THE RELATIONSHIP BETWEEN SUBSTANCE USE PROBLEMS, FAMILY COMMUNICATION, FORGIVENESS, AND MALE CHILDHOOD SEXUAL ABUSE

by

Roderick Eli Branscome

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Approved by:

_____
Dr. Lyndon P. Abrams

_____
Dr. Valerie G. Balog

_____
Dr. Richard Lambert

_____
Dr. Pamela Lassiter

_____
Dr. Amy H. Peterman

ABSTRACT

RODERICK ELI BRANSCOME. The relationship between substance use problems, family communication, forgiveness, and male childhood sexual abuse. (Under the direction of DR. LYNDON P. ABRAMS).

Boys who were sexually abused in childhood are three times as likely to report substance use problems that are associated with poor mental and physical health as well as academic, vocational, and interpersonal difficulties. A review of literature revealed commonly held beliefs that (a) boys are not vulnerable to childhood sexual abuse; (b) boys are collaborators more so than victims; (c) sexual activity is a rite of passage for boys; (d) sexual activity is synonymous with masculinity. Self-blame may be the result of these patriarchal and misogynistic cultural norms. This study hypothesized that forgiveness can replace substance use as a coping strategy.

This research examined the relationship between substance use problems, family communication, and forgiveness in men who were sexually abused in childhood. The sample consisted of 406 men who completed an anonymous survey distributed via national support and advocacy organizations. Variables were measured with the CAGE-AID; the Family Communication Scale, Heartland Forgiveness Scale, and the Adverse Childhood Experiences Questionnaire. Three dimensions of forgiveness were assessed, (a) forgiveness of self; (b) forgiveness of others; (c) forgiveness of situations.

Findings revealed statistical significance ($p = .030$) that forgiveness of self is inversely related to substance use problems in men who were sexually abused in childhood. Logistic regression analysis indicated that family communication, forgiveness of others, and forgiveness of situations did not contribute to substance use problems in this sample. Results suggest that higher scores for forgiveness of self are related to lower rates of substance use problems.

DEDICATION

This project is dedicated to the hundreds of men and women who have said to me, “You’re the only person I have ever told.” Your trust is a priceless gift and your resilience, fortitude, and forgiveness inspired this research.

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The online community at Malesurvivor.org has been extraordinarily helpful and inspiring. Contributions and participation of those courageous, determined, and resilient men provided vital momentum to this research. They put the metaphorical wind in the sails and made this study possible. Thanks guys!

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CHAPTER 1: INTRODUCTION

The effects of adverse childhood experiences may persist throughout life and fall on a continuum between resilient thriving and maladaptive surviving (Allem, Soto, Garbanati, & Unger, 2015; Beck & Shaw, 2005; Brydges, Wood, Holmes, & Hall, 2014). Compared to other forms of adversity, childhood sexual abuse (CSA) is shown to yield the greatest potential for long-term maladaptive outcomes (Allem et al., 2015; Becker-Blease, Turner, & Finkelhor, 2010; Massey & Widom, 2013). Boys may be particularly inept in attempts to cope with emotions resulting from CSA (Berliner & Elliot, in Meyers, Berliner, Hendrix, & Reid, 2002; Cermak & Molidor, 1996; Clarke & Pearson, 2000).

Adversity during childhood interferes with optimal physical, emotional, and social development. Feelings of powerlessness, fear, anger, anxiety, depression, hypervigilance, and isolation are results of adverse childhood experiences like physical, emotional, and sexual abuse or physical and emotional neglect (Browne & Finkelhor, 1986; Wilson, 2009). Strategies to ameliorate resultant negative feelings and emotional distress are natural responses to abuse. A strategy frequently embraced by survivors of male childhood sexual abuse is the use of substances for self-soothing, mood-regulation, and coping (Allem et al., 2015; Bolen & Lamb, 2007; Charuvastra & Cloitre, 2008). One goal of counseling is to help clients identify and reinforce strategies and skills for adaptive coping and pathways to resiliency.

Forgiveness is an adaptive mechanism that can be explored and implemented in counseling (Burnette, McCullough, Van Tongeren, & Davis, 2012).

Previous studies indicate that forgiveness can moderate or mediate maladaptive coping (Denham, Neal, Wilson, Pickering, & Boyatzis, 2005; Toussaint, Owen, & Cheadle, 2012) and is an adaptive response to negative emotions (Maltby, Macaskill, & Day, 2001; Walsh, Fortier, & DiLillo, 2010). This study was designed to test a hypothesis that family communication and forgiveness are negatively correlated with substance use problems associated with male childhood sexual abuse (Godbout, Briere, Sabourin, & Lussier, 2014; Paine & Hansen, 2002).

How well a family system prevents or responds to abuse is based on the degree of openness and effectiveness of communication (Godbout et al., 2014; DeWall, Baumeister, & Vohs, 2008; Olson & DeFrain, 2006; Peterson & Green, 2009). Unlike neglectful and abusive families characterized by restricted communication, families with open communication equip children with productive and adaptive self-soothing strategies (Estévez, Ozerinjauregi, Jauregui, & Orbegozo, 2016). Families that sanction substance use for coping may do so through passive, tacit modeling or by actively encouraging and/or providing substances for self-soothing (Allem et al., 2015; Buckner, Heimberg, Ecker, & Vinci, 2013; Maio, Thomas, Fincham, & Carnelley, 2008).

The following sections of Chapter 1 are organized in four parts. The first presents the variables of (a) male childhood sexual abuse (MCSA), (b) family communication, (c) dimensions of forgiveness, and (d) substance use problems (SUP). The second section presents the purpose and significance of the study. Section

three presents the methodology and research question. Operational definitions are provided in section four, followed by a chapter summary.

Variables

Childhood Sexual Abuse

Screening and assessment of MCSA was achieved with the Adverse Childhood Experiences Questionnaire (ACE) (Felitti et al., 1998), which is a ten-item instrument that also assesses physical and emotional neglect as well as physical and emotional abuse. The ACE defines childhood sexual abuse as sexual touch or attempted or actual oral or anal sex between a child and an adult or person who was five years older.

Regrettably, rates of CSA are three times higher for females (Garnefski & Arends, 1998; Maikovich-Fong & Jaffee, 2010; Martin & Silverstone, 2013). Nonetheless, rates of MCSA are substantial, with prevalence estimated from three percent (Finkelhor, 1994) to eight percent (Rapsey, Campbell, Clearwater, and Patterson, 2017). Higher estimates range from 29% (Finkelhor, 2009; Gorey & Leslie, 1997) to as high as 60% (Bullock & Beckson, 2011; Davies & Rogers, 2009; Pereda, Guilera, Forns, & Gomez-Benito, 2009). Data inconsistencies are attributed to diverse and broad parameters. Statistics drawn from consistent screening and accurate reporting may increase awareness and prevention of MCSA (Cermak & Molidor, 1996). To establish accurate prevalence rates, researchers are urged to study boys and girls separately (Alaggia, 2005) and encouraged to use definitions of CSA that are uniformly applied regardless of gender (Hardt & Rutter, 2004; WHO, 1999 & 2005). Higher rates of MCSA were reported in studies that investigated acts not involving

touch or explicit sexual acts. Examples of such instances include being directed to disrobe, exposed to sexual information that is not age appropriate, or witnessing sexual acts of others, including pornography (Draucker, 2003; Xie, Qiao, & Wang, 2016). Further examination of the inconsistent CSA definitions is presented in Chapter 2.

False negatives or inaccurate responses produce erroneous data and complicate research of prevalence and effects of sexual abuse of boys. Inconsistent or vague social norms regarding sexual activity for boys and complicates the adoption of a concise agreement as to what constitutes MCSA (Bergen, Martin, Richardson, Allison, & Roeger, 2004; Moran, Vuchinich, & Hall, 2004; Simpson & Miller, 2002). An example of problematic methodology is that some studies rely on a boy's ability to recognize sexual abuse or willingness to disclose the abuse. He may have been socialized to believe that boys cannot be sexually abused (Crete & Singh, 2015; Crisma, Bascelli, Paci, & Romito, 2004). Methodological variations of studies of girls and boys that produce extreme deviations in statistics are presented in Chapter 2.

Family Communication

Unrestricted, open, effective communication is a trait of optimal family functioning (Bergen et al., 2004; Peterson & Green, 2009) and a child's ability to thrive depends on how well a family prevents, identifies, responds to, and resolves problems (DeWall, Baumeister, & Vohs, 2008; Olson & DeFrain, 2006; Peterson & Green, 2009). Communication is essential for a safe and nurturing environment (Allem et al., 2015; Scherer et al., 2012; Xie et al., 2016) and facilitates better outcomes for CSA victims (Godbout et al., 2014; Hébert, Tourigny, Cyr, McDuff, &

Joly, 2009). To foster a healthy environment counselors can help boys and their families achieve open and effective communication (Akl & Mullet, 2010; Estévez et al., 2016; Mullet et al., 2004).

Parents are rarely aware that boys can be sexually abused (Babatsikos, 2010; Chen & Chen, 2005). Boys receive inadequate moral guidance and deficient factual information from parents. Consequently, boys are especially susceptible to cultural messages that encourage casual sexual encounters (Caldera, Huston, & O'Brien, 1989; Wurtele & Kenny, 2010) as a maturational rite of passage and evidence of male strength and dominance (Alaggia & Millington, 2008; O'Leary & Barber, 2008). Restricted or defective family communication can condone social norms and ideals that promote sexual activity for boys (Caldera, Huston, & O'Brien, 1989; Wood, Desmarais, & Gugula, 2002; Wurtele & Kenny, 2010).

Children learn procedures for self-soothing, coded within family communication, that range from maladaptive methods of avoidance (Van Zundert, Van der Vorst, Vermulst, & Engels, 2006) to healthy, adaptive, and effective coping strategies (Bandura, 2006). Dysfunctional, abusive families with restricted communication often train children to control their mood through injurious and unproductive use of substances (Buckner, Heimberg, Ecker, & Vinci, 2013; Felitti et al., 1998; Maio, Thomas, Fincham, & Carnelley, 2008). Multiple studies present findings that forgiveness is encouraged by open family communication (DeWall, Baumeister, & Vohs, 2008; Englar-Carlson & Kiselica, 2013). Forgiveness is an adaptive strategy correlated with better outcomes and responses to CSA (Akl &

Mullet, 2010; Lindert, Von Ehrenstein, Grashow, Gal, Braehler, & Weisskopf, 2014; Maio, Thomas, Fincham, & Carnelley, 2008).

Families establish norms and customs for emotional regulation that generally associate blunt affect with masculinity (Draucker, Martsolf, Roller, Knapik, Ross, & Stidham, 2011; Englar-Carlson & Kiselica 2013; Maio, Thomas, Fincham, & Carnelley, 2008) and emotional expressiveness with femininity (Busso, 2014; Charuvastra & Cloitre, 2008). Emotional distress associated with CSA may prompt male survivors to use intoxicants to suppress "feminine" emotions (Buckner et al., 2013; Marmostein, White, Loeber, & Stouthamer-Loeber, 2010; Roper, Dickson, Tinwell, Booth, & McGuire, 2010).

Forgiveness

According to Thompson et al. (2005, p. 318), forgiveness is the process of "framing of a perceived transgression such that one's responses to the transgressor, transgression, and sequelae of the transgression are transformed from negative to neutral or positive." Since the 1990s, forgiveness continues to gain attention from mental health professionals (Baskin & Enright, 2004; Cosgrove & Konstam, 2008) and researchers (Konstam, Chernoff, & Deveney, 2001; McCullough, Pargament, & Thoresen, 2000). Forgiveness is a concept (Enright & Fitzgibbons, 2000; Lew, 2004; O'Leary & Barber, 2008), a decision (Baskin & Enright, 2004; Enright & Fitzgibbons, 2000), and a process (Frise & McMinn, 2010; Thompson et al., 2005; Wade, Johnson, & Meyer, 2008) that can be accomplished in counseling (Lyons, Deane, & Kelly, 2010). Elements of forgiveness include discovery or identification of an offense, accurate assignment of blame to the perpetrator rather than self (Akl &

Mullet, 2010; Frise & McMinn, 2010; Grant, Stinson, & Harford, 2001), and a change in beliefs and constructs.

Forgiveness is associated with lower rates of SUP (Lin, Mack, Enright, Krahn, & Baskin, 2004; Lyons, Deane, & Kelly, 2010; Moorhead, Minton, & Myers, 2012). According to Freedman and Chang (2010), counselors can help clients conceptualize, define, and implement forgiveness strategies that reduce negative emotional responses to CSA and help survivors of CSA conceptualize and implement forgiveness as a coping strategy that is more productive than the maladaptive use of substances for mood regulation. Furthermore, people recovering from substance use problems find forgiveness to be an effective resource (Lin, Mack, Enright, Krahn, & Baskin, 2004; Lyons, Deane, & Kelly, 2010) for improving optimal coping, self-control, and self-soothing without substances (Baskin & Enright, 2004; Brady, 2008).

The act of 'letting go' of hostility and negative feelings is accomplished by consciously overriding deep-seated stimuli and triggers linked to CSA (Fergusson, Boden, & Horwood, 2008; Frise & McMinn, 2010; Maltby, Macaskill, & Gillett, 2007). For MCSA survivors pursuing sobriety and striving to replace substance use with positive coping skills, forgiveness is an effective resource (Lyons, Deane, & Kelly, 2010; Scherer et al., 2012; Webb, Chickering, Colburn, & Heisler, 2006) that can mediate effects of CSA and moderate adverse consequences (Enright & Fitzgibbons, 2000; Lyons, Deane, & Kelly, 2010; Worthington, Witvliet, Lerner, & Scherer, 2005). The physiological effects of forgiveness reported by Witvliet, Ludwig, and Vander Laan (2001) include reduced blood pressure and heart rate, lower stress hormones like cortisol, and tranquil brain function.

Substance Use Problem

A person who continues a pattern of substance use despite adverse consequences is regarded as having a substance use problem (Konstam, Holmes, & Levine, 2003). Additional qualities of a SUP are the use of mood-altering substances for coping with negative feelings (Busso, 2014; Kaplow & Widom, 2007; Shorey et al., 2013) and self-soothing (Beck, 1967; DeWall, Baumeister, & Vohs, 2008; Shorey et al., 2013). Childhood sexual abuse is strongly correlated with substance use problems (Bergen et al., 2004; Scherer et al., 2012; Shorey et al., 2013). No attempt was made to formally diagnose a Substance Use Disorder as defined in the *Diagnostic and Statistical Manual*, 5th Edition (*DSM-5*). Although it can indicate a probability that a person might meet diagnostic criteria for a substance use disorder, the CAGE-AID is not sufficient for diagnosis (Brown & Rounds, 1995).

This study investigated a relationship between the predictor variables of family communication and forgiveness and the outcome variable of a substance use problem. While CSA is not a common trait of families with substance use problems, substance use problems are quite common in families with CSA (Allem, et al., 2015). Risk for abuse is increased in a home in which substance use makes a family unable or unwilling to protect a child (Boden, Horwood, & Fergusson, 2007; Zimet & Jacob, 2001). The combination of restricted and ineffective communication, family dysfunction, and SUP increases opportunity for CSA (Felitti et al., 1998). Rates of SUP in sexually abused males are 2.5 times (Hamburger, Leeb, & Swahn, 2007) to four times higher (Bergen et al., 2004) than non-abused males.

Purpose and Significance

The purpose of this research was to examine how family communication and forgiveness relate to SUP in adult survivors of MCSA. Family communication is indicative of a healthy, protective, cohesive family capable of problem solving (Charuvastra & Cloitre, 2008; Kaplow & Widom, 2007; Olson, 2000; Scherer et al., 2012). This equates to reduced need for maladaptive coping strategies like substance use. Forgiveness is an adaptive coping mechanism that can replace maladaptive substance use.

The significance of this study is that findings enrich the limited body of empirical evidence regarding a relationship between family communication and MCSA and the efficacy of forgiveness as a coping strategy and counseling intervention. Childhood sexual abuse of males is rarely mentioned in literature before 1980 and research specifically focused on MCSA is even more rare (Alaggia & Millington, 2008; Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Holmes & Slap, 1998; Pereda et al., 2009). Differences in cultural norms for sexuality and unequal responses to sexual abuse of boys and girls make it important to investigate gender-specific effects of CSA on males (Bergen et al., 2004; Conley & Garza, 2011). Variations in how boys and girls conceptualize and internalize CSA lead men to deny the abuse or minimize the effects of CSA (Alaggia, 2005; Crete & Singh, 2015). As such, counselors are encouraged to suspect male clients sexually abused when presenting with substance use problems, somatic ailments, sexually transmitted disease, irritable bowel syndrome, or fibromyalgia (Bergen et al., 2004; Springer, Sheridan, Kuo, & Carnes, 2003). Identification and treatment of sexually abused

males is improved when the prevalence (actual event), incidence (reported event), and sequelae of MCSA are better understood. Treatment efficacy is also improved when counselors are able to build a therapeutic relationship (Rapsey, Campbell, Clearwater, & Patterson, 2017) when the moderating effects of family communication and mediating effects of forgiveness are better understood (Carr & Wang, 2012; Crete & Singh, 2015; O'Leary & Barber, 2008).

Research Question

What is the relationship between substance use problems, family communication, and dimensions of forgiveness in men who were sexually abused in childhood?

Hypothesis

H_1: Family communication and dimensions of forgiveness predict substance use problems in adult men who were sexually abused in childhood.

H_0: Family communication and forgiveness do not predict substance use problems in adult men who were sexually abused in childhood.

Research Design

Logistic regression analysis was used to examine how family communication and forgiveness are related to substance use problems. To obtain a clearer understanding of the relationship between forgiveness and SUP, the methodology controlled for the effects of family communication that can also predict SUP (Hébert et al., 2009; Scherer et al., 2012). This control was accomplished by comparing odds ratios for individual variables with odds ratios for all independent variables entered simultaneously.

