the aftermath of the abuse scandals in the Catholic Church in the
United States, SNAP has branches in several other Christian denominations (e.g., Baptist, Presbyterian, and Orthodox), ethnic communities (e.g., Native-American, Hispanic), and countries in North America (e.g., Mexico, Canada). SNAP provides its members opportunities for peer-to-peer support through help phone lines, internet discussions, and chat rooms as well as educational and recovery workshops at national conferences. Some examples of other SNAP activities include press releases on court cases and abuse issues, organized protests and vigils, a national clergy abuse database tracker, a publication to share personal stories of CSA, legislative initiatives, and memorial or tribute projects such as a survivor’s quilt. A complete description of SNAP resources and activities is available at their internet home page: www.SNAPnetwork.org.

SNAP has approximately 9,000 members consisting of survivors of clergy sexual abuse, supporters, and advocates (D. Clohessey, personal communication, October 9, 2008). For privacy reasons, SNAP does not keep detailed demographic information on its members. However, leaders estimate that about two-thirds of its members have histories of CSA, 50% are men, and more than 50% are over 40 years of age (B. Dorris, personal communication, October 13, 2008). Approximately 5,000 (55% of its members) provided active email accounts to SNAP. SNAP records indicate that their home page receives several thousand hits per week (B. Dorris, personal communication, December 28, 2009).

Participants were also recruited through a second organization: MaleSurvivor. MaleSurvivor emerged from the early organizing efforts of mental health practitioners dedicated to improving understanding and treatment of adult male survivors of CSA (MaleSurvivor, 2010a). In 1988, the first professional Conference on Male Sexual Victimization was held in Minneapolis, Minnesota. One year later, more than 400 professionals including writers, researchers, and practitioners in the area of male sexual victimization gathered for the second conference. In 1994, a core group of mental health professionals who had attended or organized previous conferences formed a board of
directors and took steps to incorporate the non-profit organization called the National Organization on Male Sexual Victimization. At the 1995 conference in Columbus, Ohio, participants approved by-laws and voted for incorporation of the organization.

During the process of incorporation, the name of the organization was changed to MaleSurvivor: The National Organization on Male Sexual Victimization. The official mission statement of the MaleSurvivor is as follows: “We are committed to preventing, healing, and eliminating all forms of sexual victimization of boys and men through treatment, research, education, advocacy and activism” (MaleSurvivor, 2010b). In addition to offering resources to assist mental health professionals and to educate the general public about male sexual victimization, the organization offers a variety of services to men with histories of CSA. Some of those services include national conferences, weekend therapeutic retreats, electronic discussion groups and chat rooms, resource lists of self-help books, an electronic newsletter, and an online tool for locating a therapist. Although the organization has a small national office in Washington, DC, most activities and services are organized through its internet home page at www.malesurvivor.org.

The membership of MaleSurvivor consists of approximately 4,000 members including mental health professionals, researchers, MSAC, and other people generally concerned about male sexual victimization (A. Rodriguez, personal communication, October 2, 2008). Of those members, approximately 50% were sexually abused during childhood. The organization has nearly 75% of its members’ email addresses. The majority of members interact with the organization through electronic discussion boards on the home page (K. Followell, personal communication, January 8th, 2010). The discussion board section of the home page averages 1,000s of new posts each week by active participants. An even higher number of users visit the discussion boards each week leaving a post. Although access to some of the discussion boards is restricted to
MaleSurvivor members, the discussion board dedicated to ongoing research is open to both members and non-members.

Finally, participants were also recruited through a third organization: 1in6. Founded in January, 2007, 1in6 is a national organization that is dedicated to helping men who have had unwanted or abusive sexual experiences in childhood live healthier, happier lives (1in6, 2010). Through its web site, the organization provides a wide variety of online, referral, and outreach resources to both male survivors and their supporters. Some examples of resources include basic information on sexual abuse of boys and men, a lending library of books and videos, a therapist locator network, and training opportunities for facilitators of support recovery groups. The board of directors includes several high-profile celebrities who are also survivors (e.g., cycling champion Mr. Greg LeMond; hockey all-star Mr. Theoren Fleury) as well as a distinguished group of therapists, authors, and researchers known for their expertise in the field of sexual abuse and male survivors. To promote privacy and confidentiality, the organization does not have a formal membership base, does not collect any personal information (e.g., email addresses) from its web site visitors, and operates based on donations and grants (S. LePore, personal communication, May 3, 2010).

One of the founding members of 1in6 is Dr. Jim Hopper, Ph.D. In addition to being a researcher, therapist, and independent consultant, he is currently a psychology instructor in the Department of Psychiatry at Harvard Medical School. Dr. Hopper is the web site manager of the 1in6.org, and also maintains a separate web site (www.jimhopper.com) on child sexual abuse. Dr. Hopper’s web page is an extremely thorough, informative, and practical resource in providing information on abuse and recovery resources. It is also very popular and accessible; it receives more than 400,000 visits each year. A sub-section of the home page is titled Sexual Abuse of Males: Prevalence, Lasting Effects, and Resources, which is linked to the 1in6.org
organization’s web site and is one of the most comprehensive online resources for MSAC that exists.

The primary advantage of recruiting a sample through these three organizations was that it allowed me to gain access to a hidden, marginalized population: MSAC. All three of these organizations are national in scope, have members (or visitors) in different geographic areas of the United States, and have active web sites that are available to anyone with internet access. Furthermore, two of these organizations—SNAP and MaleSurvivor—are among the largest existing survivor organizations in terms of the number of members. These characteristics allowed me to recruit a relatively large number of participants with limited resources and a small budget. Because most of the studies on MSAC have consisted of very small samples (e.g., clinical, college-aged), recruitment of participants through these three organizations represented an opportunity to conduct a study with a large sample from men living in different geographic regions that could advance the knowledge on MSAC.

Sample

Sampling procedure and selection criteria. The current study used purposive sampling to recruit men from three national organizations with membership bases that consisted of adults who were sexually abused during childhood. Purposive sampling targets a particular group of people and is very useful to identify a subset of a population that is difficult to locate or recruit (Rubin & Babbie, 2008). The national organizations represented a viable way to access a population that is very difficult to reach in the general population. Individuals were eligible to participate in the study if they reported that they were male, 18 years of age or older, and sexually abused as a child (i.e., before the age of 18 years). Additional eligibility requirements for participation were internet access and the ability to read the survey, which was written in English.

Recruitment procedure. Initially I intended to recruit participants by sending study announcements to members of the organizations through email. Due to privacy
concerns, however, leaders of the SNAP and MaleSurvivor organizations were unwilling
to provide their membership lists (1in6.org does not maintain a membership list).
Instead, the leaders agreed to help recruit study participants in other ways. Participants
were recruited into the study through two methods: (a) an email campaign (sent by the
national organization) and (b) a home page announcement.

SNAP leaders agreed to send a mass email message and two reminder messages
to all of its members who had provided email addresses. The initial email alerted
recipients of a research opportunity on the health and well-being of MSAC and provided
an electronic link (or Uniform Resource Locator [URL]) to the published survey for those
who were interested (see Appendix C). This message was sent on April 23, 2010, to
approximately 7200 members. Of those, 19.8% were immediately returned due to invalid
addresses. Thus, approximately 5800 members actually received the message (Barbara
Dorris, personal communication, April 28, 2010). Reminder messages were sent 2 weeks
(May 6) and 4 weeks (May 19) after the initial email to all of the SNAP members who
provided email addresses.

The other survivor organizations did not send emails for different reasons.
Because of the frequency of research requests and privacy concerns, MaleSurvivor has a
policy of not sending recruitment or research announcements directly to its members.
1in6.org is not a membership organization and thus was not able to send emails for
recruitment.

A second method of recruitment was through web page announcements (see
Appendix D). Both SNAP and MaleSurvivor posted a study announcement on their
home pages that began on April 26, 2010, and ended June 18, 2010. The announcement
briefly described the purpose of the study and what it entailed, and also provided the
electronic link to the survey. SNAP placed the announcement directly in the middle of
their home page. MaleSurvivor placed the announcement on their discussion boards, the
Research Forum. Both the SNAP home page and the MaleSurvivor discussion board were visible and accessible to all web site visitors regardless of membership status.

During the recruitment period, leaders at 1in6.org were in the middle of a major reconstruction of their home page including platform revisions. In a phone conversation, the president expressed concern that the web page reconstruction project would not be completed in time to assist with recruitment for the current study (S. LePore, personal communication, May 3, 2010). He referred me to Dr. Jim Hopper, the 1in6 web site manager and a founding member of 1in6.org. Dr. Hopper confirmed that the web site rework would not be completed in the immediate future, and instead suggested that I consider posting the announcement on another web site that he manages (www.jimhoppper.com), which is linked to 1in6.org (J. Hopper, personal communication, May 19, 2010). The announcement was eventually posted on www.jimhopper.com in late May 2010 and stayed active until the end of the recruitment period. The announcement was listed on the Sexual Abuse of Males page under Announcements.

Response rate. Researchers have found that the typical response rate for electronic surveys varies significantly based on a number of factors including number of total contacts, personalized contacts, and pre-contacts (Cook, Heath, & Thompson, 2000). A meta-analysis of 199 online surveys conducted through one internet service (SuperSurvey) found that the median survey response rate was 26.45% (Hamilton, 2003). In the current study, it was impossible to calculate an accurate response rate for all three organizations due to missing information. More specifically, there was no way to identify the number of eligible potential participants who learned of the study from the web pages.

It was possible, however, to calculate an estimated response rate for the email campaign through SNAP. The national outreach director of SNAP stated that approximately two-thirds of its members are survivors of CSA and that half of its members are men (B. Dorris, personal communication, October 13, 2008). Thus, of the
5800 SNAP members who received the initial recruitment email, the total number of members who were eligible for the study was approximately 1932. Because 314 of the participants who completed the survey indicated that they were members of SNAP, the estimated response rate for the email campaign to SNAP members was approximately 16% (see Appendix G). However, this response rate was based on estimates of the SNAP membership that were described by the SNAP outreach director as “very rough” (B. Dorris, personal communication, October 13, 2008). Thus, this response rate was probably not an appropriate indicator of generalizability to the SNAP membership, a topic that will be addressed later in this chapter.

**Completion rate.** Of all of the individuals who began the survey, 40.9% actually completed and submitted it. Because the study announcement was sent to all members of the SNAP organization, it is possible that a portion of the non-completers were individuals who did not qualify for the study (e.g., female clergy abuse survivors). In the first study announcement, I provided my email address for comments and concerns about the study. As a result, I received several emails from individuals who indicated that they were female survivors of clergy sexual abuse and were disappointed to learn that they were ineligible for the study.

Although female survivors may partially explain the high rate of non-completers (59.1%), it is likely that there were other reasons. One of the final questions on the survey was an open-ended item that asked participants for general feedback or comments on the survey. An exploratory content analysis was conducted to identify positive, negative, and neutral feedback on the data collection procedures. Informed by Glaser and Strauss (1967) and Weber (1990), this analysis found that of the 287 participants who responded to this item, approximately 14% provided feedback that was critical of the data collection methodology. Some examples of the negative comments included: “it took 1 hour and 10 minutes to complete this survey with 2 breaks,” “I’m getting real tired of doing this survey,” and “I felt the last section (post-traumatic growth) was a little
confusing.” Based on this feedback, it is plausible that the survey was too lengthy, frustrating, or unclear for some of the potential participants to complete.

The response to this item also provided insight into the target population. It was apparent that a segment of the MSAC sample was deeply troubled by the abusive child experiences: “I don’t trust anyone, including whomever made this survey,” “I remain in constant pain,” “The shame is often unbearable…,” “My life continues to be in shambles…,” and “I can’t think, I just feel bad.” For some MSAC who began this survey, it is possible that completing the survey was too emotionally difficult; issues of trust, shame, or anguish may have caused them to end their participation before reaching the final page.

*Power analysis.* Prior to inferential analysis, several diagnostic tests were conducted including two that assessed statistical power. Using the Cohen (1988) method, the first analysis examined the appropriate sample size at which the $r^2$ could be considered statistically significant. With an alpha set at .05, power set at 0.8, and with 20 independent variables in the model, 213 participants would be sufficient to deem an $r^2$ of 0.1 as significant. The effect size of 0.1 was chosen (instead of 0.2) because it is reasonable for individual-level data.

A second power analysis was conducted using Dillman’s (2007) method. This analysis examined whether the estimated sample size of the current study would be sufficient to make estimates for population statistics within +/- 5%. Taking into account a population size (i.e., sampling frame) of 3,000, a homogenous population (male survivors of CSA), and a sampling error of +/- 5%, a sample of 226 participants would be sufficient for estimating population statistics. Both the Cohen (1988) and Dillman (2007) approaches to calculating power indicated that a sample of approximately 500 participants would be more than adequate to test the proposed hypotheses in the model.

*Demographic characteristics.* The demographic characteristics of participants in the sample are presented in Table K1. The sample included 487. The participants ranged
in age from 19 to 84 years with a mean age of 50.37 years (SD=10.82). The vast majority of the participants reported that they were white or Caucasian (90.9%). The remaining participants reported that they were other races (3.3%), biracial or multiracial (2.9%), African-American (1%), Native-American (1%), Asian (0.4%), and Pacific Islander (0.4%). A separate item measured ethnicity (i.e., Hispanic or Latino); 5.6% of the participants (n=27) reported that they were of Hispanic, Latino or Spanish descent.

Education was measured at the ordinal level using eight categories ranging from less than high school diploma (1) to doctorate or professional degree (8). The mean level of education for this sample was 5.33 (SD=1.78), which corresponds to a 2-year (associate’s) college degree. Due to small cell size, several categories were combined and the variable was recoded. As presented in Table K1, the levels of education were high school or less (10.3%), some college (31.5%), bachelor’s degree (30.3%), and master’s degree or higher (27.8%).

Income was measured at the ordinal level using twelve categories ranging from less than $19,999 (1) to more than $120,000 (12). The mean level of income for this sample was 6.26 (SD=3.80), which corresponds to the sixth income category ($60,000-$69,000). The average number of people in the household (including the participant) supported by this income was 2.48 (SD=1.49).

More than two-thirds of the sample (69.9%) reported that they were currently living with a spouse or partner. Of those, the mean number of years that they had lived with that person was 18.89 (SD=12.09).

The majority of participants (59.3%) reported that they were currently members of the clergy survivor organization called SNAP. Other participants reported that they were members of the survivor organization called MaleSurvivor (15.9%), members of both SNAP and MaleSurvivor (5.6%), or members of neither organization (19.2%).
Participants had a mean score of 2.27 (SD=2.05) on a scale of current stressors, which ranged from 0 to 12. They had a mean score of 1.87 (SD=1.77) on a scale that measured stressors during childhood, which ranged from 0 to 8.

**Generalizability.** To determine how well the results of the study can be generalized to men with CSA histories in the general population, I attempted to compare the sample in this study to samples in nationally representative studies on demographic, abuse severity and disclosure variables. The literature review for this study identified only a few studies of MSAC with nationally representative (Briere & Elliott, 2003; Finkelhor et al., 1990; Molnar et al., 2001) or large (Dube et al., 2005) samples. Unfortunately, none of these studies contained adequate data in the published articles for comparison on demographic variables. Repeated attempts to acquire this data were unsuccessful. In communication with the lead authors in those studies, the researchers indicated that they could not provide additional demographic information because they no longer had access to the original datasets (J. Briere, personal communication, July 2, 2010; S. R. Dube, personal communication, July 17, 2010; D. Finkelhor, personal communication, January 29, 2010). Thus, a meaningful comparison on demographic characteristics was not possible.

Finkelhor et al. (1990), however, presented enough data in their article on abuse characteristics and disclosure for comparison (see Table K2). The mean age at first abuse was only slightly higher in the current study than the comparison study (10.26 v. 9.9 years). The percentage of participants abused by a family member was the same in both studies: 11%. Also, the percentage of participants in the current study whose abuse involved penetration was also similar to the percentage of participants in the comparison study (61% v. 62%). However, in the current study only 2% of participants were abused by a stranger, and 57% of participants were sexually abused for more than one year. In Finkelhor et al.’s (1990) study, 40% of participants were abused by a stranger, and only 8% of participants were abused for more than one year. In the current study, 41% of
participants reported that the sexual abuse involved the use of physical force; the corresponding percentage in the Finkelhor et al. (1990) study was 15%.

Interestingly, a higher percentage of participants in the current study reported that they had told someone about the sexual abuse in their lifetime than in the Finkelhor et al (1990) study (97% v. 58%). Although only a small percentage of participants in the current study (8%) told someone about the abuse within one year of its occurrence, 43% of participants in the comparison study told someone within one year.

This analysis indicates that participants in the current study were very similar to participants in a study with a nationally representative sample (Finkelhor et al., 1990) on several abuse characteristics: age at first abuse, incest, and penetration. However, it appears that participants in the current study survived more severe abuse as measured by two variables: duration and use of physical force. Furthermore, a smaller percentage of participants in the current study told someone about the sexual abuse within one year of its occurrence than in the comparison study, but a higher percentage of participants in the current study told someone during their lifetime. Although rudimentary, this analysis provides support for the generalizability of results to MSAC who survived more severe sexual forms of sexual abuse.

In addition to abuse severity, the men in this study may differ from MSAC in the general population on demographic characteristics. In the current study, participants were mostly Caucasian, well-educated, and cohabitating with a spouse or partner. Furthermore, the median household income was at the sixth level ($60,000 - $69,999) which is slightly above the median household income in the general population. Moreover, most of the participants (80.8%) were members of a national survivor organization. Thus, it may be more appropriate to generalize the results to MSAC who are seeking support resources in coping with CSA.
Data Collection Procedures

The study was administered through an online, internet-based survey program (WebSurveyor) under the licensure of the University of Iowa through the Department of Instructional Technology Services (ITS). Data were collected from April 23, 2010, to June 18, 2010, using a 137-item survey organized into six major areas: mental health, sexual abuse and response, account-making, masculinity, background information, and posttraumatic growth.

On April 23, 2010, data collection began. As described earlier, participants were recruited with the assistance of the survivor organizations through two methods: direct emails and home page announcements. Please see Appendix C for a sample of the initial recruitment email and Appendix D for a sample of the home page announcement. In both methods, potential participants read an overview of the study and were provided with a URL. Interested individuals then clicked on the URL of the published WebSurveyor survey and were taken directly to a welcome page (see Appendix E). The short welcome letter provided a brief overview of the project and my background. The potential participants then proceeded to three screening questions related to eligibility: 1. “Are you 18 years of age or older?”, 2. “What is your gender?”, and 3. “Were you sexually abused before the age of 18?” The potential participants who responded to those questions with something other than “yes,” “male,” and “yes,” respectively, were directed to a message that informed them that they were not eligible for the study and thanked them for their time.

The potential participants who met the inclusion criteria were then presented with the consent letter that detailed the risks and benefits of participation in the study (see Appendix F). At the end of the consent letter, the potential participants were given a choice. If they still wanted to participate in the study, they were instructed to click the “next page” button to acknowledge that they had read the consent letter and agreed to participate in the study. They were then taken to the first page of the survey. Those
people who decided not to participate in the study were advised to end the session by closing out their web browser window.

Based on pretesting (which will be described later), the survey itself took approximately 30 minutes to complete. After completing the study, the participants were presented with a message that thanked them for their time, encouraged them to contact me with any questions, and provided the same list of support resources that were presented in the consent letter at the beginning of the study. The message also reminded participants to click the “submit results” button, which entered their individual responses into the WebSurveyor database for the study.

**Procedure to Protect Human Subjects**

This study received approval from the Institutional Review Board (IRB) at the University of Iowa on November 9, 2009. The original application listed SNAP as the only organization assisting with recruitment. Because I received support from MaleSurvivor and Dr. Jim Hopper for assisting with recruitment after the initial IRB approval date, I submitted two modification requests. Those requests to expand the recruitment efforts were approved on January 30, 2010, and on May 24, 2010. This section provides details on the potential benefits, risks, and efforts to minimize risks that were contained in the IRB application.

**Benefits.** Although there were no direct benefits to participants in the study, there were several possible benefits to society including the advancement of knowledge and theory on MSAC and improvement of clinical practice with MSAC. The conceptual model included variables within five different domains: demographic information, CSA characteristics, account-making, masculinity, and posttraumatic growth. Because few researchers have examined the effect of disclosure, masculinity, or posttraumatic growth on mental health for this population, this study filled gaps in our knowledge base. The study also made theoretical contributions by integrating account-making, masculinity, and posttraumatic growth.
This study hoped to improve clinical practice with MSAC. By identifying which factors contribute to mental health problems for MSAC, this study examined factors that might be useful in designing or modifying clinical interventions. The factors in the model that influenced mental health may be especially useful targets for practitioners. Ultimately, mental health practitioners may be able to use the results of the study to reduce the suffering and increase the level of functioning of MSAC.

Finally, the study may have had some indirect benefits to the research participants. By participating in the study and contributing to the advancement of science, the participants may have believed that they helped others who were also sexually abused during childhood. The participants may have acquired new knowledge of CSA by reading the executive summary of the study, which was sent to the national organizations for posting on their web sites.

Risks. Because of the nature of the research, there were some potential risks to study participants. The general topics of CSA and mental health functioning are sensitive and personal for many adults with histories of CSA. Recalling memories of a traumatic experience may have caused psychological distress for some participants. Some of the questions inquired about issues related to masculinity and the history of confiding about the CSA experience to others. For MSAC at different stages of recovery, these topics may have raised additional issues surrounding past and present relationships and exacerbated negative feelings. Additionally, many participants may not have disclosed their abuse histories to spouses/partners, family members, friends, and employers. Being inadvertently identified as a MSAC during the course of the study could have caused embarrassment and shame to the participants.

Minimization of risk. To protect against possible psychological and social risks, this study included several safeguards. All of the participants read and acknowledged that they understood the informed consent letter before starting the survey. The document explicitly stated that participation was completely voluntary and anonymous,
that any survey item could be skipped, and that the participant could end the survey at any time without any negative repercussions. To minimize psychological risks to participants, I provided a list of resources including a toll-free crisis hotline, a website for locating the nearest community mental health center, and web sites for survivor organizations.

