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Self-disclosure among male survivors of child sexual abuse: service providers' perspective

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Abstract

Previous research regarding child sexual abuse (CSA) indicates significant gender differences in disclosure rates: specifically, males are less likely to disclose their child sexual abuse in comparison to females. CSA can have lasting impact on a child's emotional, physical, and psychological wellbeing. Trauma studies show support and early intervention is necessary for CSA survivors to re-establish a sense of safety and to experience better quality of life. Service providers play a key role in providing care and support for male CSA survivors. However, little is known about service providers, who work with male CSA survivors, and their perceptions and attitudes of CSA disclosure. This qualitative descriptive study used thematic analysis to explore the issues surrounding disclosure of CSA amongst male CSA survivors from the health service providers' perspective.

The results show that disclosure is a complex process with multiple factors determining the male CSA survivor's decision to disclose. Various barriers and facilitators play a role in the male CSA survivor's decision to disclose and occur at personal, interpersonal, institutional, and societal levels. In addition, the study revealed multiple health service gaps that negatively affect service utilization among male CSA survivors.

The results of this study have implications for both practice and further research. Public awareness programs aimed at families, educators, and community leaders are imperative in promoting an environment in which conversations about male CSA can take place without shame or stigma. Additionally, the results indicate the need to evaluate currently available services for males who have disclosed their sexual abuse histories to ensure their needs are effectively met. Further research with male CSA survivors is necessary to address the service gaps associated with male CSA.

Keywords
mental health, male sexual abuse survivor, child sexual abuse, service providers, self-disclosure, thematic analysis.

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To my colleagues and friends in the department of Health & Rehabilitation Sciences, your helpful suggestions and our ongoing research discussions were greatly appreciated. To my friends, thank you for your emotional and social support throughout my Master's program. Finally, and most importantly, thank you to my family for always being there for me and for encouraging me throughout the course of this degree.

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Chapter 1 Introduction

Child sexual abuse (CSA) is a global issue transcending racial, economic, social, and religious lines and has significant long term adverse health outcomes for survivors. Globally, one in five girls and one in ten boys have been affected by CSA (Collin-Vézina, Daigneault, & Hébert, 2013). A national U.S. study with a sample of 34,000 adults over the age of 18 found the weighted prevalence rate of CSA to be 10.14% of which 24.8% were males and 75.2 % were females (Pérez-Fuentes et al., 2013). According to Statistics Canada, 14,000 children and youth were victims of sexual offences in 2012 (Cotter & Beaupré, 2014). Townsend and Rheingold (2013) suggest that approximately 400,000 babies born in the U.S. will become victims of sexual abuse before the age of 18 unless preventive measures are taken.

CSA is a sensitive topic that can be difficult to talk about and acknowledge. Previous research that has examined CSA disclosure indicates significant gender differences in terms of disclosure rates (Alaggia, 2005; Gartner, 1999; Hanson et al., 2003; Tang, Freyd, & Wang, 2008). Studies show that in comparison to female CSA survivors, males are more reluctant to come forward and talk about their CSA(Alaggia, 2005; Gartner, 1999; Hanson et al., 2003; Tang, Freyd, & Wang, 2008). Additionally, males tend to wait longer than females to disclose their abuse to others (O'Leary & Barber, 2008). Further, in contrast to female CSA survivors, males who have been sexually abused as children deal with additional layers of complexity in disclosing their abuse history. For example, social attitudes about what it means to be "masculine" as well as "victims" and notions of male sexuality may function to further silence the male

victims of CSA (Gartner, 1997, 1999; Mendel, 1995). Societal norms such as only females can be victims or that males would welcome sexual advances negatively impact disclosure (Cromer & Goldsmith, 2010; Easton, Renner, & O'Leary, 2013; Easton, Saltzman, & Willis, 2014).

The amount of research examining sexual abuse among males as the population of interest has been disproportionate to the quantity of studies focused on female sexual abuse. Focusing predominantly on the female population can lead to false beliefs about the prevalence rate of male CSA amongst policymakers, academics, and the general public. Additionally, generalizing the findings from studies with only or a predominantly female CSA population can lead to inaccurate assumptions about the needs of male CSA survivors. Studies also note that the reported prevalence rate of male CSA may not reflect the actual number of male CSA survivors due to underreporting and delay in disclosure by male CSA survivors (Easton, 2013; Spataro, Moss, & Wells, 2001).

Service providers play an integral role in the community to provide care and support to male survivors of CSA. Since service providers can have a key role in the male survivor's healing process, it is imperative to understand their attitudes and perceptions regarding male CSA and disclosure. Service providers may facilitate the disclosure process by creating a safe environment in which male CSA survivors feel comfortable disclosing their abuse history. Additionally, service providers' perceptions and attitudes regarding CSA and disclosure not only influence their mental health assessments and diagnosis but can also impact their provision of health services. Therefore, it is important to explore the extent to which the service providers are aware of the issues faced by male CSA survivors pertaining to disclosure of being sexually abused as a child. The study

presented in this thesis explores this important area of research and, hence, adds to the current understanding of facilitators and barriers of male CSA disclosure.

Definition of Key Terms

Several key terms were specifically used in this study, namely *child*, *sexual abuse*, *disclosure*, and *service providers*. The following are definitions of these terms for the purpose of this thesis.

Child

Child was defined as "[…] any human being below the age of eighteen years, unless under the law applicable to the child, majority is attained earlier" (Convention on the Rights of the Child, 1989, p.2). This definition takes into account the age of consent for boys in Canada, which is 18 years in cases where the sexual relationship may be considered exploitative "[…] when it involves prostitution, pornography or occurs in a relationship of authority, trust or dependency (e.g., with a teacher, coach or babysitter)" (Department of Justice, 2005, p.1).