This non-experimental correlational survey assembled responses from adult men, at least 18 years of age, concerning family communication, forgiveness, substance use, and male childhood sexual abuse. The sample was recruited through electronic communication with the assistance of two support and advocacy programs (Appendix D).

Delimitations

Three delimitations could affect the findings:

1. Participants were self-identified males, aged 18 or older.
2. Participants must have had access to a computer and the ability to complete a survey in English.
3. This study engaged a convenience sample.

Limitations

1. Self-report may have affected accuracy due to memory recall or inclination to provide socially desirable responses.
2. Because a survey method does not afford the opportunity for clarifying questions, this study may show lower prevalence rates than an interview (Pereda et al., 2009).
3. Participation was dependent upon computer access and aptitude.
4. Affiliation with an advocacy organization might indicate biased attitudes.

Assumptions

Assumptions guiding the design and procedures of research were:

1. Participants answered questions accurately.
2. SUP is an indicator of a maladaptive coping response to CSA.

Validity

The sensitive and precarious nature of investigations of child sexual abuse and substance use problems presented a social desirability challenge to validity. Further challenges to validity were due to inconsistent constructs and definitions of these two variables. To reduce effects associated with inconsistent interpretation of definitions and maximize validity, pragmatic instruments were used that ask whether a participant met a given criterion. This study employed definitions of childhood sexual abuse and substance use problems from instruments with demonstrated validity and reliability.

Internal Validity. Studies involving sexual behavior or substance use are susceptible to social desirability bias (Crowne & Marlowe, 1960), which challenges validity in self-report measures. To minimize threat to internal validity, participants were assured their responses were anonymous. Another threat to internal validity was the effect of memory and recall of events (Brose, Rye, Lutz-Zois, & Ross, 2005). Internal validity may have been threatened by a tendency of men to deny or fail to identify MCSA (Bullock & Beckson, 2011; Ireland, Smith, & Thorn, 2002) or because men apply unique gender-specific filters to what constitutes MCSA (Alaggia & Millington, 2008). The survey method of this study fostered a sense of privacy because participants were able to submit responses in their homes on their own computers (Easton, 2014).

External Validity. A goal of this study was that conclusions on the effects of family communication and the efficacy of forgiveness could be generalized to the broader population of men who were sexually abused in childhood. External validity

may be threatened if findings are extended to women. Findings are also not generalizable to men who are not represented in this sample.

Men who were sexually abused in childhood made up the sample for this study. A sample was recruited through electronic communication. Because of the chance that participants affiliated with a CSA organization may have similar beliefs or willingness to participate, attempts were made to recruit participants unaffiliated with CSA advocacy organizations. To reduce threat to external validity if participants were recruited exclusively through child abuse advocacy organizations, child wellness advocacy organizations were approached for recruiting assistance. The researcher attempted to collect data from a diverse sample of men (political, religious, socioeconomic, racial, age, regional). An effort to reduce threat to external validity is inviting participants to extend the reach of the study by forwarding the survey link to other men.

Operational Definitions

Childhood Sexual Abuse

Childhood sexual abuse is any attempted or actual oral, vaginal, or anal sex or sexualized touch between a child and an adult or a person who is at least 5 years older. This definition comes from, and contained in, the ACE Questionnaire (Felitti et al., 1998).

Family Communication

The definition of positive family communication skills encompasses verbal and nonverbal messages exchanged between family members to express inclusion and belonging, needs, beliefs, feelings, acceptance, openness, and concerns (Olson, 2011).

The Family Communication Scale (Olson & Barnes, 2010) was used to measure this variable. The term 'family' indicates a group of individuals, residing together, attempting to express needs, wants, and concerns. The label 'parents' extends beyond genetic or legal bonds to include adults who are responsible for raising a child.

Forgiveness

Forgiveness was measured with the Heartland Forgiveness Scale (Thompson et al. 2005) that defines forgiveness as "the framing of a perceived transgression such that one's responses to the transgressor, transgression, and sequelae of the transgression are transformed from negative to neutral or positive" (p. 318).

Substance Use Problems

Substance use problems are defined by "impaired control, social impairment, risky use, and pharmacological criteria" (DSM-5, p. 483). Continued substance use despite adverse consequences, tolerance that requires larger amounts of a substance to produce an effect, and inordinate amount of time invested in acquisition, use, and recovery from use are features of substance use problems. SUP was determined by a score of two or more on the four-item CAGE-AID (Brown & Rounds, 1995).

Chapter Summary

Chapter 1 presented the purpose and significance of the study of the relationship between the predictor variables of family communication and forgiveness and SUP. Also described in this chapter were the hypothesis, research questions, delimitations, limitations, assumptions, and operational definitions. Also presented in this chapter was introductory data on MCSA and subsequent substance use problems.

To supplement limited data on MCSA, only male participants were surveyed. Findings were expected to be useful for counselors in several ways.

CHAPTER 2: REVIEW OF LITERATURE

This chapter presents a review of literature relevant to this examination of the relationship between substance use problems, family communication, and dimensions of forgiveness in a sample of adult men who experienced childhood sexual abuse. Male childhood sexual abuse is assessed by self-report and is a parameter for inclusion in the sample and not a variable.

The first part presents a review of the empirical literature on childhood sexual abuse. The second section describes peer-reviewed studies of family communication. Section three presents a synopsis of relevant literature on forgiveness. The fourth section reviews empirical literature on substance use problems. The final section provides an overview of peer-reviewed literature presented in Chapter 2.

Childhood Sexual Abuse

Definition

Childhood sexual abuse (CSA) is sexualized touch or attempted or actual oral, vaginal, or anal sex between a child and an adult or a person who is at least 5 years older. This definition is contained in a question in the Adverse Childhood Experiences (ACE) Questionnaire (Felitti et al., 1998). Childhood sexual abuse was determined by an affirmative response to a question in the ACE Questionnaire. Because study participants were male, ‘vaginal’ was omitted from the questionnaire.

Definition complications. Because puberty is an extended period with no conclusive start or finish, it is difficult to categorically determine a cutoff age for

childhood, and difficult to reach more than an arbitrary age of delineation (Conley & Garza, 2011). The idiosyncratic nature of puberty obscures distinction between childhood and adulthood. Agreement on the parameters of childhood is an essential component of definitive criteria for CSA. In addition to individual differences in physical, cognitive, and emotional development, there are also cultural delineations between childhood and adulthood. Even within the United States, we see incongruence. Federal law sets a uniform age of 'majority' (adulthood) 18 in all states. However, individual states have laws regarding the legal age for sexual consent that are varied and complex (Table 1). Some states make exceptions for consent at younger ages if parties are close in age (Glosser, Gardiner, & Fishman, 2004).

Table 1

Inconsistent Ages of Consent among U.S. States

Age of Consent	Close-in-Age Exemption	State
16	Yes	Alabama, Alaska, Arkansas, Connecticut, District of Columbia, Hawaii, Indiana, Iowa, Maine, Mississippi, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Vermont
16	No	Georgia, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, South Carolina, South Dakota, Washington, West Virginia
17	Yes	Colorado, New Mexico
17	No	Illinois, Louisiana, Missouri, New York, Texas, Wyoming
18	Yes	Arizona, Delaware, Florida, Tennessee, Utah, Virginia,
18	No	California, Idaho, North Dakota, Oregon, Wisconsin

In a document published by the Centers for Disease Control, *Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements*, Leeb et al. (2008, p. 54) lay out an extensive definition for childhood sexual maltreatment:

> ***Sexual abuse.*** Sexual abuse involves any completed or attempted (i.e., non-completed) sexual act or sexual contact with a child by a caregiver. Sexual abuse also includes noncontact forms of inappropriate sexual activity, sexual harassment, or exploitation of a child.
>
> ***Sexual acts.*** Sexual acts comprise acts in which contact involves penetration, however slight, between the caregiver and the child. A caregiver can also force or coerce a child to commit a sexual act on another individual (either adult or child).
>
> ***Abusive sexual contact.*** Acts are sexually abusive in which penetration is not attempted, but intentional touching occurs either directly or through the clothing of the genitalia, anus, groin, breast, inner thigh, or buttocks. Through force or coercion by the caregiver sexual contact can be performed by the caregiver on the child, by the child on the caregiver, or by the child on another adult or child. Sexual contact does not include touching required for normal care or attention to day-to-day needs of the child.
>
> ***Noncontact sexual abuse.*** Sexual abuse does not require physical contact between the caregiver and the child. However, it does include acts that expose a child to sexual activity such as filming of a child in a sexual manner, sexual harassment of a child, or prostitution of a child (p. 54).

Cummings, Berkowitz, and Scribano (2012) call attention to inconsistencies in CSA definitions (Table 2).

Table 2

Variations in CSA Definitions

	American Medical Association	Bernstein et al. (1997)	Condy et al. (1987)	Conley & Garza (2011)	Gallo-Silver, Anderson, Romo (2014)	Dilorio, Harwell, & Hansen, (2002)	Drauker (2011)	Finkelhor (1994)	Hunter (1995)	Leeb et al. (2008)	Pennebaker & Susman (2013)	Petrovich & Templer (1984)	Schechter & Roberge (1976)	Xie, Qiao, & Wang (2016)	Young, Harford, Kinder, Savell (2007)
Abuser 5 years older				■		■		■				■			
Abuser 10 years older (age 13-16)			■					■				■			
Abuser Affiliation			■												■
Abuser Gender															■
Before age 13						■		■							
Before age 16				■											
Before age 17											■				
Before age 18		■													
Duration							■								
Emotional Distress			■								■				
Exhibitionism / Nudity					■				■						
Force / Severity			■	■			■	■			■				
Molested											■				
Multiple Perpetrators							■								
Oral Sex			■		■			■	■	■		■	■	■	
Prostitution / Exploitation					■					■					
Ridicule Sexual Development									■						
Sex Child Cannot Consent To	■												■		
Sex Child Cannot Understand	■												■		
Sexual Contact		■													■
Sexual Talk									■	■					
Shown Pornography					■				■					■	
Touching, Fondling			■		■	■		■	■	■		■	■	■	
Unwanted Sexual Activity				■		■									
Vaginal, Anal Intercourse			■	■	■			■	■	■		■	■	■	
Viewing Sex Acts of Others					■										
Voyeurism, Forced Nudity									■	■				■	

Outcomes of Childhood Sexual Abuse

General. According to Keiley, Howe, Dodge, Bates, and Pettit (2001), CSA interferes with a victim's ability to process social information and cues. A developmental milestone of particular interest in this study is self-regulation. Abuse at an early age may impede development of self-soothing and mood regulation skills (Luthar, Cicchetti, & Becker, 2000). The antithesis of self-regulation is anxiety and hypervigilance, results of CSA (Wilson, 2009).

A result of being controlled by others at a developmental stage when a child should be learning self-control is that acquisition of self-regulations skills are deferred (Bandura, 1986; Briere, 2002; Lindert et al., 2014). Substance use can postpone the emotional impact of CSA and reinforce externalized (substance use) instead of internalized (psychological ability to self-soothe) coping (Busso, 2014; Roper et al., 2010).

Of the multiple forms of adversity, abuse, and neglect to which a child might endure, sexual abuse has the greatest influence on substance use problems (Alaggia & Millington, 2008; Allem, Soto, Garbanati, & Unger, 2015; Dube, Williamson, Thompson, Felitti, & Anda, 2006). Bergen, Martin, Richardson, Allison, and Roeger (2004) found that CSA victims are twice as likely to report SUP over their lifetime. Some studies show an even stronger correlation between CSA and substance use problems with rates of 2.5 times (Ferguson, 2008; Finkelhor & Browne, 2009), three times (Maldonado-Devincci, Badanich, & Kirstein, 2010), and even four times higher SUP (Bergen et al., 2004).

Medical. CSA is a significant public health problem that affects every racial, socioeconomic, and religious group (Gorey & Leslie, 1997; Hammond, 2003; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). There is a high correlation between emotional and physical wellness (Berry & Worthington, 2001; McCullough, Pargament, & Thoresen, 2000; Witvliet, Ludwig, & Vander Laan, 2001) and a strong correlation between emotional and physical pain (Salsitz, 2016). Somatic effects of CSA include

- Irritable bowel syndrome, gastro-esophageal reflux, obesity and eating disorders (Burke, Hellman, Scott, Weems, & Carrion, 2011; Wilson, 2009).
- Cardio-vascular disease (Lindert, Von Ehrenstein, Grashow, Gal, Braehler, & Weisskopf, 2014).
- Impaired immune function (Burke et al., 2011; Worthington, Witvliet, Lerner, & Scherer, 2005).
- Chronic pain, fibromyalgia, and migraine headaches (Kelly-Irving, Mabile, Grosclaude, Lang, & Delpierre, 2013; Nelson, Baldwin, & Taylor, 2012).

Pursuit of physiological remedies for psychological symptoms involve frequent medical treatment, increased burden on providers, and increased health care costs for society but provide minimal relief for the patient (Nelson, Baldwin, & Taylor, 2012). Somatic symptoms are highly correlated with SUP (Burke et al., 2011).

Gorey and Leslie (1997) found 39% of CSA survivors self-report ‘excellent’ health compared to 64% of non-abused people who report ‘excellent’ health. When asked if they consider themselves to have “above average” mental health, abused and non-abused participants scored 23% and 56% respectively. Numbers who have seen a

mental health provider: 82.6% for CSA, and 31.9% for non-CSA. People who experienced childhood sexual abuse frequently report chronic pain and subsequent opiate dependence due to "biopsychosocial phenomenon that includes sensory, emotional, cognitive, developmental, behavioral, spiritual, and cultural components" (Salsitz, 2016, p. 54).

Legal. As an extension and representation of society, courts of law have historically considered an erection, and especially an orgasm, as consent to sex (Deering & Mellor, 2011; Smith, Pine, & Hawley, 1988). Judicial programs and social services must deal with cases of child abuse and subsequent aggressive, violent, and criminal acts linked to impaired behavioral control, impulsivity (Bandura, 1986, 2006), and drug offenses (Finkelhor, 1994). Petrovich and Templer (1984) report 59% of men convicted of rape reported having had sexual intercourse before age 16 with women at least 5 years older. Romano and De Luca (2001) argue that hyper-sexuality and using sex to reclaim, assert, or prove masculinity is linked to perpetration of sexual assault. Similarly, Kia-Keating, Sorsoli, and Grossman (2010) discovered MCSA linked to aggressive sexual behaviors and desires to prove manhood.

Because female-perpetrated CSA is rare (De Frances, 1969; Lew, 1988) and considered innocuous, female abusers rarely face criminal proceedings (Alaggia & Millington, 2008; Knoll, 2010; Maynard & Wiederman, 1997). Stroud, Martens, and Barker (2000) reviewed CSA cases and found that MCSA is less likely to be prosecuted. Only recently has United States law considered males as potential victims of CSA (Alaggia & Millington, 2008; Cermak & Molidor, 1996; Larimer, Lydum, Anderson, & Anderson, 1999).

Behavioral. Ireland, Smith, and Thornberry (2002) stated that complications in normal development at an early age have cascading effects on later development and positive relationships to maladaptive behaviors. Socially defined gender roles compel males to hide their vulnerability (Rhodes et al., 2011) and appear strong, rugged, and self-sufficient (Alaggia & Millington, 2008). MCSA victims who display hyper-masculine traits like aggression, impulsivity, homophobia, and violence may be attempting to assert their masculinity (Conley & Garza, 2011; Shorey, Stuart, & Anderson, 2013; Zucker, 2008). Bandura's theory of social learning (1986) argues that observed behaviors become a code for future action. Overcompensation may be more likely in patriarchal western cultures where masculinity is prioritized (Parent & Bannon, 2012; Zimet & Jacob, 2001).

Additional behaviors intended to compensate for the emasculating effects of MCSA are truancy, poor academic and vocational performance, intoxication, violence, and interpersonal social conflict (Kia-Keating, Sorsoli, & Grossman, 2010; Parent & Bannon, 2012; Shorey, Stuart, & Anderson, 2013). Cohen and Miller (1998) report that half of all mental health clients experienced CSA. Schools are expected to address truancy, aggressive behavior, and learning deficits that can be consequences of CSA (Burke, Hellman, Scott, Weems, & Carrion, 2011). A study by Wilson (2009) found half of college students who were sexually abused in childhood drop out of school which impacts earning potential over one's life span.

A lack of inquiry by helping professionals contributes to underreporting of MCSA (Hornor, 2010; O'Leary & Barber, 2008). Counselors encounter sexually abused males in schools, agencies, and private practice and have a responsibility to

screen for sexual victimization (Alaggia & Millington, 2008), especially if a substance use is a presenting problem (Bergen et al., 2004). A long-term sense of isolation can be rectified through counseling (Alaggia, 2005; Enright & Fitzgibbons, 2000). Previous studies have recommended inclusion of males into prevention messages and victim services (Black & DeBlassie, 1993; Finkelhor, 2017).

Knowledge of CSA gives counselors a better understanding of a client's biopsychosocial history and informs clinical interventions that can transform ineffective behaviors and minimize problematic emotional conditions (Dilorio, Hartwell, & Hansen, 2002; Dube, Anda, Whitfield, Brown, Felitti, Dong, & Giles, 2005; Felitti et al., 1998). Black and DeBlassie (1993) admonish counselors to be purposeful and conscious of phrasing associated with CSA when working with men, as they are less likely than women to recognize or reveal childhood sexual abuse. A counselor who screens for CSA with a female client but fails to do the same with a male client not only misses an opportunity to facilitate disclosure but also is demonstrating cultural incompetence (Alaggia, 2010; Finkelhor, Hotaling, Lewis, & Smith, 1990; Hepworth & McGowan, 2013).