The privacy of research participants was protected throughout the project. The internet-based survey was completed anonymously by each participant. Also, the participants were not asked to provide any identifying information (e.g., names, birthdates, social security numbers, email, or mailing addresses). Any personally identifying information that was provided by the participant was removed prior to data analysis.

All data were stored on highly secure servers at the University of Iowa. These servers used the latest firewall technology to prevent unauthorized users from accessing their data files. Only a limited number of the ITS staff members—those who are responsible for maintaining the system—had administrative privileges to access the actual data. Moreover, the ITS staff members actively managed the Web Surveyor program for security and disaster recovery purposes (ITS Staff, personal communication, December 15, 2008). On a daily basis, staff members backed up the operation system to a system image and the database to a tape library. Operating system patches were applied on a monthly basis. Both the web and database servers were located in a secure data center at the ITS office. Scheduled maintenance occurred on a weekly basis from Friday at 10:00 p.m. to Saturday at 6:00 a.m.

As the WebSurveyor account-holder, I exported data from the University of Iowa server to my portable storage device and home computer. The data files that were imported to either the storage device or the personal computer were password-protected. When not in use, the portable storage device was stored in a locked file cabinet in my locked home office. The personal computer was also located in my locked home office.
The files on the home computer were protected by firewall technology and anti-virus programs included in McAfee software.

During the data analysis process, I periodically produced data reports and printouts using the Statistical Package of the Social Sciences (SPSS). These reports presented the quantitative data in aggregate form without any information that could identify individual participants. I reviewed these statistical reports with some committee members and expert consultants (e.g., statistician). After each use, all printed reports were stored in the locked file cabinet in my locked home office or destroyed. Data in the final SPSS reports were summarized in tables in the study.

Instrument Development

Prior to data collection, the survey was pretested in three stages from June, 2009, to December, 2009. During Stage One in June, 2009, five graduate students (four doctoral students and one master student) in the School of Social Work at the University of Iowa examined a Word version of the survey. The primary purpose of this pre-test was to develop and refine the survey instrument prior to submission to the Institutional Review Board (IRB).

In Stage One, the pretest participants were instructed to read through the survey and provide feedback using an evaluation form (see Appendix H). The first half of the evaluation form instructed the participants to provide general comments or thoughts on the survey, and how it could be improved. The second half of the evaluation form instructed the pre-testers to evaluate each item in the survey using the following criteria:

1. The question and response choices are written clearly,
2. The question and response choices are understandable,
3. The question and response choices are free from any jargon or complicated language,
4. The response choices are exhaustive, and
5. There aren’t any other problems with the question or response choices.
For problematic items, the participants listed the item number and provided comments on why the item did not meet one or more of the criteria. I used feedback from the Stage One pretest to revise items and instructions, and the order of sections in the survey.

Stage Two was conducted to ensure that the topics and items in the instrument were sensitive to the needs of the study’s target population: male survivors of CSA. Although it would have been ideal to conduct this stage of pretesting with a group of MSAC, this would have necessitated extensive planning, required separate IRB approval, and delayed the project considerably. Instead, I sent the survey to five key informants (therapists, clinicians) who have experience working with sexually abused boys and/or MSAC.

Of the five pretest participants in Stage Two, three were either current or retired clinical directors of counseling departments at private agencies in Eastern Iowa. One of these directors managed a clinic that specialized in treating men with abuse histories and addictive behaviors. Of the other two pretest participants, one was a general practitioner at a private agency who has provided therapy to many MSAC over her 25-year career. The final pretest participant was employed in a full-time academic position but formerly had a clinical practice that specialized in treating MSAC. He is also well-known for his research on the mental health needs of MSAC. At the time of the pretest, four of the five participants held the highest level of professional social work licensure in their state (e.g., LISW, LCSW).

The Stage Two pretesters were instructed to read through the survey to determine whether each item in the survey was sensitive to the needs of MSAC. Although all five of the therapists indicated that the survey was generally sensitive to the needs of MSAC, they provided helpful feedback on how to improve a few of the individual items. They also provided helpful feedback on the ordering of sections and on support resources for participants.
Stage Three of the pretest occurred during the month of December 2009. The purpose of this stage of pretesting was to assess the operation of the electronic version of the survey and the level of administrative burden on study participants (i.e., length of time to complete). I asked several social workers (e.g., practitioners, professors, doctoral students) in Eastern Iowa to take the survey through WebSurveyor and report how long it took to complete. To gain access to the study, the social workers were instructed to respond to the screening question by indicating that they were male, 18 years of age, and sexually abused during childhood. Six pretest participants (three males and three females) completed the survey. Their ages ranged from 28 to 62 years. Two of the pretest participants were international graduate students for whom English was not their first language.

For this pretest, the length of time to complete the survey ranged between 15 and 31 minutes. The mean time to complete the survey was 20.7 minutes. However, there are several reasons why this estimate may be less than the mean time to complete the survey for participants in the actual study. First, none of the pretest participants provided narrative responses to the open-ended items. Second, because of previous research experience, some of the pretest participants were already familiar with one of the standardized measures included in the survey. Finally, participants in this pretest were instructed to select “yes” to the screening question on sexual abuse, but it is unclear whether any of them actually were sexually abused during childhood. Because some of the survey items required reflection on past events related to the abuse, participants in the pretest who were not sexually abused most likely completed the items more quickly than participants in the actual study. For these reasons, I estimated that the mean time to complete the survey was higher for MSAC in the current study (30 minutes) than for those who participated in the Stage Three pretest (20.7 minutes).
Measures

The instrument contained 137 items that were organized into six sections:

1. current mental health problems (dependent variable)
2. sexual abuse characteristics and response
3. account-making process
4. masculinity norms
5. background information (e.g., demographic information)
6. posttraumatic growth.

The measures used in each of the sections are listed in Appendix I. Details of each measure are provided below.

Section One: General Mental Distress Scale. The measure for mental health problems was the General Mental Health Distress Scale (GMDS; Dennis, White, Titus, & Unsicker, 2007). The GMDS is part of a comprehensive biopsychosocial assessment, the General Assessment of Individual Needs (GAIN; Dennis et al., 2007). The GAIN is a reliable and valid health screening instrument that includes over 100 scales and indices (Dennis, Funk, Godley, Godley, & Waldron, 2004; Dennis et al., 2002). Researchers have established norms for both adults and adolescents (Modisette, Hunter, Ives, Funk, & Dennis, 2009).

The General Mental Distress Scale (GMDS) is a symptom count of internal sources of distress that were experienced in the past 12 months. Based on a factor and item response theory analysis (Bohlig & Dennis, 1996) of the Hopkins Symptom Checklist 90 (HSCL-90; Derogatis et al., 1974), the GMDS has high internal consistency ($\alpha=.90$), generally increases with age, and has demonstrated an ability to detect differences in symptom patterns by gender, race, age, and other factors such as primary substance for individuals in substance abuse treatment (Chan, Dennis, & Funk, 2008; Conrad, Dennis, Riley, & Funk, 2009).
The 26-item GMDS consists of four subscales based on DSM-IV criteria for internalizing disorders: *Somatic Symptom Index* (SSI; 4 items), *Depressive Symptom Scale* (DSS; 10 items), *Homicidal Suicidal Thought Scale* (HSTS; 5 items), and *Anxiety/Fear Symptom Scale* (AFSS; 12 items). Although the HSTS consists of 5 items, only one of them is included in the GMDS. It also categorizes people in terms of severity of mental distress related to these disorders (M. Ives, personal communication, May 5, 2009).

The instructions for the GMDS included: “The next questions are about common nerve, mental, or psychological problems that many people have. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you cannot go on” (Dennis et al., 2007). The item stem asked: “During the past 12 months, have you had significant problems with…?” (original emphasis). The item stem was followed by a list of statements that reflect psychological symptoms. Participants selected yes (1) or no (0) for each statement.

The GMDS is usually scored by adding the number of symptoms that each participant endorses (range=0-26). Higher scores indicate more psychological distress. The cut points for three levels of severity are as follows (low=0-3, moderate= 4-6, high=7-26). Due to an error in setting up the electronic survey, one of the 26 items related to anxiety (“During the past 12 months, have you had significant problems with thoughts that other people were taking advantage of you, not giving you enough credit, or causing you problems?”) was inadvertently omitted from the final version of the survey. Thus, for this research project, the dependent variable, the GMDS, was based on 25 items instead of 26 items (range=0-25). Cronbach’s alpha for the index was .904.

**Section Two: Sexual abuse and response.** This section of the instrument measured characteristics of the CSA experience and the history of disclosure. The characteristics of the CSA experience sub-section included 12 items including indicators of CSA severity.
(e.g., duration, frequency, penetration). The instructions included: “This section has a series of questions to better understand the experiences of men who have been sexually abused during childhood. Because some men were sexually abused by more than one person, please answer these questions based on the first time you were sexually abused.” All of the items in this section were close-ended and were measured at the nominal or ordinal level.

Many of the items in this section measured indicators of CSA severity. These indicators were selected based on previous research outlined in Chapter 2. The indicators of CSA severity along with their response choices included:

- frequency (1 time, 2-5 times, 6-10 times, 11-20 times, more than 20 times, and don’t know)
- duration (1 time only, less than 1 month, 1-6 months, 6 months-1 year, 1-3 years, more than 3 years, don’t know)
- use of physical force (yes, no, don’t know)
- penetration (yes, no, don’t know)
- physical injury from the CSA (yes, no, don’t know)
- total number of abusers (1 person, 2 people, 3 people, more than 3 people, don’t know)

One item asked participants their relationship to the abuser and included 15 response choices. Due to small cell size, the response choices were later recoded into two new dichotomous variables (no=0; yes=1) including incest (abused by a biological relative) and clergy abuser (abused by a member of the clergy). Because being abused by a biological relative or a member of the clergy is related to more severe trauma, the variables incest and clergy abuser represented additional indicators of CSA severity. Thus, a total of eight indicators of CSA severity were used in this study.

The history of disclosure sub-section included 20 items that measured disclosure of the CSA experience by the participant to other people in his life. These items were
selected based on research and theory outlined in Chapter 2. Eighteen of the items were close-ended questions at the nominal, ordinal, or interval/ratio level of measurement. The final two items in this section were open-ended items that elicited qualitative responses.

The first item asked participants: “Not including this survey, have you ever told anyone that you were sexually abused?” Participants who responded no to this item skipped to the final item in this section. Participants who responded yes to the initial item were presented with additional questions on disclosure.

Several of the items in this section measured aspects of disclosure during childhood. For example, an item asked participants: “About how old were you when you first told someone about being sexually abused?” By subtracting age at first abuse from age first told, another variable (years until told) was created; it measured the number of years until the participant told someone else about being sexually abused. The new variable was then transformed to create a nominal level variable that measured whether the participant delayed disclosure at least one year from the time of the sexual abuse (told after one year=1).

Another item asked: “How helpful was the response from the first person that you told?” Response choices were based on a 5-point Likert scale ranging from very helpful (1) to very unhelpful (5). Because the hypothesis related to this variable was based on a threshold (i.e., very helpful response), I recoded the response choices into a new dichotomous variable, response to first told. A response of “very helpful” in the original item was given a 0 in the recoded variable. The other responses (very unhelpful, somewhat unhelpful, mixed, somewhat helpful) were collapsed and assigned a value of 1 (not “very helpful”).

Participants were asked whether they told their mother about the abuse during childhood. Participants who responded “yes” were presented with four statements about the nature of their mother’s reaction to the disclosure. All four of the statements began
with the stem “Did your mother…” and had the same nominal level response set (yes=1; no=2; don’t know=3). The statements were: “…believe you?”, “…support you?”, “…protect you?”, and “…help or encourage you to get mental health treatment?” These items were added to measure maternal support (mother support) after being told about the sexual abuse (theoretical range: 0 to 4, with high scores indicating more support). Cronbach’s alpha for the index was .794.

Participants were asked whether they told someone else during their childhood (besides their mother) about the abuse. Participants who responded “yes” were presented with four statements about the nature of the other person’s reaction to their disclosure during childhood. All four of the statements began with the stem “During childhood, did someone that you told (other than your mother)…” and had the same nominal level responses (yes=1; no=2; don’t know=3). The statements were: “…believe you?”, “…support you?”, “… protect you?”, and “…help or encourage you to get mental health treatment?” These items were later added to measure support by someone other than the mother, another support (theoretical range: 0 to 4, with high scores indicating more support). This variable had a Cronbach’s alpha of .727.

Mother support and another support were added to measure overall support received to disclosure during childhood. The new index, support in childhood, had a range of 0 to 8 with higher scores indicating more support in response to disclosure during childhood. Cronbach’s alpha for the index was .869.

To measure the response to disclosure during adulthood (i.e., after the age of 18 years), I created an index called support in adulthood. Participants were asked items using the following stem: “During adulthood, did anyone that you told…” and had response choices of yes (1), no (2), and don’t know (3). The statements were: “…believe you?”, “…support you?”, “… protect you?”, and “…help or encourage you to get mental health treatment?” The index was created by adding the responses to the four items. Thus, the range for support in adulthood was 0 to 4 with higher scores indicating
more support in response to disclosure during adulthood. Cronbach’s alpha for the index was .662.

The next item measured overall responses to disclosure. Participants were asked: “Overall, how would you evaluate the responses you received when you told others you were sexually abused?” Response choices were based on a 5-point Likert scale ranging from very helpful (1) to very unhelpful (5). This item was recoded into a dichotomous variable, overall response to telling, that indicated whether the overall response to disclosures was “very helpful” (0) or not (1) for the participant.

Participants were then asked: “Beyond telling someone that you were sexually abused, have you ever had an in-depth discussion with someone about the sexual abuse?” (original emphasis). This item was used to create the variable ever discuss (no=0; yes=1).

The next item asked participants: “About how old were you when you first had an in-depth discussion about the sexual abuse”. By subtracting age at first abuse from responses to this item, another variable was created which measured the length of time until the participant had an in-depth discussion about the abuse: years until discussion.

To measure the level of support received from each participant’s most supportive discussant (response most supportive discussant), the participant was asked: “Please think of all the people that you’ve ever had an in-depth discussion with. Of those people, now think of the person that was most supportive. How helpful was that person’s response?” The responses ranged from very helpful (1) to very unhelpful (5). To address the hypothesis related to this variable, the responses were recoded into a dichotomous variable. A response of very helpful was assigned a 0; the other response choices (very unhelpful, somewhat unhelpful, mixed, and somewhat helpful) were collapsed and assigned a value of 1.

All of the items in Section Two of the survey were constructed by the researcher, but were developed through extensive discussions with two experts in child abuse (Dr.
Carol Coohey, University of Iowa, and Dr. Patrick O’Leary, University of Southampton) and the methodologist for the dissertation (Dr. Rob Baller, University of Iowa). The items were also compared to similar items from well-known epidemiological studies of adults who were sexually abused during childhood and pretested with three different groups described earlier in this chapter.

Section Three: Account-making. This section of the instrument contains items developed for this project to measure components of the account-making process: stage of the model, well-developed accounts, and productive confiding. Because few alternative measures exist, these items were developed in consultation with one of the primary authors of account-making, Dr. John Harvey (University of Iowa).

The stage of the model scale consisted of six items that asked each participant the degree to which he agreed with statements related to the following account-making stages: denial, intrusion, working through, and completion. The items were constructed by developing statements that described the stage in the general trauma processing model, and then customizing those statements for the specific trauma of child sexual abuse. For example, one of the items that assessed the denial stage read: “Because the sexual abuse is hard to deal with emotionally, I try not to think about it.” Two of the items measured the denial stage, two items measured the intrusion stage, one item measured working through stage, and one item measured the completion stage. The response choices ranged from strongly disagree (1) to strongly agree (6). Participants who responded with either agree (5) or strongly agree (6) to any item measuring a stage were then classified as being in that stage.

Further analysis, however, revealed that the stages were not mutually exclusive. Many participants provided responses that put them into multiple stages. For example, 66.5% (n=314) of the participants were classified as being in the working through stage (i.e., responded with a 5 or a 6 to working through items) and 39.6% (n=187) of the participants were classified as being in the completion stage (i.e., responded with a 5 or a
6 to end items). A cross-tabulation found that of those who endorsed working through items, 48.4% (n=152) also endorsed completion stage items. Thus, the stage of the model scale was not useful in definitively classifying participants into one of the stages of the account-making model.

Although the stages were not mutually exclusive, I thought it would be useful to explore whether the various stages were related to the dependent variable. Thus, I created three dichotomous variables (no=0; yes=1): denial stage, intrusion stage, and working through stage. Participants who responded with a 5 or a 6 to items on these stages were assigned a 1 (yes) for the new variables.

To measure completion, a single item asked: “At first the sexual abuse was hard to deal with and I tried not to think about it. Later, even when I wanted to, I couldn’t stop thinking about it. Now I’ve worked through it and understand how the sexual abuse has affected my life.” Participants who responded with that they agree (5) or strongly agree (6) were assigned a value of 1 (yes) for the dichotomous variable end stage. Participants who responded with scores less than a 5 were assigned a 0 (no) for this new variable.

Eight items addressed the development of an account or narrative of the CSA experience. The dimensions of the personal narrative that were measured included naming the experience, assessing responsibility, identifying the impact of the CSA, and feeling in optimistic and in control of the future. These four dimensions have been identified as important markers of a completed account in previous studies of account-making (Harvey et al., 1991; Orbuch et al., 1994). For example, one item measuring responsibility read: “The person who sexually abused me is responsible for the abuse”. The response choices for each item ranged from strongly disagree (1) to strongly agree (6). Because one of the items on the future optimism dimension was negatively correlated to the other items, it was omitted.

The Account Development Scale thus consisted of six items (representing three dimensions of an account). The Cronbach’s alpha for the scale was .737. The scale
ranged from 6 to 36 with higher scores indicating a more developed account. This scale was recoded into an average ranging from 0 to 6 with higher scores indicating a more developed account.

Two items of the items in this section measured new model stages and pathways in account-making. One item asked participants to assess their level of agreement with the following statement: “My progress toward understanding the effects of being sexually abused has been filled with temporary setbacks.” Another statement read: “I periodically engage in activities to maintain my progress in dealing with being sexually abused (e.g., read self-help books, attend survivor workshops, volunteer).” The response choices for both of these items were based on a 6-point Likert scale ranging from strongly disagree (0) to strongly agree (6).

I assessed the face and content validity of the account-making measures through extensive consultations with two experts on child sexual abuse (Dr. Carol Coohey, University of Iowa; Dr. Patrick O’Leary, University of Southampton). Face and content validity were also assessed through consultations with the primary author of the account-making model, Dr. John Harvey (University of Iowa), and the pioneer of traumatic stress processing, Dr. Mardi J. Horowitz (University of California at San Francisco, Center on Stress and Personality at the Langley Porter Psychiatric Institute). These consultations led to numerous revisions of the items.

Section Four: Conformity to Masculine Norms Inventory. The Conformity to Masculine Norms Inventory (CMNI-22; Mahalik, Locke, et al., 2003) is an abbreviated, 22-item version of the original 94-item Conformity to Masculine Norms Inventory (CMNI, Mahalik, 2000; Mahalik, Locke, et al., 2003) and is used to measure overall conformity to traditional male norms. The original validation study of the 94-item CMNI (Mahalik, Locke, et al., 2003) included factor analyses that supported the 11-factor structure of the CMNI. The CMNI has strong convergent validity; it is significantly related to several other existing measures of masculinity, and significantly and positively
related to constructs such as social dominance, aggression, psychological distress, negative attitudes towards help-seeking, and a desire to be more muscular (Mahalik, Locke, et al., 2003). The CMNI also has good concurrent validity differentiating groups, high test-retest estimates for a 2-3 week period (.96), and internal consistency estimates ranging from .75 to .91 for the 11 masculinity norms with an alpha of .94 for the CMNI total score. The CMNI has been used in studies of the general population of men (Mahalik et al., 2008) as well as several sub-populations such as men with spinal cord injuries (Schopp et al., 2007), Asian men (Liu et al., 2007), African-American men (Mahalik, Pierre, & Wan, 2005), gay men (Kimmel, 2004; Kimmel & Mahalik, 2005), college-aged men (Locke & Mahalik, 2005; Mahalik, & Rochlen, 2006), prostate cancer survivors (Burns & Mahalik, 2008), and men in therapy (Mahalik et al., 2005).

The shortened version of the CMNI correlates at .92 with the CMNI total score. In various studies that have used the CMNI-22, the measure has demonstrated good internal consistency with Cronbach’s alpha ranging from .64 -.70 (Burns & Mahalik, 2008; Rochlen, McKelly, Suizzo, & Scaringi, 2008). The CMNI-22 has been used in studies of stay-at-home fathers (Rochlen et al., 2008), prostate cancer survivors (Burns & Mahalik, 2008), and business professionals (McKelley & Rochlen, 2010).

The CMNI-22 uses the two highest loading items for each of the 11 factors from the original CMNI: winning, emotional control, risk-taking, violence, dominance, playboy, self-reliance, primary of work, power over women, disdain for homosexuals, and pursuit of status (Ludlow & Mahalik, 2002; Mahalik, Locke, et al., 2003). The CMNI-22 consists of statements such as: “My work is the most important part of my life,” “It is important to me that people think I am heterosexual,” and “I tend to share my feelings.”

For each of the 22 items of the scale, participants were asked how much they agreed with the statement based on their own feelings, actions, and beliefs (i.e., affective, behavioral, and cognitive components). The response choices were based on a 4-point
Likert scale ranging from strongly disagree (1) to strongly agree (4). Nine of the items were reverse-coded so that higher agreement on each item equated to higher conformity to masculine norms. The total score was created for each participant by adding together their scores on the 22 items (range= 22-88) with higher scores indicating a higher level of conformity. The total score was later transformed into an average score (CMNI Average) which ranged from 0 to 4. The Cronbach’s alpha for the index was .714.

During diagnostic testing, it appeared that there was a curvilinear relationship between CMNI and the dependent variable. A polynomial term (CMNI Squared) was created that confirmed this u-shaped distribution. Further analysis revealed that the turning point for the u-shaped distribution (i.e., the point where the effect of conformity on mental distress changed from positive to negative) was at approximately 2.0. A visual inspection of the distribution of CMNI Squared using a scatterplot diagram found that most of the action occurred on the right side of the curve (i.e., high conformity). However, sensitivity checks to reproduce a CMNI effect on the low end were unsuccessful, possibly due to a small number of cases below the 2.0 threshold. For these reasons, I focused on analyzing the effect of high conformity on mental distress.