Sexual Abuse

Sexual abuse was defined as: 1) forced vaginal or anal penetration; 2) oral–genital contact; 3) touching of the breasts or genitalia; 4) touching of another person's genitalia; 5) exhibitionism; 6) deliberately exposing a child to the act of sexual intercourse; 7) masturbating in front of a child; or 8) exposure to pornographic material via internet pornography, videos, or printed materials; 9) online child luring by cyber predators or; 10) involving a child in prostitution or pornography (Broman-Fulks et al., 2007; Collin-Vézina et al., 2013; Hanson et al., 2003; Ruggiero et al., 2004).

Disclosure

The definition of *disclosure* was inclusive and included both overt forms of disclosure, such as telling someone that they have been sexually abused, as well as more subtle forms of disclosure including indirect verbal and behavioral attempts (Alaggia, 2005, 2010).

Service Providers

Service provider was defined as "A person who by education and experience is professionally qualified to provide counselling interventions designed to facilitate individual achievement of human development goals and remediate mental, emotional or behavioral disorders, and associated distresses, which interfere with mental health and development" (McGraw-Hill Concise Dictionary of Modern Medicine, 2002). These individuals may include professionals such as social workers, psychologists, psychiatrists, and mental health counsellors.

Background and Significance

According to the National Centre for Post-traumatic stress disorder (PTSD), CSA includes a wide range of sexual behaviors between an adult and a child meant to sexually arouse the adult without regard for the consequences to the child. CSA can have a lasting negative impact on children and their future growth and development. Research shows victims of CSA experience long term adverse health outcomes (Chen et al., 2010; Coles, Lee, Taft, Mazza, & Loxton, 2014; Hillberg, Hamilton-Giachritsis, & Dixon, 2011). Common physical and psychological effects of CSA include gastro-intestinal (GI) disorders, chronic pelvic pain in females, pain disorders, cardiopulmonary symptoms,

obesity, behavioral problems, emotional issues, post-traumatic stress symptoms (PTSD), depression, suicidal ideation and self-harming behaviours, suicidal attempt, anxiety, externalizing behaviour, substance abuse, self-esteem issues, academic problems, and sexualized behaviours (Chen et al., 2010; Garnefski & Diekstra, 1997; Irish, Kobayashi, & Delahanty, 2010; Martin, Bergen, Richardson, Roeger, & Allison, 2004; Molnar, Berkman, & Buka, 2001; Nalavany, Ryan, & Hinterlong, 2009; Putnam, 2003). CSA also has associated economic costs. Specifically, it has been reported that CSA costs the Canadian healthcare system, legal system, education and research institutions, and employment industry approximately 3.6 billion dollars annually (Hankivsky & Draker, 2003). CSA, therefore, has serious implications for the health and well-being of children and the Canadian economy.

Several health promoting strategies have been introduced to combat CSA, such as increasing public awareness as well as enhancing disclosure among survivors. Disclosure is known to be important in addressing CSA. Studies have found that early disclosure can have a positive impact including both an earlier end to sexual abuse andvictims receiving appropriate help, leading to better mental health outcomes (Alaggia, 2010; McElvaney, Greene, & Hogan, 2014; Somer & Szwarcberg, 2001)

Research on CSA has focused predominantly on female survivors. The lack of research on males only serves to perpetuate the myths surrounding the prevalence rate of male childhood abuse. The reported number of males who have experienced CSA is considered only a fraction of the cases, and that the true prevalence rate for male CSA may be much higher than what is reported in the literature (Bolen & Scannapieco, 1999, as cited in Tang et al., 2008). Male CSA survivors are reported to be less likely to

disclose their CSA, or delay their disclosure, compared to their female counterparts (Easton, 2013; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Ullman & Filipas, 2005). The significant underreporting of male CSA can further perpetuate the societal belief that CSA does not affect males (Cromer & Goldsmith, 2010), which in turn may prevent male survivors from seeking and receiving needed services for their childhood sexual abuse. Research has shown that traumatic events of any nature with young children results in long term adverse health outcomes. With the increased awareness of the impact of early childhood trauma on health outcomes, both prevention and early intervention are imperative to prevent the development of serious negative health outcomes for survivors of childhood sexual abuse (Alaggia, 2010; Osofsky, 2005). Males are just as likely as females, if not more so, to be impacted by previous childhood sexual abuse (Gartner, 1999; Putnam, 2003; Steever, Follette, & Naugle, 2001). For example, male victims of CSA are known to have experienced greater violence and physical harm during the abuse and to have been abused by multiple perpetrators (Ellerstein & Canavan, 1980, as cited by Steever et al., 2001).

This study contributes to the current literature on CSA among males in multiple ways. There is a significant gap in knowledge in the barriers and facilitators to disclosure in male CSA survivors. Most research on abuse to date focuses on CSA and its impact on females. Although research on female CSA survivors is crucial, it is important to recognize the impact of gender on the experience. Male CSA survivors face unique barriers and issues that need further investigation. Primarily focusing on female CSA will potentially perpetuate incorrect social attitudes and perceptions regarding male CSA.