Unique Characteristics of Male Childhood Sexual Abuse

Long-term effects of CSA may be similar for men and women (Gallo-Silver, Anderson, & Romo, 2014). But different constructs, norms, and social roles influence male and female experiences of shame, guilt, and stigma (Cermak & Molidor, 1996; De Frances, 1969; Draucker, 2003). These feelings are common in people who have been sexually abused in childhood (Browne & Finkelhor, 1986; Wilson, 2009).

Coping strategies are needed for feelings of powerlessness, anger, anxiety, depression, hypervigilance, and isolation.

Social bias. Lew (2004) points out "our culture does not provide room for a male as a victim" (p. 66). Confusion as to what is and is not MCSA is rooted in permissive social norms for sexual activity of boys (Knoll, 2010). The notion that "it just depends" that accompanies definitions of male CSA is not employed in studies of female CSA. Examples of qualifiers used in MCSA research include: (a) did the boy enjoy it, (b) was the abuser female, (c) did the boy resist, and (d) did he have an erection or ejaculate (Easton, 2014). Such factors obstruct good research and blame the victim. Imprecise data reinforces in all strata of society (boys, adolescents, men, families, courts, and care professionals) the concept that sexual abuse of boys is subjective rather than objective.

Repeated studies show that males do not define (Dilorio et al., 2002; Draucker, 2003; Dube et al., 2005; Moran, Vuchinich, & Hall, 2004), identify (Clarke & Pearson, 2000), disclose (Finkelhor et al., 1990; Hovey, Stalker, Schachter, Teram, & Lasiuk, 2011; O'Leary & Barber, 2008; Teram, Stalker, Hovey, Schachter, & Lasiuk, 2006), or understand the effects of sexual activity in childhood (Schraufnagel, Davis, George, & Norris, 2010). Due to this misunderstanding, use of the term 'sexual abuse' in studies of MCSA can distort data (Alaggia & Millington, 2008; Kia-Keating, Sorsoli, & Grossman, 2010; Thombs, Lewis, Bernstein, Medrano, & Hatch, 2007). To obtain responses that are more accurate and reduce the potential for false negatives, researchers are advised to ask if men have had specific experiences and avoid use of any reference to, or effects of, the subjective term of 'childhood sexual abuse' (Teram

et al., 2006; Koerner & Fitzpatrick, 2002). Factors associated with cultural norms and ascribed gender roles may account for false negative responses when males are asked about their experiences of sexuality in childhood (Hardt & Rutter, 2004; Hunter, 2010; Steever, Follette, & Naugle, 2001).

Under-reporting and inadequate protection for MCSA might be a result of attitudes of professionals and researchers (Alaggia, 2005; Hébert, Tourigny, Cyr, McDuff, & Joly, 2009). There is evidence that providers of clinical, medical, and social services are not immune to gender bias regarding CSA (Maikovich-Fong and Jaffee, 2010). According to Davies, Patel, and Rogers (2013), male counselors regard incest to be more harmful for girls than boys.

Gaps and Conflicting Findings in Empirical Literature

Deficiencies in MCSA literature could be improved with studies that are longitudinal, quantitative, and collecting opinions and observations of more than one family member (Alaggia & Millington, 2008; Hepworth & McGowan, 2013; Horner, 2010). Male survivors continue to be a neglected population (Cermak & Molidor, 1996). Understanding the gender-specific effects of CSA and developing best practices for clinicians could be drawn from research that studies boys and girls independently while matching findings based on gender and affiliation of abuser, type, frequency, duration, and use of force (Simpson & Miller, 2002).

Research of childhood sexual abuse of females is designed to help girls and women achieve resiliency and wellness. Conversely, the limited research done on childhood sexual abuse of males (Cermak & Molidor, 1996, Kia-Keating, Sorsoli, & Grossman, 2010) targets pathologies such as sexual dysfunction (Sorsoli, Kia-Keating

& Grossman, 2008), risk factors and prospects the male survivor of CSA may become a perpetrator (Larimer et al., 1999), or substance abuse, violence, and criminality (Kia-Keating et al., 2010; Wilsnack et al., 2000).

Male-specific exceptions or exemptions regarding what is sexually appropriate and uneven definitions and methodologies in CSA studies attribute to lower rates of MCSA (Alaggia & Millington, 2008; Becker-Blease et al., 2010). A common approach to studies of male CSA not seen in female CSA studies is relinquishing to the boy the duty to determine whether sexual activity was abusive and emotionally distressing (Bullock & Beckson, 2011; Easton, 2014) or whether he considers the experience normal (Babatsikos, 2010; Lew, 1999; Tennfjord, 2006). Use of male perception of CSA is problematic because boys are trained to be tough, hide vulnerability, and appreciate sex at any age. He is not aware of the adverse, long-term consequences of CSA (Hébert, Tourigny, Cyr, McDuff, & Joly, 2009). Even if he knows the experience to be abusive, he may not feel comfortable broaching the subject and may require assistance with disclosure (Alaggia & Millington, 2008; Easton, 2014).

Rates of MCSA are extremely varied and range from three percent (Finkelhor, 1994), 8% (Gorey & Leslie, 1997; Pereda, Guilera, Forns, & Gomez-Benito, 2009; Putnam, 2003), 29% (Finkelhor, 1994), 46% (Farber, Showers, Johnson, Joseph, & Oshins, 1984), and up to 60% (Bullock & Beckson, 2011; Davies & Rogers, 2009). Dube et al., (2005), Finkelhor, Hotaling, Lewis, and Smith (1990), as well as Schraufnagel, Davis, George, and Norris (2010) estimate it is probable that 13% to 20% of boys experience some form of MCSA. When criteria for MCSA are

determined by gender roles, social norms, and patriarchy the relevance, standardization, and accuracy of data is compromised (Ray, 2001, Seymour, 1998).

Earlier abuse. Keiley, Howe, Dodge, Bates, and Pettit (2001) report that sexual abuse at an earlier age is predictive of greater long-term maladjustment. Some reports suggest boys are abused at younger ages (Alaggia, 2010; Finkelhor, 2009; Holmes & Slap, 1998; Stroud, Martens, & Barker, 2000) with risk subsiding at the onset of puberty that risk subsides earlier for boys than for girls (Martin & Silverstone, 2013). However, there is debate whether boys are sexually abused at younger ages than females. Some studies show younger children (age 0-7) are subject to similar rates of CSA regardless of gender (Conley and Garza; 2011; Dhaliwal, Gauzas, Antonowicz, and Ross, 1996; Martin & Silverstone, 2013). An explanation for similar ages at first CSA proposed by Kendall-Tackett, Williams, and Finkelhor, (1993) is that perpetrators perceive insignificant gender differences in pre-pubescent children. King and Wollett (1997) report mean age of sexually abused boys is 8.6 years.

Increased substance use. Children and adolescents link sexual activity with maturity and maturity with substance use (Scherer et al., 2012; Schraufnagel et al., 2010), which explains a positive correlation between age of first CSA event and first substance use (Bergen et al., 2004). This is important because early substance use increases the probability of a SUP in adulthood (Hamburger, Leeb, & Swahn, 2007; Kaplow & Widom, 2007; Maldonado-Devincci, Badanich, & Kirstein, 2010). Some studies report childhood sexual abuse correlated to higher rates of SUP in boys than girls (Alaggia & Millington, 2008; Denov, 2004; Hamburger et al., 2007). However,

other investigations indicate sexually abused boys and girls exhibit similar rates of substance use problems (Bergen et al., 2004; Conley & Garza, 2011; Maikovich-Fong & Jaffee, 2010).

Regardless of CSA, boys initiate substance use at a younger age than girls (Bergen et al., 2004). Zucker (2008) reasons that females are discouraged from substance use to minimize risk sexual assault. Conversely, social norms and concepts of masculinity urge males to use substances (Bergen et al., 2004; Hamburger et al., 2007).

Patriarchy. Patriarchy is the concept of male dominance, authority, privilege, and control (Seymour, 1998). As Struve (1990) explains, "Patriarchy imprisons all people, male and female, who live under its influence. Ironically, there are numerous negative repercussions even for men, including their greater social isolation and the cultural expectation that they must internalize or withhold emotions..." (p. 35). Parent and Bannon (2012) speculate that little social, academic, and political attention is given to male CSA because the topic is uncomfortable, contradicts male invincibility, and is difficult to isolate from issues of homophobia.

In light of messages that boys are not vulnerable to sexual abuse (Bergen et al., 2004) and messages that male victims are responsible for any sexual activity (Bullock & Beckson, 2011) males deny CSA and avoid questions that reference it. Constructs of power, dominance, and masculinity create a belief that males cannot be abused (Bullock & Beckson, 2011) and acknowledgment of sexual abuse constitutes weakness and violation of masculinity (Parent & Bannon, 2012). There is an assumption among parents and caretakers that boys do not need to be protected from

sexual abuse (Babatsikos, 2010; Chen & Chen, 2005; Wood, Desmarais, & Gugula, 2002). Englar-Carlson and Kiselica (2013) highlight social and familial expectations and messages that assert that boys and men are self-reliant and able to handle difficult circumstances and situations. Disclosure can be a necessary but insufficient process for resilience and healing, (Bass, 2000) but studies find that the majority of MCSA victims do not disclose the abuse (Finkelhor et al., 1990; O'Leary & Barber, 2008).

Misogyny. Misogyny is the prejudice against and contempt for women and girls. It arises from a patriarchal society and underpins sexual violence (Bullock & Beckson, 2011). Teram et al., (2006) and Unger, Norton, and De Luca (2009) suggest any victimization, especially sexual, is strongly associated with the maligned traits of femininity, weakness, or homosexuality. Sexual abuse calls into question a male victim's strength, sexuality, and masculinity (Alaggia & Millington, 2008; Kia-Keating et al., 2010; Hébert et al., 2009). Especially if the abuser is female, the paradigms of masculinity and male dominance sustain a belief that a boy, by virtue of his maleness, has power over sexual decision-making (Thombs et al., 2007). According to Deering and Mellor (2011), consequences of CSA are enduring and adverse regardless of the gender of perpetrator.

Self blame. Social bias leads boys to regard sexual abuse as a normal, socially acceptable, rite of passage (Alaggia & Millington, 2008; Crisma, Bascelli, Paci, & Romito, 2004). The message is that boys should appreciate 'being chosen' and celebrate transition into manhood, as if sexual activity epitomizes maleness (Kia-Keating et al., 2010; Bullock & Beckson, 2011). These norms and customs are most relevant when the abuser is female (Bergen et al., 2004; Kia-Keating et al., 2010;

Thombs et al., 2007). Disclosure is suppressed because doing so would violate expectations that males hide vulnerability (O'Leary & Barber, 2008). A sexually abused boy must weigh risks of physical and social consequences against potential advantages (Keaten & Kelly, 2008). Nondisclosure jeopardizes safety of other potential victims and disallows support for those who may suffer in isolation (Afifi et al., 2005).

Bender and Blau (1937) claimed that children are appreciative collaborators in CSA and De Francis (1969) state that sexual abuse of boys is rare and perhaps nonexistent. Peer-reviewed articles describe social tenets that boys welcome and enjoy CSA (Bullock & Beckson, 2011; Draucker, 2003; Schraufnagel et al., 2010; Wurtele & Kenny, 2010). An explanation of self-blame is a tendency of males to blame victims of sexual assault, including children, and considers a sexually abused boy as more collaborator than victim (Bullock & Beckson, 2011; Berry, Worthington, O'Connor, Parrott, & Wade, 2005; Davies & Rogers, 2006).

Gender and affiliation of abuser. There are diverging reports regarding affiliation of abuser. Some data indicates boys are more likely to be abused by strangers (Finkelhor et al., 1990). However, Conley and Garza (2011) report boys and girls encounter similar percentages regarding affiliation of abuser, either intra- or extra-familial. Finkelhor (2009), and Hébert et al. (2009) report boys are typically sexually abused by family members or people closely connected to the family. Abuse of younger children is usually committed by a father figure and may be more severe, frequent, forceful, and include threat of harm (Easton, 2014; Rhodes et al., 2011). Female abusers are usually extra-familial, not in the home or part of the family

(Deering & Mellor, 2011). In contrast to abuse of older children who may be coerced, bribed, or manipulated into sexual abuse by non-family abusers (Easton, 2014), the combination of earlier abuse by a father figure using force is the trifecta for extremely high rates of SUP (Gallo-Silver, Anderson, & Romo, 2014).

Intra-familial sexual abuse is more likely in younger children and results in more trauma than abuse by extra-familial perpetrators (Carr & Wang, 2012; Finkelhor, 2017). Threat or actual violence used in childhood sexual abuse may be higher for boys (Browne & Finkelhor, 1986; Watkins & Bentovim, 1992) but may be similar for boys and girls (Conley & Garza, 2011). Early studies, like those reporting boys were subjected to greater degrees of violence, sampled clinical and prison populations that may have experienced greater physical harm whether or not they were sexually abused. This increased trauma is attributed to betrayal and violation of trust.

Homophobia. Every aspect of MCSA is aggravated by societal and internalized homophobia (Alaggia & Millington, 2008). A main difference in CSA of boys and girls is the same-sex element that can be confusing and frightening, and triggers confusion regarding sexual identity and orientation (Clarke & Pearson, 2000; O'Leary & Barber, 2008). For example, a homosexual man might suspect that being abused by a female caused his homosexual orientation, or that abuse by a male caused his homosexuality. Furthermore, a heterosexual man can experience similar internal confusion: was same-sex abuse evidence of latent homosexuality or how can he be genuinely heterosexual if he considers sexual abuse by a female as abusive? Homophobia compounds feelings of anger, shame, isolation, and powerlessness

(Alaggia, 2005; Cermak & Molidor, 1996) and feeds a misperception that gay male victims are immune to the traumatic effects of CSA (Bullock & Beckson, 2011).

Women reportedly commit 4% of childhood sexual abuse (Stroud, Martens, & Baker, 2000). Among men who report CSA, homosexual men report the abuser to be male in 46% of cases, which is in stark contrast to the seven percent of heterosexual men who report their abuser was male (Tomeo, Templer, Anderson, & Kotler, 2001). This range is attributed to homophobia; it is statistically unrealistic that 93% of sexual abuse of heterosexual males was done by women and that 54% of sexual abuse of homosexual males was committed by women (Alaggia & Millington, 2008; Kia-Keating et al., 2010).

Suicidal ideation. Martin, Bergen, Richardson, Roeger, and Allison (2004) report that sexually abused boys are twice as likely to attempt suicide, at a rate of 55% compared to 26% of sexually abused girls. Additional studies indicate boys exhibit higher rates of suicidal ideation and attempts (Dube et al., 2006; Sigurdardottir, Halldorsdottir, & Bender, 2014). A theory posed by Rhodes et al. (2011) for higher rates of suicidality is the same-sex nature of MCSA and stigma of homosexuality and homophobia. Other studies (Elliot & Briere, 1994; Garnefski & Diekstra, 1997; Young, Harford, Kinder, & Savell, 2007; Wilson, 2009) indicate CSA elicits similar suicidality for males and females. No empirical evidence was discovered indicating that females experience higher rates of suicidality.

Summary of Childhood Sexual Abuse

Deficiencies regarding statistics on prevalence and effects of CSA can be attributed to these features of the body of empirical evidence:

- Most studies only surveyed females (Bullock & Beckson, 2011; Dube et al., 2005; Cermak & Molidor, 1996, Kia-Keating et al., 2010),
- Occasional studies engaged mixed-gender participants (Schraufnagel, Davis, George, & Norris, 2010; Sorsoli, Kia-Keating, & Grossman, 2008),
- Rarely did any focus exclusively on males (Alaggia & Millington, 2008; Garnefski & Arends, 1998; Steever, Follette, & Naugle, 2001).

Improved understanding of prevalence, incidence, and effects of MCSA may improve counselors' ability to identify and treat sexually abused boys (Walsh, Fortier, & DiLillo, 2010). Uniform methodologies and consistent definitions of CSA are needed to monitor prevalence, magnitude, and trends over time and between populations and jurisdictions (Leeb, Paulozzi, Melanson, Simon & Arias, 2008; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011; Thombs et al. 2007).

Family Communication

Koerner and Fitzpatrick (2002) define family "as a group of intimates who generate a sense of home and group identity and who experience a shared history and shared future" (p. 71). To avoid complex and restrictive distinctions and description of genealogical or legal connections, this study uses 'family' as an inclusive term for a system of individuals residing together.

Family communication has been chosen as a predictor variable for CSA because it influences vulnerability (Duncan et al., 2008; Wurtele & Kenny, 2016) and is associated with disclosure, protection, and remediation (Afifi et al., 2005; Xie, Qiao, & Wang, 2016). Children in families with good communication experience less abuse (Akhlaq, Malik, & Khan, 2013; DeWall, Baumeister, & Vohs, 2008, Olson,

2000). If a child is sexually abused, family communication can determine whether a child adopts coping strategies that are positive and adaptive or negative, maladaptive, and avoidant (Duncan et al., 2008). Other effects of family communication of interest are the buffering effects of adversity (Lindert et al., 2014) and increased forgiveness (Denham, Neal, Wilson, Pickering, & Boyatzis, 2005).

Definition

"Family communication is defined as the act of making information, ideas, thoughts, and feelings known among members of a family unit" (Olson & Barnes, 2010, p. 1). Effective family communication is positive, open, and effective when it allows members to express needs, wants, and concerns, thereby facilitating resolution of problems (Akhlaq, Malik, & Khan, 2013; Olson & DeFrain, 2006; Peterson & Green, 2009). A family with open, truthful, collaborative communication creates both perceived (DeWall, Baumeister, & Vohs, 2008; Allem et al., 2015) and actual safety (Alaggia, 2005; Finkelhor, 2009; Olson, 2011). Family functioning that provides a safe and protective environment for children is dependent upon communication. Through effective communication, a family is more likely to be protective, accessible, cohesive, adaptive, and instructive (Olson, 2000; Olson & DeFrain, 2006; Peterson & Green, 2009).