The variable CMNI High was created by adding one standard deviation (.317) to the mean for CMNI Average (2.339). The new dichotomous variable separated participants into whether their score for CMNI was greater than 2.66 (0=no, 1=yes). As a result, approximately 13% of the participants met the criteria for high conformity. Additional sensitivity checks for the top 20% and 25% held.

Section Five: Background information. This section consisted of 12 items that elicited socio-demographic and background information. Ten items measured age, race, ethnicity, education, household income, number of people supported by household income, whether living with partner/spouse, longevity of living with partner/spouse, membership in survivor organization (e.g., SNAP, MaleSurvivor), and engagement in public advocacy. Although these variables were developed for this study, most of the
variables were adapted from well-established studies and surveys (e.g., NDACAN, 2002; NDACAN, 2007; U.S. Census Bureau, 2000).

Two demographic variables were transformed. For the variable race, there were too few cases to justify separate categories such as Native-American, Asian-American, and African-American. Instead of using race, I created a new variable, non-white race (1, 0=white). To measure membership in survivor organizations, I created three dichotomous variables: MaleSurvivor (1=MaleSurvivor, 0=no), SNAP (1=SNAP, 0=no), or both organizations (1=BothMSSNAP, 0=neither).

Recent life stressors were measured using the List of Threatening Events Questionnaire (LTEQ; Brugha & Cragg, 1990). Participants were asked, yes or no,: “Have any of the following life events or problems happened to you during the past 12 months?” for 13 life events and problems (e.g., financial problems, major illness, death of family member). To create the variable current stressors, I added the number of stressors (theoretical range= 0-13) with higher scores indicating a greater number of current stressors. The Cronbach’s alpha for the index was .631.

Although the original LTEQ (Brugha & Cragg, 1990) asked about the recent life stressors that occurred in the past 6 months, I changed this timeframe to the past 12 months for consistency with the dependent variable. Also, because of the potential for natural disasters to impact a person’s current mental health, I added “problems due to a natural disaster (e.g., flood, tornado, earthquake)” as an additional event on the list. Thus, the total number of life events or problems increased from 12 in the original questionnaire to 13 in the current study.

The LTEQ was shown to have high test-retest reliability, good agreement with informant information, and concurrent validity that consisted of high specificity and sensitivity (Brugha & Cragg, 1990). The instrument is especially useful for studies of adult psychiatric disorders and psychological dysfunction in which intervening variables such as social support, coping, and cognition are of interest, but practical considerations
(e.g., time, cost) prevent the use of extensive interview measures of stress (Brugha & Cragg, 1990). Because the current study examined factors affecting the mental health of MSAC that are related to social support and coping, the LTEQ seemed like an effective measure of stress.

Finally, to measure childhood adversity, one item was adapted from a standardized index: the Child and Adult Stressors Index (Statistics Canada, 2002). Participants were asked “Did any of the following things happen to you while you were a child or a teenager (under the age of 18)?” and were presented with a list of nine events: extended hospitalization, divorce, parental unemployment, parental substance use, physical abuse, parental mental illness, parental criminal activity, and witnessing domestic violence. To create the variable childhood stressors, I added the number of events endorsed by the participant (theoretical range= 0 – 9 with higher scores indicating a greater number of childhood stressors). The Cronbach’s alpha for the index was .635.

The Child and Adult Stressors Index (Statistics Canada, 2002) contains seven stressors that were selected based on unpublished analyses by McDowell, Boulet, and Kristjansson (I. McDowell, personal communication, February 2, 2010) of a pool used in research conducted on stressors (Wheaton, 1994). One of the items included the following: “Something happened to you that scared you so much you thought about it for years after.” This stressor was eliminated in the current study because of its potential to overlap with one of the inclusion criteria (i.e., sexually abused before the age of 18). Also, I added three stressors to the original index: parental mental illness, parental involvement in criminal activity, and witnessing domestic violence. These stressors were added because the research literature suggested that they are common familial risk factors for CSA (Holmes & Slap, 1998; Molnar et al., 2001; Putnam, 2003). Thus, the number of events in the index changed from seven in the original index to nine in the current study. Finally, because the original instructions were written for use during in-person interviews, they were modified in the current study for use in an online survey format.
Section Six: Post-traumatic Growth Inventory. The Post-traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) is a subjective measure that assesses the degree of positive change (i.e., perceived benefits) experienced by a person in the aftermath of a severe stressor or a traumatic event. The 21-item scale includes five factors: new possibilities, relating to others, personal strength, spiritual change, and appreciation for life. Some examples of statements include, “I established a new path for my life,” “I discovered that I am stronger than I thought I was,” and “I have a new sense of closeness to others.”

For each of the statements, participants were asked to indicate the degree to which this change occurred in their life as a result of their crisis or traumatic event. A 6-point Likert response format was used ranging from 0 (“I did not experience this change as a result of my crisis”) to 5 (“I experienced this change to a very great degree as a result of my crisis”). The responses to each of the 21 items were then added together to get a total (range=0-105). To create the variable PTGI Average, the total was divided by the number of items (theoretical range = 0 to 5 with higher scores indicating a higher level of growth). The Cronbach’s alpha for the PTGI Average was .957.

In the instructions for using the PTGI, Tedeschi and Calhoun (1996) encouraged researchers to customize the instrument to tailor it to the crisis of traumatic event being examined. For the current study, the instructions and response choices were modified to more precisely measure post-traumatic growth due to the experience of sexual abuse. For example, the instructions read: “For each of the statements below, please indicate the degree to which this change occurred in your life as a result of being sexually abused as a child.” For the response choices, the phrase “my abuse” replaced the original phrase, “my crisis.”

Confirmatory factor analyses provided support for the five dimensions of the PTGI (Taku, Cann, Calhoun, & Tedeschi, 2008). Furthermore, the internal consistency of the PTGI was excellent (α = .90) and the test-retest reliability over a 2-month period
was acceptable \((r = .71; \text{Tedeschi et al., 1996})\). Tests of concurrent and discriminant validity indicate that PTGI is modestly related to optimism and extraversion, but not related to social desirability (Tedeschi et al., 1996). The construct validity of the PTGI appears to be good; the measure is able to determine how successful people who have faced a crisis are in strengthening their perceptions of self, others, and the meaning of the event (Tedeschi et al., 1996). The PTGI has been used extensively in research across many disciplines in studies on different populations including war veterans (Maguen, Vogt, King, King, & Litz, 2006), bereaved parents (Polatinsky & Esprey, 2000), and stem-cell transplant survivors (Andrykowski et al., 2005).

**Open-ended items.** There were five open-ended items that allowed participants to type a response with no restriction on length (see Appendix J). The first item was a follow-up question to a previous item on the most helpful person that the participant told: “What did he/she (the most helpful person) do that was helpful to you?” The second open-ended item read: “Some men take many years to tell someone that they were sexually abused. Others choose to never tell. Please describe why it may be difficult for men to tell someone about/discuss the sexual abuse.” The third open-ended item read: “Some research indicates that child sexual abuse can negatively affect a person’s self-identity. Please describe how—if at all—the sexual abuse has affected your self-identity.” The fourth open-ended item followed a close-ended item that read: “Some adults who were sexually abused struggle for years and then reach a turning point where they decide to commit to healing and improving their health. Did you experience such a turning point?” If participants responded “yes,” then they were asked to describe the turning point. The final open-ended item asked participants to share anything that wasn’t covered in the survey or that they’d like to elaborate on.

**Permissions.** I received permission to use the standardized measures from the primary authors and/or their organizations. Permission was granted to use the General Mental Distress Scale (T. Mullenix, personal communication, June 30, 2009), the
Conformity to Masculine Norms Inventory (J. Mahalik, personal communication, June 18, 2009), the Post-Traumatic Growth Inventory (L. G. Calhoun, personal communication, June 10, 2009), the List of Life Threatening Events (T. Brugha, personal communication, June 12, 2009), and the Childhood and Adult Stressors Index (C. Dick, personal communication, June 11, 2009). Documentation of these permissions is available upon request.

Data Analysis

Data entry and cleaning. Data were initially exported from WebSurveyor into an Excel spreadsheet. Because export values were not assigned in WebSurveyor, most of the data in the Excel spreadsheet were in a string format. To convert the string data into a numeric format (e.g., yes → 1, no → 0), I used the “find and replace” command within Excel. Although this process was time-consuming, it was necessary so that SPSS could read and perform calculations on the numeric data.

There were originally 546 cases that were exported into the Excel file. A closer examination of these data revealed that there was a subset of cases that were missing data for all of the items on the survey except for the screening questions. Potential participants who did not qualify for the study based on their responses to the three screening items were redirected to a message thanking them for their interest. Although they were not allowed to complete the survey, the WebSurveyor program treated their responses to the screening items as a completed survey. After sorting the 546 cases according to the three screening items, I identified 59 cases in which the respondent did not meet criteria for the study.

Three of the items in the survey asked participants about their relationship to other people (i.e., the abuser, the first person they told, their most helpful discussant). Participants were asked to select a response from a long list of choices in a drop-down menu. One of the choices was “other.” Participants who selected “other” were then prompted to “please specify” by typing in their relationship to the other person. In a few
of the cases, participants selected “other” and then proceeded to type a response that was identical or nearly identical to one of the choices in the drop-down menu. For these cases, I changed the response choice from “other” to the appropriate choice during the cleaning process.

Data were then imported from Excel into a data file in SPSS 17.0 for analysis.

*Data transformations.* For most of the nominal level variables in the instrument that elicited a yes or no response, the values assigned to the response choices in the original codebook were 0 for no and 1 for yes. However, for 12 of the nominal level variables, these values were reversed. For consistency during data analysis, I recoded these 12 variables (0=no, 1=yes).

*Missing data.* Overall, there were very little missing data in this study (see Table K3). The percentage of missing data for items was generally under 3%. However, there were some items in the Account Development Scale that were missing up to 8% of the data. In this section, I will describe how missing data were handled.

Data were imported into SAS/STAT and analyzed for missing value patterns (SAS Institute, 2004). The analysis produced 159 patterns of missing data. The first pattern contained 48.87% of the sample (n=238) and consisted of cases that had no missing data on any of the items in the instrument. Of the remaining 158 patterns, only a few of them contained more than five cases. The vast majority of patterns consisted of a single case. These results provide evidence that the missing data were not caused by any questions in particular.

Preliminary analyses found that the level of missing data on independent variables was not significantly related to mental distress, although it approached significance (p<.085). Therefore, the missing data could be described as missing completely at random (MCAR). This conclusion allowed me to use listwise deletion as a remedy for missing data (Allison, 2002).
Overall, the missing data in the study could be classified into three categories: skipped missing (due to skip filters), don’t know, and actual missing. Table K3 provides the percentages for these three types on all of the variables used in the final models. In the following paragraphs, I describe in more detail how I handled the missing data in each of these types.

The first type of missing data was skipped missing due to a skip filter (i.e., valid missing). For example, in Section 2, one of the items asks participants whether they have ever told someone about being sexually abused. Participants who responded “yes” were then asked a series of items related to the nature and history of disclosure. Participants who responded “no” skipped the subsequent items on disclosure and continued on to items after the disclosure section. This skip pattern generated a considerable amount of valid missing data on the subsequent disclosure items.

To address this type of missing data, I used mean substitution. I replaced the missing data with a “no” for nominal yes/no items, the mode for other nominal items, and the mean for ordinal or scale level items. The primary advantages of mean substitution were that it is commonly used, is superior to listwise deletion, and uses the existing data. These substitutions did not produce bias in the multivariate results because the skip filters (e.g., “ever told someone about being sexually abused”) were controlled.

A second type of missing data was “don’t know” missing. For 30 items on the instrument, one of the response choices was “don’t know.” Responses of “don’t know” were replaced using a “no” (for nominal yes/no items), the mode (for other nominal items), and the mean (for ordinal or scale level items). A new variable was created for each item in the original instrument that had a “don’t know” response choice (e.g., Duration -> DKDuration). This new variable allowed me to control for responses of “don’t know” during statistical modeling.
The final type of missing data was created when participants did not provide a response on items that they were supposed to complete. These missing data were handled through listwise deletion.

For scales that contained missing data due to a lack of response by the participant, I used the mean substitution approach within each case. Within each case, the existing responses for items of a scale were averaged together to produce a scale score. However, if a case had missing data for all of the items within a scale, the scale score for that case was considered missing and addressed through listwise deletion.

**Diagnostic testing.** Diagnostic tests were conducted prior to inferential testing, including multivariate regression analyses. These tests examined potential problems related to multicollinearity, model specification, nonlinearity, heteroscedasticity, normality of residuals, and influential outliers. Unless otherwise indicated, assumptions were met for statistical tests.

**Analytic strategies.** The analyses proceeded in four phases. In the first phase, the data were analyzed using univariate statistics to provide information on the characteristics of the sample. In the second phase, I examined relationships between the independent variables and mental distress using bivariate analyses: analysis of variance (ANOVA) and correlation (Pearson’s *r*). These analyses provided information on the nature of the relationships among variables and allowed for comparison with results from previous studies. In the third phase, I used multiple regression analysis to test the nonspurious direct and indirect effects (both of which are “causal”) of the potential predictors on mental distress (Davis, 1985). These analyses controlled for demographic factors and causally prior variables. Causally prior variables are variables thought to affect both the dependent variable and the independent variable of interest. In the fourth phase, I tested hypotheses for conditional effects by adding interaction terms to the multivariate models and by conducting tests for mediation. In the next sections, I explain the third and fourth phases in greater depth.
For the third and fourth phases, multiple regression models (Ordinary Least Squares) were used to test the hypotheses. Rather than using one final model to address all of the hypothesized relationships, I constructed separate models for each hypothesis, controlling for causally prior factors. My approach to model building addressed several important concerns including conceptual redundancy and causal order. Regarding the former issue, this study included more than one variable to measure the same concept. For example, there were several variables that measured abuse severity (e.g., duration, frequency, physical force), disclosure (e.g., overall response, response to first disclosure), and account-making (e.g., end, working through, denial, ADS). Entering potentially redundant variables into a model at the same time may have resulted in an overly conservative analysis which could have masked significant effects. To avoid problems related to redundancy, I evaluated each variable independently in a separate model.

Another important consideration was the issue of causal ordering. Entering all of the independent variables at the same time may have masked significant effects due to mediation. For the analyses, I examined distal variables (e.g., abuse severity variables) first, and then included them in subsequent models. Causally prior variables—those that might affect the dependent variable and the hypothesized independent variable—were controlled to eliminate the possibility of spurious effects. This approach attempted to create a balanced analysis that was neither too conservative nor insufficiently conservative. Each of the following sub-sections provides more details on the models that were constructed to test the hypotheses.

a. Control variables and mental distress: The control variables were entered into a multiple regression model to identify significant relationships between the control variables and mental distress ($p<.05$). The control variables included in all of the subsequent models were age (2 variables), race, age at first abuse, and childhood stressors. As will be explained later, some analyses used the following additional control variables: education, income (2 variables), number of dependents, cohabitation, and
current stressors. Although variables related to membership in a survivor organization (SNAP member, MaleSurvivor member, member of both SNAP and MaleSurvivor) were included in univariate and bivariate analyses, these variables were excluded in multivariate analyses due to the potential confounding effect with other variables (e.g., clergy abuser).

b. Abuse severity and mental distress: Multiple regression was used to test the hypotheses related to abuse severity (Hypotheses 1A through 1H). To identify the independent effect of the eight severity indicators on mental distress, each severity variable was entered separately into an OLS model with the first set of control variables and a control for don’t know responses for that severity variable. The other seven severity variables were not included in each model because of potential confounding effects (e.g., duration and frequency).

c. Disclosure and mental distress: Multiple regression models were used to test the hypotheses related to disclosure (Hypotheses 2-9). To address redundancies in these effects (e.g., overall response, childhood support, adulthood support), each disclosure variable was entered into a separate model that examined the independent effect of the disclosure variable on mental distress. The models also included the first set of control variables, significant abuse severity variables, and controls for don’t know responses for abuse severity variables. Because it served as a skip filter in the survey for the disclosure variables, whether the participant had ever told was also added as a control for all of these models. For the final four disclosure models (Hypotheses 6-9) and all subsequent models (Hypotheses 10-15), the following control variables were also included: education, income (2 variables), number of dependents, cohabitation, and current stressors. These control variables were not introduced until Hypothesis 6 due to causal ordering. In other words, these controls may mediate the effects of interest in the earlier models.
d. **Account-making and mental distress:** Multiple regression was used to test the hypotheses related to account-making (Hypotheses 10-11). Preliminary analyses revealed that there was considerable overlap between the stages of account-making: denial, intrusion, working through, and end. For example, 48.4% of participants who met criteria for working through also met criteria for the end stage. Because some participants endorsed items that met criteria for more than one stage, I concluded that the stages were not mutually exclusive. To avoid redundancy in these effects, each stage variable was entered into a separate model that examined the independent effect of that concept on mental distress. Because of possible overlap with the end stage, the ADS was entered into a separate model as well.

All of these account-making models included the complete set of control variables, the abuse severity variables that were significant in earlier analyses (clergy abuser, physical force, penetration, injury), the controls for don’t know responses for those severity variables, whether the participant ever told someone about the abuse, and the disclosure variables that were significant from the previous step (told after one year, overall response to telling, ever discuss). Although significant in the previous step, response to first told was not included in these models because of a high degree of conceptual overlap with overall response to telling.

e. **Masculine norms, posttraumatic growth, and mental distress:** Finally, models were created to test the hypotheses related to posttraumatic growth and high conformity to masculine norms (Hypotheses 12-13). These models included all of the variables in the final account-making model (excluding ADS). To assess account-making, the variable end was included because of face validity (it is conceptually analogous to the ADS), content validity (it subsumed the other stage variables), and performance (it was significant in prior modeling while the ADS was not).

f. **Final model:** The model used to examine the effect of posttraumatic growth in the previous analysis represented the final direct effects model. This model allows the
reader to see the effect of posttraumatic growth and the remaining direct effects of the other variables, controlling for possible mediators. The final model included 12 control variables, four severity variables (clergy abuser, physical force, penetration, injury), three disclosure variables (told after one year, overall response to telling, in-depth discussion), account completion (end), conformity to masculine norms, and post-traumatic growth.

g. **Moderators**: Four hypotheses related to moderation were examined (Hypotheses 14A-14D). To determine whether a variable had a moderating effect on a relationship within the model, an OLS model was created that included all of the variables in the final model and the interaction term.

h. **Mediators**: Two hypotheses related to mediation (Hypotheses 15A, 15B) were examined. To test for mediation, I used the three-step method described by Baron and Kenny (1986). I assessed whether the regression coefficient between the dependent variable and the independent variable decreased when a third variable (i.e., mediator) was introduced (i.e., partial mediation). If the introduction of the third variable reduced the original regression coefficient between the dependent and independent variables to zero, then a complete mediation was inferred (Keith, 2006). The relationship between the independent variable and the hypothesized mediator was also assessed in models of the hypothesized mediator.

In the next chapter, I will present the results of these analyses.
In this chapter, I will present the results of the study. The chapter is organized into three sections: univariate, bivariate, and multivariate results.

**Univariate Results**

*Dependent variable.* Table K4 shows that participants (n=487) had a mean score of 12.5 on the Mental Distress Scale (range= 0–25; SD=6.27). A score of 0 to 3 indicates low levels of distress, a score of 4 to 6 indicates moderate levels of distress, and a score of 7 or above indicates high levels of distress (i.e., clinical range).

*Abuse severity.* The average age at first abuse was 10.26 years. Most of the participants (61.5%) reported that their abuser was a member of the clergy. Some of the participants (11.4%) reported that they were abused by a biologically related member of the family (i.e., incest). For frequency, 38.4% of the participants reported that they were abused more than 20 times, and 26.1% reported that they were abused between two and five times. Many of the participants (31.4%) indicated that the abuse lasted more than 3 years; one-fourth of the participants (25.5%) indicated that the abuse lasted between 1 to 3 years.

A majority of the participants (61.0%) reported that the sexual abuse involved penetration, 40.6% reported that the abuser used physical force during the sexual abuse, and approximately one-fourth (23.8%) reported that the sexual abuse resulted in a physical injury. On average, participants were abused by two abusers.

*Disclosure variables.* Almost all of the participants reported that they told someone about the abuse during their lifetime (97.3%). The amount of time it took the participants to tell someone about the abuse ranged from 0 to 63 years. The mean number of years before the participants told someone was 21.38 (SD=14.88). Thus, it was not surprising that the vast majority of the participants took longer than one year to tell someone about the abuse (91.6%).
Beyond telling someone about the abuse, the participants were asked if they had ever had an in-depth discussion about the abuse with someone during their lifetime. More than three-fourths of the participants (77.1%) reported having an in-depth discussion with someone. The length of time before participants had an in-depth discussion ranged from 0 to 72 years. The mean was 28.23 years ($SD=12.88$). The mean number of years before the participant had a helpful in-depth discussion was even longer: 29.98 ($SD=12.07$).

The responses that participants received after telling and discussing the abuse were measured in several ways. Most participants reported that the response that they received when they first told someone about the abuse was not “very helpful” (70.2%). For the Support in Childhood index (which ranged from 0 to 8), the mean score was 1.75 ($SD=2.07$). The Support in Adulthood index ranged from 0 to 4; the mean for this measure was 2.85 ($SD=1.16$). Slightly more than one in three participants reported that the response that they received from their most supportive discussant was not “very helpful” (35.6%). Finally, most participants reported that the overall response to telling others about the sexual abuse was not “very helpful” (78.2%).

*Account-making variables.* A large percentage of participants met criteria for each of the account-making stages: denial (44.9%), intrusion (57.9%), working through (66.7%), and end (39.4%). These results indicate that many participants endorsed items for more than one of the account-making stages. The mean score for the Account Development Scale (ADS) was 4.77 ($SD=0.87$). The scale ranged from 0 to 6.