Examining the current mental health and counseling services available to male CSA survivors is important given the long term adverse physical and psychological effects of traumatic experiences. Research indicates that interventions following CSA have a tremendously positive effect on the long-term health of CSA survivors (Harvey & Taylor, 2010; Hetzel-Riggin, Brausch, & Montgomery, 2007). Furthermore, research that examines the attitudes and perceptions of service providers is limited. Service providers play a crucial role in the healing process following any childhood trauma. Service providers' perceptions and attitudes are both influenced by societal norms and influence how they conduct themselves throughout their contact with male CSA survivors. Service providers' awareness of the barriers and facilitators to disclosure may shape and create the way in which services are offered. Therefore, it is important to understand their perceptions and attitudes surrounding male CSA disclosure as well their awareness of the issues that male CSA survivors face regarding disclosure. Identifying factors impacting disclosure among male CSA survivors from the perspective of service providers encourages the re-evaluation of currently available services leading to better service quality as well as facilitating the development of new services that address the needs of male CSA survivors.

Purpose of the Study

The purpose of this qualitative descriptive study was twofold: (1) to explore from the perspective of service providers the barriers and facilitators to disclosure among male child sexual abuse survivors; and (2) to describe the gaps in services available for male child sexual abuse survivors.

Research Questions

The research questions addressed in this qualitative descriptive study are: (1) What are the perceptions and experiences of service providers who work with male CSA survivors regarding barriers and facilitators to disclosure of male CSA?; and (2) What are the gaps in services addressing the needs of male CSA survivors?

Researcher's Assumptions

My knowledge, assumptions and previous experiences in the social service field may have contributed to the way I conducted data collection and interpreted the research findings. Therefore, it is important to share information about myself to provide context to the integrity of the data.

My background consists of clinical work in the mental health and social services field including volunteering at the Child Access program with the Children's Aid Society of Toronto as well as the Distress Centre Crisis Line. These clinical experiences provided me with a unique opportunity to work first-hand with children and adults who have experienced CSA. Through the work I did with the agencies, I was exposed to the long lasting impact that CSA can have on an individual. My motivation for conducting this research stemmed from my past experience of working with children and adults who had experienced CSA and had accessed these services in an attempt to obtain help, but were reluctant to disclose their sexual abuse history. Even in cases where the CSA was documented, males were reluctant to disclose their sexual abuse to service providers. With disclosure being an imperative part of attaining services in many cases, this reluctance to disclose their CSA history was of particular concern to me as an individual

interested in promoting positive mental health and led me to explore this topic further as my Master's thesis work.

One of my assumptions prior to conducting this research was the extent to which fear of homophobia would be considered as a major barrier to disclosure among male survivors of CSA. While homophobia emerged as a barrier to disclosure in the service providers' narratives, I was surprised to find that service providers believed it to be only one of many fears experienced by male survivors of CSA.

Another belief I held was that changing attitudes about masculinity and increasing acceptance of homosexuality will result in an increase in disclosure of male CSA. However, while these attitude changes may soften some of the identified barriers experienced by male CSA survivors, disclosure was found to be a process in which multiple barriers and facilitators interact with each other to form a complex relationship.

Summary

Given the low rate of disclosure by male survivors of CSA, and the adverse physical and mental health outcomes associated with not receiving the appropriate treatment following a traumatic experience, it is imperative to explore the barriers and facilitators to disclosure specific to male CSA survivors. The purpose of this study was to explore the male survivors' disclosure of CSA from the viewpoint of service providers who work with male CSA survivors. An increased understanding of barriers and facilitators associated with disclosure and the service gaps will help to enhance programs to meet the needs of male CSA survivors. In the following chapter, I present a review of the literature to provide a context of CSA in males, health outcomes of CSA, and disclosure in male CSA survivors. In the third chapter, I discuss the methodology and

methods used for the purpose of this research study. In the fourth chapter, I present the

study findings. Finally, in the fifth chapter, I conclude with a discussion of the findings in

relation to the literature and outline the implications for practice and further research.

Chapter 2 Literature Review

In the literature review, I examine child sexual abuse (CSA), health outcomes associated with disclosure of CSA particularly for males, and services and service providers for male survivors. The literature was retrieved from searching the following databases: CINAHL, EMBASE, PsychINFO, PubMed, Scopus and Science Direct. Search terms used in the search strategy included: sexual abuse, CSA, male, disclosure, self disclosure, physical health, mental health, depression, PTSD, child abuse survivor(s), and psychosocial factor(s). Titles and abstracts were screened for relevance to the study purpose. In order to identify what is known and not known on the topic of disclosure among male CSA survivors, articles were not limited to peer-reviewed journals and books but also included grey literature. Grey literature was located with the use of the search engine Google. In addition to using databases for the literature search, footnote chasing and citation searching were also employed to find relevant articles. During the search, the articles were not limited by a year in order to get a more comprehensive list. However, articles were limited to those written in English. In this thesis, 46 articles were included in the literature review.

Child Sexual Abuse

CSA is a sexual interaction between a child and an adult or between children with age difference of 2 to 5 years (Collin-Vézina et al., 2013). The definition of CSA is problematic due to the lack of consensus amongst researchers in the field (Collin-Vézina et al., 2013). Until recently only contact abuse, abuse that involved physical contact between a minor and an adult, was considered to be CSA (Collin-Vézina et al., 2013).