Family communication serves many functions, including (a) expression of needs (Peterson & Green, 2009); (b) creation and sharing of meaning (Olson & Gorall, 2003); (c) resolution of problems (Olson & DeFrain, 2006; Peterson & Green, 2009). Communication of verbal and nonverbal messages of safety, justice, and inclusion is an important part of family functioning (Olson & DeFrain, 2006). When a

family is adaptive and cohesive, it is better able to create an environment and functional system that is ideal for human growth and development (Bandura, 2006). There are several positive results of open and effective family communication, such as healthy coping skills and resiliency (Ballester, Sastre, & Mullet, 2009; Boss, 2010) which result in lower rates of SUP (Luthar & Brown, 2007). Self-expression is a skill derived from family communication that allows for the expression of physical and emotional needs (Worthington, Witvliet, Lerner, & Scherer, 2005). The opportunity for a parental figure to respond in supportive and effective ways may depend upon disclosure or discovery of CSA. Another important gift of open communication within a family is healthy self-esteem (Akl & Mullet, 2010).

Measuring Family Communication

The Family Communication Scale (Olson & Barnes, 2010) was used to measure the degree a family member feels that family communication is open, satisfying, unconstrained, and effective. The instrument evaluates the member's perception of where the family falls on a continuum from poor communication to very effective communication. Long-term outcomes of CSA are mediated by support and open and responsive communication (Alaggia & Turton, 2005; Frazier, Tashiro, Berman, Steger, & Long, 2004; Murthi & Espelage, 2005). As such, it is essential to study family communication because family systems with open and balanced communication exhibit higher functioning (Hops, Tildesley, Lichenstein, Ary, & Sherman, 1990; Olson, 2000) and optimal development (Allem et al., 2015).

Family response. Family support, guidance, and communication are critical traits of a protective and nurturing family (Elliott & Carnes, 2001; Kendall-Tackett,

Williams, & Finkelhor, 1993). The same traits give families the ability to acknowledge and respond to disclosure, which buffers the negative outcomes of CSA (Elliott & Carnes, 2001; Lindert, von Ehrenstein, Grashow, Gal, Braehler, & Weisskopf, 2014). Whether the emotional and behavioral outcomes of disclosure are optimal or detrimental depend on the degree to which a family accepts or rejects disclosure of CSA (DeWall, Baumeister, & Vohs, 2008). Disclosure is stifled when a child doubts that caretakers would respond favorably because privacy and secrecy are prioritized over safety (Afifi et al., 2005; Wurtele & Kenny, 2010). Implied or literal messages from the family that discourage openness put a child at a disadvantage (Afifi et al., 2005).

Parental attitudes and concern toward CSA are influenced by a child's gender (Xie et al., 2016). Multiple studies show parents are often unaware that boys can be sexually victimized (Babatsikos, 2010; Chen & Chen, 2005). Parents believe boys to be at either minimal or no risk even when told that CSA of boys is possible (Babatsikos, 2010; Xie et al., 2016). A notable finding of that study was that parents believed boys would experience no negative effects of CSA.

Prevention of CSA is greatly influenced by family communication and instruction (Estévez, Orzerinjauregi, Jauregui, & Orbegozo, 2016; Wurtele & Kenny, 2010; Lin, Mack, Enright, Krahn, & Baskin, 2004). Essential for decreasing risk of victimization is a child's ability to recognize and disclose sexual abuse through possession of functional terminology and vocabulary (Afifi & Wegner, 2004; Elliot & Briere, 1994; Holmes & Slap, 1998; Keaton & Kelly, 2008; Wurtele & Kenny, 2010). In a study of children's vocabulary, Wurtele and Kenny (2010) learned 89% could

name ‘non-private’ body parts but only 10% knew ‘penis’ and 7% knew ‘vagina.’ Kia-Keating et al. (2010) describe a failed attempt to disclose CSA due to a child’s inability to articulate the abuse: a participant informed his mother on multiple occasions that his brothers were “bothering him.” The mother’s response was appropriate considering the communicated message but did not respond to the sexual abuse.

Lindert et al. (2014) and Wood, Desmarais, and Gugula (2002) report disparities in quantity, quality, moral guidance, and content of sexual education provided to boys and girls. Likely due to their own sexual socialization and discomfort with the topic (Wester, Vogel, Pressly, & Heesacker, 2002), fathers rarely provide sexual information to sons (Babatsikos, 2010). Higher rates of sexual activity are seen in boys who received sexual advice from fathers (Nolin & Petersen, 1992). Incongruences in content of sexual education can be seen in families enforcing double standards for boys and girls (Wurtele & Kenny, 2010), which makes sons more receptive to peer pressure and pro-sexual social norms (Nolin & Petersen, 1992). Because boys receive negligible information that lacks factual and moral guidance, they are especially susceptible to cultural messages that encourage casual sexual encounters (Caldera, Huston, & O’Brien, 1989; Wurtele & Kenny, 2010).

Family plays a crucial role presenting socially defined norms and customs expecting a male to be strong, rugged, and able to protect himself (Alaggia & Millington, 2008; Caughlin, 2003; Unger, Norton, & DeLuca, 2009). Wood, Desmarais, and Gugula (2002), as well as Platsidou and Tsirogiannidou (2016), report gender roles as being much more rigid for boys. Teaching parents to protect children

is more effective than teaching children to avoid harm (Wurtele, 2009; Wurtele & Kenny, 2010). Teaching a child to not be sexually abused is akin to teaching a child to not ingest a colorful, aromatic toxic liquid.

Family cohesion. Cohesiveness and solidarity are elements of a strong family with open and productive communication (Hops et al., 1990; Marsac & Alderfer, 2010; Zimet & Jacob, 2001) while poor family communication is characterized by unyielding expectations of conformity. Norms and expectations for conformity and concealment may demand that secrets be kept from outsiders (Caughlin, 2003; Koerner & Fitzpatrick, 2002). Bolen and Lamb, (2007) argue that families may resist disclosure and intervention from outside the family due to shame, guilt and fears they have been or may be perceived to be bad parents. Functions of family secrets are bonding, maintenance, privacy, defense, communication, and loyalty (Englar-Carlson & Kiselica, 2013; Keaten & Kelly, 2008). Revealing abuse can protect a child from further exploitation (Alaggia & Turton, 2005) and open the possibility for remediation and healing through counseling (Barber, Maltby, & Macaskill, 2005).

Disclosure of CSA is often a dilemma for a child. Disclosure may elicit protection from further abuse or the consequence of dissolution of the family unit (Alaggia & Turton, 2005; Paine & Hansen, 2002; Wurtele & Kenny, 2010). Dissolution of a family structure can equate to loss of access to physical, emotional, and practical resources and a feeling of isolation (Afifi et al., 2005; Pinel, Long, Murdoch, & Helm, 2017). Not only do these reactions fail to protect and help a victim of CSA, they can be re-victimizing if the family is indifferent (Alaggia & Turton, 2005; Wurtele & Kenny, 2010) or even hostile and abusive (Rieser, 1991). Inaction of

a family may be due to fear of the abuser (Coohey & O'Leary, 2008) or an effort to maintain the family unit (Afifi, Olson, & Armstrong, 2005).

Secrecy may also protect a child from blame or even violence and retribution from the abuser (Browne & Finkelhor, 1986; Wilson, 2009; Rhodes et al., 2011). Anxiety, fear, isolation, and maladaptive coping strategies are common results of an undisclosed secret that functionally leads to thought suppression or repression as a subconscious attempt to prevent inadvertent disclosure (Afifi et al., 2005). When an abuser is powerful or threatening, disclosure is unlikely (Afifi et al., 2005; Alaggia & Turton, 2005). Rejection of an abuser may compromise or threaten the support system, a circumstance that might trigger familial pressure to suppress or retract a disclosure (Alaggia, 2010; Bradley & Wood, 1996; Rieser, 1991). Efforts to silence children are more powerful with younger victims (Caughlin, 2003; Keaton & Kelly, 2008) due to vocabulary and terminology deficits (Keaton & Kelly, 2008; Wurtele & Kenny, 2010) and power/threats from abusers (Burnette, McCullough, Van Tongeren, & Davis, 2012; Carr & Wang, 2012). Secrecy can maintain an abuser's access to victims, restrict aid, and maintain a stressful environment (Afifi et al., 2005). Suppressing potentially disruptive secrets and embarrassing information is stressful and adds to the litany of negative emotions that can challenge a child's ability to cope (Afifi et al., 2005; Femina, Yeager, and Lewis, 1990).

Family adaptability. Typical problems that occur within all families can usually be resolved through communication (Akhlaq, Malik, & Khan, 2013; Maio, Thomas, Fincham, & Carnelley, 2008). Emotionally available, responsive, nurturing families support ideal child development (Keaten & Kelly, 2008) and enable adaptive,

healthy, and constructive ways to manage unconstructive emotions (Busso, 2014). An adaptive family with open, effective, and balanced communication may enable self-esteem, self-efficacy, adaptive coping, and confidence in problem-solving skills (Olson & DeFrain, 2006; Peterson & Green, 2009; Vangelisti, Macguire, Alexander, & Clark, 2007). These are crucial mechanisms for coping with the adverse sequelae of CSA (Akl & Mullet, 2010; Lin, Mack, Enright, Krahn, & Baskin, 2004; Turner, Finkelhor, Hamby, Leeb, Mercy, & Holt, 2012). Lower rates of CSA and SUP are related to open, cohesive, and effective communication between family members. Psychological and physiological wellness can be influenced by the presence or absence of positive lasting family relationships (DeWall, Baumeister, & Vohs, 2008).

In the absence of open and effective communication, a family may fail to protect, promote dysfunctional thoughts and behaviors, and impede development of healthy coping skills (Olson, 2000; Rapsey, Campbell, Clearwater, & Patterson, 2017). Rarely would a child experience sexual abuse exclusive of other forms of adversity, abuse, or neglect because CSA is indicative of a multi-problem home (Simpson & Miller, 2002). Turner et al., (2012) states that the family is the most likely source of abuse and exposure to violence. Family communication in a dysfunctional, multi-problem home may actively or passively promote substance use for self-soothing and mood regulation (Buckner, Heimberg, Ecker, & Vinci, 2013; Maio, Thomas, Fincham, & Carnelley, 2008).

Families communicate norms and customs for substance use (Felitti et al., 1998; Wilsnack, Vogeltanz, Wilsnack, & Harris, 2000). When one is confronted with family or household dysfunction, substance abuse may operate as a coping device that

regulates mood (Allem et al., 2015; Charuvastra & Cloitre, 2008; Kia-Keating et al., 2010). For children from multi-problem homes characterized by closed, ineffective communication, substance use is often the most accessible way to cope with negative feelings (Beck, 1967; Busso, 2014; DeWall, Baumeister, & Vohs, 2008; Salsitz, 2016; Shorey et al., 2013; Roper, Dickson, Tinwell, Booth, & McGuire, 2010).

Family dysfunction. Childhood adversity includes emotional, physical, and sexual abuse as well as emotional and physical neglect. A home affected by woman abuse, mental illness, household substance abuse, divorce or separation, and incarceration of a family member, subjects a child to multiple forms of adversity (Alaggia & Turton, 2005; Hiebert-Murphy, 2002). Kellogg and Menard (2003) found a co-occurrence between abuse of primary female caregiver and CSA that ranged from 40% to 78% and report that 52% of sexually abused children witnessed woman abuse in the home. Substance use problems can obstruct a parent or caretaker's ability to recognize or adequately respond to a child's unmet needs. If a family fails to prevent or protect a child from sexual abuse, communication is necessary for termination of abuse (Estévez et al., 2016), and engagement with necessary support systems (Bradley & Wood, 1996; Olson & Barnes, 2010).

Greater psychological distress and more intense feelings of betrayal and distrust results from sexual abuse perpetrated by a family member compared to a non-family abuser. Intra-familial abuse exacerbates a sense of betrayal and distrust and can increase psychological suffering (Hébert et al., 2009; Roper et al., 2010; Russell, 1986). Cases in which the perpetrator of sexual abuse is a parent/stepparent show the lowest percentage of criminal prosecution (Stroud, Martens, & Barker, 2000).

Perpetrators are known to the child at rates between 70-90% according to Finkelhor (2017). Regardless of evidence that a known person commits most CSA, many parents believe strangers pose more threat (Babatsikos, 2010; Crisma, Bascelli, Paci, & Romito, 2004). Victims minimize the severity of CSA when they perceive their abuser as being powerful (Afifi et al., 2005) or when they believe exposing CSA is a threat to the family unit (Crisma et al., 2004; Englar-Carlson, & Kiselica, 2013). Disclosure may not elicit protective responses, as would be the case if preservation of family takes precedence over child safety (Bolen & Lamb, 2007; Koerner & Fitzpatrick, 2002).

Family communication, counseling, and disclosure. Counselors are better able to help a family improve communication (Scherer et al., 2012) and facilitate disclosure of CSA. Types of disclosure were categorized by Bradley and Wood (1996) in these ways: (a) accidental disclosure (74%), (b) immediate family member (35%), (c) extended family or friend (16%), (d) school official (13%), and (e) police or government officials (6%). Lemelin (2006) cautions against precarious unqualified disclosure, when a friend, family member, or non-professional person is told about the sexual abuse of a child; precarious because disclosure to a non-professional can be unproductive at best or at worst re-victimizing. By screening all clients for CSA, counselors can be the antithesis of an unqualified disclosure and respond to disclosure adequately. Lemelin asserts that an unqualified disclosure is more likely when a crucial affiliation with the perpetrator is at stake. Counselors can help clients achieve recovery from SUP by helping them process lingering effects of poor family

communication, outcomes of CSA, or help improve the quality and function of family communication.

Rejection of a child's attempts to disclose abuse and express negative feelings may lead him to infer that his emotions are not important and should not be expressed (Jones, Bowling, & Cumberland, 1998). When a counselor suspects CSA, inquiry should also be made about violence in the home and possible woman abuse (physical or emotional). This can be achieved by teaching parents how to act right, teaching children healthy boundaries, helping family members communicate, intervening when necessary, and promoting changes in family dynamics. The quantity of family communication influences a child's resiliency and development of healthy coping strategies.

Summary of family communication

Open and responsive communication determines how well a family protects children from CSA and how responsive it was if a child is sexually abused. Family cohesion, adaptability, protection, and instruction supply children with healthy coping skills that diminish the use of substances to cope with negative feelings.

Forgiveness

Until the last several decades, the topic of forgiveness was ceded to the fields of theology and philosophy (Akl & Mullet, 2010; Brown, Barnes, & Campbell, 2007). It has come to be regarded as an important tool for counselors (Godbout, Briere, Sabourin, & Lussier, 2014; Hornor, 2010; Maynard, Piferi, & Jobe, 2016). Forgiveness is a component of constructive adaptation and resilience (Maltby, Macaskill, & Day, 2001; Walsh, Fortier, & DiLillo, 2010). Forgiveness was chosen as

a variable for this study because of evidence it can be an effective coping strategy for survivors of CSA, as well as for people in pursuit of sobriety (Denham et al., 2005; Lyons, Deane, & Kelly, 2010; Toussaint, Owen, & Cheadle, 2012).

Definition

Consideration of what forgiveness is not is a useful preface to what forgiveness is. Consensus can be found in discussions of what forgiveness is not. The phrase "forgive and forget" has become so commonplace the two words are virtually synonymous (Clarke & Pearson, 2000). Forgiveness is certainly not forgetting (Worthington, Scherer, & Cooke, 2006), but rather to remember and alter the interpretation and meaning of the transgression (Olson, & Gorall, 2003). Theories of forgiveness do not encourage one to condone or pardon an offense (Barber, Maltby, & Macaskill, 2005; Enright & Fitzgibbons, 2000) nor do they recommend minimizing or denying abuse (Cosgrove and Konstam, 2008; Worthington, Scherer, & Cooke, 2006). Because forgiveness is internal (Ballester et al., 2009; Frise & McMinn, 2010), it is not dependent upon external events of apology, restitution, revenge, or retribution (Barber, Maltby, & Macaskill, 2005; Enright & Fitzgibbons, 2000). Reconciliation and forgiveness are independent constructs and functions (Frise & McMinn, 2010). Forgiving oneself for inability to prevent or stop CSA and/or forgiving any physiological response, such as an erection or reaction to stimuli, is a critical step toward resiliency (Bullock & Beckson, 2011; Deering & Mellor, 2011).

Thompson et al. (2005) define forgiveness as:

> "the framing of a perceived transgression such that one's responses to the transgressor, transgression, and sequelae of the transgression are transformed

> from negative to neutral or positive. The source of a transgression, and therefore the object of forgiveness, may be oneself, another person or persons, or a situation that one views as being beyond anyone's control. Forgiveness helps one resolve the dissonance and distress that accompany negative life events." (p. 318)

By all accounts, forgiveness is difficult to define even though most definitions share common components. Forgiveness is decreased negative thoughts, feelings, and actions followed by an increase in positive thoughts, feelings, and actions (Ballester et al., 2009; Lin, Enright, & Klatt, 2011; Maynard, Piferi, & Jobe, 2016). Researchers Lyons, Deane, and Kelly (2010) describe forgiveness as a process of deconstructing prior assumptions and perceived truths regarding an offense and synthesizing new meanings for circumstances and effects of abuse, the abuser, and self.

Forgiveness happens when a neutral or perhaps even positive emotional response supersedes a negative emotional reaction to a transgression. Creating a positive response toward people responsible for causing injury is a typical feature of forgiveness definitions (McCullough, Pargament, & Thoresen, 2000). McCullough et al. defined forgiveness as "intra-individual, pro-social change toward a perceived transgressor that is situated within a specific interpersonal context" (p. 9).