*Other variables.* The mean score for the Conformity to Masculine Norms scale was 2.34 ($SD=0.32$). The range for this scale was from 0 to 4. Nearly 15% of participants reported scores that indicated high conformity to masculine norms (14.6%). A similar percentage reported scores that indicated low conformity to masculine norms (14.4%). The scale that measured post-traumatic growth ranged from 0 to 5. The mean score for post-traumatic growth was 2.21 ($SD=1.31$).
**Bivariate Results**

To better understand the relationships between the independent variables and the dependent variable and to allow comparison to results from previous studies, bivariate analyses were conducted. The bivariate analyses consisted of one-way analysis of variance (ANOVA) and correlation using Pearson’s $r$. Table K5 displays the results for these analyses.

Of the eight indicators of abuse severity, five indicators were related to mental distress in the bivariate tests. Both duration of the abuse and number of abusers were positively related to mental distress. Participants who reported that the abuse involved physical force, penetration, or injury had more mental distress than participants who did not report physical force, penetration, or injury. In the bivariate tests, three indicators of abuse severity were not related to mental distress: incest, clergy abuser, and frequency.

Of all of the disclosure variables, five variables were related to mental distress in the bivariate tests. The number of years until the participant told someone about the sexual abuse was positively related to mental distress ($r = .119, p < .010$). Participants who waited 1 year (or more) to tell about the abuse had more mental distress than participants who told within 12 months of the abuse ($F(1, 465) = 9.13, p < .003$). Participants who received a response from the first person told that was not “very helpful” ($F(1, 448) = 5.18, p < .023$) had more mental distress than participants who received a “very helpful” response from the first person that they told. Participants who received an overall response to telling that was not “very helpful” had more mental distress than participants who received a “very helpful” overall response to telling ($F(1, 457) = 22.01, p < .000$). Finally, participants who received a response from their most supportive discussant that was not “very helpful” had more mental distress than participants who received a “very helpful” response from their most supportive discussant ($F(1, 360) = 6.18, p < .013$).

All five of the account-making variables were related to mental distress in the bivariate tests. Participants who endorsed items for the denial stage had more mental
distress than participants who did not endorse items for the denial stage. This result was similarly found for both the intrusion and working through stages. Participants who were in the last stage of account-making—end-- reported less mental distress than participants who were not in the last stage (F(1, 478) = 5.34, \( p < .021 \)). There was a negative relationship between the Account Development Scale and mental distress (\( r = -151, p < .001 \)).

Of the remaining variables, the level of conformity to masculine norms was positively related to levels of mental distress (\( r = .207, p < .000 \)). Participants who reported high conformity to masculine norms (>2.66) had more mental distress than those who did not report high conformity (F(1, 483) = 8.29, \( p < .004 \)). Post-traumatic growth was not related to mental distress in the bivariate tests.

**Multivariate Results**

To understand the relationship between independent variables and mental distress after controlling for other variables, multivariate analyses were conducted. Initially a multiple linear regression model was constructed that included a set of control variables (see Table K6). This model was significant (\( F(5,475) = 5.29, p < .000, R^2 = .104 \)). Of the five control variables, four variables were related to mental distress: older age, younger age, age 1st abused, and total childhood stressors. This set of control variables was included in all subsequent multivariate analyses. As described in Chapter 3, membership variables were excluded due to potential confounding effects with other variables of interest (e.g., clergy abuser).

A second model was constructed with additional control variables. The results are presented in Table K7. This model was also significant (\( F(12, 418) = 12.716, p < .000, R^2 = .267 \)). In this model, only two variables were significant: older age and total current stressors. Although age first abused and younger age were significant in the previous analysis, they were not significant in this model as well as in the final model. A
post-hoc analysis revealed that a combination of the additional control variables reduced their influence.

*Abuse severity.* Hypotheses 1A through 1H predicted that participants who reported more severe abuse would have more mental distress than participants who reported less severe abuse. Regression models were used to assess each of the eight hypotheses based on indicators of abuse severity. To examine the independent effect of each severity variable on mental distress, each severity variable was entered into a separate model with five control variables and the number of don’t know responses for that severity variable. Table K8 presents the results of these analyses.

Hypothesis 1A stated that participants who reported that they were biologically related to their abuser (i.e., incest) would have a higher level of mental distress than participants whose abusers were not related. Although the overall model was significant, the variable incest was not. Thus, the hypothesis was not supported.

Hypothesis 1B stated that participants who were abused by a member of the clergy would have a higher level of mental distress than participants who were not abused by a clergy member. Clergy abuser was significant. The results supported this hypothesis.

Hypothesis 1C stated that the frequency of the sexual abuse would be positively related to the level of mental distress. Frequency was not related to mental distress in the model.

Hypothesis 1D stated that duration of the sexual abuse would be positively related to the level of mental distress. Duration, however, was not significant in the model.

Hypothesis 1E stated that participants who reported that their abuser used physical force on them would have a higher level of mental distress than participants who reported that their abuser did not use physical force. Physical force was significant in the model.
Hypothesis 1F stated that participants who reported that the abuse involved penetration would have a higher level of mental distress than participants who were not penetrated during the sexual abuse. In the model, penetration was significant.

Hypothesis 1G stated that participants who reported that they were physically injured during the sexual abuse would have a higher level of mental distress than participants who were not physically injured. In the model, physical injury was significant.

Hypothesis 1H stated that the number of sexual abusers would be positively related to the level of mental distress. The number of abusers was not significant in the model.

Of the eight abuse severity variables, the following four variables were significant in early models of mental distress: clergy abuser, physical force, penetration, and injury.

Disclosure variables. The next nine hypotheses (H2 to H9) were based on the relationship between aspects of disclosure of the sexual abuse and mental distress. In addition to the hypothesized variable, the models used to test these hypotheses consisted of the control variables, severity variables that were significant in Table K8, the number of don’t know responses for the severity variables, and whether the participant ever told someone about the abuse. For these hypotheses, each disclosure variable was entered separately into a model to test its independent effect on the dependent variable. The results are presented in Table K9.

The second hypothesis stated that participants who did not tell someone within one year of the abuse (or who never told) would have a higher level of mental distress than participants who told someone within one year. Waiting longer than one year to tell someone about the abuse predicted higher levels of mental distress. Therefore, the results provided support for the hypothesis.

The third hypothesis stated that participants who did not receive a “very helpful” response to first disclosure (or who never told) would have a higher level of mental
distress than participants who received a “very helpful” response to first disclosure. Because this variable was significant, the results provided support for the hypothesis.

The fourth hypothesis stated that the level of support to disclosure in childhood (i.e., being believed, supported, and protected) would be negatively related to mental distress. Support in childhood was not significant. The results did not support the hypothesis.

The fifth hypothesis stated that the level of support to disclosure in adulthood (i.e., being believed, supported, and protected) would be negatively related to mental distress. Similar to the previous hypothesis, support in adulthood was not significant. The results did not support the hypothesis.

The sixth hypothesis stated that participants who had never had an in-depth discussion about the sexual abuse would have a higher level of mental distress than participants who had discussed their abuse in-depth. Ever discuss was significant in this early model. The results provided support for the hypothesis.

The seventh hypothesis stated that participants who did not discuss the abuse within 1 year (or who never discussed the abuse) would have a higher level of mental distress than participants who did discuss the abuse within one year. Because of a small cell problem, the length of time to discuss the abuse was kept at the scale level of measurement. This variable was significant; the results provided support for the hypothesis.

The eighth hypothesis stated that participants who reported that their most supportive discussant was not “very helpful” (or who never discussed) would have a higher level of mental distress than participants whose most supportive discussant was “very helpful.” This variable was not significant.

The ninth hypothesis stated that participants who reported that the overall response to telling was not “very helpful” (or who never told) would have a higher level of mental distress than participants who reported that the overall response to telling was
“very helpful.” This variable was significant. Thus, the results provided support for the hypothesis.

*Account-making variables.* The tenth hypothesis stated that participants who were in the earlier stages of the account-making process would have a higher level of mental distress than participants who were in the later stages. Because of measurement problems (i.e., the variables representing different stages were not mutually exclusive), this hypothesis was evaluated by examining each of the stage variables independently (see Table K10). By entering each account-making stage variable (denial, intrusion, working through, end) separately into a model, the independent effect of that stage on mental distress was evaluated. The account-making models included the control variables, severity variables that were significant in Table K8, don’t know responses for the significant severity variables, disclosure variables significant from Table K9, and Ever Told.

Initially, denial was entered, but it was not significant. In the next model, Intrusion was examined and found to be significant. Participants who endorsed criteria for intrusion scored higher on mental distress than participants who did not meet intrusion criteria. The subsequent model included working through which was also significant. Participants who endorsed criteria for working through scored higher on mental distress than participants who did not meet criteria for working through. Next, the variable end was entered and was significant. As predicted, participants who met criteria for end had lower scores on mental distress than participants who did not meet criteria for the end. Thus, with the exception of denial, the results of the other models provided support for the hypothesis.

The eleventh hypothesis stated that scores on the Account Development Scale would be negatively related to mental distress. Scores on the scale were not significant in predicting mental distress. Thus, the results did not provide support for the hypothesis.
Other variables. The next two hypotheses were based on models that included the control variables, severity variables significant in Table K8, the number of don’t know responses for severity variables, disclosure variables significant in Table K9, and ever told. The results are presented in Table K11.

The twelfth hypothesis stated that participants who reported high conformity to masculine norms would have a higher level of mental distress than participants who did not report high conformity. The variable was significant. The results provided support for the hypothesis.

The thirteenth hypothesis stated that the level of posttraumatic growth would be negatively related to mental distress. Posttraumatic growth, however, was not significant in the model. Thus, the results did not support the hypothesis.

Final model. The model used in the previous hypothesis related to posttraumatic growth was the final model for direct effects. That model consisted of a total of 28 variables: 27 independent variables and the constant term. This model was significant ($F(28, 372) = 7.548, p<.000, R^2=.362$). Seven of the variables predicted mental distress: older age, total childhood stressors, total current stressors, told after one year, overall response to telling, end, and high conformity to masculine norms.

Five variables that were significant in earlier models did not reach significance in the final direct effects model: ever discuss and four severity variables (clergy abuser, physical force, penetration, injury). Post-hoc analyses identified how these five variables were reduced in influence. More specifically, physical force was mediated by the three other severity variables included in the final model. Penetration was mediated by the inclusion of total current stressors. Clergy abuser was mediated by a combination of the additional control variables listed in Table K7. Injury was mediated by total current stressors and a combination of the additional control variables. Finally, ever discuss was mediated by overall response to telling.
**Moderating variables.** Four hypotheses examined the effects of an interaction between indicators of severity and posttraumatic growth on mental distress. The models included all of the variables in the final direct effects model as well as the interaction term. The results are presented in Tables K13 through K16.

Hypothesis 14A stated that the relationship between clergy abuser and mental distress would be moderated by posttraumatic growth. The interaction term (posttraumatic growth x clergy abuser) was not significant. The results did not provide support for the hypothesis.

Hypothesis 14B stated that the relationship between physical force and mental distress would be moderated by post-traumatic growth. The interaction term (post-traumatic growth x physical force) was significant in the expected direction. For those who reported that their abuse involved physical force, higher levels of post-traumatic growth predicted lower levels of mental distress. The results provided support for the hypothesis.

Hypothesis 14C stated that the relationship between penetration and mental distress would be moderated by post-traumatic growth. The interaction term (post-traumatic growth x penetration) was significant in the expected direction. For those who reported that the sexual abuse involved penetration, higher levels of post-traumatic growth predicted lower levels of mental distress. The results provided support for the hypothesis.

Hypothesis 14D stated that the relationship between injury and mental distress would be moderated by post-traumatic growth. The interaction term (post-traumatic growth x injury) was not significant in the expected direction. The results did not provide support for the hypothesis.

**Mediating variables.** Hypothesis 15A stated that account-making would mediate the relationship between high conformity to masculine norms and mental distress. To evaluate this hypothesis, three paths were examined. Although high conformity to
masculine norms predicted mental distress even after controlling for the account development (Paths 1 and 2), high conformity to masculine norms did not predict account development (Path3). Thus, mediation was not demonstrated (see Table K17).

Hypothesis 15B stated that post-traumatic growth would mediate the relationship between high conformity to masculine norms and mental distress. To evaluate this hypothesis, three paths were examined. Although high conformity to masculine norms predicted mental distress (Path 1), post traumatic growth was not a significant predictor of mental distress (Path 2). Also, high conformity to masculine norms did not predict post-traumatic growth (Path 3). Thus, the results did not provide support for mediation (see Table K18).

Appendix L presents a summary of the multivariate results by hypothesis.
CHAPTER 5
DISCUSSION

The purpose of this study was to examine which factors were related to mental health problems in adulthood for MSAC. The study focused on concepts that were grouped into four domains (abuse severity, account-making, masculine norms, and posttraumatic growth) and relied primarily on account-making theory (Harvey et al., 1990) to explain mental distress among MSAC. In this chapter, I will review and interpret the major findings, explore their implications for knowledge development, theory development and practice, identify limitations of the study, and make recommendations for future research.

Major Findings

The results provide support for some of the hypothesized relationships in the conceptual model. In this sample, several of the indicators of abuse severity were related to higher levels of mental distress during model building: clergy abuser, physical force, penetration, and injury. However, all four of these variables were not significant in the final model. They were mediated by other variables in the model such as total current stressors. The other four severity indicators (incest, frequency, duration, and number of abusers) were not related to mental distress.

Disclosure and discussion of the sexual abuse, key aspects of account-making, were important predictors of mental distress. Specifically, delayed disclosure (told after one year), response to first told, and overall response to telling were significant in the final model. Participants who waited longer than one year to tell someone about the sexual abuse had more mental distress than participants who told within one year of the abuse. Participants who received a “very helpful” response to first disclosure had less mental distress than participants who did not receive a “very helpful” response. Finally, the overall response to disclosure was important in the final model. Participants who
received a “very helpful” overall response to telling during their lifetime had less mental distress than participants who did not receive a “very helpful” response to overall telling.

Beyond telling someone about the sexual abuse, participants who discussed it in-depth during their lifetime had less mental distress than participants who had never discussed the abuse in-depth during in the early models. However, having an in-depth discussion was not significant in the final model. Ever discuss was mediated by overall response to telling.

Participants who were in the completion (or end) stage of account-making had a lower level of mental distress than participants who were in earlier stages of account-making. High conformity to masculine norms was positively related to mental distress. Although PTG did not have a direct effect on mental distress in this study, it did moderate the relationship between two severity variables (physical force and penetration) and mental distress.

Of the many control variables in this study, three of them were related to mental distress in the final model: older age, the number of childhood stressors, and the number of current stressors. Participants who were 64 years of age or older had a lower level of mental distress than participants who were younger than 64 years of age. The number of childhood stressors and the number of current stressors were both positively related to mental distress.

Discussion

The first domain in the conceptual model consisted of eight indicators of abuse severity. Four of these indicators were related to mental distress for MSAC during the model building stage: clergy abuser, physical force, penetration, and injury. Although any form of CSA can be damaging, the egregious nature of being abused by a member of the clergy may heighten the sense of betrayal because a clergy member is someone in a special position of authority entrusted to protect and guide members of the faith community and nurture their development. A few exploratory, qualitative studies have
documented some of the devastating effects of clergy abuse for both male (Fater & Mullaney, 2000) and female survivors (Van Wormer & Berns, 2004) including the loss of a primary support resource: spirituality. However, in the current study, abuse by a clergy member was not significant in the final model.

Post hoc analyses revealed that clergy abuser was mediated by a combination of the non-significant control variables in the final model including education, income, dependents and other variables. This set of control variables reduced the effect of clergy abuser on mental distress to the point that it was not significant. Attempts to isolate individual control variables responsible for the mediation were unsuccessful. Thus, it is not possible to definitely state how clergy abuser was mediated. Because few studies have evaluated the effect of clergy abuser among MSAC, future studies should include both clergy abuse survivors and MSAC who were abused by someone not in the clergy.

Similarly, the use of physical force, penetration and injury were related to mental distress for MSAC during model building but not in the final model. The literature is mixed on all three of these factors. Because penetration is more intrusive than other types of sexual abuse (e.g., pornography, flashing), it is often considered more severe, and, therefore, more likely to negatively impact mental health. Some researchers have found that penetration was related to mental health problems for adult female survivors (Briere & Runtz, 1988). However, other researchers have not found support for this relationship (Banyard et al., 2004). Physical force and injury may reinforce helplessness, powerlessness, and despair, thereby contributing to the long-term mental health problems of survivors. Some researchers have found evidence that physical force or injury is related to mental health problems (Banyard et al., 2004; Boudewyn et al., 1995; Briere & Runtz, 1988; O’Leary et al., 2010; Roesler et al., 1994). However, other researchers have found either a weak association or no relationship between severity indicators and long-term mental health problems such as depression for adult survivors of CSA (Dube et al., 2005; Merrill et al., 2001; Rind et al., 1998),
Post-hoc analyses of these three severity variables demonstrated that they were mediated by other variables in the final model. Penetration and injury were both mediated by the total number of current stressors, but injury was also mediated by a combination of the other control variables. Because physical force was correlated with penetration and injury, it was not surprising that physical force was mediated by them in the final model. It is possible that MSAC who survived more severe forms of CSA—penetration, injury, physical force—lived in problem-saturated households with stressors such as parental mental illness, parental substance abuse, unemployment and co-occurring forms of abuse. These other childhood stressors appear to directly undermine the long-term mental health of MSAC.

These findings are consistent with the emerging literature on abuse severity. Although early studies focused on the direct effects of severity indicators on the long-term mental health of adult survivors (e.g., Briere & Runtz, 1988), more recent studies have revealed that the relationship between abuse severity and the mental health of adult survivors of CSA is mediated by factors such as coping strategy and parental support (Merrill et al., 2001), shame and attributional style (Feiring, Taska, & Lewis, 2002), stigma and self-blame (Coffey et al., 1996) and cognitive schemas (Cukor & McGinn, 2006). The results of the current study indicate that abuse severity may indirectly influence the long-term mental health of adult CSA survivors through mediation processes. More research is needed to identify these mediation processes in more detail.

The second domain of the model used in this study included variables that measured disclosure, discussion and account-making. Univariate results showed that the length of time it took participants to tell someone about the abuse ranged from 0 to 63 years with a mean of about 21 years. The length of time it took participants to discuss the abuse in-depth was even longer: about 28 years. These findings are consistent with research that indicates that MSAC often delay disclosure for years and even decades (O’Leary & Barber, 2008; Sigmon et al., 1996; Spataro et al., 2001; Ullman & Filipas,
2005), a likely result of the process referred to as self-silencing (O’Leary & Barber, 2008).

In the multivariate analyses, telling someone early (i.e., within one year of the abuse) predicted less mental distress. Telling earlier may end the abuse earlier, prevent more severe forms of abuse, and lead to more support and recovery resources for children. This finding is consistent with other studies that found that early disclosure is related to fewer PTSD symptoms for female adult survivors of CSA (Arata, 1998; Ruggiero et al., 2004; Ullman et al., 2007). However, not all of the research supports this finding. For example, one study found that early disclosure predicted more mental health symptoms for adult CSA survivors (O’Leary et al., 2010) and another study found that the length of time to disclose was not related to PTSD symptoms for MSAC (Ullman & Filipas, 2005). The current study provides preliminary support for the benefits of early disclosure for MSAC, but more research is needed with this population.

Based on account-making theory and empirical studies, I hypothesized that response to disclosure would be an important factor in the mental health of MSAC. The results, however, were mixed. On the one hand, participants who received a “very helpful” response to first disclosure had less mental distress than participants who did not receive a “very helpful” response. This finding is consistent with existing research that found that a supportive response to disclosure promotes successful coping and adjustment (Harvey et al., 1991; Orbach et al., 1994) and that negative social reactions to disclosure are associated with PTSD symptoms for adult CSA survivors (Ullman, 2007; Ullman & Filipas, 2005). Furthermore, the overall response to disclosure was related to mental distress in the current study. Participants who reported that they received a “very helpful” overall response to disclosure had less mental distress than participants who did not receive a “very helpful” overall response to telling. These findings provide support for the importance of the confiding process in account-making and the potential benefits
of receiving a helpful response to not only the first disclosure, but to subsequent disclosures of CSA throughout the lifespan of the survivor.

On the other hand, two composite measures of support to disclosure--support during childhood and support during adulthood--were not related to mental distress in this study. Although the composite measures were based on dimensions identified in the literature (i.e., belief, protection, and assistance), they were developed for this project and lacked established psychometric properties for reliability and validity. To understand the long-term mental health for MSAC more fully, future research should examine specific dimensions of support (e.g., belief, protection) and the people who are providing the support (e.g., mothers, spouses/partners) in both childhood and adulthood.

Beyond telling someone about the abuse, having an in-depth discussion about the sexual abuse was negatively related to mental distress in the model-building stages of this study but not in the final model. The literature is mixed on the benefits of emotional expression of the sexual abuse for survivors. Some researchers have found, for example, that more detailed, direct disclosures during adulthood may actually increase mental health problems for adult survivors of CSA (Lamb & Smith, 1994; McNulty & Wardle, 1994; Ullman & Filipas, 2005). Conversely, in one of the few studies of MSAC and disclosure, O’Leary (2009) found that seeking instrumental social support was related to fewer mental health symptoms. Post-hoc analyses in the current study found that discussing in-depth was mediated by overall response to telling. Because a helpful disclosure may lead to in-depth discussion of the sexual abuse which in turn may lead a participant to have a positive overall assessment of response to telling. Thus, it is not surprising that the overall response to telling mediated the effects of in-depth discussion on mental distress. Future studies should pursue the distinction between telling and discussing, key components of the confiding step in the account-making process.

Other results suggest that account-making is an important factor related to mental health for MSAC. More specifically, account completion (or reaching the end stage)--
whether a participant had worked through the abuse and understood its effects--was related to mental distress. Participants who met criteria for the end stage had less mental distress than participants who did not meet criteria for the end stage. This finding provides support for the account-making model (Harvey et al., 1990) and for the importance of talking about and expressing emotions arising from traumatic events (Pennebaker, 1997; Pennebaker et al., 1988). It suggests that thinking about, recounting, and reviewing the sexual abuse and its effects may be beneficial for the mental health of MSAC. Because of the dearth of research on this topic for this population, more research is clearly needed to understand how MSAC process, gain understanding, and complete their accounts of the sexual abuse.