However, there has been a shift towards a more inclusive definition (Collin-Vézina et al., 2013). In a paper by Vézina, Daigneault, and Hébert (2013) CSA was defined as any sexual activity perpetrated against a minor by threat, force, intimidation, or manipulation. For the purpose of the current study, CSA was defined as sexual abuse of a child which includes: 1) forced vaginal or anal penetration; 2) oral–genital contact; 3) touching of the breasts or genitalia; 4) touching of another person's genitalia; 5) exhibitionism; 6) deliberately exposing a child to the act of sexual intercourse; 7) masturbating in front of a child; 8) exposure to pornographic material via internet pornography, videos, or printed materials; 9) online child luring by cyber predators or; 10) involving a child in prostitution or pornography (Broman-Fulks et al., 2007; Collin-Vézina et al., 2013; Hanson et al., 2003; Ruggiero et al., 2004). The experience of the victims of CSA may vary in terms of the duration, frequency, intrusiveness of acts perpetrated, and relationship with perpetrator (Collin-Vézina et al., 2013).

A report by the Canadian Centre for Child Protection (2009) entitled *CSA Images: An Analysis of Websites by Cybertip.ca* indicated that more than 82% of the images assessed by Cybertip.ca depicted very young, pre-pubescent children under 12 years of age and that more than 35% of these images depicted acts of serious sexual violence. The Canadian Centre for Child Protection report underscores the pervasiveness of CSA. However, while CSA is acknowledged to be an extensive global issue its prevalence rate is frequently debated and may vary greatly between researchers depending on the definition and criteria used to judge CSA (Douglas & Finkelhor, 2005; Johnson, 2004). Bolen and Scannapieco (as cited in Tang et al., 2008) concluded that estimates of CSA prevalence are likely an underestimate of the actual prevalence. The lack of consensus on

the prevalence rate is due to various issues including, but not limited to, the lack of

consensus on the definition of CSA, differences in data collection methods, type of

population being studied, low disclosure rates, and lack of economic resources to manage

reports of CSA (Collin-Vézina et al., 2013; Johnson, 2004; Schönbucher, Maier, Mohler-

Kuo, Schnyder, & Landolt, 2014).

Numerous studies indicate a wide range in reported prevalence rates of CSA. A

meta-analysis conducted by Holmes and Slap (1998) examined the prevalence of CSA

amongst boys in North America through data extraction of 166 papers. The results

showed that the prevalence estimates varied between 4% to 76% (Holmes & Slap, 1998).

Similarly, a more recent study by Barth, Bermetz, Heim, Trelle, and Tonia (2013)

examined the prevalence of CSA in 24 countries based on a meta-analysis of 32 studies.

The results showed that the prevalence rates ranged from 0-69% for girls and 0-47% for

boys, based on four types of sexual abuse: non-contact abuse, contact abuse, forced inter-

course, and mixed sexual abuse (Barth, Bermetz, Heim, Trelle, & Tonia, 2013).

There is a lack of consensus on prevalence even among studies that examine

prevalence rate of CSA in the same country. A meta-analysis of 27 papers conducted by

Ji, Finkelhor and Dunne (2013) examined prevalence rate of CSA in China. The

researchers found that the prevalence rate of CSA ranged from 3% to 26.1% for males

and between 2% and 35.2% for females (Ji, Finkelhor, & Dunne, 2013). Prevalence

studies in the U.S. have shown a significant decrease in reported CSA (Finkelhor &

Jones, 2012, 2004; Finkelhor, Turner, Ormrod, & Hamby, 2010). According to a 2012

report by Finkelhor and Jones (2012) there has been a 62% decline in reported CSA cases

from 1992 to 2010 with data from three independent agencies and from four victim self-

report surveys showing a decline in reported sexual abuse from the1900's through to 2010 (Finkelhor & Jones, 2012). Similar results were reported in a U.S. study by Finkelhor, Turner, Ormrod, and Hamby (2010) which compared juvenile victimization data from 2003 developmental victimization survey (DVS) and 2008 National Survey of Children's Exposure to Violence (NATSCEV). The results showed that in comparison to 2003 there was a significant reduction in several types of victimization including CSA in 2008. The authors concluded that their data confirms the results of other research and depicts a reduction in crime against children.

While these U.S. studies seem to indicate a decline in reported CSA, this trend does not reflect the global or Canadian trends. The decrease in CSA in the U.S. should not be generalized to other parts of the world without consideration of the socio-cultural context (Collin-Vézina, Hélie, & Trocmé, 2010). In an attempt to identify CSA trends in Canada, a review of existing statistics gathered from child protection services was conducted by Collin-Vézina, Hélie, and Trocmé (2010). They found a 30% drop in substantiated cases of CSA between 1998 and 2003 in Canada. However, in contrast to other provinces, CSA in Quebec had increased by 24% over the same time period (Collin-Vézina et al., 2010).

Health Outcomes of CSA

Studies show children with experience of CSA tend to have long lasting adverse health outcomes (Coles et al., 2014; Irish et al., 2010; Johnson, 2004). The repercussions associated with CSA may affect many domains of a child's life and their overall growth and development. CSA has been found to contribute to myriad of negative physical and

psychological health outcomes (Coles et al., 2014; Irish et al., 2010; Johnson, 2004; Leeb, Lewis, & Zolotor, 2011).

CSA has been found to have both immediate and long-term psychological effects (Briere & Elliott, 1994; Chou, 2012; Hillberg et al., 2011; Johnson, 2004; Jonas et al., 2011; Moody, 1999). For example, CSA has been shown to be a factor in developing a range of psychological issues during adulthood, including behavioral problems, emotional issues**,** post-traumatic stress disorder (PTSD), depression**,** suicidal ideation and self-harming behaviours, suicidal attempts, anxiety**,** externalizing behaviour, substance abuse, self-esteem issues, academic problems, and sexualized behaviours (Chen et al., 2010; Deering & Mellor, 2011; Garnefski & Diekstra, 1997; Hillberg et al., 2011; Johnson, 2004; Martin et al., 2004; Nalavany et al., 2009; Putnam, 2003; Sperry & Gilbert, 2005; Steever et al., 2001; Ullman, 2007).