Function of Forgiveness

Recurring themes exist in forgiveness literature. Most common is cessation of negative emotions connected with the offense (Cosgrove & Konstam, 2008) and relinquishment of a desire for retaliation or revenge (Frise & McMinn, 2010). Other common themes in forgiveness literature are letting go of resentment, hostility, and

negative judgment toward the offender (Ballester, Sastre, Mullet, 2009; Enright & Fitzgibbons, 2000) or toward self (Brose et al., 2005; Vangelisti, Macguire, Alexander, & Clark, 2007). Automatic and dysfunctional thoughts and concepts of self as being worthless are not only mechanisms that promote SUP but also targets for therapeutic change (Rapsey, Campbell, Clearwater, & Patterson, 2017; Roper et al., 2010). Forgiveness can replace negative cognitive processes that support poor self-esteem with an identity that distinguishes the self from the abuse (Rapsey et al., 2017). Forgiveness has the potential to replace destructive coping strategies with positive strategies. Forgiveness can also move survivors toward resilience and reduction in resentment and negative thoughts and feelings toward the offender.

Men often lack compassion for, and may even blame, victims of sexual abuse (Davies & Rogers, 2009; Maynard & Wiederman, 1997). Self-forgiveness can liberate MCSA survivors from self-blame for causing or failing to prevent abuse. Tangney et al. (2005) discovered maladaptive coping traits in individuals who were on either end of a self-forgiveness continuum, either overly generous or overly restricted. Instead of self-blame, victims who blame the perpetrator demonstrate adaptive coping (Estévez et al., 2016; Finkelhor, 2009).

Although apologies, expressions of remorse, and efforts to make amends are not necessary components of forgiveness, they can expand forgiveness (McCullough et al., 2010; Ristovski & Wertheim, 2005). Forgiveness is an acquired skill and process that engages logic and reason (Akl & Mullet, 2010; Baskin & Enright, 2004; Zimet & Jacob, 2001; Wilkowski, Robinson, & Troop-Gordon, 2010). Use of forgiveness in counseling embraces the male-centric value described by Englar-

Carlson and Kiselica (2013) as a natural inclination to achieve objectives through action (Davis, Hook, Van Tongeren, DeBlaere, Rice, & Worthington, 2015).

Empathy is a way to find and consider alternate meanings of event/story not absolution for abuser (Konstam, Holmes, & Levine, 2003) and may produce positive feelings, pro-social behavior, and better relationships (DeWall, Baumeister, & Vohs, 2008; Richman & Leary, 2009). Evaluation of empathic notions is a practical approach for a pragmatic person not naturally inclined to forgive. Dispositional forgiveness indicates that one is inherently adept at forgiving, that forgiveness is an element of one's identity and is a principal indicator of mental health and well-being (Thompson et al., 2005).

Process of Forgiveness

Unlike attempts to change situations or events, cognitive and behavioral transformations are possible. Forgiveness is rarely a succinct event; a typical timeline is an evolutionary, developmental process that begins with a decision or choice to forgive (Davis et al., 2015; Enright & Fitzgibbons, 2000; Maynard, Piferi, & Jobe, 2016) and arrives at diminished desire for revenge and reduced resentment. Forgiveness gives one a cognitive approach to reconstructing meaning assigned to any given offense, which affords the opportunity for altered affective outcomes (Enright & Fitzgibbons, 2000; Olson, 2005; Witvliet et al., 2001). Psychological, emotional, and cognitive development can be disrupted by CSA (Brady, 2008) but forgiveness can improve emotional status and behavioral patterns through cognitive processes (Barber, Maltby, & Macaskill, 2005; Konstam et al., 2003; Lin, Enright, & Klatt, 2011). Cognitive paradigms allow for the encoding, screening, interpretation, and

responses to stimuli (Beck, 1967; Grossman, Sorsoli, & Kia-Keating, 2006; Shorey et al., 2013). One such cognitive reconstruction is rejection of the notion that a boy is a collaborator or liable for abuse and assigning sole blame to the abuser (Davies & Rogers, 2006).

In this process men are able to identify and embrace the reality that they were emotionally, cognitively, and physically unable to control their environment or abusive acts of others. Richman and Leary (2009) point out that the same cognitive process that ties CSA to negative outcomes and feelings is susceptible to altered interpretations that yield positive affect and decreases need to self-soothe with substance use (Richman & Leary, 2009). Forgiveness entails the use of logic and reason to assign a new interpretation to an offense and offender as flawed (Boss, 2010; Richman & Leary, 2009). Casarjian (1992) explains the effects of forgiveness in this statement, "The beliefs that you hold about forgiveness open or close possibilities for you, determine your willingness to forgive, and, as a result, profoundly influence the emotional tone of your life" (p. 12).

Rewards of Forgiveness

Resilience and coping with negative emotions can be acquired skills. A lack of resilience and maladaptive coping are revealed when substance use is the primary coping strategy for adults subjected to MCSA (Felitti et al., 1998; Schraufnagel et al., 2010; Helm, Cook, & Berecz, 2005). Forgiveness can replace substance use as one's primary approach to coping (Baskin & Enright, 2004; Lin, Mack, Enright, Krahn, & Baskin, 2004; Scherer et al., 2012). Forgiveness increases agreeableness, conflict

resolution, and healthy relationships and reduces anger and resentment that might prompt substance use (Richman & Leary, 2009).

Maladaptive substance use can be avoided (Felitti et al., 1998) or replaced with adaptive coping strategies (Chandy, Blum, & Resnick, 1996) like forgiveness interventions (Beck & Shaw, 2005). As an alternative to substance use, forgiveness is a cognitive, affective, and behavioral route to resilience (Lyons, Deane, and Kelly, 2010; Thompson et al., 2005). According to the Big Book of Alcoholics Anonymous, "resentment is the number one offender" (2001, p. 64) of recovery and sobriety. Forgiveness is an effective resource for men who seek recovery from SUP (Lyons, Deane, & Kelly, 2010; Scherer et al., 2012).

Similar to substances, forgiveness has anaesthetizing effects that calm emotional distress (Lin, Enright, & Klatt, 2011; Richman & Leary, 2009). Similar to the anaesthetizing effects of substances, forgiveness correlates to a neurological phenomenon that severs a cognitive connection between a specific offense, like CSA, and an emotional response (Lin, Enright, & Klatt, 2011; Richman & Leary, 2009). Forgiveness holds the potential to liberate a person from feelings of resentment, animosity, and anxiety (Worthington, Scherer, & Cooke, 2005) and a desire for revenge (McCullough et al., 2000). Forgiveness is a process that holds the potential to moderate or mediate maladaptive responses to MCSA (Thompson et al., 2005). Stronger emotional attachments are benefits of a disposition to forgive (Bass & Davis, 1994; Boney-McCoy & Finkelhor, 1995). Age is positively correlated with shame and negatively correlated with forgiveness (Konstam et al., 2001). Konstam, Chernoff, and Deveney (2001) found forgiveness associated with a reduction in anger, and

Draucker (2003) found forgiving men less eager for revenge. Other studies discovered forgiveness to be a way to cope with negative thoughts and emotions (Kadiangandu, Gauché, Vinsonneau, & Mullet, 2007; McCullough, Pargament, & Thoresen, 2000).

Risks of Forgiveness

Wade and Worthington (2003) recommend that forgiveness and unforgiveness be regarded as separate domains, instead of unforgiveness being the opposite of forgiveness. The authors of the HFS also indicate them as separate but correlated factors. Unforgiveness is sometimes advantageous (Hébert et al., 2009; Orr, Sprague, Goertzen, Comock, & Taylor, 2005; Peterson & Green, 2009). Forgiveness may be misconstrued as a moral or social mandate that encourages a victim to maintain a relationship with his abuser, thereby facilitating future abuse (Orr et al., 2005). Trust is separate from forgiveness and may actually be contraindicated if trust puts one at risk of being re-victimized (Cooney, Allan, Allan, McKillop, & Drake, 2011; Worthington, Witvliet, Lerner, & Scherer, 2005). Forgiveness, without safety, autonomy, and self-efficacy, may facilitate further abuse if forgiveness puts a child at risk of re-victimization (Frise & McMinn, 2010; Lin, Enright, & Klatt, 2011; Murphy, 2005).

There is a risk of self-blame when a victim is too quick or overly inclined to forgive an abuser, or if blame is not accurately assigned (Alaggia, 2010; Bass & Davis, 1994; Crete & Singh, 2015). Maintenance of an abusive relationship may occur in situations in which one may "perceive that there are many costs associated with a loss of the relationship show evidence of being motivated to repair the damaged relationship" (Richman & Leary, 2009, p. 373). A sense of security

accompanies an inclination to forgive and willingness to trust family and environment (Scherer et al., 2012).

Assessment of Forgiveness

The Heartland Forgiveness Scale (HFS) (Thompson et al., 2005) presents subscales for forgiveness of self, others, and situations. Forgiveness is best portrayed as a continuum between unforgiving and forgiving (Berry, Worthington, O'Connor, Parrott, & Wade, 2005; Brose, Rye, Lutz-Zois, & Ross, 2005).

Forgiveness and Family Communication

Families demonstrate the purpose and methods of forgiveness to children (Denham et al., 2005). According to a 2011 study by Stoltenborgh, Van Ijzendoor, Euser, and Bakermans-Kranenburg, families are the primary source of instruction and implementation of justice. Family communication is also a confounding variable that suggests a quality of safety. An atmosphere of forgiveness within a family informs a child's understanding of, and aptitude for, forgiveness (Akl & Mullet, 2010; Walrond-Skinner, 1998; Worthington, 1998). Mothers are apparently better able to influence one's proclivity for forgiving. Denham et al., (2005) report that a mother's anger is negatively correlated and a father's anger is positively correlated to child forgiveness. The theory is that children model a mother's forgiveness. However, because children regard an angry father as threatening, in order to avoid confrontation, children forgive without evaluating risks of forgiveness (Maio, Thomas, Fincham, & Carnelley, 2008).

Communication is a family dynamic that informs the process of forgiveness (Alaggia & Turton, 2005; Walrond-Skinner, 1998). Families define, demonstrate, and communicate forgiveness (Lin, Mack, Enright, Krahn, & Baskin, 2004; Maio,

Thomas, Fincham, & Carnelley, 2008; Olson, 2000; Worthington, Scherer, & Cooke, 2006). Introduction of forgiveness promotes support within the family (Lin, Mack, Enright, Krahn, & Baskin, 2004; Olson, 2000; Worthington et al., 2006). A family with open and effective communication is a family that can forgive (Maio, Thomas, Fincham, & Carnelley, 2008).

Inadvertent or accidental disclosure of CSA certainly occurs. This might be the result of physical damage requiring medical attention. Most disclosure is a process of communication from the child, and living in a family with open and effective communication makes disclosure much easier (Simpson & Miller, 2002). Disclosure may prevent further harm (Peterson & Green, 2009), moderate effects of abuse (Alaggia & Turton, 2005), and present healthy coping strategies (Scherer et al., 2012).

Early observations of forgiveness within the family unit (Denham et al., 2005; DeWall, Baumeister, & Vohs, 2008) can mediate future cognitive, behavioral, and environmental interactions (Bandura, 2006). A dysfunctional family may inhibit an aptitude for forgiving (Godbout et al., 2014), promote maladaptive reactions to adversity, and restrict resiliency (Rapsey, Campbell, Clearwater, & Patterson, 2017). Family communication and forgiveness facilitate disclosure, safety, resiliency, and concepts of justice (Berry, Worthington, O'Connor, Parrott, & Wade, 2005; Godbout et al., 2014; Lin, Mack, Enright, Krahn, & Baskin, 2004).

Forgiveness and Substance Use Problems

Forgiveness is shown to be an integral part of recovery from SUP (Lyons, Deane, Kelly, 2010; Webb & Brewer, 2010) while unforgiveness is associated with increased depression, anxiety, social difficulties, and increased SUP (Maltby,

Macaskill, & Day, 2001; Salsitz, 2016). Male CSA victims who use mood-altering substances to subdue feelings of shame and guilt have discovered forgiveness to have a similar result (Worthington et al., 2006; Lin, Mack, Enright, Krahn, & Baskin, 2004). By acknowledging substance use as a coping mechanism, clients and counselors can applaud capacity to survive but set a new goal to thrive. Forgiveness and substance use are interchangeable coping mechanisms (Brennan, Hellerstedt, Ross, & Welles, 2007; Freedman & Enright, 1996).

Forgiveness can be a crucial counseling intervention and conduit for coping skills that, unlike SUP, offer long-term positive results (Cosgrove & Konstam, 2008; Luthar & Brown, 2007; Worthington et al., 2005; Scherer et al., 2012). When SUP is a maladaptive response to adversity (Allem et al., 2015; Sigurdardottir et al., 2014), forgiveness can reorient one's cognitive processes toward positive adaptation (Worthington, 2005). Richman and Leary (2009) present a modification in one's interpretation of an offense as healthy and productive coping.

Effective treatment of SUP depends upon therapeutic processes that identify and address CSA (Simpson & Miller, 2002). Before classifying any behavior as dysfunctional, counselors should recognize that some males regard substance use as a functional coping strategy (Felitti et al., 1998; Conley & Garza, 2011). A boy, adolescent or adult who feels threatened may feel bolstered by substance use (Roper et al., 2010). Englar-Carlson and Kiselica (2013) not only recommend male-only therapy groups that prioritize a spirit of fraternity and brotherhood over victimhood, they regard humor as an effective coping mechanism for men. They argue that laughter can be a pro-masculine way to diffuse tension and express affection in a safe

socially acceptable manner and caution therapists against labeling laughter as avoidant or maladaptive.

Forgiveness can be a key pivotal experience for CSA survivors who struggle with substance use problems (Exline & Zell, 2009; Scherer et al., 2012; Webb et al., 2006). Forgiveness is related to safe and nurturing families, and counselors should help clients repair family relationships or set boundaries if that is not advisable or possible (Scherer et al., 2012).

Summary of Forgiveness

Literature reports survivors of MCSA find forgiveness correlated with improved family communication (Mullet, Girard, & Bakhshi, 2004; Richman & Leary, 2009), resiliency (Becker-Blease et al., 2010; Ferguson, 2008), and reduced SUP (Moorhead et al., 2012). A decrease in frequency and intensity of negative responses to recollection of CSA, or a higher inclination for forgiveness, accounts for 25% to 49% of the variance in SUP (Berry & Worthington, 2001; Brown, 2003; Thompson et al., 2005). For healing and forgiveness to take place, men need thoughts, feelings, and behaviors to become more positive and less negative (Berry & Worthington, 2001; McCullough et al., 2000). Cognitive approaches to forgiveness and functional assessment and reconstruction of communication are helpful tools for boys, adolescents, or adults.

Substance Use Problems

Definition

A substance use problem exists when use of mood altering, intoxicating substance is continued despite adverse consequences (Allem et al., 2015; Scherer et

al., 2012). *Diagnostic and Statistical Manual*, 5th Edition (*DSM-5*) criteria for diagnosis of substance use disorder (SUD) is evidence of (a) impaired control; (b) social impairment; (c) risky use; and (d) pharmacological factors. Additional features of a SUD diagnosis include placement on a continuum (mild, moderate, and severe) as well as an indication of the primary substance of intoxication. Because depth of inquiry of this investigation is not sufficient for diagnosis of SUD, the term 'substance use problem' is used.

Assessing Substance Use Problems

The CAGE-Adapted to Include Drugs (CAGE-AID) (Brown & Rounds, 1995) can identify lifetime likelihood of alcohol and other drug problems conjointly. Answers to the four questions of the CAGE-AID are answered with either a yes or no response. Psychometric properties reported by Brown and Rounds are a validity coefficient for true positive is 0.79 and validity for a true negative is 0.85. Leonardson, Kemper, Ness, Koplin, and Leonardson, (2005) found the CAGE-AID to be brief, simple, having good validity and reliability coefficients above .90, and to have sufficient concurrent and divergent validity shown by moderate correlations with a battery of similar instruments.

Effects of Substance Use

Griffin (2009) compares addiction to a costume "that allows [one] to hide [the] true self" (p. 3). A major maladaptive coping strategy that allows one to temporarily escape from emotive anguish and existential pain is use of mood-altering substances (Crete & Singh, 2015; Sigurdardottir et al., 2014). Self-regulation is a developmental skill that facilitates optimal adaptations to adversity by modifying perception and

meaning of present circumstances (Bandura, 1986, 2006; Kaplow & Widom, 2007). This is achieved when, in the words of Bandura, (2006, p. 164), a person is able to "override environmental influences." To 'override' is to liberate oneself from, to move on from, or let go of hostility and adverse feelings (Ferguson, 2008; Frise & McMinn, 2010; Maltby, Macaskill, & Gillett, 2007). Although substances can only provide momentary relief, easy access and quick results make substances a first choice for some people attempting to ease emotional distress (Alaggia & Millington, 2008; Kaplow & Widom, 2007; Roper et al., 2010). Reinforcing this approach is the neurological anaesthetizing effect of substances that temporarily dissolve a connection between CSA and emotional suffering (Lin, Enright, & Klatt, 2011; Richman & Leary, 2009).

Berliner and Elliot (in Meyers, Berliner, Hendrix, & Reid, Eds., 2002) report that CSA instills a sense of powerlessness that is particularly overwhelming for boys' ability to cope. Counselors can help survivors of any age develop strategies for self-regulation and self-soothing that do not involve the use of substances. Influence of substances instills a sense of courage and strength. Victims of CSA consistently report a sense of isolation, a feeling that is instinctively threatening. Substance use may help an isolated person gain access and acceptance into a substance-using subgroup (Richman & Leary, 2009). Steps can be taken to replace harmful substance abusing peers with healthy relationships that can fulfill the need for inclusion and belonging (Richman & Leary, 2009; Rojas & Stenberg, 2010).