Unexpectedly, the scale that measured the extent of account development—the Account Development Scale (ADS)—was not related to mental distress in this study. The ADS was a composite variable that consisted of six items that measured blame, response to the abuse, and understanding of the effects of the abuse. It was based on preliminary research that suggested that a more complete account was an important factor in promoting long-term adjustment for CSA survivors (Harvey et al., 1991; Orbuch et al., 1994). Although the ADS had good internal consistency, it was developed for this project and lacked established psychometric properties for validity. Furthermore, post-hoc analyses revealed that three of the six items which focused on understanding the effects of the abuse were related to mental distress. These core elements of a completed or well-developed account are similar to the earlier measure of the completion (end) stage of account-making. Future research should improve the measure of account development or completion, for example, by interviewing MSAC (or therapists who treat MSAC) to generate a list of additional indicators of a fully completed account of CSA.

The third domain of the model focused on conformity to masculine norms. In this study, meeting criteria for high conformity to masculine norms predicted a higher level of mental distress. Previous studies demonstrated that CSA can profoundly affect the
masculine identity of MSAC, or what it means to be a man, by causing identity
Because CSA violates many established norms of masculinity (e.g., self-protection,
heterosexuality, dominance), researchers and clinicians have proposed that some
survivors adopt a hegemonic or hypermasculine persona as a coping mechanism (Dorais,
2002; Lisak, 1994). A key aspect of hegemonic masculinity is to not express feelings
that makes one appear vulnerable or submissive. Rather than attempting to understand,
address, and reconcile the internal conflict that may arise surrounding masculine identity,
some survivors deny, repress or suppress the sexual abuse experience. Based on this
study, rigid adherence to masculine norms has a detrimental effect on the mental health
of MSAC.

The fourth domain focused on posttraumatic growth. The results indicated that
PTG was not directly related to mental distress. This finding was not surprising because
the literature on the relationship between PTG and mental health among trauma survivors
is mixed. In a review of the empirical research on this topic, Tedeschi et al. (2004)
concluded that PTG is sometimes—but not always--correlated with a reduction in levels
of psychological distress. Thus, it is possible to have high levels of PTG but poor mental
health.

Interestingly, however, PTG was related to mental distress in the current study
through an interaction with two indicators of abuse severity: physical force and
penetration. For participants who endorsed items for either physical force or penetration,
a higher level of PTG was related to less mental distress. This finding suggests that PTG
may indirectly affect mental health through interaction effects. Abusers may use physical
force to coerce, restrain or intimidate their victims, resulting in a greater sense of
helplessness for MSAC. As a highly intrusive form of sexual abuse, penetration may
similarly reinforce helplessness among MSAC. Thus, among MSAC who were
physically forced or penetrated during the sexual abuse, some men may overcome their
feelings of helplessness and achieve personal growth, both leading to improved mental health.

Furthermore, PTG among MSAC is a topic worth pursuing in future studies. The version of the PTGI that was used in this study consisted of 21 items that measured growth in five areas: relating to others, new possibilities, personal strength, spiritual change, and appreciation for life. Although the overall PTG score was not directly related to mental distress, it is possible that one (or more) of these dimensions of PTG could exert a direct influence on mental health for this population. For example, if a MSAC perceives that he is better able to handle difficulties because he was sexually abused (an item under personal strength), then he might have a greater sense of self-efficacy which could result in less mental distress. A concept similar to PTG, resilience, has been examined among MSAC by only a few researchers (e.g., Kia-Keating et al., 2005; Sorsoli et al., 2008). Another related concept to PTG is sense of coherence (SOC): “a global orientation, a pervasive feeling of confidence that the life events one faces are comprehensible, that one has the resources to cope with the demands of these events, and that these demands are meaningful and worthy of engagement” (Antonovsky, 1987, p. 19). To improve our understanding of the pathways to better mental health, future studies could examine specific aspects of PTG or related concepts such as resilience or sense of coherence among MSAC.

Of the three control variables that reached significance in the final model, two of them were based on the number of stressors: childhood stressors and current stressors. The literature on the effect of childhood stressors on mental health of CSA survivors is well-established. Other researchers have found that that CSA seldom occurs in a vacuum (Finkelhor et al., 1998); child victims often face multiple forms of abuse and violence (Edwards et al., 2003; Finkelhor et al., 2009) which can have an additive negative effect on psychological outcomes (Banyard et al., 2004; Draper et al., 2008; Edwards et al., 2003; MacMillan et al., 2001; Molnar et al., 2001). For MSAC, the co-occurrence of
CSA and physical abuse is common (Edwards et al., 2001; Finkelhor et al., 1990; Holmes et al., 1998) and is associated with higher depression scores (Health et al., 1996; MacMillan et al., 2001; Rosen et al., 1996; Whiffen et al., 1997; Windle et al., 1995). Other environmental stressors such as parental substance use, unemployment, criminal behavior, and domestic violence often co-occur with CSA (Holmes & Slap, 1998; Hurwitz et al., 2001; Hunter, 2001; Putnam, 2003) and can negatively impact long-term mental health (Hurwitz et al., 2001; Lisak, 1994; Molnar et al., 2001; Nelson et al., 2002; Windle et al., 1995). The current study provides more evidence that environmental stressors during childhood contribute to mental health problems in adulthood for survivors of CSA.

The total number of current stressors also was related to mental health among MSAC. The literature in this area is under-developed; few studies have examined the effect of recent stressors on the mental health of adult survivors of CSA. Horwitz et al. (2001) found that adult stressors (e.g., unemployment, homelessness, divorce/separation) were highly correlated with CSA. They also found that adult stressors independently contributed to higher rates of lifetime dysthymia and anti-social behavior among MSAC. Boudewyn et al. (1995) found that recent stressors explained variance in depression and self-destructiveness. The results of the current study suggest that the number of current stressors is important in understanding the mental health of MSAC. Because current stressors can be addressed and reduced through intervention, this finding has important implications for practice which will be discussed later in this chapter.

**Limitations**

Like all research projects, this study had several limitations that merit discussion. The first limitation was the cross-sectional design of the study. Because it was cross-sectional, it is not clear whether the independent variables caused a change in the level of mental distress for participants. The results were based on correlational analyses only. For instance, the number of current stressors was positively related to the level of mental
distress. However, it is also possible that mental distress could increase the number of stressors for MSAC. Therefore, the results should not be used to infer causal relationships in the conceptual model. The use of a longitudinal design would be necessary to establish causal ordering of variables to determine whether the independent variables occurred prior to the dependent variable.

A second limitation of this study was that data were collected through self-report questionnaires from a single source: MSAC. The survey consisted of questions about topics (e.g., abuse severity, childhood stressors) that occurred many years (or even decades) prior to the study. Although the survey was designed to minimize problems with retrospective recall (e.g., most questions focused on current functioning and attitudes, memory questions had response choices that were meaningful but did not require a high level of specificity), the self-report approach to data collection may have reduced the accuracy of the data. For example, if the abuse occurred when a participant was very a young child, then he might not have been able to accurately recall the frequency or duration of the abuse. To confirm the accuracy of the self-report data, future studies would benefit from collecting data not only from MSAC, but from other sources as well (e.g., spouse/partner, therapist, family member, administrative records).

A third limitation was sampling bias due to the recruitment strategy. Recruitment through the three national survivor organizations was essential to gain access to MSAC, a hidden, stigmatized population that is extremely difficult to reach for research purposes. However, the members of these survivor organizations may not be representative of MSAC in the general population. Researchers have found that many men who meet criteria for CSA do not label those experiences as abusive (Fondacaro et al., 1999; Holmes & Slap, 1998; Holmes et al., 1997; Holmes, 2008; Rind et al., 1998; Widom et al., 1997) or seek support resources such as therapy even though they may be experiencing psychological distress (Holmes et al., 1997; Hunter, 2001; Lew, 1990). Members of national survivor organizations, however, may be more likely than MSAC in
the general population to have acknowledged the abuse, discussed the abuse with others, and spent time understanding its effects. Thus, the responses to items related to disclosure, discussion, and account-making in the current study may be different than data collected from MSAC in the general population who are not members of survivor organizations.

As discussed in Chapter Three, a high percentage of this sample consisted of participants who survived more severe forms of abuse and were experiencing clinically high levels of distress. For example, 61% of participants indicated that the sexual abuse involved penetration. Additionally, the mean level of distress for the sample was 12.5 (range=0-25), well above the cut point for high distress (>6). Thus, it would be inappropriate to conclude that 61% of MSAC in the general population experience abuse that involves penetration or that the average MSAC has clinically high levels of mental distress. Although membership in survivor organizations was not significant in bivariate analyses, it is possible that MSAC who are more severely abused or more distressed are more likely to join survivor organizations. To increase the generalizability of results, future studies should recruit a probability sample of MSAC from the general population.

One of the inclusion criteria—Internet access—represented another source of sampling bias. Researchers have found that internet access and use are related to socio-demographic factors such as race, household income, education level, household location, and age (Hoffman, Novak, & Schlosser, 2000; NTIA, 1999). Although income, education, and race were not significant in the final model of the current study, concepts such as PTG or masculinity and processes such as disclosure of traumatic experiences may vary depending on income, education, or race. For example, it is possible that masculinity may function differently for Hispanic or African-American MSAC. Future studies should examine these concepts and processes among MSAC who are members of under-represented minority groups.
A fourth limitation was selection bias based on who volunteered for the study. Participants had to be willing to complete a survey on very sensitive topics (e.g., sexual abuse, mental health). Because the completion rate for those who started the survey was only 40.9%, a large number of potential participants were interested in the survey, but did not finish it. The final question in the survey was an open-ended item that asked participants to share anything that wasn’t covered in the survey. A cursory review of the responses to this item identified some plausible reasons for non-completion including mistrust, administrative burden, and the sensitive nature of the survey.

- I don't trust anyone, including whomever made this survey. (Participant #7)
- It took 1hr 10min to complete this survey, with 2 breaks. (Participant #163)
- Too tired to tackle this. How about a survey you can leave and come back to? (Participant #386)
- The subject is taboo to speak about. (Participant #227)

Other comments, however, illustrate why participants may have been motivated to complete the survey.

- Thank you for doing this project. I hope others can find help and a place of peace in their lives through your work. (Participant #258)
- I only did this survey so that you might be able to help a survivor in the future. (Participant #238)
- I have not shared this much in a long time, but I see how even now I feel so much better being able to do it. I hope that this information can help anyone else who has suffered abuse. (Participant #156)
- I think in a way, this survey was therapy. Thanks. (Participant #291)

Participants who completed this survey, then, may have been motivated by a desire to help others. Compared to MSAC in the general population, participants in this study may have higher levels of PTG or lower scores on masculine norms. To minimize this
problem, researchers need to overcome mistrust with this population, reduce the administrative burden of surveys, and recruit participants from the general population.

The fifth limitation consisted of measurement issues. Most of the measures in the study were standardized, validated measures. However, several of the measures were created by the researcher for this project (e.g., *Account Development Scale*). Although the ADS had high internal consistency reliability, was based on existing empirical literature on account-making, and passed face validity tests with national experts (see Chapter Three), it nonetheless lacked well-established psychometric properties. Multivariate results indicated that the ADS was not a significant predictor of mental distress in this study. However, it would be inappropriate to conclude that account completeness is not important for mental health of survivors. Future studies could refine the ADS and replicate the study or examine how individual dimensions of the ADS are related to mental health.

A sixth limitation of the study was that the results may have been influenced by other variables not included in the models. For example, although some researchers have found that coping style explains some of the variance in psychological outcomes for CSA survivors (Merrill et al., 2001; Sigmon et al., 1996; Ullman & Filipas, 2005), coping style was not included in the current study. Another example of an important variable is personality type. More specifically, Bonnano (2004) contended that emotional expression and processing of traumatic events are not necessary for individuals with resilient personalities to achieve positive adjustment following a traumatic event. Although this study had a large number of independent variables across several domains and included numerous control variables, it did not include all variables that could influence mental distress for MSAC. It is possible that coping style or resilient personality might directly affect mental health or mediate variables such as conformity to masculine norms. Future research should explore well-established concepts (e.g., coping
styles) and relatively new concepts (e.g., resilient personalities) that were not included in this study with MSAC.

Implications

Despite these limitations, the study has important implications for knowledge and theory development and for clinical practice.

Knowledge and theory development. Since its emergence as a publicly recognized social problem in the 1970s, CSA has been widely studied by researchers in the fields of social work, psychology, nursing, and related health and social science disciplines. Although a significant number of boys are sexually abused each year (Fergusson et al., 1999; Finkelhor et al., 1990; Holmes & Slap, 1998), the vast majority of scholarship has focused on girls (Andrews et al., 2003; Banyard et al., 2004; Browne et al., 1986) and short-term mental health outcomes. Studies that have examined long-term mental health outcomes have focused primarily on female adult survivors. Furthermore, the effect of gender on mental health outcomes for survivors of CSA is unclear. The current study thus advanced knowledge by focusing on an under-studied population of sexual abuse survivors: MSAC.

Researchers who have included male survivors in studies about the effects of CSA have collected data from small clinical samples or samples with participants less than 50 years of age (e.g., college students). To date only a handful of studies have included older men in their studies (e.g., Briere & Elliott, 2003, Dube et al., 2005, Molnar et al., 2001; O’Leary et al., 2010). This is problematic because this study found that older age was significant in predicting less distress among MSAC. By collecting data from a large sample (n=487) of men ranging from 18 to 84, this study increased our understanding of the factors (e.g., age) that influence the long-term mental health of MSAC.

Additionally, this study increased our knowledge on MSAC through its conceptualization of the disclosure process. Although some researchers have examined the effects of disclosure of CSA on the long-term mental health of adults who were
sexually abused (Arata, 1998; Ruggiero et al., 2004; Ullman, 2007), most studies have narrowly defined disclosure as the act of reporting or telling another person about the abuse during childhood. This study examined disclosure in depth by conceptualizing it as a multi-dimensional, interpersonal process that unfolds across the lifespan. For example, overall response to telling measured response to disclosure during both childhood and adulthood. Also, disclosure was viewed as a process that has the potential to assist survivors in creating a meaningful account of the abusive experience, thereby reducing mental health problems.

By applying a general trauma processing model, account-making (Harvey et al., 1990) to MSAC, this study also contributed to theory development. Account-making assumes that individuals attempt to create meaning from traumatic experiences by constructing personal narratives. The few exploratory studies that have examined account-making among sexual assault survivors used very small samples that included only a handful of men and did not measure mental health using a standardized index of symptoms. This study was the first attempt to apply account-making to MSAC using a large sample, a standardized measure of mental health, and measures of core account-making concepts such as model stages. During model-building, several stages of the model were related to mental distress (see Table K10): intrusion, working through, and end. However, because some participants endorsed items in multiple stages, I chose to use only the end stage as the measure of account-making progress. These findings suggest that further refinement of the items used to measure account-making stage might be fruitful in understanding the mental health of MSAC. Nonetheless, the current study advanced our understanding of how account-making is related to mental health among MSAC.

Few researchers have considered how masculinity (attitudes, cognitions, and behavior) or post-traumatic growth impact the mental health of MSAC. The literature review in this study did not identify any studies that investigated post-traumatic growth
among MSAC and only a few qualitative studies that have examined masculine identity, behavior, and norms among MSAC (e.g., Kia-Keating et al., 2005; Lisak, 1994). The current study contributed to knowledge development by examining the relationships between both masculinity and post-traumatic growth and mental health among MSAC using standardized measures. I found that high conformity to masculine norms was one of the strongest predictors of mental distress in the final model. Furthermore, an interaction between PTG and two severity variables (penetration and physical force) predicted lower levels of mental distress. In future studies of mental health among MSAC, it is paramount that researchers consider the effect of both masculine norms and PTG.

Finally, few studies on this population have adequately controlled for important concepts such as childhood or current stressors which may be stronger predictors of mental distress than, for example, severity of the sexual abuse. In the current study, childhood stressors were measured with an index of nine stressors ranging from parental substance use to domestic violence. Adult stressors were measured with an index of 13 stressors ranging from unemployment to a natural disaster. Although these indices did not include all of the possible stressors in either childhood or adulthood, they provided an excellent mechanism to control for environmental factors that can impact the mental health of MSAC. Based on the literature review, the current study was one of the only studies to date that has included such an elaborate set of control variables. This is important because both childhood and adult stressors were significant in the final model and appear to be important factors that influence the long-term mental health of MSAC.

Clinical practice. The findings of the current study have important implications for MSAC who seek mental health treatment for various psychological problems. This section focuses on implications related to account-making, masculine norms, and current stressors. However, it should be noted that the following discussion of clinical implications consists of recommendations and not mandates. Before these
recommendations are incorporated into clinical interventions, more studies are needed to replicate the findings.

One key finding in the study was that whether a participant was in the end stage of account-making was related to mental distress. Participants who met criteria for the completion (or end) stage indicated that they had worked through their abuse and reached a clear understanding of how the CSA has impacted their lives. Mental health professionals who work with MSAC should assess how well each client understands the possible effects of CSA on their lives. For clients who have little understanding of CSA, therapists can provide general information on CSA (e.g., fact sheets on prevalence rates of CSA). For example, many clients may feel isolated and stigmatized because they believe the popular notion that the CSA of boys is rare. Therapists can review statistics on the prevalence of CSA for boys with their clients, thereby helping them understand that their personal history of CSA is not an anomaly, but rather a part of a larger social problem.

Although the ADS was not significant in model-building, post-hoc analyses indicated that specific items within the ADS were related to mental distress. For example, the third item stated that “I understand how the sexual abuse has affected me emotionally” and was related to mental distress. Although this item was not included in the final model, it is consistent with the completion stage which assesses whether the participants has reached a greater understanding of the effects of the CSA on their lives. Thus, therapists can share research findings that document the relationship between CSA and emotional symptoms or disorders such as depression, anxiety, or somatization. The therapist can help the client examine possible connections between their own sexual abuse and subsequent emotional problems.

To promote an understanding of the effects of CSA, mental health professionals can connect clients to the growing number of support resources for MSAC. Therapists can provide references to articles, self-help books, and video documentaries customized
for MSAC. Therapists can also connect the client to web sites of national survivor organizations which offer resources in a private, confidential setting. These resources may help the client realize that many clinical problems (e.g., substance abuse, depression, anger) are often connected to a history of CSA, thereby increasing the client’s self-understanding and insight into their own emotional and behavioral problems.

Because this study found that disclosure of CSA was related to mental distress, mental health professionals should assess the history of disclosure of CSA for their clients. Many clients may have delayed telling someone about the abuse for decades and received a response to first disclosure and an overall response to telling that was not “very helpful.” In reality, many survivors have received non-supportive, non-believing, or hostile responses to disclosure during their lifetime. Therapists can help their clients understand the impact of keeping the abuse a secret for so long and receiving unhelpful responses. To increase social support, therapists may help clients identify key people in their lives who might provide a helpful response to future conversations about CSA.

Another key finding of the current study was that high conformity to masculine norms was related to a higher level of mental distress. Using brief, standardized measures of masculine norms, mental health professionals can assess MSAC for their conformity to masculine norms at the cognitive, affective and behavioral levels. The results of these assessments can then be used to initiate discussions surrounding masculine norms, identity, and gender roles. Therapists can provide written material demonstrating the link between high masculine conformity to mental health problems in the general population and, more specifically, for MSAC. With this knowledge, the therapeutic conversation can focus on identifying and deconstructing specific gender norms (e.g., restriction of emotional expression, winning, dominance) that may impair recovery from CSA. This deconstruction of exaggerated masculine norms can be accomplished through a variety of techniques (e.g., role playing, homework, journals). Because many MSAC carry stigma based on being abused by a male abuser (e.g.,
Grubman-Black, 1990; Holmes, 1997; Paine & Hansen, 2002), therapists may also discuss sensitive topics that intersect with masculine norms such as homophobia and sexual orientation. Thus, adherence to higher levels of masculine norms may serve as an impediment to the well-being and recovery of MSAC. Modifying these norms may be a central clinical goal in treatment planning.

Finally, this study found that the number of current stressors was positively related to mental distress. Thirteen stressors were included in the index that measured current stressors including, for example, financial problems, major illness, and death of family member in the past 12 months. These stressors are commonly included in clinical assessments that use a multi-axial format based on the DSM-IV (American Psychiatric Association, 2000). Axis IV of the assessment is psychosocial and environmental problems which are grouped into nine categories. These problems are often considered secondary to the primary focus of clinical attention. However, in some cases environmental problems may also be noted on Axis I as “other conditions that may be a focus of clinical attention” (American Psychiatric Association, 2000).

Although environmental stressors are often a standard part of the clinical assessment process, the findings of this study indicate that the number of current stressors is particularly relevant in treating MSAC for mental distress. Thus, it may therapeutically beneficial for therapists to devote extra time and energy to documenting these stressors and incorporate them into the treatment plan. For example, if a MSAC who is being treated for depression endorses multiple stressors including housing problems, providing emotional support in coping with those stressors might not be adequate to treat the depression. The therapist may need to go further and connect the client to tangible resources such as housing assistance programs to mitigate stressors while pursuing other treatment goals.
Future Research

Although there has been an increase in the number of studies of MSAC, they remain a hidden, understudied population (Holmes et al., 1998; Spataro et al., 2001). Generally, more research is needed to understand the relationship between CSA and mental health for MSAC, especially research that identifies factors that explain variability in mental health outcomes. As discussed earlier in the limitations section of this chapter, future studies that use longitudinal designs, collect data from national probability samples, triangulate data from MSAC with multiple sources (e.g., therapists, spouses/partners), and examine intra-ethnic or inter-racial differences would greatly enhance our knowledge of this population. To build on the findings in this study, I will provide more specific recommendations for future research in this section.

Little is known about the effect of age on mental health outcomes for MSAC. The current study was one of the first studies to include MSAC over 50 years of age. In this study, older age (more than 63 years old) was related to better mental health outcomes. However, it is unclear whether this finding was due to a developmental process, a cohort effect, or another explanation. A combination of longitudinal and cross-sectional studies with MSAC from different age groups could advance our understanding of the relationship between age and mental health. For example, a prospective study that follows the mental health of sexually abused boys across the lifespan might be able to identify developmental processes at different ages that affect mental health for this population.