The magnitude of the psychological effects of CSA on the individual may be influenced by various factors including: child's age at the time of the abuse, severity of the abuse, physical acts performed, threats and bribes, fear of retribution, fear of culpability, duration of the abuse, relationship to the perpetrator, number of perpetrators, and effective treatment (Hillberg et al., 2011; Johnson, 2004). The negative consequences of CSA frequently persist through to adulthood (Johnson, 2004). A study by Bonomi et al. (2008) examined health care utilization of 3333 females with a history of childhood abuse. The results showed that women with a history of childhood abuse had significantly higher healthcare use and health costs (Bonomi et al., 2008). Women with a history of both physical and sexual abuse had on average 36% higher health care use and costs

while women who had experienced only sexual abuse had 16% higher utilization and costs with an adjusted annual healthcare cost increase of $382 (Bonomi et al., 2008).

Devries et al. (2014) conducted a meta-analysis to determine if CSA exposure had an effect on incidence of suicide attempts in males and females. Seven longitudinal and two quantitative studies on co-twins met the inclusion criteria resulting in a sample population of 8733 participants. All longitudinal studies except one showed an increase risk in suicide outcomes following CSA (Devries et al., 2014). Overall the results indicated that between 20.1% and 22.3% of suicidal behaviours in women and between 9.6% and 10.8% in men can be attributed to CSA (Devries et al., 2014). Similarly, a systematic review of meta-analyses conducted by Hillberg, Hamilton-Giachritsis, and Dixon (2011) explored the relationship between CSA and adult mental health difficulties. In total, seven meta-analyses met the inclusion criteria, comprising a total of 248 published and unpublished papers focusing on 41 adult mental health difficulties categorized into 25 different symptoms or disorders. The results of this study indicated that adults who are survivors of CSA are more likely to develop mental health difficulties in comparison to non-abused individuals (Hillberg et al., 2011).

Self-mutilation as a coping strategy has also been found to be common amongst CSA victims (Briere & Elliott, 1994). Additionally, positive correlation between bulimic binging and purging and a history of CSA has also been reported (Briere & Elliott, 1994). Results of a quantitative study exploring the relationship between various childhood maltreatment and non-suicidal self-injury by Glassman et. al. (n=73) showed physical neglect, emotional abuse and sexual abuse to be significantly associated with self-harm (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007).

However, the negative health outcomes of CSA are not limited to experiencing psychological and mental health difficulties. CSA has also been linked to increased physical health difficulties. Numerous studies have revealed that CSA can result in immediate physical injuries, including tearing of the hymen, deep lacerations or laxity of the anal sphincter, trauma to the penis and scrotum, as well as long term physical health effects such as chronic bodily pain, obesity, cardiopulmonary issues, and compromised stress response/immune system (Coles et al., 2014; Irish et al., 2010; Johnson, 2004; Leeb et al., 2011; Moody, 1999). Health issues such as sexually transmitted diseases and unwanted pregnancy pose further risks (Houck, Nugent, Lescano, Peters, & Brown, 2010; Leeb et al., 2011).

Irish et al. (2010) conducted a meta-analysis to explore the long-term physical health consequences of CSA. In total, 31 independent studies met the inclusion criteria, comprising six health factors: general health, gastrointestinal (GI) health, gynecologic or reproductive health, pain, cardiopulmonary symptoms, and obesity (Irish et al., 2010). Overall, experiences of CSA were found to have small to moderate group differences on almost all health outcomes, with only GI health and obesity not showing any significant mean group differences (Irish et al., 2010). Similarly, Coles et al. (2014) conducted a study exploring the relationship between CSA and adult violence to mental and physical health of Australian women between the ages of 28-33. The study sample (n=7700) consisted of four groups: women who have experienced no violence; women with a history of CSA; women who have experienced adult violence (AV) including intimate partner violence and adult sexual violence; and women who have a history of CSA and have experienced AV (Coles et al., 2014). Their results indicated that in comparison to

women who have not experienced CSA or adult violence the participants with a history of CSA were significantly more likely to experience increased body pain and poor general health (Coles et al., 2014). Additionally, the study's findings indicate that women who experience CSA alone have higher odds of bodily pain (Coles et al., 2014). A limitation of the study was the exclusion of men.

In addition to the adverse mental and physical health outcomes, CSA may also leads to high risk health behaviours among survivors. Studies have indicated that adolescent and adult survivors of CSA often engage in risky sexual practices with multiple short term partners, resulting in unintended pregnancies as well as the contraction of sexually transmitted diseases (Briere & Elliott, 1994; Houck et al., 2010; Noll, Shenk, & Putnam, 2009). A meta-analysis conducted by Noll et al. (2009) found CSA to be a significant predictor of teen pregnancy, with women who have a history of CSA being two times more likely to become pregnant during adolescence. Similarly, a study conducted by Houck et al. (2010) explored the association between sexual abuse and risky sexual behaviour in boys and girls between the ages of 12-19 placed in alternate and therapeutic school settings. Of the 162 youth, 23% (n=37) reported moderate to severe sexual abuse (Houck et al., 2010). Students with history of sexual abuse reported engaging in sexual activity within the last 90 days (Houck et al., 2010). Additionally, the study found that sexually abused youth reported condom use in only 37% of their sexual encounters in comparison to 67% in the non-abused peer group (Houck et al., 2010).