Consequences of Substance Use

Experiencing CSA triples a man's odds of SUP that can result in higher rates of concomitant social, academic, vocational, and health problems (Moran, Vuchinich, & Hall, 2004; Wilsnack, Vogeltanz, Wilsnack, & Harris, 2000). Substance use problems have negative effects on (a) individuals, (b) relationships (Coohey & O'Leary, 2008; Farber et al., 1984; Garnefski & Arends, 1998), (c) families (Hébert, Tourigny, Cyr, McDuff, & Joly, 2009), and (d) society (Gorey & Leslie, 1997; Nelson, Baldwin, & Taylor, 2012).

Age at Initial Substance Use

Males are reported to use substances at earlier ages than females (Shorey, Stuart, & Anderson, 2013; Zucker, 2008). The likelihood, and even severity, of substance use problems in adulthood is directly linked to how young one is when substance use begins. This argument has broad support (Bergen, Martin, Richardson, Allison, & Roeger, 2004). A study by Maldonado-Devincci et al. (2010) discovered pre-adolescent substance use linked to delayed and diminished behavioral and emotional functioning and discovered a four-fold increase in SUP in sexually abused boys aged 13 to 15.

Summary of Substance Use Problems

While substance use is a quick and effective mode of ameliorating negative emotions, the effects are short-term and substance use eventually becomes an additional problem. Coping with substances celebrates external resources and fails to recognize, appreciate, and implement internal resources of strength and fortitude. Not only does CSA increase the probability but also the magnitude of SUP (Busso, 2014;

Fergusson, Boden, & Horwood, 2008; Helm, Cook, & Berecz, 2005; Sigurdardottir et al., 2014).

Chapter Summary

This chapter contained a review of literature on childhood sexual abuse, family communication, forgiveness, and substance use problems. Gathering data on family communication, forgiveness, male-specific reactions to CSA, and how these variables influence long-term outcomes of SUP is the goal of this research. It is hypothesized that forgiveness and family communication scores of men who experienced CSA is inversely related to substance use problems. Results of this study should help prepare counselors to respond to the effects of CSA at any point of a client's lifespan (Worthington, Witvliet, Lerner, & Scherer, 2005).

CHAPTER 3: METHODOLOGY

This non-experimental study followed a correlation research design. This study examined a relationship between substance use problems, family communication, and dimensions of forgiveness in men who were sexually abused in childhood. Specifically, how are family communication and forgiveness related to substance use problems? Male childhood sexual abuse was assessed by self-report and was a parameter for inclusion in the sample. Childhood sexual abuse was not a variable but was a criteria for participation in the study.

Methodology of the study is outlined in this chapter. Section one describes the protocol and procedure for recruiting participants. The second section describes the sample. Instruments and associated psychometric properties are explained in section three. The final section describes the logistic regression model selected for data analysis. The following research question guides the study, "What is the relationship between substance use problems, family communication, and dimensions of forgiveness in men who were sexually abused in childhood?"

Procedures

This study was designed in accordance with policies and procedures of the Institutional Review Board of the University of North Carolina at Charlotte and honored best practices for ethical research involving sensitive subjects. The survey was conducted electronically. Participants were presented a letter of introduction that explained (a) purpose of the study; (b) participation is voluntary and may be stopped

at any point without penalty; (c) responses are entirely anonymous. Informed consent was indicated by use of an Internet hyperlink that connected participants to the survey.

Recruitment

To reach prospective participants, twelve organizations (Appendix D) were asked to introduce this survey to their constituents through blogs, chat rooms, emails, forums, and posts on agency websites. The missions of these organizations include prevention, advocacy, and treatment of childhood abuse and neglect. Their members consist of survivors, advocates, and providers of therapeutic, medical, legal, and social services. Of the twelve organizations that initially agreed to assist with recruitment two organizations subsequently declined and six organizations did not respond to follow-up communication. Only two, MaleSurvivor.com and Pandora's Project are known to have facilitated recruitment.

Eighty-five men participated in this study during the initial four weeks of data collection, when it was announced exclusively through Pandora's Project. Pandora's Project prefaced the informed consent with an additional note of caution warning participants of potential emotional distress. In the following two weeks, after addition of MaleSurvivor.com to the research protocol, 885 participants, roughly 91% of responses were collected. MaleSurvivor.com presented the survey to their constituents without a warning beyond that contained in the informed consent.

Nine hundred and seventy (970) people accessed the survey. Cases with non-random missing values (n = 236) stemming from terminated participation and cases that denied MCSA (n = 328) were excluded from the dataset and subsequent analysis.

Given these parameters, data from 406 men were appropriate for analysis and included in the logistic regression.

Online Survey

Establishing rapport and trust may be complicated when a researcher is the same gender as the abuser. As most perpetrators are male (Crisma et al., 2004; Deering & Mellor, 2011), the online method chosen for this survey avoided possible influence of researcher's male identity (Alaggia, 2005). Recruiting members through support programs did not bias results because this study investigated the mediating and moderating effects of family communication and forgiveness, not CSA. The inclusion criteria for participants were self-identification as male and being at least 18 years of age. Being a victim or survivor of childhood sexual abuse was not a condition for participation.

Partial Masking

Alaggia and Millington (2008) recommend researchers gradually advance from innocuous topics and ease into questions that are more explicit and potentially distressing. "Male childhood sexual abuse" was not indicated in the title of this study to minimize false negatives due to male inclination to deny or minimize childhood sexual abuse (Crete & Singh, 2015). Putting 'male survivors of childhood sexual abuse' in the title of a study can result in substantially restricted participation that equates to potential for a high percentage of false negative responses (Hébert, Tourigny, Cyr, McDuff, & Joly, 2009; Hooper & Warwick, 2006; Thombs, Lewis, Bernstein, Medrano, and Hatch, (2007) due to socialization (Alaggia, 2005; Crete & Singh, 2015; Drauker et al., 2011). MCSA was partially masked by selecting cases

with a positive response to the CSA question on the ACE Questionnaire. The debriefing presented at the conclusion of the survey fully disclosed the focus of this study.

Ensuring and maintaining anonymity minimized threat to internal validity (Bowling, 2005). This survey was conducted via participants' computers in a familiar environment that was expected to strengthen a sense of privacy. This study did not offer an incentive for participation because doing so would require collection of identifying information, thus transforming anonymous participation into confidential. Another reason for not incentivizing participation was to reduce potential that participants might submit invalid and fictitious responses to attain an incentive.

Average time required for completion of this 48-question survey was 5.83 minutes. Simplicity and brevity likely contributed to participation and completion. Telephone and Internet contact information for supportive resources was provided at the end of the survey. If a participant chose to terminate participation, the survey was closed and responses were excluded from the dataset.

Sample

The target sample was comprised of men (a) 18 years old or older; (b) English speaking; (c) in a non-clinical community setting. Details collected as demographic data (Appendix C) include (a) current age; (b) whether he has ever engaged in counseling; (c) age at time of initial MCSA; (d) race; (e) sexual orientation; (f) mother's highest level of education; (g) how the participant became aware of this study. This information made it possible to describe the sample, aided in secondary analysis, and provided relevant data for future research and data comparisons.

Variables and Instrumentation

This study combined four validated questionnaires to assemble responses that were analyzed through logistic regression:

1. Family Communication Scale (Olson & Barnes, 2010).
2. Heartland Forgiveness Scale (Thompson et al., 2005).
3. Adverse Childhood Experiences (ACE) Questionnaire (Felitti et al., 1998).
4. CAGE-AID (Brown & Rounds, 1995).

Family Communication Scale

The ten-item Family Communication Scale (FCS) created by Olson and Barnes, (2010) used a 5-point Likert scale to measure openness in communication within a family system. It is a standardized instrument for examining how effectively a family communicates (Olson & DeFrain, 2006; Peterson & Green, 2009). The FCS measured key functions of communication, such as expressing thoughts, feelings, and information. Participants were instructed to regard 'family' as the group of people with whom they spent the bulk of their childhood. An example of an item on the FCS is, "Family members are able to ask each other for what they want."

Total scores can range from 10 to 50. Lower scores indicated restricted communication and higher scores indicated open communication. With a sample of 2,465 participants, the FCS showed internal consistency alpha reliability of .90 with a test/re-test reliability of .86. The FCS was normed on a non-clinical sample of 2,465 participants and demonstrated a standard deviation of 9.0, and a mean score of 36.2.

Heartland Forgiveness Scale

The Heartland Forgiveness Scale (HFS) created by Thompson et al., (2005) is an 18-item self-report measure of dispositional forgiveness. Thompson et al. report a Cronbach's alpha reliability of 0.87, demonstrating validity by being positively related to comparable forgiveness instruments. Kaleta and Mroz (2018) report satisfactory reliability and validity. Forgiveness of self, forgiveness of others, and forgiveness of situations beyond anyone's control are subscales of the HFS.

The HFS used a Likert scale ranging from "1 = almost always false of me" to "7 = almost always true of me." Half of the items were reverse-scored. "I continue to be hard on others who have hurt me" is an example of an item on the HFS. Scores on the HFS fall into three ranges: low (scores between 18-54), moderate (scores between 55-89), or high (scores between 90-126). Lower scores signified low disposition or a disinclination to forgive and higher scores signified greater disposition or inclination to forgive.

Adverse Childhood Experiences Questionnaire

Felitti et al. (1998) created the ten-item Adverse Childhood Experiences (ACE) Questionnaire that discriminated between five forms of childhood adversity; (a) physical neglect, (b) emotional neglect, (c) physical abuse, (d) emotional abuse, (e) and sexual abuse. To investigate a link between childhood adversity and poor physical health later in life, the initial ACE study engaged over 17,000 participants. Test re-test reliability of the sexual abuse part of the ACE, according to (Dube, Williamson, Thompson, Felitti, & Anda, 2004) was .69 (95% CI, .61–.77). Validity and reliability of the total ACE is supported by positive and significant correlations

with similar self-report measures of CSA (Dube et al., 2005; Edwards, Anda, Nordenberg, Felitti, Williamson, & Wright, 2001; Felitti et al., 1998).

A low ACE score indicates a childhood with minimal adversity and a high score indicates a childhood with excessive adversity. The question on the ACE that measures CSA asked, "Did a person who was at least five years older than you attempt or engage in oral, vaginal, or anal sex with you, or touch you or have you touch them in a sexual way? Responses received dummy codes of 0 = No or 1 = Yes.

CAGE-AID

The CAGE-AID (Brown & Rounds, 1995) assesses substance use problems and indicates the probability that a person might meet diagnostic criteria for substance use disorder. The name is an acronym representing a key word (cut, angry, guilty, or eye-opener) in one of the four questions of the instrument:

1. Have you ever tried to cut (C) back on use of alcohol or other drugs,
2. Have you ever been angry or annoyed (A) when people comment about your drug or alcohol use,
3. Have you ever felt guilty (G) about your drug or alcohol use, or
4. Have you ever used alcohol or other drugs as an eye-opener (E) in the morning to get you going?

The original CAGE (Ewing, 1984) measured alcohol use exclusively. Expanding the CAGE to include other mood altering substances, Brown and Rounds (1995) created the CAGE-AID and added the acronym "AID", which represents 'Adapted to Include Drugs.' A score on the CAGE-AID can range from zero to four with each point indicating an affirmative response to one of the four items. Because

Brown and Rounds consider a score of two or more indicative that a person would meet diagnostic criteria for a substance use disorder, CAGE-AID scores of 0 or 1 imply an absence of a substance use problems and scores of 2 or more signify a substance use problem. Because logistic regression requires outcome variables to be dichotomous, scores were dummy coded as No = 0 or Yes = 1.

Psychometric properties reported by Leonardson et al., (2005) assert the CAGE-AID demonstrates high concurrent validity, internal consistency, and a Cronbach's alpha of 0.92. High internal consistency of Cronbach's $\alpha = 0.77$ was also reported by Couwenbergh, Van Der Gaag, Koeter, Ruiter, and Van Den Brink (2009).

The CAGE-AID can be completed in less than one minute, was available for use without fee, and offered flexibility of computer administration and scoring. It was normed on a general population of individuals over age 16 in a primary medical care setting.

Statistical Methodology

Logistic regression analysis was selected for this study because it facilitated investigation of a dataset containing variables that are categorical (family communication and forgiveness) and dichotomous (substance use problem). Another reason logistic regression was chosen was that it accommodated a relationship between predictor and outcome variables and did not require a linear relationship between the independent variables. Additionally, logistic regression did not require groups to demonstrate an equal variance, which consequently afforded a more generous process for statistical analysis. Logistic regression required a sufficient number of cases relative to the number of discrete variables in order to avoid large

standard errors (Tabachnick & Fidell, 2013). The minimum number of participants targeted for this study was 300.

Hypothesis

H_1: Family communication and dimensions of forgiveness are related to substance use problems in adult men who were sexually abused in childhood.

H_0: Family communication and forgiveness are not related to substance use problems in adult men who were sexually abused in childhood.

Data Analysis

This retrospective study used logistic regression to investigate variables and circumstances that would be unethical and harmful to implement in an experimental study. Logistic regression produced coefficients, standard errors, and significance levels (Mertler & Vannatta, 2013) indicating probability that the independent variables predicted a substance use problem. Inability to make causal inferences was a limitation of this relational methodology.

Analytical software, Statistical Package for the Social Sciences (SPSS), was used to analyze data. Data analysis followed a screening process that examined data, identified outliers, and reviewed normality of distribution. Assumptions associated with logistic regressions determined a sufficient sample size. A goal of three hundred participants, a sufficient sample size for valid and reliable results, was established.

Univariate analysis. Analysis of mean scores of all variables was done as well as an examination of frequency distribution and dispersal. Data were graphically illustrated to demonstrate mean, median, and mode. Psychometric properties of the

instruments, as well as analysis of standard deviation, mean, and outliers are indicated.

Bivariate analysis. Bivariate comparisons were examined. Analysis was done to discern whether family communication affected prevalence and outcomes of CSA (Bandura, 2006; Cohen & Wills, 1985; Estévez, Orzerinjauregi, Jauregui, & Orbegozo, 2016), and if so, what was the direction and power of relationship of these variables. Analysis of family communication and forgiveness was measured and analyzed for moderating effects on substance use problems (Busso, 2014; Webb, Robinson, & Brower, 2011). Statistical analysis responded to the research question and described how, and to what extent, family communication and dimensions of forgiveness were related to SUP.

Multivariate Analysis. Before performing logistic regression analysis, relevant assumptions were tested. Data was checked for evidence of multicollinearity (Tabachnick & Fidell, 2001). Analysis in Model 1 evaluated contributions of family communication and forgiveness in predicting SUP in adult men who were sexually abused in childhood. This contribution was determined by an odds ratio that the predictor variables are related to the outcome variable. CAGE-AID scores were dummy coded as either 0 = no or 1 = yes to represent SUP. An absence of SUP was indicated by CAGE-AID raw scores of either 0 or 1. The presence of a SUP was indicated by raw scores of 2 or greater.

Chapter Summary

It was hypothesized that family communication and forgiveness were related with SUP. The research questions presented in this chapter informed and directed the

investigation of the relationship between the predictor variables and the outcome variable. Specifically, what was the relationship between family communication, dimensions of forgiveness, and substance use problems in adult men who experienced childhood sexual abuse? Research design and protocol were explained, as were reliability and validity psychometrics for the selected instruments. This chapter concluded with an explanation and rationale for using a logistic regression model for data analysis.

CHAPTER 4: RESULTS

Introduction

The purpose of this research was to examine how family communication and three dimensions of forgiveness relate to substance use problems in adult men who were sexually abused in childhood. Forgiveness of self, forgiveness of other(s), and forgiveness of situation(s) beyond anyone's control are the three dimensions of forgiveness in this study. The research question was: What is the relationship between substance use problems, family communication, and dimensions of forgiveness in men who were sexually abused in childhood? Results are presented in the following order: (a) description of participants; (b) univariate analysis; (c) bivariate comparisons; (d) results; and (e) chapter summary.

Description of Participants

Participants were men who were at least 18 years old who reported a history of sexual activity before age 18. With this in mind, findings are not generalizable to the overall public or to all men, only to adult men with histories of childhood sexual abuse. The sample was recruited through national support and advocacy organizations that posted the anonymous survey on their websites; two organizations were especially helpful in recruitment efforts. One, Pandora's Project, posted the study with a cautionary statement regarding potential emotional distress. During the initial four weeks of data collection, 85 cases were gathered. When a second program, Malesurvivor.org, was added to the research protocol, 91% of total number of cases

was collected during the following two weeks. Because participants were not asked to indicate how they became aware of the survey, the growth in response rate cannot be attributed to a specific organization. However, it must be noted that Malesurvivor.org presented the study to their members without a warning beyond what was included in the informed consent.

Nine hundred seventy (970) people accessed the survey. Cases with non-random missing values (n = 236) stemming from terminated participation and cases that denied MCSA (n = 328) were excluded from the final dataset and subsequent analysis. Given these parameters, data from 406 men were appropriate for analysis and included in the logistic regression models.

The percentage of the respondents who reported CSA was 55 percent (n = 406) while 45 percent (n = 328) reported no CSA. Data reflects that 63.1 percent (n = 256) reported substance use problems while 36.9 percent (n = 150) did not. In addition to the primary assessment of CSA, the demographic questionnaire also asked: How old were you the first time you experienced or observed any sexual activity? Responses indicated such events occurred between the ages of five and nine years in 54.1% (n = 189) of cases and between the ages of 10 and 14 years in 26.5% (n = 108) of the cases.