The current study examined general mental distress as the dependent variable. Mental distress consisted of items that measured symptoms of depression, anxiety, somatization, and suicide. Although these DSM-IV illnesses have similarities, each of them may have a different set of predictors. Future studies should examine factors that influence each one of them individually as well as factors that influence psychological illnesses that were not included in this study but are commonly addressed in clinical work.
with MSAC (e.g., substance abuse). If the results indicate that disorders such as depression and somatization have different sets of predictors for MSAC, then therapists could develop differential treatment plans for their clients.

The results of this study indicated that factors such as high conformity to masculine norms, PTG, and overall response to disclosure were predictors of mental distress for MSAC. To improve our understanding of the processes leading to mental distress, future studies should examine the predictors of the independent variables in this study and model the mediation pathways to mental distress. This is important because like direct effects, indirect effects are potentially causal too (Davis, 1985). In clinical work with MSAC, for example, it would be helpful to understand which factors contribute to high conformity to masculine norms. In the current study having an in-depth discussion about the sexual abuse was not directly related to mental distress. However, if having an in-depth discussion about the CSA predicted lower levels of conformity to masculine norms for MSAC, then therapists could encourage clients to talk about the effects of the sexual abuse in more depth. The use of statistical procedures such as path analysis would be helpful in uncovering these indirect pathways to mental distress for this population.

The theory of account-making provided a useful framework for this study and deserves further exploration with MSAC. However, aspects of the model such as account completeness lacked specificity and were difficult to test in this study. For example, the scale to assess account-making stages did not perform well as a composite measure and had to be replaced with a single item that measured account completion: end stage. The scale that measured the extent of account-making (ADS) also did not perform well. However, post-hoc analyses identified specific items within the ADS that were related to mental distress. Future studies should refine the measures for core concepts within account-making (e.g., increase the pool of items for each concept) and assess their relationship to mental health for MSAC.
The account-making theory could also be extended by examining its utility in predicting mental distress among other populations. Because the current study focused exclusively on men who had histories of CSA, it is unclear whether account-making would be useful for female survivors of CSA. It is possible that gender significantly impacts the account-making process for CSA survivors or that disclosure and discussion of CSA operates differently for female survivors of CSA. Beyond CSA, account-making has been applied to survivors of trauma such as war or the death of a spouse. However, this work consists of mostly exploratory studies that merit replication. Potentially stressful events (e.g., diagnosis and treatment of cancer) or stressful situations (e.g., caregiving for relatives with dementia) could also be examined. These types of studies could greatly expand the application of account-making theory and help in the development of clinical interventions that might benefit a wide range of populations.

Finally, this study was primarily based on quantitative analyses. Although quantitative research has many advantages, it does not allow researchers to understand all of the underlying processes or the *context* of social life for participants (Rubin & Babbie, 2008). Unlike qualitative research where the emphasis is on exploring meaning by listening to the voices of participants, quantitative survey research relies heavily on the standardization of concepts into questionnaire items with multiple choice or Likert scale responses, a process likened to the “fitting of round pegs into square holes” (Rubin & Babbie, 2008, p. 384). Qualitative research can be ideal in developing an in-depth understanding of topics, identifying topics for future quantitative studies, and documenting the lived experience of participants, thereby giving voice to marginalized and stigmatized populations (Ragin, 1994).

In this study, measuring highly subjective processes (e.g., account-making) through quantitative measures was challenging. In response to the final open-ended question, some participants expressed concerns related to the limitations of the quantitative survey design and standardization process. Following are some examples:
• My answers are simplified snapshots of what has been a very complex and agonizing process. (Participant# 188)

• In responding to the survey I found that I felt I was telling only a part of the story. (Participant #232)

• I’m surprised a question wasn’t asked about how we felt regarding our perpetrator? (Participant #545)

• Unless I missed it, this survey doesn’t get into the whole impact sexual abuse has on… marriage and long-term relationship, etc. (Participant #547)

Qualitative studies could advance our understanding of MSAC by asking participants about complex processes such as barriers to treatment, supportive responses to disclosure, or the effects of CSA on their lives. A few researchers have employed qualitative designs with MSAC on the effects of CSA (Fater & Mullaney, 2000; Gill & Tutty, 1997; Gill & Tutty, 1999; Lisak, 1994) and, more specifically, on issues of disclosure (Alaggia, 2005; Kia-Keating et al., 2005; Sorsoli et al., 2008). Nonetheless, more qualitative studies are clearly needed with this population.

Conclusions

This study increased our knowledge on factors that are related to the long-term mental health of men who were sexually abused as children. Because this was one of the largest studies to date on MSAC, it included participants from ages across the lifespan and found that older age predicted less mental distress. Moreover, this study was one of the first studies of MSAC to use standardized measures of masculinity, PTG, and stressors in both childhood and adulthood. Using standardized measures was important to accurately test whether these factors influenced mental distress. I found that high conformity to masculine norms was one of the strongest predictors of mental distress for participants. Additionally, childhood and current stressors were directly related to mental distress and PTG was related to mental distress through an interaction with abuse severity (physical force, penetration).
Account-making theory (Harvey et al., 1990) was a useful framework for understanding the mental health of MSAC. Using this theory, I conceptualized disclosure as a multi-dimensional process that unfolds across the lifespan and was able to identify factors that were beneficial to the mental health of MSAC: disclosing within one year of the sexual abuse, receiving a supportive response to first disclosure, receiving supportive responses to subsequent disclosures, and reaching an understanding of the effects of sexual abuse on their lives. Each of these findings related to important steps in the account-making model. In addition to contributing to the empirical literature, then, this study also made important contributions to theory development.

The results of the study generated preliminary recommendations for clinical practice with MSAC. More specifically, I suggested that therapists working with MSAC should promote their clients’ understanding of the effects of CSA through educational literature, Internet-based survivor organizations, and summaries of empirical literature. Therapists should also incorporate disclosure history into clinical assessments and help clients identify potentially supportive people for future disclosures. Finally, therapists should help clients deconstruct rigid masculine norms and manage environmental stressors.

In the future, researchers can build on the findings of this study not only to advance our knowledge of MSAC, but to promote the health and well-being of this understudied, marginalized, and stigmatized population through useful interventions.
APPENDIX A

MASTER LIST OF HYPOTHESES
**Abuse Severity**

H1 (A-H). MSAC who report any of the following indicators of CSA severity will have a higher level of mental distress than MSAC who do not report that severity indicator:

- A. abuser was a biologically-related member of the immediate family (i.e., incest)
- B. abuser was a religious official (e.g., priest, nun)
- C. higher frequency
- D. longer duration
- E. use of physical force
- F. more intrusive abuse (i.e., “involved penetration”)
- G. physical injury from the CSA
- H. higher number of abusers

**Disclosure**

H2. MSAC who did not tell within one year of the abuse (or who never told) will have a higher level of mental distress than MSAC who told someone within one year of the abuse.

H3. MSAC who did not receive a “very helpful” response to first disclosure (or who never told) will have a higher level of mental distress than MSAC who received a “very helpful” response to first disclosure.

H4. The level of support to disclosure during childhood (i.e., being believed, supported, and protected) will be negatively related to the level of mental distress.

H5. The level of support to disclosure in adulthood (i.e., being believed, supported, and protected) will be negatively related to the level of mental distress.

H6. MSAC who have not had an in-depth discussion about the sexual abuse will have a higher level of mental distress than MSAC who have not had an in-depth discussion about the sexual abuse.

H7. The number of years until the abuse was discussed will be positively related to the level of mental distress.

H8. MSAC who report that their most helpful discussant was not “very helpful” (or who never discussed) will have a higher level of mental distress than MSAC who report that their most helpful discussant was “very helpful”.

H9. MSAC who report that the overall responses to telling were not “very helpful” (or who never told) will have a higher level of mental distress than MSAC who report that the overall responses to telling were “very helpful”.
**Account-making**

H10. MSAC who are in the earlier stages of the account-making process will have a higher level of mental distress than MSAC who are in the later stages.

H11. For MSAC, the level of account development (as measured by the Account Development Scale) will be negatively related to the level of mental distress.

**Other Variables**

H12. MSAC who report high conformity to masculine norms will have a higher level of mental distress than participants who do not report high conformity to masculine norms.

H13. The level of post-traumatic growth will be negatively related to the level of mental distress.

**Moderators**

H14. The level of post-traumatic growth will moderate the relationship between abuse severity and the level of mental distress.

- H14A. Clergy Abuser
- H14B. Force
- H14C. Penetration
- H14D. Injury

**Mediators**

H15. Two variables (account-making and post-traumatic growth) will mediate the relationship between conformity to masculine norms and the level of mental distress.

- H15A. Account-making
- H15B. Post-traumatic growth
APPENDIX B
INSTRUMENT
Health and Well-Being Survey

Outline:

Section 1. Personal Health*

Section 2. Sexual abuse and response

Section 3. Coping (i.e., account-making process)

Section 4. Male norms*

Section 5. Background information (demographics & stressors)

Section 6. Personal growth*

* Standardized measures.
Section 1. Personal Health

Instructions: The following questions are about common psychological or mental health problems that many people have. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you cannot go on. Please answer the next questions using yes or no.

During the past 12 months, have you had significant problems with...

1. headaches, faintness, dizziness, tingling, numbness, sweating, or hot or cold spells?
2. sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?
3. having dry mouth, loose bowel movements, constipation, trouble controlling your bladder, or related itching?
4. pain or heavy feeling in your heart, chest, lower back, arms, legs or other muscles?

During the past 12 months, have you had significant problems with...

1. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?
2. remembering, concentrating, making decisions, or having your mind go blank?
3. feeling very shy, self-conscious or uneasy about what people thought/were saying about you?
4. thoughts that other people did not understand you or appreciate your situation?
5. feeling easily annoyed, irritated, or having trouble controlling your temper?
6. feeling tired, having no energy, or feeling like you could not get things done?
7. losing interest or pleasure in work, school, friends, sex, or other things you cared about?
8. losing or gaining 10 or more pounds when you were not trying?
9. moving and talking much slower than usual?

During the past 12 months, have you...

1. thought about killing or hurting someone else?
2. thought about ending your life or committing suicide?
3. had a plan to commit suicide?
4. gotten a gun, pills or other things to carry out your plan?
5. attempted to commit suicide?

During the past 12 months, have you had significant problems with...

1. feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?
2. having to repeat an action over and over, or having thoughts that kept running over in your mind?
3. trembling, having your heart race, or feeling so restless that you could not sit still?
4. getting into a lot of arguments and feeling the urge to shout, throw things, beat, injure or harm someone else?
5. feeling very afraid of open spaces, leaving your home, having to travel or being in a crowd?
6. avoiding snakes, the dark, being alone, elevators or other things because they frightened you?
7. thoughts that other people were taking advantage of you, not giving you enough credit, or causing you problems?
8. thoughts that someone was watching you, following you, or out to get you?
9. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?
10. thoughts that you should be punished for thinking about sex or other things too much?
11. having a lot of tension or muscle aches because you were worried?
12. being unable or finding it difficult to control your worries?

Section 2. Sexual Abuse and Response

Instructions: This section has a series of questions to better understand the experiences of men who have been sexually abused during childhood. Because some were sexually abused by more than 1 person, please answer these questions based on the first time you were sexually abused.

1. About how old were you when you were first sexually abused? ___ years of age
2. What was the gender of the abuser? Male/Female/DK
3. What was your relationship to the abuser?
   - Biological parent
   - Parent’s boyfriend or girlfriend
   - Step-parent
   - Adoptive parent
   - Adult relative (e.g., aunt/uncle, grandparent)
   - Clergy member (e.g., priest, nun)
   - Teacher or coach
   - Childcare provider
   - Adult neighbor
   - Adult stranger
   - Brother/sister
   - Step-brother/step-sister
   - Other adolescent or child
   - Other (please specify) __________
   - Don’t know
4. About how many times were you sexually abused by this abuser?
   - 1 time
   - 2-5 times
   - 6-10 times
   - 11-20 times
   - More than 20 times
   - Don’t know

5. About how long was it from the first time you were sexually abused (by that abuser) to the last time? That is, about how long did the sexual abuse last?
   - 1 time only
   - Less than one month
   - 1 month to 6 months
   - 6 months to 1 year
   - 1 to 3 years
   - More than 3 years
   - Don’t know

6. Did the abuser use physical force? Y/N/DK

7. Did the sexual abuse involve penetration of you or the abuser? (oral, anal or vaginal) Y/N/DK

8. Were you physically injured from the sexual abuse? Yes/No/DK

9. Was the sexual abuse ever reported to the police or child protective services? Y/N/DK

10. Before the age of 18, how many people sexually abused you? 1/2/3/more than 3/DK

11. Before the age of 18, did you ever receive mental health treatment that addressed being sexually abused (e.g., therapy, counseling, support group)? Yes/No/Don’t know

12. As an adult, have you ever received mental health treatment that addressed being sexually abused as a child (e.g., therapy, counseling, support group)? Yes/No/Don’t know
Instructions: The next questions focus on how men who have been sexually abused share information about the abuse with others.

1. Not including this survey, have you ever told anyone that you were sexually abused?
   Yes
   No  (**SKIP TO Q#20**)

2. About how old were you when you first told someone about being sexual abused? ____ years

3. What was that person’s relationship to you?
   - Parent or guardian
   - Sibling
   - Relative (e.g., aunt/uncle, grandparent)
   - Friend (less than 18 years old)
   - Friend (adult)
   - Clergy member
   - Teacher or coach
   - Law enforcement officer or child protection worker
   - Medical professional (e.g., nurse, doctor)
   - Counselor, therapist or other mental health professional
   - Spouse/partner
   - Boyfriend/girlfriend
   - Own children
   - Other (**please specify**) _______

4. How helpful was the response from the first person that you told?
   - Very helpful
   - Somewhat helpful
   - Mixed: both helpful and unhelpful
   - Somewhat unhelpful
   - Very unhelpful
   - Don’t know

5. During childhood, did you tell your mother about the sexual abuse?
   Yes
   No  (**SKIP TO Q#7**).

6. Did your mother:
   - believe you (yes/no/dk)
   - provide emotional support to you (yes/no/dk)
   - try to protect you (yes/no/dk)
   - help/encourage you to get mental health treatment (yes/no/dk)
7. During childhood, did you tell someone (other than your mother) about the sexual abuse?
   Yes
   No   (SKIP TO Q#9)

8. During childhood, did anyone that you told (other than your mother):
   • believe you (yes/no/dk)
   • provide emotional support to you (yes/no/dk)
   • try to protect you (yes/no/dk)
   • help/encourage you to get mental health treatment (yes/no/dk)

9. During adulthood, did anyone that you told:
   • believe you (yes/no/dk)
   • provide emotional support to you (yes/no/dk)
   • try to protect you (yes/no/dk)
   • help/encourage you to get mental health treatment (yes/no/dk)

10. In your lifetime, about how many people have you told that you were sexually abused? ____

11. Have you ever told a spouse or partner that you were sexually abused? Y/N/DK/Not app

12. Overall, how would you evaluate the responses you received when you told others you were sexually abused?
   Very helpful
   Somewhat helpful
   Mixed: both helpful and unhelpful
   Somewhat unhelpful
   Very unhelpful
   Don’t know

13. Beyond telling someone that you were sexually abused, have you ever had an in-depth discussion with someone about the sexual abuse?
   Yes
   No   (SKIP TO Q#20)
   DK   (SKIP TO Q#20)

14. About how old were you when you first had an in-depth discussion about the sexual abuse? ____ years of age

15. Have you ever had an in-depth discussion about the sexual abuse with a spouse or partner? Y/N/DK/Not applicable
16. Please think of all the people that you’ve ever had an **in-depth discussion** with. Of those people, now think of the person that was most supportive. How helpful was that person’s response?
   - Very helpful
   - Somewhat helpful
   - Mixed: both helpful and unhelpful
   - Somewhat unhelpful
   - Very unhelpful
   - Don’t know

17. What was that person’s relationship to you?
   - Parent or guardian
   - Sibling
   - Relative (e.g., aunt/uncle, grandparent)
   - Friend (less than 18 years old)
   - Friend (adult)
   - Clergy member
   - Teacher or coach
   - Law enforcement officer or child protection worker
   - Medical professional (e.g., nurse, doctor)
   - Counselor, therapist or other mental health professional
   - Spouse/partner
   - Own children
   - Other (*please specify*) _______

18. About how old were you when you had this discussion & received a supportive response? __

19. **Open-ended question:** What did he/she do that was **helpful** to you? (*Please type your response below; there is no limit on the length of your response*)

20. **Open-ended question:** Some men take many years to tell someone that they were sexually abused. Others choose to never tell. Please describe why it may be difficult for men to tell someone about/discuss the sexual abuse. (*Please type your response below; there is no limit to your response*).
Section 3. Account-making Process

Instructions: This section is about how men think or feel about being sexually abused. Please read each statement and indicate the extent that you agree or disagree using the following scale. All statements refer to your experience of being sexually abused as a child (before the age of 18).

Strongly disagree  
Disagree  
Somewhat disagree  
Somewhat agree  
Agree  
Strongly agree  

1. Because the sexual abuse is hard to deal with emotionally, I try not to think about it.

2. Whenever I am reminded of the sexual abuse, I do something to take my mind off of it.

3. Even when I don’t want to, I can’t stop thinking about the sexual abuse.

4. Whenever I think about the sexual abuse, I get overwhelmed with strong feelings.

5. I am actively working to understand how the sexual abuse has affected my life.

6. My progress toward understanding the effects of being sexually abused has been filled with temporary setbacks.

7. I periodically engage in activities to maintain my progress in dealing with being sexually abused (e.g., read self-help books, attend survivor workshops, volunteer).

8. At first the sexual abuse was hard to deal with and I tried not to think about it. Later, even when I wanted to, I couldn’t stop thinking about it. But now I’ve worked through it and understand how the sexual abuse has affected my life.
**Completed Account Scale:**

9. The sexual abuse was not my fault.

10. The person who sexually abused me is responsible for the abuse.

11. I understand why I initially responded the way I did to the abuse.

12. I understand why my caregivers responded the way they did to the abuse.

13. I understand how the sexual abuse has affected me emotionally.

14. I understand how some of my negative behaviors are related to the sexual abuse.

15. I am not permanently damaged because of the sexual abuse.

16. The person who sexually abused me does not control my thoughts, feelings or behaviors.

**Section 4. Male Norms**

Instructions: This section contains a series of statements about how men might think, feel, or behave. The statements are designed to measure attitudes, beliefs, and behaviors associated with both traditional and non-traditional masculine gender roles.

**Thinking about your own actions, feelings and beliefs,** please indicate how much you personally agree or disagree with each statement by checking SD for “strongly disagree,” D for “disagree,” A for “agree,” and SA for “strongly agree.” There are no right or wrong responses to the statements. You should give the responses that most accurately describe your personal actions, feelings and beliefs. It is best if you respond with your first impression when answering.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My work is the most important part of my life</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>2. I make sure people do as I say</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>3. In general, I do not like risky situations</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>4. It would be awful if someone thought I was gay</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>5. I love it when men are in charge of women</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>6. I like to talk about my feelings</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>7. I would feel good if I had many sexual partners</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>8. It is important to me that people think I am heterosexual</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>9. I believe that violence is never justified</td>
<td>SD</td>
<td>D</td>
<td>A</td>
</tr>
</tbody>
</table>
10. I tend to share my feelings
11. I should be in charge
12. I would hate to be important
13. Sometimes violent action is necessary
14. I don’t like giving all my attention to work
15. More often than not, losing does not bother me
16. If I could, I would frequently change sexual partners
17. I never do things to be an important person
18. I never ask for help
19. I enjoy taking risks
20. Men and women should respect each other as equals
21. Winning isn’t everything, it’s the only thing
22. It bothers me when I have to ask for help

23. **Open-ended question:** Some research indicates that child sexual abuse can negatively affect a person’s self-identity. Please describe how—if at all—the sexual abuse has affected your self-identity. *(Please type your response below; there is no limit to your response).*

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**Section 5. Background Information**

Instructions: The next questions are about yourself.

1. What is your age? _____

2. Are you of Hispanic, Latino, or Spanish descent? Yes/No

3. What is your race?
   - American Indian or Alaska Native
   - Asian
   - Black or African-American
   - Native Hawaiian or Other Pacific Islander
   - White
   - Other (*please specify*) ________________

4. What is the highest degree or level of education that you have completed?
   - Less than high school diploma
   - High school diploma or GED
   - Technical or vocational school
   - Some college coursework but no degree
   - Associate’s degree (2 year degree)
   - Bachelor’s degree (4 year degree)
   - Master’s degree
   - Doctorate or professional degree
5. Including all sources of income (salary, interest, rent, benefits) from all household members, what was your total household income last year?
   - Less than $20,000
   - $20,000 - $30,000
   - $30,000 - $40,000
   - $40,000 - $50,000
   - $50,000 - $60,000
   - $60,000 - $70,000
   - $70,000 - $80,000
   - $80,000 - $90,000
   - $90,000 - $100,000
   - $100,000-$110,000
   - $110,000-$120,000
   - More than $120,000

6. Including you, how many people are supported by this income? _____

7. Are you currently living with a spouse, partner, or boyfriend/girlfriend?
   Yes/ No (SKIP TO Q#8)/ DK (SKIP TO Q#8)

8. About how many years have you been living with your spouse, partner, or boyfriend/girlfriend? _____ years

9. Did any of the following things happen to you while you were a child or a teenager? (please check all that apply)
   - You spent 2 weeks or more in the hospital.
   - Your parents got a divorce.
   - Your father or mother didn’t have a job for a long time when they wanted to be working.
   - You were sent away from home because you did something wrong.
   - One of your parents drank or used drugs so often that it caused problems for the family.
   - You were physically abused by someone close to you.
   - One of your parents had a mental illness.
   - One of your parents was arrested or convicted of a crime.
   - You saw a parent (or caregiver) punch, hit, slap, or strike his/her partner or spouse.

10. Have any of the following life events or problems happened to you during the last 12 months? (please check all that apply)
    - You suffered a serious illness, injury, or an assault.
    - A serious illness, injury, or assault happened to a close relative.
    - Your parent, child, or spouse died.
    - A close family friend or another relative (aunt, cousin, grandparent) died.
You had a separation due to marital difficulties.
You broke off a steady relationship.
You had a serious problem with a close friend, neighbor, or relative.
You became unemployed or were seeking work unsuccessfully for more than one month.
You were sacked from your job.
You had a major financial crisis.
You had problems with the police and/or a court appearance.
Something you valued was lost or stolen.
You had problems due to a natural disaster (flood, tornado, earthquake).