Furthermore, a study by Chartier, Walker and Naimark (2009) examined the effects of CSA on adult health in 8,116 participants between the ages of 15 and 64 who participated in the Ontario Heath Survey. The study showed an increase in smoking,

alcohol issues and lack of regular exercise among those with a history of CSA (Chartier, Walker, & Naimark, 2009).

Overall, studies show experiences of CSA to be a significant predictor of a multitude of negative health problems in childhood and later life. CSA can lead to physical and psychological health issues as well as negative lifestyle choices. It is important to note however that many of the studies that have examined the health consequences of CSA either have a disproportionately large or only female sample population. Further research on the health impact of CSA on male survivors of CSA is needed.

Effects of CSA in Males

Discourse about sexual abuse in general and CSA in particular has been gendered with the predominant focus being on females. However, while the scientific literature and mainstream conversations seem to suggest that CSA is an issue faced primarily by girls, this perception may be due to the underreporting of CSA by male survivors (Spataro et al., 2001; Tang et al., 2008). Recent high profile media coverage of individuals who used their positions of trust to take advantage of boys have led to increase in public awareness of the issue of male CSA. . This includes individuals such as ex-weatherman Fred Talbot, serving a five-year sentence for assaulting two schoolboys when he was a teacher; Raymond Frolander, an 18 years old man who was caught molesting an 11 years old boy he was babysitting; and Canadian businessman Ernest Fenwick MacIntosh, jailed for molesting a boy in Nepal. Recent media coverage has resulted in an increase in public awareness about the issue of CSA amongst men (Easton et al., 2014; Scrandis & Watt, 2014). However, the amount of research that focuses on sexual abuse among boys as the

population of interest has been disproportionate. Studies that have explored the topic of CSA have primarily focused on females, and research that has included a combined sample population of boys and girls frequently have skewed number of boys included compared to girls.

One of the misconceptions related to sexual abuse in boys is the belief that it is less harmful for boys than for girls (Martin et al., 2004). However, evidence indicates that this notion is false and has been disputed by several studies (Garnefski & Diekstra, 1997; Steever et al., 2001). In a study conducted by Garnefski and Diekstra (1997) a self-reported questionnaire was administered to middle school children between the ages of 12 and 19 (n=1490). Participants included 745 children with a self-reported history of sexual abuse and 745 children without such a history. The study used a self-reported questionnaire to measure emotional problems, aggressive/criminal behaviours, addiction-risk behaviours, and suicidality. The results showed that boys who have been sexually abused had more emotional and behavioural problems including suicidality in comparison to non-abused children and sexually abused girls (Garnefski & Diekstra, 1997). Similarly, a study conducted by Ellerstein and Canavan (as cited in Steever et al., 2001) found that male victims are more likely to experience greater physical harm during their victimization.

Boys and men who have experienced CSA are reluctant to seek out help because of societal beliefs that 'real men' don't get abused or in cases where the boys are abused by older women it may be viewed as sexual initiation (Gartner, 1999). Therefore, although both genders may experience similar levels of physical and psychological harm,

male victims of CSA face additional challenges due to society's preconception of males and male victims of CSA.

Research has shown that male CSA survivors are more likely to engage in high risk sexual behaviours and have trouble forming intimate relationships (Dimock, 1988). A qualitative study conducted by Dimock (1988) explored common characteristics of 25 adult males who had experienced CSA using data collected from case records, clinical observations, and a questionnaire. The results showed that the male participants had frequent and multiple sexual partners and engaged in sexual activity with other men in pornographic book stores and restrooms (Dimock, 1988). Additionally, the study's results indicated that all the men who were in a partnership during the time of the study had difficulty in maintaining a stable relationship or maintaining intimacy in a long-term relationship (Dimock, 1988). Similarly, a quantitative study by Holmes, Foa and Sammel (2005) examined sexual risk behaviours amongst 298 men. The researchers found that CSA was associated with significantly greater number of lifetime sexual partners (LSP) among men with a history of CSA than men without such a history (Holmes, Foa, & Sammel, 2005). Additionally, CSA male survivors with a combination of PTSD or depression had an even higher number of LSP (Holmes et al., 2005).

In addition to the difficulty in forming intimate relationships, research has also indicated that male survivors of CSA often experience confusion over their gender identity and sexual orientation (Alaggia, 2005; Dimock, 1988; Easton et al., 2014; Gartner, 1999; Myers, 1989). In the previously mentioned study by Dimock (1988) six men had sex with males while identifying as being heterosexual, three were unable to cognitively state their sexual preference, three men fit into both of the former categories,

and five men were able to cognitively state their sexual preference and their sexual activity were congruent with their sexual preference but had questions about their sexual preference as a result of the CSA (1988).

CSA may also lead male survivors to have feelings of inadequacy about their masculinity. Dimock (1988) found that male victims of CSA felt they had failed to protect themselves and viewed this failure to be reflective of their "manliness". The study participants considered themselves to be weak and vulnerable following the CSA (Dimock, 1988). When with their peers, the participants expressed feeling like outsiders and having trouble relating to others because of the shame associated with the CSA (Dimock, 1988). Similarly, a clinical study with 14 male CSA survivors by Myers (1989) examined eight problem areas among male CSA survivors: repression, denial, or normalization of the trauma; self-blame and shame; post-traumatic stress disorder; male gender identity fragility; sexual orientation ambiguity and internalized homophobia; sexual difficulties; mis-trustfulness of adult men; and disturbances of self-esteem and body image. 13 of the 14 men reported a history of CSA while one was a victim of adult sexual assault. The results showed that all of the individuals had damage to their subjective sense of masculinity as a result of their experience (Myers, 1989). A more recent qualitative study by Kia-Keating (2005) examined the role of masculinity amongst 16 males with a history of CSA. The findings revealed that males exhibited hyper-masculine traits and characteristics (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005). Additionally, some participants in the study engaged in violent behaviours in an attempt to prove their toughness (Kia-Keating et al., 2005). Despite strong evidence of the negative effects of CSA on boys, there continues to be insufficient research on how to

address male CSA resulting in sexually abused boys becoming a forgotten population. The lack of research on this group leads to a gap in literature as well as a lack of knowledge pertaining to the needs of this aggregate.