Additional descriptive data were collected with demographic questions regarding age, sexual orientation, mother's educational attainment, and race. Participant ages ranged from 18 to greater than 74 with the majority, 27.3% (n = 112), between the ages of 44 and 55. Thirty nine percent (39%) of respondents reported a heterosexual orientation, 36.6% homosexual, and 23.9% bisexual, and two

participants did not provide a response (.5 %). The majority of participants (78%) identified as white and 25.4 percent reported their mother's educational attainment to be a bachelor's degree. A depiction of frequencies and percentages are displayed in Table 3 below.

Table 3

Frequency and Percentage of Demographic Variables

Variable	Frequency	Percentage
Substance Use Problem		
Yes	256	63.1 %
No	150	36.9 %
Missing	4	1 %
Age at First Exposure to Sex		
1 – 4 (sig .024)	59	14.5 %
5 - 9	189	54.1 %
10 - 14	108	26.5 %
15 - 18	20	4.9 %
Sexual Orientation		
Heterosexual	160	39 %
Homosexual	150	36.6 %
Bisexual	98	23.9 %
Other	0	0 %
Missing	2	.5 %
Participant Age		
18-24	32	7.8 %
25-34	60	14.6 %
35-44	82	20.0 %
45-54	112	27.3 %
55-64	82	20.0 %
65-74	34	8.3 %
75 +	4	1 %
Missing	4	1 %
Mother's Education		
Less than high school	76	18.5 %
High school	64	15.6 %
Some college	54	13.2 %

Associate degree	40	9.8 %
Bachelor degree	104	25.4 %
Graduate degree	70	17.1 %
Missing	2	.5 %
Race		
American Indian / Alaskan	4	1.0 %
Asian / Pacific Islander	6	1.5 %
Black / African American	50	12.2 %
Hispanic	0	0 %
Multiple Ethnicities / Other	28	6.8 %
White / Caucasian	320	78.0%
Missing	2	.5 %

Univariate Results

Data were collected with the (a) Adverse Childhood Experiences Questionnaire (Felitti et al, 1998); (b) Family Communication Scale (Olson & Barnes, 2010); (c) Heartland Forgiveness Scale (Thompson et al., 2005); (d) CAGE-AID (Brown & Rounds, 1995). Data were screened for accuracy, missing values, outliers, normality of distribution, and multicollinearity before analysis was executed. Mean imputation was used in cases with random omissions. No outliers were discovered. Analysis produced coefficients, standard errors, and significance levels. Data was analyzed with statistical Package for the Social Sciences (SPSS). Instruments were evaluated for reliability and internal consistency using Cronbach's alpha values (Huck, 2012). Cronbach's alpha scores for internal consistency and reliability for all instruments were acceptable.

The Family Communication Scale (FCS) has 10 questions that generate a total score that indicated the degree of openness of communication within a family unit. Possible scores ranged from 10 (signifying restricted and ineffective communication)

to 50 (signifying open and effective communication). Observed scores for the scale in this study ranged from 10 to 50 with a mean score of 23.96 (SD = 10.28) and a Cronbach's alpha measure of internal consistency for FCS of .729. Further analyses indicated a normal distribution of scores. Olson and Barnes reported a mean score of 36.2 (SD = 9.0) and an internal consistency $\alpha = .90$ for a non-clinical sample of 2,465 participants for whom this instrument was normed.

The Heartland Forgiveness Scale has three 6-question subscales that assess forgiveness of self, forgiveness of other(s), and forgiveness of situation(s) beyond anyone's control. Scores on subscales can range from six to 42. Higher scores indicate that one is inclined to forgive and lower scores indicate that one is not inclined to forgive. The mean score for forgiveness of self was 25.57 (SD = 8.33). The mean score for forgiveness of other(s) was 25.91 (SD = 6.12). The mean score for forgiveness of situation(s) was 28.78 (SD = 7.90).

The CAGE-AID (Brown & Rounds, 1995) has four questions that predict the likelihood that a participant might meet diagnostic criteria for a substance use disorder. Total scores range from zero to four. Cases with scores of zero or one were labeled negative. A score equal to or greater than two indicated a positive result. Dummy codes were assigned, where '0' = No and '1' = Yes. Table 4 presents the values for alpha coefficients, items, means, and standard deviation for instruments in this study.

Table 4

Psychometric Properties of Instruments

	Family Communication Scale	Forgive Self	Forgive Other	Forgive Situation	CAGE-AID Substance Abuse Scale
Coefficient α	.729	.623	.636	.559	.709
Items	10	6	6	6	4
Mean	23.96	25.57	25.91	23.78	.63
Std. Deviation	10.28	8.33	6.61	7.90	.48
Variance	105.729	69.46	43.71	62.33	.234
Range	36	33	33	33	1
Minimum	10	9	9	9	0
Maximum	46	42	42	42	1
N	392	400	400	404	406

Psychometric properties discovered in this study were compared with previous research. Mean scores on the Family Communication Scale were within 10% of historically reported data. Results for Forgiveness of Self were within 20% range of mean scores in previously reported studies. Compared with prior studies, mean scores for Forgiveness of Others and Forgiveness of Situations discovered in this study varied no more than 17% and mean scores for CAGE-AID were within 14% of scores reported in previous studies.

Bivariate Comparisons

Results for the variables of substance use problem, family communication, forgiveness of self, forgiveness of others, and forgiveness of situation were compared. Findings are presented in Table 5. Relationships were determined by Pearson correlation coefficients.

Table 5

Pearson Correlation Matrix

	Family Communication	Forgive Self	Forgive Others	Forgive Situations	Substance Use Problem
Family Communication	1				
Forgive Self	.275 **	1			
Forgive Others	- .077	- .044	1		
Forgive Situations	.061	.216 **	.604 **	1	
Substance Use Problem	- .072	- .089	.006	.021	1

** Correlation is significant at the .01 level (2-tailed).

Sig. (2 tailed) of .000 was discovered for (a) Family Communication and Forgive Self, (b) Forgive Self and Situation, and (c) Forgive Other and Forgive Situation.

Logistic Regression

This retrospective study used binary logistic regression to examine the relationship between substance use problems, family communication, and dimensions of forgiveness in men who were sexually abused in childhood. All variables were entered simultaneously to prevent prioritizing one independent variable over another.

Accurate interpretation of results required preliminary analysis of data to determine if assumptions were met for logistic regression. Assumptions for logistic regression satisfied by this research include (a) dependent/outcome variable is dichotomous; (b) sufficient number of cases were collected; (c) no multicollinearity. Logistic regression requires a sufficient number of cases relative to the number of discrete variables and logistic regression is also sensitive to variables that are highly correlated; such multicollinearity could have produced large standard errors and exaggerated regression estimates (Tabachnick & Fidell, 2013). The number of cases suitable for analysis was 25 percent larger than the target of 300.

Multicollinearity between family communication and forgiveness would have existed if the variables were highly correlated and if either predicted the other, making rejection of the null hypothesis challenging. A score between one and ten indicates no multicollinearity and scores that fall below one or greater than ten indicate multicollinearity (1-10 = no multicollinearity, <1 or >10 = multicollinearity). Testing for multicollinearity was accomplished by calculating values for variance inflation factor (VIF) by doing a linear regression of independent variables on other independent variables and evaluating the R^2. A VIF value of 1.304 showed that variance for family communication was 30 percent greater than if it was entirely uncorrelated with other IVs. Forgiveness of self showed a similar VIF of 1.344. VIF values were less impressive for forgiveness and other(s) and forgiveness of situation(s) at 2.026 and 2.014 respectively but well below the threshold of five that would have signified multicollinearity. Another test of multicollinearity was tolerance. None of the tolerance scores were less than .1 and therefore presented no problems requiring further investigation. These findings are presented in Table 6 below.

Table 6

Collinearity Statistics

Variable	Tolerance	VIF
FAMCOM	.767	1.304
FORTOT	.979	1.021
SELF	.744	1.344
OTHER	.494	2.026
SITUATION	.496	2.014

a. Dependent Variable: SUP

Research Question: What is the relationship between substance use problems, family communication, and dimensions of forgiveness in men who were sexually abused in childhood?

Results of binary logistic regression did not support the hypothesis of this study. The first model of analysis showed no significant relationships between the outcome variable and (a) family communication and substance use problems (p = .240); (b) forgiveness of self (p = .084); (c) forgiveness of others (p = .978); (d) forgiveness of situations (p = .265). Table 7 illustrates scores for B values, significance, and odds ratios of Exp(B) estimated predictive powers of variables presented in the research question (Mertler & Vannatta, 2013). Nagelkerke R square value provided a pseudo R-square because logistic regression does not provide an R-square value found in other models of statistical analysis. The predictor variables did not show statistical significance and did not appear to influence substance use rates. Although not statistically significant, forgiveness of self was the predictor variable that exhibited unique qualities and contrasted other variables.

Table 7

Results for Model 1

							95% C.I. for Exp(ß)	
	B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
FAMCOM	-.013	.011	1.379	1	.240	.987	.965	1.009
SELF	-.024	.014	2.980	1	.084	.976	.950	1.003
OTHER	-.022	.021	1.136	1	.287	.978	.938	1.019
SITUATION	.020	.018	1.243	1	.265	1.020	.985	1.056
Constant	1.577	.593	7.067	1	.008	4.840		

a. Variable(s) entered on step 1: SELF_TOT, OTHER_TOT, SITUATION_TOT, FC_TOT.

The impetus for further consideration of the predictor variables of family communication and self-forgiveness was based on the body of literature. Another reason for further investigation of self-forgiveness is its exceptional p-value seen in Model 1. Like Model 1, the second model revealed no significant relationship between SUP and the predictor variables of forgiveness of other(s) (p = .247) and forgiveness of situation(s) (p = .277).

To investigate more thoroughly, an interaction variable was computed in SPSS by multiplying the mean centered scores of self-forgiveness and family communication. Scores for B values, significance, odds ratios of Exp(B), and confidence intervals of Model 2 can be seen in Table 8 below. Model 2 analysis included an interaction variable created by multiplying mean-centered scores for family communication and self-forgiveness. A mean-centered variable was achieved in SPSS by subtracting the mean from all values to decrease multicollinearity between interaction terms. Results of a logistic regression analysis that included the new variable revealed high family communication (p = .015) and self-forgiveness (p = .030) to be significant predictors of substance use problems. Without this interaction variable, measures of high and low family communication scores and combined scores for the three dimensions of forgiveness might have cancelled out effects of other variables.

After controlling for other variables, the odds ratio for family communication is that for every unit increase the likelihood of a substance use problem decreases .92 times. For every unit increase in self-forgiveness the likelihood of a substance use problem decreases .97 times. This effect is found only when the interaction variable is entered into the analysis model. The relationship between substance use problems and

family communication (p = .015) and substance use problems and self-forgiveness (p = .030) is shown to be statistically significant and supports the hypothesis of this study. The Cox & Snell R^2 value of .028 suggests that the independent variables combined predict 2.8% of variance between having a substance use problem or not.

Table 8

Results for Model 2 with Interaction Variable

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for Exp(ß)	
							Lower	Upper
FAMCOM	-.081	.033	5.890	1	.015	.922	.863	.984
SELF	-.032	.015	4.721	1	.030	.969	.941	.997
OTHER	-.025	.021	1.339	1	.247	.976	.936	1.017
SITUATION	.020	.018	1.183	1	.277	1.020	.984	1.056
INTERACTION	-.003	.001	4.681	1	.030	.997	.995	1.000
Constant	3.558	1.099	10.475	1	.001	35.096		

a. Variable(s) entered on step 1: FC_TOT, SELF_TOT, OTHER_TOT, SITUATION_TOT, SELF_TOT_x_FC_TOT.

Chapter Summary

The mission of this study was to examine how family communication and dimensions of forgiveness relate to substance use disorders in adult men who were sexually abused in childhood. A model that analyzed effect of family communication, forgiveness of self, forgiveness of others, and forgiveness of situations did not reveal statistical significance.

Keeping in mind significance was only seen in forgiveness of self, it is noteworthy that unlike other variables forgiveness of situation(s) exhibits a positive B value (B = .020). This might accompany a sense of power or invulnerability that could be contradicted by an acceptance that any situation might be 'beyond anyone's control.' Crete and Singh (2015) argued that one might find self-blame preferable to acceptance that one might be powerlessness to overcome uncontrollable situations.

Cooney et al. (2011) highlight the possibility that some people assigned blame to self for getting into a circumstance that others might accept as unavoidable. Another rationale for a positive relationship between forgiveness of situation and substance use problems could be self-centric interpretation of situation being within a male's control, a result of actions or inaction (Briere, 2002).

Chapter 5 will present a summary and discussion of the results of this investigation of the relationship between substance use problems, family communication, and dimensions of forgiveness in men who were sexually abused in childhood. An overview of the study and the statement of the problem will be presented. Additionally, Chapter 5 provides a brief review of methodology and summary of the findings.

CHAPTER 5: SUMMARY AND DISCUSSION

A summary and discussion of the results of this investigation of the relationship between family communication, dimensions of forgiveness, male childhood sexual abuse, and substance use problems are presented in this chapter. Results are presented and organized in this chapter as follows: (a) overview, (b) statement of the problem, (c) review of methodology, (d) summary of results, and (e) discussion of results, (f) conclusion.

Overview

Childhood sexual abuse (CSA) can cause long-term maladaptive outcomes and interfere with optimal physical, emotional, and social development (Allem et al., 2015; Becker-Blease, Turner, & Finkelhor, 2010; Massey & Widom, 2013). Estimated rates of male childhood sexual abuse (MCSA) extend from 3% Finkelhor, 1994) to 60% (Bullock & Beckson, 2011; Davies & Rogers, 2009). Regardless of inconclusive data on MCSA rates, the long-term effects are substantial and include feelings of powerlessness, fear, anger, anxiety, depression, hypervigilance, and isolation (Brydges, Wood, Holmes, & Hall, 2014; Wilson, 2009). Attempts to ameliorate such resultant negative feelings and emotional distress are natural responses to childhood sexual abuse (Buckner, Heimberg, Ecker, & Vinci, 2013; Clarke & Pearson, 2000; Marmostein, White, Loeber, & Stouthamer-Loeber, 2010) and are often substance use, which can persist throughout life (Allem et al., 2015; Beck & Shaw, 2005; Brydges, Wood, Holmes, & Hall, 2014).

How well a family prevents or responds to abuse was determined by the openness and effectiveness of communication within a family system (Estévez, Ozerinjauregi, Jauregui, & Orbegozo, 2016; Olson & DeFrain, 2006; Peterson & Green, 2009). Boys may receive messages of invulnerability and dominance. Disclosure of abuse may be discouraged or dismissed. Strategies for coping with effects of abuse are also contingent on family communication (Akl & Mullet, 2010; Lin, Enright, & Klatt, 2011; Zimet & Jacob, 2001). Families may exhibit restricted communication and fail to impart healthy, productive, and effective coping skills (Allem, Soto, Garbanati, & Unger, 2015; Vangelisti, Macguire, Alexander, & Clark, 2007) and may even promote substance use for the regulation of affect (Allem et al., 2015; Buckner, Heimberg, Ecker, & Vinci, 2013; Maio, Thomas, Fincham, & Carnelley, 2008). This can be especially problematic for survivors of MCSA who adopt substance use as a mechanism to self-soothe and cope with emotional distress (Allem et al., 2015; Bolen & Lamb, 2007; Charuvastra & Cloitre, 2008).

Statement of Problem

The goal of this research was to identify the relationship between family communication, dimensions of forgiveness (self, others, and situations) and substance use problems in adult men who were sexually abused in childhood.

Review of Methodology

This study was designed to test a hypothesis that family communication and dimensions of forgiveness were negatively correlated with substance use problems in adult men who were sexually abused in childhood (Godbout, Briere, Sabourin, & Lussier, 2014; Paine & Hansen, 2002). An invitation to participate in this study was

posted online by various national support and advocacy organizations devoted to preventing and treating child abuse. Considering the independent predictor variables of family communication and dimensions of forgiveness, a model of logistic regression analysis produced odds ratios of the likelihood of a substance use problem. All variables were entered into the equation simultaneously.

Summary of Results

An initial logistic regression model analyzed scores for family communication and the subscales of forgiveness. Although none of the variables were found to be statistically significant predictors of the outcome variable of substance use problems, the p value for self-forgiveness was notably different compared to all other variables. Based on data reported in peer-reviewed studies, and the remarkable, although not statistically significant result for self-forgiveness ($p = .084$), further analysis was pursued.

Multiplying mean-centered scores for family communication and self-forgiveness created an interaction variable that was included in Model 2 analysis. Creating a mean-centered variable was achieved in SPSS by subtracting the mean from all values, which does not alter frequency distribution. Mean centered scores can decrease multicollinearity between interaction terms by standardizing the variables. Results of a logistic regression analysis that included the new variable revealed high family communication ($p = .015$) and self-forgiveness ($p = .030$) to be significant predictors of substance use problems.

Discussion of Results

Interpretation of Results

Communication within a family system establishes expectations and norms for substance use (Estévez et al., 2016; Zucker, 2008), forgiveness (Akl & Mullet, 2010;

Maio, Thomas, Fincham, & Carnelley, 2008), and sexual behavior (Crete & Singh, 2015; Draucker, 2003; Lindert, Von Ehrenstein, Grashow, Gal, Braehler, & Weisskopf, 2014). Family communication was expected to predict scores for SUP. The results in Model 2 of this study match findings of previous studies. Possibly due to the three subscales cancelling out effects of each other, dimensions of forgiveness did not display a statistically significant effect on SUP in Model 1. Further analysis revealed that high scores indicating open family communication canceled out the effect of self-forgiveness.

Previous studies indicate that males do not recognize MCSA as abusive when the perpetrator's gender is in harmony with his sexual orientation (Maynard & Wiederman, 1997). Nielsen (2016) pointed to evidence that embracing a 'victim of CSA' identity was a key predictor of maladaptive coping. Statistical findings of this study could have been better explained if participants were asked whether or not, or to what degree, he identified as a victim of childhood sexual abuse. Statistical significance may be tied to whether men who experienced childhood sexual abuse report symptoms of trauma (Finkelhor, 2017).