11. Which of the following organizations, if any, do you belong to?
   MaleSurvivor
   Survivors Network of those Abused by Priests (SNAP)
   Both
   Neither

12. Have you ever engaged in any public advocacy related to child sexual abuse or clergy abuse (e.g., wrote a letter-to-the-editor, attended a rally or protest, met with public officials)? Yes/No

Section 6. Personal Growth

Instructions: The next section is about personal growth. For each of the statements below, please indicate the degree to which this change occurred in your life as a result of being sexually abused as a child using the following scale:

0 = I did not experience this change as a result of my abuse.
1 = I experienced this change to a very small degree as a result of my abuse.
2 = I experienced this change to a small degree as a result of my abuse.
3 = I experienced this change to a moderate degree as a result of my abuse.
4 = I experienced this change to a great degree as a result of my abuse.
5 = I experienced this change to a very great degree as a result of my abuse.

Relating to others
PG1  1. I more clearly see that I can count on people in times of trouble.
PG2  2. I have a greater sense of closeness with others.
PG3  3. I am more willing to express my emotions.
PG4  4. I have more compassion for others.
PG5  5. I put more effort into my relationships.
PG6  6. I learned a great deal about how wonderful people are.
PG7  7. I accept needing others.
New Possibilities
PG8  8. I developed new interests.
PG9  9. I established a new path for my life.
PG10 10. I am able to do better things with my life.
PG11 11. New opportunities are available which wouldn’t have been otherwise.
PG12 12. I am more likely to try to change things which need changing.

Personal Strength
PG13 13. I have a greater feeling of self-reliance.
PG14 14. I know better that I can handle difficulties.
PG15 15. I am better able to accept the way things work out.
PG16 16. I discovered that I’m stronger than I thought I was.

Spiritual Change
PG17 17. I have a better understanding of spiritual matters.
PG18 18. I have a stronger religious faith.

Appreciation for Life
PG19 19. I changed my priorities about what is important in life.
PG20 20. I have a greater appreciation for the value of my own life.
PG21 21. I can better appreciate each day.

22. Some adults who were sexually abused struggle for years and then reach a turning point where they decide to commit to healing and improving their health. Did you experience such a turning point?
    Yes
    No (SKIP TO END)
    Don’t know (SKIP TO END)

23. Open-ended question. If so, please describe your turning point.
(Please type your response below; there is no limit on the length of your response).

24. Open-ended question. In the space below, feel free to share anything that wasn’t covered in the survey or that you’d like to elaborate on.

END OF SURVEY
APPENDIX C
RECRUITMENT LETTER (EMAIL CAMPAIGN)
To: SNAP member  
From: SNAP National Office  
Re: National Survivor Study

Dear SNAP Member:

As you know, child sexual abuse of boys is more common than most people realize. Many male survivors feel isolated and misunderstood, and negative effects can linger into adulthood. More research is needed to understand how sexual abuse affects men and what can be done to improve their well-being.

I am writing you today to make you aware of a unique research opportunity that you may be eligible to participate in. Scott Easton is a licensed master’s level social worker (LMSW) and doctoral candidate at the University of Iowa. He is conducting a one-time, anonymous online survey on male survivors of childhood sexual abuse. He hopes this research will advance our understanding, create more awareness, and generate improvements for treatment.

If you are interested, please visit the study home page by clicking on the following link (or cutting and pasting it into your browser):

http://survey.uiowa.edu/wsb.dll/1070/FINALHealthSurvey.htm

At the study home page you will receive more information to help you decide whether to participate. If you have any questions, you can contact Mr. Easton by email at scott-easton@uiowa.edu.

Thank you for considering this research opportunity.

Sincerely,

SNAP President  
Contact Info.
APPENDIX D

RECRUITMENT MESSAGE (WEB PAGE)
National Survivor Study: Research Participants Invited!

Scott Easton, is a licensed master’s level social work (LMSW) and a doctoral candidate at the University of Iowa. He is currently conducting a national study on the well-being of male survivors of childhood sexual abuse. Participants will be asked to complete a one-time, anonymous online survey. If you are interested, please visit the study home page at:

http://survey.uiowa.edu/wsb.dll/1070/FINALHealthSurvey.htm

(either click on the link, or cut and paste it into your internet browser).

If you have any questions, feel free to contact Mr. Easton by email at scott-easton@uiowa.edu.
APPENDIX E

WELCOME LETTER ON STUDY HOME PAGE
WELCOME!

My name is Scott Easton. I am a licensed social worker (LMSW) and part-time therapist. At the same time, I’m a doctoral student in social work at the University of Iowa. Currently I am conducting a national study on the well-being of male survivors of child sexual abuse.

While a great deal has been written on the sexual abuse of girls, the same is not true for boys. Although fairly common, the sexual abuse of boys is under-recognized, under-treated and misunderstood (Holmes & Slap, 1998). Even less is known about how child sexual abuse affects the well-being of adult men. Because this topic deserves more attention, I made it the focus of my dissertation. It is my hope that the study will improve our understanding of male survivors of child sexual abuse.

Thank you for taking the time to consider participating in this one-time, anonymous survey. To determine whether you are eligible, please click on the "next page" button below and answer three eligibility questions.

Best wishes to you for good health and well-being!

Sincerely,
Scott D. Easton, LMSW
University of Iowa
APPENDIX F

CONSENT LETTER
Date

Dear Participant:

We invite you to participate in a national research study that we’re conducting at the University of Iowa. The purpose of the study is to learn about the well-being of men with histories of childhood sexual abuse. The findings may increase our understanding of male survivors and improve services available to them.

You are being invited to be in this study because you indicated that you are an adult male who was sexually abused before the age of 18. Approximately 1,000 people across the United States who meet these criteria will take part in the study. Two organizations—MaleSurvivor and the Survivors Network of those Abused by Priests (SNAP)—support this project and are helping with recruitment. The researchers have not been given your name or contact information.

If you agree to participate, you will be asked to complete an online survey that asks about you, your experience, and your response to that experience. The survey consists of questions that are divided into six sections and should take about 30-45 minutes to complete. Please know that you may skip any question that you do not wish to answer.

We will keep the information you provide confidential. However, federal regulatory agencies and the University of Iowa Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. Your responses will be collected anonymously. This means that we will not collect your name or any personal information that could be used to identify you in the online survey or on the study web page. We will store study data in password protected computers. If we write a report about this study we will do so in such a way that you cannot be identified.

When collecting research information on the Internet, there is always a risk that your responses may be viewed by unauthorized persons. However, because we will not be collecting any personally identifying information, your name will not be associated with your responses. Also, we will use protected computer systems to collect and store the study data. You may be uncomfortable answering questions about your past experiences. If you have any concerns about your responses or experience any distress, a list of support resources is provided below.

You will not benefit from being in this study. However we hope that others may benefit in the future from what we learn as a result of this study.
There are no costs for being in this research study and you will not be paid for your participation.

Taking part in this research study is completely voluntary. If you decide not to be in this study or if you stop participating at any time, you won’t be penalized. You may end your participation at any time by closing the web browser window without submitting your survey.

If you have any questions about the research study or to report a research related problem, please contact Scott Easton by phone at (319) 270-2993 or by email at scott-easton@uiowa.edu. If you have questions about the rights of research participants, please contact the Human Subjects Office, 300 College of Medicine Administration Building, The University of Iowa, Iowa City, IA 52242, (319) 335-6564, or e-mail irb@uiowa.edu. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

Thank you very much for your time and consideration. If you wish to participate in the study, please click the icon below which will take you directly to the survey.

Sincerely,

Scott D. Easton, LMSW
Doctoral Candidate
University of Iowa School of Social Work

**Support Resources:**

1. Mental Health Service Locator

2. National Suicide Prevention Lifeline
   Phone: (800) 273-TALK (8255)
   Web site: [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)

3. Other resources for survivors (e.g., literature, online support groups)
   Male Survivor Organization: [http://www.malesurvivor.org/library.html](http://www.malesurvivor.org/library.html)
   SNAP (Survivors Network of those Abused by Priests):
APPENDIX G
RESPONSE RATE TO EMAIL CAMPAIGN
Survivors Network of those Abused by Priests (SNAP)

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of members</td>
<td>9,000</td>
</tr>
<tr>
<td>Number of emails sent</td>
<td>7,192</td>
</tr>
<tr>
<td>Number of “bouncebacks/returns”</td>
<td>1,422</td>
</tr>
<tr>
<td>Number of emails sent to valid addresses</td>
<td>5,770</td>
</tr>
<tr>
<td>Percentage of members with CSA histories</td>
<td>67%</td>
</tr>
<tr>
<td>Percentage of members who are male</td>
<td>50%</td>
</tr>
<tr>
<td>Estimated eligible participants</td>
<td>1,932</td>
</tr>
<tr>
<td>[(5770 \times 0.67) \times 0.50] = 1932</td>
<td></td>
</tr>
<tr>
<td># of SNAP respondents</td>
<td>314</td>
</tr>
<tr>
<td>Response rate</td>
<td>16%</td>
</tr>
</tbody>
</table>
APPENDIX H

INSTRUMENT DEVELOPMENT

(PRETEST EVALUATION FORM)
A. General Comments.
Please type any general comments or thoughts on the survey, or how it could be improved.

B. Item Evaluation.
Please go through each item in Sections 2-5 on the survey and evaluate them using the following criteria:

- The question and response choices are written clearly.
- The question and response choices are understandable.
- The question and response choices are free from any jargon or complicated language.
- The response choices are exhaustive.
- There aren’t any other problems with the question or the responses choices.

For any problematic items, please list the item number below along with an explanation.

<table>
<thead>
<tr>
<th>Item #</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(e.g., not clear, not understandable, includes jargon, not exhaustive, other)</td>
</tr>
</tbody>
</table>
APPENDIX I

LIST OF MEASURES
<table>
<thead>
<tr>
<th>Concept</th>
<th>Standardized Measures</th>
<th>Source</th>
<th>Scale</th>
<th>Qual</th>
<th># of items</th>
<th>Total items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Dependent Variable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health problems</td>
<td>General Mental Distress Scale (GMDS)</td>
<td>Dennis et al. (2002)</td>
<td>X</td>
<td>26</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Additional suicide items (from IMDS)</td>
<td>Dennis et al. (2002)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Sexual abuse &amp; response</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuse characteristics</td>
<td>Project-created (PC)</td>
<td></td>
<td>X</td>
<td></td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Disclosure</td>
<td>PC</td>
<td></td>
<td></td>
<td></td>
<td>12</td>
<td>32</td>
</tr>
<tr>
<td><strong>3. Coping (i.e., account-making)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage in model</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Account development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td><strong>4. Male Norms</strong></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td><strong>5. Background Info</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(controls)</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Demographic info.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current stressors</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Childhood stressors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>6. Growth</strong></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Posttraumatic Growth Index (PTGI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional growth questions</td>
<td>Tedeschi &amp; Calhoun (1996)</td>
<td></td>
<td></td>
<td>21</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PC</td>
<td></td>
<td></td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>137</td>
</tr>
</tbody>
</table>
APPENDIX J

LIST OF QUALITATIVE ITEMS
List of Qualitative Items*

Section II. Disclosure

19. What did he/she (the most helpful discussant) do that was helpful to you?

20. Some men take many years to tell someone that they were sexually abused. Others choose to never tell. Please describe why it may be difficult for men to tell someone about/discuss the sexual abuse.

Section IV. Masculine Norms

23. Some research indicates that child sexual abuse can negatively affect a person’s self-identity. Please describe how—if at all—the sexual abuse has affected your self-identity.

Section VI. Post-traumatic Growth

23. If so, please describe your turning point.

24. In the space below, feel free to share anything that wasn’t covered in the survey or that you’d like to elaborate on.

* For each open-ended item, the question was followed with the following instructions: “Please type your response below; there is no limit on the length of your response.”
APPENDIX K

TABLES
Table K1. Demographic Characteristics of Participants \((n=487)\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percent</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>50.37 (SD=10.82)</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian/white</td>
<td>90.9</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Native American</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Bi/multiracial</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Hispanic (% yes)</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school diploma or less</td>
<td>10.3</td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>31.5</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>30.3</td>
<td></td>
</tr>
<tr>
<td>Master’s degree or higher</td>
<td>27.8</td>
<td></td>
</tr>
<tr>
<td>Income Level</td>
<td>6.26 (SD=3.80)</td>
<td></td>
</tr>
<tr>
<td>$60,000-$69,999</td>
<td>$60,000-$69,999</td>
<td></td>
</tr>
<tr>
<td>Dependents (number of)</td>
<td>2.48 (SD=1.49)</td>
<td></td>
</tr>
<tr>
<td>Living with spouse or partner (% yes)</td>
<td>69.9</td>
<td></td>
</tr>
<tr>
<td>Years cohabitating (number of)</td>
<td>18.89 (SD=12.09)</td>
<td></td>
</tr>
<tr>
<td>Membership in survivor group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNAP</td>
<td>59.3%</td>
<td></td>
</tr>
<tr>
<td>MaleSurvivor</td>
<td>15.9%</td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td>5.6%</td>
<td></td>
</tr>
<tr>
<td>Neither</td>
<td>19.2%</td>
<td></td>
</tr>
<tr>
<td>Current Stressors (number of)</td>
<td>2.27 (2.05)</td>
<td></td>
</tr>
<tr>
<td>Childhood Stressors (number of)</td>
<td>1.87 (1.77)</td>
<td></td>
</tr>
</tbody>
</table>
Table K2. Comparison of Sample to Other Studies

<table>
<thead>
<tr>
<th></th>
<th>Current Study (n=487)</th>
<th>Finkelhor et al. (1990) (n=169)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abuse Characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at 1st Abuse</td>
<td>10.26</td>
<td>9.9</td>
</tr>
<tr>
<td>CSA by family member</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>CSA by a stranger</td>
<td>2%</td>
<td>40%</td>
</tr>
<tr>
<td>Duration-more than 1 year</td>
<td>57%</td>
<td>8%</td>
</tr>
<tr>
<td>Force</td>
<td>41%</td>
<td>15%</td>
</tr>
<tr>
<td>Penetration</td>
<td>61%</td>
<td>62%</td>
</tr>
<tr>
<td><strong>Disclosure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever told</td>
<td>97%</td>
<td>58%</td>
</tr>
<tr>
<td>Told within 1 year</td>
<td>8%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Table K3. Percentage of Missing Values ($n=487$)

<table>
<thead>
<tr>
<th></th>
<th>Substantive Response</th>
<th>Don’t Know</th>
<th>Valid Skip</th>
<th>Missing</th>
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</thead>
<tbody>
<tr>
<td><strong>Dependent Variable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Distress#</td>
<td>97.5</td>
<td></td>
<td></td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Demographics &amp; Controls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>99.8</td>
<td></td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>99.2</td>
<td>0.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>98.4</td>
<td>1.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>99.6</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>97.1</td>
<td></td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>Dependents</td>
<td>98.4</td>
<td></td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>Cohabitation</td>
<td>99.4</td>
<td>0.2</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Years Cohabitation</td>
<td>62.0</td>
<td>30.8</td>
<td>7.2</td>
<td></td>
</tr>
<tr>
<td>Membership</td>
<td>99.4</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Stressors#</td>
<td>100.0</td>
<td>0.0</td>
<td></td>
<td>0.0</td>
</tr>
<tr>
<td>Childhood Stressors#</td>
<td>100.0</td>
<td>0.0</td>
<td></td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Abuse Severity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at 1st Abuse</td>
<td>99.6</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship to Abuser</td>
<td>99.2</td>
<td>0.6</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>87.3</td>
<td>12.5</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>90.3</td>
<td>6.6</td>
<td>3.1</td>
<td></td>
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<tr>
<td>Force</td>
<td>88.9</td>
<td>10.7</td>
<td>0.4</td>
<td></td>
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<tr>
<td>Penetration</td>
<td>88.9</td>
<td>10.1</td>
<td>1.0</td>
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</tr>
<tr>
<td>Injured</td>
<td>86.5</td>
<td>12.9</td>
<td>0.6</td>
<td></td>
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<td>4.5</td>
<td>2.7</td>
<td>0.4</td>
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<tr>
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<td>1.2</td>
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<td>Support in Childhood# (mother or another)</td>
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<td>78.9</td>
<td>1.2</td>
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<td>Support in Adulthood#</td>
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<td>0.6</td>
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Table K3 (continued)

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<td>1.2</td>
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<td>74.4</td>
<td>0.2</td>
<td>24.8</td>
</tr>
<tr>
<td>(not “very helpful”)</td>
<td></td>
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<tr>
<td>Overall Response</td>
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<td>2.7</td>
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<tr>
<td>(not “very helpful”)</td>
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<tr>
<td><strong>Other Variables</strong></td>
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</tr>
<tr>
<td>Conformity to Masculine Norms#</td>
<td>97.7</td>
<td></td>
<td>2.3</td>
</tr>
<tr>
<td>Post-traumatic Growth#</td>
<td>94.5</td>
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<td>5.5</td>
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</tbody>
</table>

Notes:
1. The symbol # denotes a composite variable. For these variables, the missing values information is based on the single item in the composite with the highest percentage of missing values.
2. The rows represent the responses for a single variable and add to 100%.
Table K4. Univariate Results

<table>
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<tr>
<th>Dependent Variable:</th>
<th>n</th>
<th>%</th>
<th>Mean (SD)</th>
<th>Minimum and Maximum Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Distress</td>
<td>487</td>
<td></td>
<td>12.5 (6.27)</td>
<td>0 - 25</td>
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</tbody>
</table>

**Control Variables**

<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Age</td>
<td>486</td>
<td></td>
<td>50.37 (10.38)</td>
<td>19 - 84</td>
</tr>
<tr>
<td>Older Age ( &gt; 63 years)</td>
<td>486</td>
<td>14.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger Age (&lt; 40 years)</td>
<td>486</td>
<td>14.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-white</td>
<td>483</td>
<td>9.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Stressors</td>
<td>487</td>
<td></td>
<td>1.87 (1.77)</td>
<td>0 - 8</td>
</tr>
<tr>
<td>Age at First Abuse</td>
<td>485</td>
<td></td>
<td>10.26 (3.81)</td>
<td>1 - 18</td>
</tr>
</tbody>
</table>

**Recent**

<table>
<thead>
<tr>
<th>Education</th>
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<th></th>
</tr>
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<tbody>
<tr>
<td>High school diploma or less</td>
<td>485</td>
<td>5.33</td>
<td>3.33 (1.78)</td>
<td>1 - 8</td>
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<tr>
<td>Some college</td>
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<td></td>
</tr>
<tr>
<td>Bachelor’s degree</td>
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<td></td>
</tr>
<tr>
<td>Master’s degree or more</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>473</td>
<td></td>
<td>6.26 (3.8)</td>
<td>1 - 12</td>
</tr>
<tr>
<td>Income High ( &gt; 10.1)</td>
<td>473</td>
<td>19.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income Low ( &lt; 2.5)</td>
<td>473</td>
<td>22.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependents</td>
<td>479</td>
<td></td>
<td>2.48 (1.49)</td>
<td>1 - 9</td>
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<tr>
<td>Cohabitation</td>
<td>483</td>
<td>69.2</td>
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<td></td>
</tr>
<tr>
<td>Years Cohabitation</td>
<td>302</td>
<td></td>
<td>18.49 (12.09)</td>
<td>1 - 49</td>
</tr>
<tr>
<td>Current Stressors</td>
<td>487</td>
<td></td>
<td>2.27 (2.05)</td>
<td>0 - 12</td>
</tr>
</tbody>
</table>

| Membership                   |      |      |              |                           |
| SNAP Member                  | 484  | 59.3 |              |                           |
| MaleSurvivor Member          | 484  | 15.9 |              |                           |
| Both SNAP & MaleSurvivor Member | 484 | 5.6  |              |                           |

**Abuse Severity**

| Abuser Biologically Related (incest) | 483 | 11.4 |
| Clergy Abuser                     | 483 | 61.5 |
| Frequency                        | 425 |     |
| Once                             | 84  | 19.8 |
| 2-5 times                        | 111 | 26.1 |
| 6-10 times                       | 36  | 8.5  |
| 11-20 times                      | 31  | 7.3  |
| More than 20 times               | 163 | 38.4 |

| Duration                        | 440 |     |
| 1 time only                     | 71  | 16.1 |
| Less than 1 month               | 13  | 3.0  |
| 1 to 6 months                   | 58  | 13.2 |
| 6 months to 1 year              | 48  | 10.9 |
| 1-3 years                       | 112 | 25.5 |
| More than 3 years               | 138 | 31.4 |
Table K4 (continued)

<p>| | | |</p>
<table>
<thead>
<tr>
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<tr>
<td>Force</td>
<td>433</td>
<td>40.6</td>
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<tr>
<td>Penetration</td>
<td>433</td>
<td>61.0</td>
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<tr>
<td>Injured</td>
<td>421</td>
<td>23.8</td>
</tr>
<tr>
<td>Number of Abusers</td>
<td>467</td>
<td>1.85 (1.07)</td>
</tr>
</tbody>
</table>

**Account-making**

|                  |         |         |
| Denial           | 485     | 44.9    |
| Intrusion        | 484     | 57.9    |
| Working Through  | 477     | 66.7    |
| End              | 480     | 39.4    |
| Account Development Scale | 485 | 4.77 (0.87) | 1 - 6 |

**Disclosure Variables**

|                  |         |         |
| Ever Told        | 486     | 97.3    |
| Years Until Told | 467     | 21.38 (14.88) | 0 - 63 |
| Told After One Year | 467 | 91.6    |
| Response First Told | 450 | 70.2    |

|                  |         |         |
| Mother Support (childhood) | 68 | 1.19 (1.33) | 0 - 4 |
| Another Support (childhood) | 96 | 1.42 (1.26) | 0 - 4 |
| Support in Childhood (mother/another) | 124 | 1.75 (2.07) | 0 - 8 |
| Support in Adulthood | 463     | 2.85 (1.16) | 0 - 4 |
| Ever Discuss      | 471     | 77.1    |
| Years Until Discussed | 356 | 28.23 (12.88) | 0 - 72 |
| Years Until Helpful Discussion | 358 | 29.98 (12.07) | 1 - 73 |
| Most Supportive Discussant (not “very helpful”) | 362 | 35.6 |
| Overall Response (not “very helpful”) | 459 | 78.2 |