Disclosure

According to Alaggia (2004), disclosure can take three forms: accidental, purposeful, and prompted/elicited disclosures. Evidence indicates that, in general, disclosure positively impacts a person's physical and psychological health (Gries et al., 2000). However, research shows that many children withhold disclosing about their sexual abuse (Alaggia, 2004). The consequences of CSA disclosure or non-disclosure are dependent on various factors. Children who do not disclose their abuse to others do not receive the necessary therapeutic intervention potentially leading to immediate and/or long-term mental health issues (Alaggia, 2010; Homma, Wang, Saewyc, & Kishor, 2012; Sorsoli, Kia-Keating, & Grossman, 2008). Disclosure may lead to the abuse being stopped earlier and the victim receiving appropriate help, including counselling as well as social and mental support services (Alaggia, 2010; Kogan, 2005). Children who do not disclose may face the danger of further abuse and re-victimization (Alaggia, 2010; Goodman-Brown et al., 2003; Kogan, 2005; McElvaney et al., 2014).

Studies have shown that supportive reaction to disclosure of CSA plays a key role in improving mental health outcomes in later life and preventing re-victimization (Zlotnik, 2013). A quantitative study by Gries et al. (2000) explored how reaction to disclosure can shape the recovery of CSA victims in a sample of 19 females and 2 males between the ages 6 and 18 in various stages of disclosure from no disclosure to recanting. The results indicated that children who disclosed sexual abuse earlier showed fewer

externalizing behaviours as measured by delinquent and aggressive behaviour (Gries et al., 2000). Additionally, children who fully disclosed without recanting were found to have significantly lower dissociation than children in other stages of disclosure (Gries et al., 2000).

A quantitative study by Kogan (2005) explored the effects of disclosure on adolescent adjustment and re-victimization with 111 adolescents aged 12-17. Presence of PTSD, Major Depressive Disorder, illegal drug use, participation in delinquent acts, or alcohol abuse were characteristics of poor adolescent adjustment (Kogan, 2005). The results indicated that individuals who delayed disclosure experienced two or more of the indicators of poor adolescent adjustment, while prompt disclosure resulted in individuals experiencing none. (Kogan, 2005). The study also showed significantly lower risk of re-victimization when disclosure happened within 30 days of the sexual abuse (Kogan, 2005).

Similarly, a quantitative study conducted by Ruggiero et al. (2004) explored the outcomes of non-disclosure, short-delay disclosure (less than 1 month), and long-delay disclosure (longer than 1 month) of childhood sexual. The study consisted of a nationally representative sample of 3,220 adult women between the ages of 18 and 34 who completed the second wave of a three wave telephone survey in the United States (Ruggiero et al., 2004). The study found women who were part of the long-delay disclosure were more likely to meet the criteria for PTSD symptoms in comparison to the other two groups (Ruggiero et al., 2004).

Considerable delays in disclosure among CSA survivors have been documented, with some children delaying disclosure for years or indefinitely (Alaggia, 2005;

Goodman-Brown et al., 2003; Hébert, Tourigny, Cyr, McDuff, & Joly, 2009; Kogan, 2004; Ullman, 2007). A quantitative study by Priebe and Svedin (2008) examined disclosure in a sample of 4,339 third year high school students in Sweden. The researchers found that 19% of adolescent girls and 31% of adolescent boys did not disclose their abuse (Priebe & Svedin, 2008). In Canada, Hébert, Tourigny, Cyr, McDuff, and Joly (2009) conducted a telephone survey in a sample of 804 adults from Quebec on prevalence and timing of CSA disclosure. The results showed 20% of participants had not disclosed their abuse (Hébert et al., 2009). In addition, only 21.2% of the sample population reported having disclosed within one month of the abusive event while 57.5% delayed disclosing more than 5 years (Hébert et al., 2009). Similarly, a qualitative study conducted by Alaggia (2005) examined disclosure of CSA amongst 30 participants between the ages of 18 and 65. Study results showed that 58% of the sample only disclosed their CSA history in adulthood (Alaggia, 2005).

The high non-disclosure rate has been attributed to numerous factors including: relationship to the perpetrator, shame and fear, inadequate communication skills to report the issue, repression of unpleasant memories, active silencing of victim by perpetrator or others, contact abuse, or duration and frequency (Johnson, 2004; McElvaney et al., 2014; O'Leary & Barber, 2008; Ullman, 2007). In their study, Somer and Szwarcberg (2001) explored the variables of delayed disclosure among 41 adults with a history of CSA. The sample population consisted of 39 women and 2 men with a mean age of awareness of sexual abuse at 15.8 years and disclosure at 22.08 years (Somer & Szwarcberg, 2001). The researchers identified multiple variables related to delayed disclosure including,

namely, belief in the importance of obedience to grown-ups, mistrust of people, fear of social rejection, and fear of the criminal justice system (Somer & Szwarcberg, 2001).