Misogyny may be responsible for increased self-blame, especially when the perpetrator was female, because males are socialized to believe that they cannot be victims and that women are not strong enough or capable of sexual predation (Romano & DeLuca, 2001). Homophobia could account for variations in forgiveness (Crete & Singh, 2015; Parent & Bannon, 2012). Insight into this matter could have been explored if information regarding the gender of the abuser had been collected and compared to data regarding participants' sexual orientation. Literature suggested

that survivors experience a lesser degree of emotional distress when the gender of the perpetrator of CSA aligns with one's sexual orientation. An argument for why forgiveness may not be related to substance use problems was patriarchal beliefs that males possess power and dominance and regards males as collaborators, if not the instigators, in sexual activity (Drauker et al., 2011; Fontes & Plummer, 2010).

Substance use problems commonly associated with CSA are considered maladaptive responses to stressors and poor self-efficacy (Martens et al., 2008). Previous research indicated that forgiveness can moderate or mediate maladaptive coping (Denham, Neal, Wilson, Pickering, & Boyatzis, 2005; Toussaint, Owen, & Cheadle, 2012) and is an adaptive response to negative emotions (Maltby, Macaskill, & Day, 2001; Walsh, Fortier, & DiLillo, 2010). The CAGE-AID is better suited for screening for substance dependence than problematic use and may have limited cross-cultural validity (Humeniuk & Ali, 2006).

A relationship between self-forgiveness and substance use problems was anticipated because of previous research highlighting a male tendency to blame any victim of CSA, including blaming himself (Crete & Singh, 2015; Davies & Rogers, 2006; Romano & DeLuca, 2001). Additional research that shows an unrealistic sense of self-reliance in males (Crisma et al., 2004; Kia-Keating, Sorsoli, & Grossman, 2010) could explain the lack of significance for forgiveness of others or forgiveness of situations.

Contribution to Counseling

Because half of all individuals receiving counseling services are survivors of CSA (Cohen & Miller, 1998), counselors must be vigilant regarding MCSA and

prepared and able to work with male survivors. Counselors can strive for gender parity in assessment and honor a professional obligation to screen for MCSA, promote prevention messages that include boys, and advocate for CSA services regardless of gender, (Alaggia, 2005; Alaggia & Millington, 2008; Nielsen, 2016). Social messages and cultural norms can be scrutinized and challenged when they do not effectively preserve sexual boundaries of boys (Bergen, Martin, Richardson, Allison, & Roeger, 2004; Nelson, Baldwin, & Taylor, 2012). When addressing behavioral, professional, relational, spiritual, physical, social, or addiction issues, men need counselors to be attentive to the experiences and effects of male childhood sexual abuse. MCSA assessment, especially important when treating SUP (Scherer et al., 2012; Rapsey et al., 2017), is best accomplished with open-ended questions.

This study points to the complexity of relationship between forgiveness, family communication, and maladaptive coping behaviors. Nevertheless, helping clients explore, define, and implement forgiveness can be effective counseling interventions (Orr et al., 2005). This process should include discussion of what forgiveness is not (i.e. not condoning, excusing, forgetting, or reconciling). This research illuminated differences in dimensions of forgiveness.

Recommendation for Future Research

Findings of this study contributed to the body of empirical knowledge and provided implications to the field of counseling but questions for future studies remain. Future studies could examine if and to what extent males are evaluated for childhood sexual abuse and examine counselors' advocacy efforts regarding MCSA.

Evaluation of differences in how counselors respond to suspected or disclosed CSA of boys versus CSA of girls and the likelihood counselors engage in cases of sexually abused boys. With more accurate MCSA statistics the problem may receive increased attention and counselors may be better prepared to identify and treat sexually abused boys and men.

Complex and inconsistent gender-biases and social norms regarding sexual activity for boys warrant attention in future research. What effect do family messages regarding sex, physical boundaries, safety, and mechanisms for self-soothing have on MCSA? Does open and effective family communication directly or indirectly minimize risk for MCSA? Does ineffective family communication increase risk of MCSA and raise the risk of SUP?

It would be wise to investigate effectiveness of forgiveness education programs and examine how age influences forgiveness. Do men regard forgiveness as weak, contrary to masculine ideals, or even a maligned feminine trait? Effectiveness or appropriateness of forgiveness interventions may depend upon whether a male survivor identifies as having been harmed. Among sexually abused men, those who do not identify as a victim or survivor demonstrate better mental health. Comparison studies could be done between men who do and those who do not identify as a survivor of MCSA. Additional comparison studies could be conducted for groups of gay, bisexual, or heterosexual men or comparison of effects based on gender of abuser. A dichotomous assessment of MCSA is insufficient. Future studies should investigate how males subjected to CSA interpreted the event.

Future research should expand the empirical body of knowledge regarding both the incidence (reported) and prevalence (actual) rates of male childhood sexual abuse as well as the outcomes of such abuse. Statistics drawn from consistent screening and accurate reporting may increase awareness and prevention of MCSA, a problem that is overlooked and which Cermak and Molidor (1996) describe as "inadvertent negligence" (p. 3).

Use of other instruments for assessing substance use problems might reveal important findings. For example, the Substance Abuse Subtle Screening Inventory (SASSI) would extend participation time but results might justify any reduction in number of participants. The SASSI has 93 items, compared to the 4 questions on the CAGE-AID. Studies using the entire FACES-IV instrument, rather than the Family Communication Scale component of FACES-IV, may be advisable.

Conclusion

Despite the fact that childhood sexual abuse causes significant psychological and physical problems for individuals and adverse effects on society, rates remain unclear. The field of counseling has evolved, embraced new clinical approaches, and become aware of and engaged in various social justice issues. In light of recent attention to various ways men commit sexual offenses and the social movement to help men be sensitive, it is timely to bring attention to sexual abuses committed against boys and how these abuses may have far reaching, adverse social consequences. Counselors are particularly well positioned to facilitate the social dialog. This study challenged social norms by studying childhood sexual abuse of boys and subsequent consequences.

Families can develop and communicate messages to boys that convey healthy boundaries and dignified norms regarding sexuality. In addition to protecting boys from sexual abuse family communication may help men be thoughtful sexual partners who respect sexual boundaries of others. This study may encourage counselors to embrace and implement forgiveness as a clinical intervention. For males, self-forgiveness may be especially constructive. Although male childhood sexual abuse is a complex problem the adverse consequences are clear. Efforts to prevent childhood sexual abuse or repair adverse outcomes are warranted.

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APPENDIX A: INFORMED CONSENT

Hello,

If you are at least 18 years old and self-identify as male, I would appreciate your assistance and participation in a survey examining the relationship between family communication, forgiveness, childhood adversity, and substance use in adult men. This anonymous online survey should take between five and ten minutes. Participation is voluntary. You may withdraw at any time.

Your responses are anonymous and will not identify you or link you to your responses. While there are no known risks of participation, the survey contains a few questions about adversity, abuse, and neglect during childhood. Links to support organizations are provided if you wish to contact them. Your input will enrich knowledge that is specific to men and help counselors address childhood adversity.

You can send questions to Eli Branscome at rbransco@uncc.edu or 704-661-1429, or Lyndon Abrams, Ph. D., at 704-687-8964 or lpabrams@uncc.edu. The University of North Carolina at Charlotte office of research compliance ensures that you are treated with respect and fairness. If you have concerns about your rights as a participant contact the Office of Research Compliance at 704-687-1871 or uncc-irb@uncc.edu.

With Sincere Gratitude,
Eli Branscome, LPCS, LCAS
Doctoral Candidate, Dept. of Counseling, Univ. of North Carolina at Charlotte

Consent to participate in this study:

If you are 18 years of age or older, identify as male, understand the statements above, and freely give consent to participate in the study, click on the link to begin the survey. If you chose to not participate, close your browser. (You may print a cop of this form.)

Link to Survey: (https://www.surveymonkey.com/r/CKKTRV2)

APPENDIX B: DEBRIEFING

This study is specifically interested in childhood sexual abuse men may have experienced. Men instinctively dismiss the topic, thinking participation is not relevant. Rationale for presenting the study as an investigation of 'childhood adverse experiences' rather than 'male childhood sexual abuse' is in these points:

- The focus of this study is family communication and forgiveness and how those variables relate to substance use.
- Studies that present male childhood sexual abuse as a variable produce false negative responses, such as non-participation, and skewed results (Afifi et al., 2005; Brydges et al., 2014; Thombs et al., 2007).
- Men receive misinformation regarding sexuality and childhood sexual abuse (Gallo-Silver et al., 2014).
- Parents are often unaware of the risk of sexual abuse of boys (Babatsikos, 2010; Chen & Chen, 2005).
- Because the information boys receive from parents is negligible and lacks factual and moral guidance, boys are especially susceptible to cultural messages that encourage casual sexual encounters (Caldera, Huston, & O'Brien, 1989; Wurtele & Kenny, 2010).
- An inconsistent or unclear social norm regarding sexual activity for boys impedes study participation (Bergen, Martin, Richardson, Allison, & Roeger, 2004; Moran, Vuchinich, & Hall, 2004; Xie, Qiao, & Wang, 2016).

- Boys and girls are subject to double standards of different behavioral criteria and moral ideals regarding sexuality (Babatsikos, 2010; Wurtele & Kenny, 2010).
- In some circumstances, social norms urge boys to celebrate childhood sexual abuse as a rite of passage into manhood (Alaggia & Millington, 2008; O'Leary & Barber, 2008).
- Sexual abuse challenges concepts of male strength, sexuality, and masculinity (Alaggia & Millington, 2008; Kia-Keating et al., 2010; Hébert et al., 2009).
- Especially if the abuser is female, paradigms of masculinity and male dominance sustain a belief that a boy, by virtue of his maleness, has power over sexual decision-making (Nolin & Petersen, 1992; Thombs, Lewis, Bernstein, Medrano, & Hatch, 2007).
- Misogynistic contempt for women and girls that underpins sexual violence and abuse is a result of a patriarchal society (Bullock & Beckson, 2011; Crete & Singh, 2015). Teram et al., (2006) and Unger, Norton, and De Luca (2009) suggest any victimization, especially sexual, is strongly associated with the maligned traits of femininity, weakness, or homosexuality.
- According to Deering and Mellor (2011), consequences of CSA are enduring and adverse regardless of the gender of perpetrator.

A result of these factors is that men are often unqualified (Finkelhor et al., 1990; Fontes & Plummer, 2010; Thombs et al., 2007) or reluctant (Afifi et al., 2005; Alaggia, 2005; Femina et al., 1990) to label their childhood sexual experiences as abusive.

APPENDIX C: DEMOGRAPHIC QUESTIONS

Instructions: Please indicate your answer by either typing your answer into the text box or clicking the button that matches your response.

1. What is your current age?
2. Have you ever been in therapy?
3. How old were you the first time you experienced or observed any sexual activity?
4. What is your racial identity?
5. What is your sexual orientation?
6. What is your mother's highest level of education?
7. How did you become aware of this study?
    a. Website or email of an advocacy organization
    b. Email from friend or family member
    c. Counselor, attorney, physician, or other professional
    d. Other

APPENDIX D: ADVOCACY ORGANIZATIONS

Provided Assistance with Survey Distribution:

Adult Survivors of Child Abuse (ASCA), Morris Center for Healing from Child Abuse, P.O. Box 14477, San Francisco CA 94114, 415-928-4576; www.ascasupport.org.

Male Survivor, PMB 103, 5505 Connecticut Avenue NW, Washington DC, 20015-2601; 800-738-4181; www.malesurvivor.org.

Metropolitan Organization to Counter Sexual Assault (MOCSA); 3100 Broadway, Kansas City MO 64111; 816-931-4527; Fax 816-931-4532; www.mocsa.org.

Pandora's Project, 3109 W. 50th Street #320, Minneapolis, MN 55410; 612-234-4204; admin@pandys.org; www.pandys.org.

Declined Request for Survey Assistance:

1in6, Inc., P.O. Box 222033, Santa Clarita CA 91322; http://1in6.org; research: https://1in6.org/therapists-and-other-professionals/research-on-male-survivors/

Darkness to Light; 7 Radcliffe St #200, Charleston SC 29403; National Administrative Office: 843.965.5444; Fax: 843.965.5449; Helpline: 866-367-5444; www.d2l.org.

Rape Abuse and Incest National Network (RAINN), 2000 L Street NW, Suite 406, Washington DC, 20036; hotline: 800-656-4673; info@rainn.org; www.rainn.org.

Survivors Network of those Abused by Priests (SNAP); P.O. Box 6416, Chicago IL 60680-6416; 312-455-1499; fax 312-455-1498.

Participation unknown, response not received from:

A Voice For Men, 3735 Franklin Rd. SW #172, Roanoke, VA 24014

C4 Recovery Foundation**,** Algonquin, IL 60102 (800) 611-5735

Covenant House Headquarters, 461 Eighth Ave, New York, NY 10001

Dan Griffin, dangriffin.com

Stop It Now; 351 Pleasant Street # B-319, Northampton, MA 01060; Tel: 413-587-3500; Fax: 413-587-3505; www.stopitnow.org.

The Good Men Project, 87 N. Raymond Ave. Suite 230, Pasadena, CA 91103

APPENDIX E: FAMILY COMMUNICATION SCALE

1	2	3	4	5
Strongly Disagree	Generally Disagree	Undecided	Generally Agree	Strongly Agree

1) Family members are happy with how they communicate with each other.
2) Family members are very good listeners.
3) Family members enjoy talking to each other.
4) Family members are able to ask each other for what they want.
5) Family members can calmly discuss problems with each other.
6) Family members discuss their ideas and beliefs with each other.
7) When family members ask questions of each other, they get honest answers.
8) Family members try to understand each other's feelings.
9) When angry, family members seldom say negative things about each other.
10) Family members express their true feelings to each other.

Permission for use granted.

APPENDIX F: HEARTLAND FORGIVENESS SCALE

Directions: In the course of our lives negative things may occur because of our own actions, the actions of others, or circumstances beyond our control. For some time after these events, we may have negative thoughts or feelings about ourselves, others, or the situation. Think about how you **typically** respond to such negative events. For each of the following items indicate the number (on the 7-point scale) that best describes how you **typically** respond to the type of negative situation described. There are no right or wrong answers. Please be as open as possible in your answers.

1	2	3	4	5	6	7
Almost Always False of Me		More Often False of Me		More Often True of Me		Almost Always True of Me

1) Although I feel bad at first when I mess up, over time I can give myself some slack.
2) I hold grudges against myself for negative things I've done.
3) Learning from bad things that I've done helps me get over them.
4) It is really hard for me to accept myself once I've messed up.
5) With time I am understanding of myself for mistakes I've made.
6) I don't stop criticizing myself for negative things I've felt, thought, said, or done.
7) I continue to punish a person who has done something that I think is wrong.
8) With time I am understanding of others for the mistakes they've made.
9) I continue to be hard on others who have hurt me.
10) Although others have hurt me in the past, I have eventually been able to see them as good people.

11) If others mistreat me, I continue to think badly of them.

12) When someone disappoints me, I can eventually move past it.

13) When things go wrong for reasons that can't be controlled, I get stuck in negative thoughts about it.

14) With time I can be understanding of bad circumstances in my life.

15) If I am disappointed by uncontrollable circumstances in my life, I continue to think negatively about them.

16) I eventually make peace with bad situations in life.

17) It's really hard for me to accept negative situations that aren't anybody's fault.

18) Eventually I let go of negative thoughts about bad circumstances that are beyond anyone's control.

Scoring Heartland Forgiveness Scale

Scores for items 1, 3, 5, 8, 10, 12, 14, 16, & 18 are the same as the answer provided.

Scores are reversed for items 2, 4, 6, 7, 9, 11, 13, 15, and 17. For example, an answer of 1 is given a score of 7 (1 = 7, 2 = 6, 3 = 5, 4 = 4, 5 = 3, 6 = 2, and 7 = 1).

To calculate the Total HFS, Forgiveness of Self, Forgiveness of Others, and Forgiveness of Situations, sum the values for the items that compose each scale or subscale (*with appropriate items being reverse scored*).

Four scores are calculated for the Heartland Forgiveness Scale (HFS):

- Total HFS (items 1-18) with range of scores from 18 to 126.
- Subscales of HFS
  - Forgiveness of Self (items 1-6) with range of scores of 6 to 42.
  - Forgiveness of Others (items 7-12) with range of scores of 6 to 42.
  - Forgiveness of Situations (items 13-18) with range of scores of 6 to 42.

APPENDIX G: ACE QUESTIONNAIRE

Answer yes or no to each item.
While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** . . .
   Swear at you, insult you, put you down, or humiliate you?
   —or—
   Act in a way that made you afraid that you might be physically hurt?
2. Did a parent or other adult in the household **often** . . .
   Push, grab, slap, or throw something at you?
   —or—
   Ever hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you **ever** . . .
   Touch or fondle you or have you touch their body in a sexual way?
   —or—
   Try to or actually have oral, vaginal, or anal sex with you?
4. Did you **often** feel that . . .
   No one in your family loved you or thought you were important or special?
   —or—
   Your family didn't look out for each other, feel close to each other, or support each other?
5. Did you **often** feel that . . .
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   —or—
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Were your parents **ever** separated or divorced?
7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   —or—
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   —or—
   Ever hit over at least a few minutes or threatened with gun or knife?
8. Did you live with anyone who was a problem drinker or alcoholic or who used drugs?
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
10. Did a household member go to prison?

APPENDIX H: CAGE-AID QUESTIONNAIRE

Directions: When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed.

1. Have you ever felt that you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you ever felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Permission for use granted by Richard Brown, MD.

Brown, R. L. & Rounds, L. A. (1995). Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal, 94*(3), 135-140.