**Other Variables**

|                  |         |         |
| Conformity to Masculine Norms | 485 | 2.34 (0.32) | 1.59 - 3.55 |
| High Conformity (> 2.66) | 485     | 14.6    |
| Low Conformity (< 2.02) | 485     | 14.4    |
| Post-traumatic Growth | 472     | 2.21 (1.31) | 0 - 5 |
Table K5. Bivariate Results: Correlations and ANOVAs for Predictors of Mental Distress

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<th>N</th>
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<tr>
<td>Younger Age (&lt; 40 years)</td>
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<td>14.78</td>
<td>10.66**</td>
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<td>14.23</td>
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<tr>
<td>Childhood Stressors</td>
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<td>Age at First Abuse</td>
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<tr>
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<td>15.33</td>
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<td>7.14**</td>
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Table K5 (continued)

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<td>Told After One Year</td>
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<td>12.78</td>
<td>9.13**</td>
<td>467</td>
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<td>Another Support (childhood)</td>
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<td></td>
<td>96</td>
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<td>Support in Childhood (mother or another)</td>
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<td>Support in Adulthood</td>
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<td>463</td>
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<td>Ever Discuss</td>
<td>13.50</td>
<td>12.24</td>
<td>3.35</td>
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<td>13.36</td>
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<td>Overall Response (not “very helpful”)</td>
<td>9.99</td>
<td>13.26</td>
<td>22.01***</td>
<td>459</td>
</tr>
</tbody>
</table>

| Other Variables                               |       |       |       |       |
| Conformity to Masculine Norms                 | .207***|       |       | 485   |
| High Conformity (> 2.66)                      | 12.16 | 14.47 | 8.29**| 485   |
| Low Conformity (< 2.02)                       | 12.62 | 11.73 | 1.22  | 485   |
| Post-traumatic Growth                         | -.005 |       |       | 472   |
Table K6. Multivariate Results: Standard Control Variables Predicting Mental Distress

<table>
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<th>S.E.</th>
<th>$B$</th>
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<tr>
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<td>-3.234***</td>
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<td>-.182</td>
</tr>
<tr>
<td>Younger Age (&lt; 40 years)</td>
<td>1.630*</td>
<td>.809</td>
<td>.090</td>
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<tr>
<td>Nonwhite</td>
<td>.865</td>
<td>.963</td>
<td>.040</td>
</tr>
<tr>
<td>Age At First Abuse</td>
<td>-.159*</td>
<td>.074</td>
<td>-.097</td>
</tr>
<tr>
<td>Childhood Stressors</td>
<td>.577***</td>
<td>.157</td>
<td>.163</td>
</tr>
</tbody>
</table>

Notes:
1. * $p < .05$, ** $p < .01$, *** $p < .001$ (2-tailed tests)
2. The $R^2$ was .104.
Table K7. Multivariate Results: All Control Variables Predicting Mental Distress

<table>
<thead>
<tr>
<th>Control Variables</th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
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<tr>
<td>Older Age ( &gt; 63 years)</td>
<td>-2.502**</td>
<td>.810</td>
<td>-.138</td>
</tr>
<tr>
<td>Younger Age (&lt; 40 years)</td>
<td>1.366</td>
<td>.785</td>
<td>.078</td>
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<td>Age At First Abuse</td>
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<td>Childhood Stressors</td>
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<td>.084</td>
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<td>Education</td>
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<td>-.050</td>
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<td>.707</td>
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</tr>
<tr>
<td>Income Low (&lt; 2.5)</td>
<td>1.197</td>
<td>.719</td>
<td>.081</td>
</tr>
<tr>
<td>Dependents</td>
<td>-.002</td>
<td>.202</td>
<td>.000</td>
</tr>
<tr>
<td>Years Cohabitation</td>
<td>-.004</td>
<td>.023</td>
<td>-.009</td>
</tr>
<tr>
<td>DK Cohabitation</td>
<td>-1.857</td>
<td>5.456</td>
<td>-.014</td>
</tr>
<tr>
<td>Current Stressors</td>
<td>1.159***</td>
<td>.143</td>
<td>.364</td>
</tr>
</tbody>
</table>

Notes:
1. * p <.05, ** p <.01, *** p < .001 (2-tailed tests)
2. Four variables approached significance (p<.10): Age Low, Age At First Abuse, Childhood Stressors, and Income Low.
3. The R² was .267.
Table K8. Multivariate Results: Severity Variables Predicting Mental Distress

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuser Biologically Related (incest)</td>
<td>.129</td>
<td>.932</td>
<td>.007</td>
</tr>
<tr>
<td>Clergy Abuser</td>
<td>1.581**</td>
<td>.623</td>
<td>.122</td>
</tr>
<tr>
<td>Frequency</td>
<td>.193</td>
<td>.182</td>
<td>.050</td>
</tr>
<tr>
<td>Duration</td>
<td>.261</td>
<td>.164</td>
<td>.074</td>
</tr>
<tr>
<td>Force</td>
<td>2.211***</td>
<td>.584</td>
<td>.170</td>
</tr>
<tr>
<td>Penetration</td>
<td>2.123***</td>
<td>.606</td>
<td>.169</td>
</tr>
<tr>
<td>Injury</td>
<td>3.034***</td>
<td>.702</td>
<td>.196</td>
</tr>
<tr>
<td>Number of Abusers</td>
<td>.317</td>
<td>.287</td>
<td>.054</td>
</tr>
</tbody>
</table>

Notes:
1. * p <.05, ** p < .01, *** p < .001 (1-tailed tests; directional hypotheses)
2. All models controlled for the standard control variables identified in Table N6.
3. To examine the independent effects of each indicator of abuse severity, we constructed new models for each severity variable. The models included the control variables, the severity variable of interest, and the number of don’t know responses for that severity variable. Thus, the models did not control for the other severity variables.
4. The R² ranged from .105 to .153 for these eight models.
Table K9. Multivariate Results: Disclosure Variables Predicting Mental Distress

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Told After One Year</td>
<td>2.172*</td>
<td>1.014</td>
<td>.095</td>
</tr>
<tr>
<td>Response to First Told (not “very helpful”)</td>
<td>1.506**</td>
<td>.606</td>
<td>.107</td>
</tr>
<tr>
<td>Mother Support (childhood)</td>
<td>-.666</td>
<td>.543</td>
<td>-.069</td>
</tr>
<tr>
<td>Another Support (childhood)</td>
<td>-.778</td>
<td>.495</td>
<td>-.100</td>
</tr>
<tr>
<td>Support in Childhood (mother/another)</td>
<td>-.389</td>
<td>.317</td>
<td>-.081</td>
</tr>
<tr>
<td>Support in Adulthood</td>
<td>.272</td>
<td>.246</td>
<td>.055</td>
</tr>
<tr>
<td>Overall Response to Telling (not “very helpful”)</td>
<td>2.240***</td>
<td>.682</td>
<td>.142</td>
</tr>
<tr>
<td>Ever Discuss</td>
<td>-1.060*</td>
<td>.629</td>
<td>-.074</td>
</tr>
<tr>
<td>Years Until Discussed</td>
<td>.042</td>
<td>.028</td>
<td>.075</td>
</tr>
<tr>
<td>Response of Most Supportive Discussant (not “very helpful”)</td>
<td>.970</td>
<td>.641</td>
<td>.078</td>
</tr>
</tbody>
</table>

Notes:
1. * p <.05, ** p < .01, *** p < .001 (1-tailed tests; directional hypotheses)
2. All models controlled for the standard control variables identified in Table N6 as well as Ever Told. The models also included the severity variables that were significant in Table N8 and the number of don’t know responses for each severity variable. The last four models also included the following control variables: Education, Income High, Income Low, Dependents, Years Cohabitation, and Total Current Stressors.
3. To examine the independent effects of each disclosure variable, we ran separate models for each variable in this table. Thus, each model did not control for the other disclosure variables.
4. The R² ranged from .189 to .334 for these models.
Table K10. Multivariate Results: Account-making Variables Predicting Mental Distress

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td>.430</td>
<td>.543</td>
<td>.034</td>
</tr>
<tr>
<td>Intrusion</td>
<td>3.679***</td>
<td>.524</td>
<td>.291</td>
</tr>
<tr>
<td>Working Through</td>
<td>1.660**</td>
<td>.587</td>
<td>.125</td>
</tr>
<tr>
<td>End</td>
<td>-1.138*</td>
<td>.559</td>
<td>-.088</td>
</tr>
<tr>
<td>Account Development Scale</td>
<td>-.473</td>
<td>.316</td>
<td>-.065</td>
</tr>
</tbody>
</table>

Notes:
1. * p <.05, ** p < .01, *** p < .001 (1-tailed tests; directional hypotheses)

2. The models controlled for the full set of control variables (Table N7), severity variables that were significant in Table N8 (and the number of don’t know responses for each severity variable), Ever Told, and disclosure variables that were significant in Table N9 (excluding Response to First Told). Response to First Told was omitted because of potential confounding effects with Overall Response to Telling.

3. To examine the independent effects of each account-making variable, we ran separate models for each variable in this table. Thus, each model did not control for the other account-making variables.

4. The R² ranged from .345 to .417 for these five models.
Table K11. Multivariate Results: Masculine Norms and Post-traumatic Growth as Predictors of Mental Distress

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Conformity to Masculine Norms (&gt;2.66)</td>
<td>2.085**</td>
<td>.753</td>
<td>.116</td>
</tr>
<tr>
<td>Post-traumatic Growth (M)</td>
<td>.179</td>
<td>.218</td>
<td>.038</td>
</tr>
</tbody>
</table>

Notes:
1. * p < .05, ** p < .01, *** p < .001 (1-tailed tests; directional hypotheses)
2. Both models controlled for the full set of control variables (Table N7), severity variables that were significant in Table N8 (and the number of don’t know responses for each severity variable), Ever Told, End, disclosure variables that were significant in Table N9 (excluding Response to First Told). Response to First Told was omitted because of potential confounding effects with Overall Response to Telling. The last model also controlled for High Conformity to Masculine Norms.
3. The R² for the first model was .364; the R² for the second model (with PTG) was .362.
Table K12. Multivariate Results: Predictors of Mental Distress (direct effects only)

<table>
<thead>
<tr>
<th>Controls</th>
<th>$b$</th>
<th>S.E.</th>
<th>$B$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Age (&gt; 63 years)</td>
<td>-2.665**</td>
<td>.827</td>
<td>-.149</td>
</tr>
<tr>
<td>Younger Age (&lt; 40 years)</td>
<td>.770</td>
<td>.798</td>
<td>.044</td>
</tr>
<tr>
<td>Nonwhite</td>
<td>-.513</td>
<td>1.015</td>
<td>-.022</td>
</tr>
<tr>
<td>Childhood Stressors</td>
<td>.270*</td>
<td>.161</td>
<td>.075</td>
</tr>
<tr>
<td>Age at First Abuse</td>
<td>-.079</td>
<td>.084</td>
<td>-.048</td>
</tr>
<tr>
<td>Education</td>
<td>-.105</td>
<td>.162</td>
<td>-.030</td>
</tr>
<tr>
<td>Income High (&gt; 10.1)</td>
<td>-1.014</td>
<td>.718</td>
<td>-.065</td>
</tr>
<tr>
<td>Income Low (&lt;2.5)</td>
<td>.702</td>
<td>.721</td>
<td>.047</td>
</tr>
<tr>
<td>Dependents</td>
<td>.008</td>
<td>.209</td>
<td>.002</td>
</tr>
<tr>
<td>Years Cohabitation</td>
<td>-.009</td>
<td>.024</td>
<td>-.019</td>
</tr>
<tr>
<td>Current Stressors</td>
<td>.957***</td>
<td>.148</td>
<td>.303</td>
</tr>
<tr>
<td>Ever Told</td>
<td>1.795</td>
<td>1.781</td>
<td>.045</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abuse Severity</th>
<th>$b$</th>
<th>S.E.</th>
<th>$B$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clergy Abuser</td>
<td>.636</td>
<td>.607</td>
<td>.050</td>
</tr>
<tr>
<td>Force</td>
<td>.930</td>
<td>.683</td>
<td>.072</td>
</tr>
<tr>
<td>Penetration</td>
<td>.674</td>
<td>.640</td>
<td>.054</td>
</tr>
<tr>
<td>Injured</td>
<td>1.321</td>
<td>.886</td>
<td>.084</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Account-making and Disclosure</th>
<th>$b$</th>
<th>S.E.</th>
<th>$B$</th>
</tr>
</thead>
<tbody>
<tr>
<td>End</td>
<td>-1.242*</td>
<td>.601</td>
<td>-.097</td>
</tr>
<tr>
<td>Told After One Year</td>
<td>1.699*</td>
<td>.961</td>
<td>.078</td>
</tr>
<tr>
<td>Overall Response (not “very helpful”)</td>
<td>1.971**</td>
<td>.706</td>
<td>.125</td>
</tr>
<tr>
<td>Ever Discuss</td>
<td>-.369</td>
<td>.647</td>
<td>-.026</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Masculinity &amp; Growth</th>
<th>$b$</th>
<th>S.E.</th>
<th>$B$</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Conformity-Masculine Norms (&gt; 2.66)</td>
<td>2.049**</td>
<td>.762</td>
<td>.115</td>
</tr>
<tr>
<td>Post-traumatic Growth</td>
<td>.235</td>
<td>.224</td>
<td>.049</td>
</tr>
</tbody>
</table>

Notes:
1. * $p < .05$, ** $p < .01$, *** $p < .001$ (1-tailed tests; directional hypotheses)
2. The constant for this model was 4.744 (S.E.= 2.638). All VIFs were under 1.85. The $R^2$ for this model was .362.
Table K13. Interaction Effects of Post-Traumatic Growth and Clergy Abuser

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clergy Abuser</td>
<td>-.557</td>
<td>1.101</td>
<td>-.044</td>
</tr>
<tr>
<td>Post-traumatic Growth</td>
<td>-.076</td>
<td>.328</td>
<td>-.016</td>
</tr>
<tr>
<td>Clergy Abuser x Post-traumatic Growth</td>
<td>.538</td>
<td>.414</td>
<td>.123</td>
</tr>
</tbody>
</table>

Table K14. Interaction Effects of Post-Traumatic Growth and Force

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Force</td>
<td>3.176**</td>
<td>1.220</td>
<td>.246</td>
</tr>
<tr>
<td>Post-traumatic Growth</td>
<td>.587*</td>
<td>.273</td>
<td>.122</td>
</tr>
<tr>
<td>Force x Post-traumatic Growth</td>
<td>-.976*</td>
<td>.441</td>
<td>-.206</td>
</tr>
</tbody>
</table>

Table K15. Interaction Effects of Post-Traumatic Growth and Penetration

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penetration</td>
<td>2.341*</td>
<td>1.110</td>
<td>.187</td>
</tr>
<tr>
<td>Post-traumatic Growth</td>
<td>.623*</td>
<td>.307</td>
<td>.129</td>
</tr>
<tr>
<td>Penetration x Post-traumatic Growth</td>
<td>-.761*</td>
<td>.415</td>
<td>-.174</td>
</tr>
</tbody>
</table>

Table K16. Interaction Effects of Post-Traumatic Growth and Injury

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>S.E.</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>2.091</td>
<td>1.483</td>
<td>.133</td>
</tr>
<tr>
<td>Post-traumatic Growth</td>
<td>.297</td>
<td>.243</td>
<td>.062</td>
</tr>
<tr>
<td>Injury x Post-traumatic Growth</td>
<td>-.357</td>
<td>.551</td>
<td>-.058</td>
</tr>
</tbody>
</table>

Notes:
1. * p < .05, ** p < .01, *** p < .001 (1-tailed tests; directional hypotheses)
2. All models included the variables in Table K12 and the interaction term.
Table K17. Mediation Results: Account-making as Mediator of the Relationship between High Conformity to Masculine Norms and Mental Distress

<table>
<thead>
<tr>
<th>High Conformity</th>
<th>Path 1 Mental Distress</th>
<th>Path 2 Mental Distress</th>
<th>Path 3 Account-making (End)</th>
</tr>
</thead>
<tbody>
<tr>
<td>b</td>
<td>2.174**</td>
<td>2.085**</td>
<td>-.447</td>
</tr>
<tr>
<td>SE</td>
<td>.745</td>
<td>.753</td>
<td>.332</td>
</tr>
</tbody>
</table>

Mediator:
Account-making (End)

| b | N.A. | -1.070* | N.A. |
| SE | N.A. | .555    | N.A. |

Table K18. Mediation Results: Post-traumatic Growth as Mediator of the Relationship between High Conformity to Masculine Norms and Mental Distress

<table>
<thead>
<tr>
<th>High Conformity</th>
<th>Path 1 Mental Distress</th>
<th>Path 2 Mental Distress</th>
<th>Path 3 Post-traumatic Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>b</td>
<td>2.085**</td>
<td>2.049**</td>
<td>-.050</td>
</tr>
<tr>
<td>SE</td>
<td>.753</td>
<td>.762</td>
<td>.177</td>
</tr>
</tbody>
</table>

Mediator:
Post-traumatic Growth

| b | N.A. | .235 | N.A. |
| SE | N.A. | .224 | N.A. |

Note: N.A. = not applicable.
APPENDIX L

SUMMARY OF MULTIVARIATE RESULTS OF DIRECT EFFECTS BY HYPOTHESIS
Table L1. Summary of Multivariate Results of Direct Effects by Hypothesis

<table>
<thead>
<tr>
<th>Variable</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severity</strong></td>
<td></td>
</tr>
<tr>
<td>1. a. biologically related abuser</td>
<td>N</td>
</tr>
<tr>
<td>b. clergy abuser</td>
<td>N</td>
</tr>
<tr>
<td>c. higher frequency*</td>
<td>N</td>
</tr>
<tr>
<td>d. longer duration*</td>
<td>N</td>
</tr>
<tr>
<td>e. physical force</td>
<td>N</td>
</tr>
<tr>
<td>f. penetration</td>
<td>N</td>
</tr>
<tr>
<td>g. physical injury</td>
<td>N</td>
</tr>
<tr>
<td>h. number of abusers*</td>
<td>N</td>
</tr>
<tr>
<td><strong>Disclosure</strong></td>
<td></td>
</tr>
<tr>
<td>2. Did not tell within one year of abuse</td>
<td>Y</td>
</tr>
<tr>
<td>3. Response to 1st disclosure (not “very helpful”)</td>
<td>Y</td>
</tr>
<tr>
<td>4. Support in childhood*</td>
<td>N</td>
</tr>
<tr>
<td>5. Support in adulthood*</td>
<td>N</td>
</tr>
<tr>
<td>6. Never had in-depth discussion</td>
<td>N</td>
</tr>
<tr>
<td>7. # of years until in-depth discussion*</td>
<td>N</td>
</tr>
<tr>
<td>8. Most helpful discussant (not “very helpful”)</td>
<td>N</td>
</tr>
<tr>
<td>9. Overall response to telling (not “very helpful”)</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Account-making</strong></td>
<td></td>
</tr>
<tr>
<td>10. Earlier stages*</td>
<td>Y</td>
</tr>
<tr>
<td>11. Account development*</td>
<td>N</td>
</tr>
<tr>
<td><strong>Other variables</strong></td>
<td></td>
</tr>
<tr>
<td>12. High conformity to masculine norms</td>
<td>Y</td>
</tr>
<tr>
<td>13. Post-traumatic growth*</td>
<td>N</td>
</tr>
<tr>
<td><strong>Moderators</strong></td>
<td></td>
</tr>
<tr>
<td>14. PTG will moderate relationship between severity variables and mental distress:</td>
<td></td>
</tr>
<tr>
<td>a. clergy abuser</td>
<td>N</td>
</tr>
<tr>
<td>b. physical force</td>
<td>Y</td>
</tr>
<tr>
<td>c. penetration</td>
<td>Y</td>
</tr>
<tr>
<td>d. injury</td>
<td>N</td>
</tr>
</tbody>
</table>
Table L 1 (continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Support</th>
</tr>
</thead>
</table>

Mediators

15. Two variables will mediate relationship between high masculine norms and mental distress:
   - account-making (end stage) N
   - post-traumatic growth N

Notes:
1. * denotes scale level variable (all other variables were at the nominal level).
2. Y denotes “yes” and N denotes “no”.
3. All hypotheses predicted negative relationships with dependent variable: mental distress.
4. Five variables were significant in early modeling but not in the final “direct effects” model: In-depth Discussion (H6), Clergy abuser (H1b), Force (H1e), Penetration (H1f), and Injury (H1g).
APPENDIX M

FIGURES
Figure M1. Conceptual Model: Factors That May Influence the Mental Health of MSAC

**Abuse Characteristics**
Severity indicators
(e.g., duration, freq, injury)

**Account-making**
1. Stage of model
2. Account development
3. Disclosure

**Masculinity**
Conformity to norms

**Posttraumatic Growth**
Level of PTG

**Mental Health Problems**
General Mental Distress in the past 12 months (depression, anxiety, somatization, & suicidality).

**Controls**
1. Demographics (e.g., age)
2. Childhood stressors
3. Recent stressors
Figure M2. Moderator of the Relationships between Abuse Severity and Mental Distress

Abuse Severity (Force, Penetration, Clergy Abuser, Injury) → Posttraumatic Growth → General Mental Distress
Figure M3. Mediators of Relationship between Masculine Norms and Mental Distress

Masculine Norms

1. Account-making
2. PTG

General Mental Distress
Figure M4. Original Account-making Model (1990)

Model of Account-making in Stress Response Sequence
Harvey, Orbuch, & Weber, 1990 (p. 197)
(Adapted from Horowitz, 1986, p. 41)


Figure M5. Revised Account-making Model (2007)

REFERENCES

Agar, K., & Read, J. (2002). What happens when people disclose sexual or physical abuse to staff at a community mental health center? *International Journal of Mental Health Nursing, 11*, 70-79.