Disclosure in Males

Research indicates both males and females have low disclosure rates and that approximately 60-80% of CSA victims withhold disclosing to others (Alaggia, 2010). However, studies have consistently shown that males are less likely to disclose their sexual abuse experience to others than females (Easton, 2013; O'Leary & Barber, 2008; Ullman & Filipas, 2005). Although previous studies report that one in six boys are sexually abused compared to one in three girls, the low numbers attributed to boys may be due to high non-disclosure rates by males who have been abused (Tang et al., 2008). A qualitative study by O'Leary and Barber (2008) examined gender differences in disclosure of CSA amongst 145 men and 151 women (n=296) through face-to-face and telephone interviews. The study found that only 23% (n=73) of the male population in their sample disclosed their sexual abuse in comparison to the 63.6% (n= 96) of the female victims (O'Leary & Barber, 2008). In addition, results showed that males were significantly less likely to disclose their abuse at the time of the abuse in comparison to females (O'Leary & Barber, 2008).

Compared to the barriers to disclosure faced by women, male victims of CSA also face additional unique barriers to disclosure. The evidence suggests that men are less likely to disclose their sexual abuse in fear of being viewed as homosexual and victims (Alaggia, 2004, 2005; Tang et al., 2008). Abney and Priest (as cited in Tang et al., 2008) indicated that African-American men face a greater burden in disclosing their sexual abuse due to the greater homophobia present within the African-American community.

Along with the internal obstacles faced by males, overt and covert societal attitudes also contribute to the high non-disclosure rate in males (Alaggia, 2010; Ullman & Filipas, 2005). Society's perception of what constitutes as CSA and who may become victims of CSA can further alienate males (Alaggia, 2010). A quantitative study conducted by Ullman and Filipas (2005) examined gender differences in disclosure, social reaction, post-abuse coping and PTSD among 733 college students. The results of the study indicated that men received less positive reaction to their disclosure of CSA in comparison to women (Ullman & Filipas, 2005). Similarly, research has also shown perceived family support to be predictive of negative self-worth and greater depressive symptoms (Stroud, 1999). A study by Stroud (1999) examined familial support as perceived by 66 adult undergraduate students with a history of CSA. The results showed that male victims of CSA received less support from their father, parent, brother and sister and less family protectiveness after disclosure when compared to female victims (Stroud, 1999).

Beliefs that CSA by an older woman is desirable and an initiation into manhood also function to further minimize the experience of male survivors of CSA (Alaggia, 2005; Gartner, 1999). This is particularly problematic as it perpetuates incorrect assumptions about female perpetrators and the effect of female sexual abuse of male children. A quantitative study by Dube et al.(2005) examined the long-term consequences of CSA by the gender of the victim among 17,337 Health Maintenance Organization (HMO) members with 16% of men and 25% of women reporting history of CSA. The results showed that male CSA survivors reported females to be the perpetrator of the

abuse nearly 40% of the time (Dube et al., 2005). Additionally, the negative effects of CSA were similar when comparing the gender of the perpetrators (Dube et al., 2005).

Services and Service Providers

A longitudinal study conducted by Silverman, Reinherz, and Giaconia (1996) explored psychosocial functioning in 375 mid-adolescence children who have experienced childhood physical and sexual abuse. Silverman et al. (1996) stressed the importance of early intervention and prevention as an important aspect of minimizing serious consequences of CSA as well the development of additional psychopathologies in later life (1996). Similarly, a quantitative study by Harrison, Fulkerson, and Beebe (1997) examined multiple substance abuse amongst Minnesota youth with history of physical and sexual abuse (n= 122,824). The conclusions drawn from the study indicated that early prevention and intervention are important in preventing substance abuse amongst youth with experience of physical and sexual abuse (Harrison, Fulkerson, & Beebe, 1997).

It is essential that children with a history of CSA receive appropriate treatment following their abuse. However, a scan of support services in Canada available to males conducted by Fuller and Smith (as cited in Mcdonald & Tijerino, 2013) found only three services dedicated to providing support to male survivors. Tewksbury (as cited in Mcdonald & Tijerino, 2013) noted many of the sexual assault/rape crisis centers may only provide services applicable to women or lack services that address the specific needs of male victims (Mcdonald & Tijerino, 2013).This is particularly troubling as male-centered support services are imperative in the healing process of male survivors (Mcdonald & Tijerino, 2013). A qualitative study by McDonald and Tijerino (2013)

examined the experiences of 59 male CSA survivors between the ages of 26 and 55. Most of the participants in the McDonald and Tijerino (2013) study reported that the services provided by the men's support centers to be the only support they have in coping with the trauma.

In addition to the lack of services available, studies show that assessment for CSA among males by mental health providers may also be lacking or may be unsystematic. Lab, Feigenbaum and De Silva (2000) conducted a secondary analysis to examine the practices and attitudes of mental health providers in the assessment of sexual abuse in male patients. A total of 111 mental health professionals completed a survey with a response rate of 62%. The results of the survey showed that 33% of the staff never inquire about sexual abuse, 49% indicated they ask only a quarter of the time and only 18% reported asking half the time or more (Lab, Feigenbaum, & Silva, 2000). Additionally, 65.3% of the study participants noted that disclosure of sexual abuse will have an impact on their approach to their client's care (Lab et al., 2000).

While studies on perception of service providers of disclosure of CSA among male survivors are lacking, studies on the impact of service providers' perception and response to disclosure of sexual victimization show that support providers play an important role in disclosure and recovery process (Ahrens, 2006). A qualitative study by Ahrens (2006) examined the impact of negative social reactions on the disclosure of rape among 8 female rape survivors. The results of this study indicated that when professional service providers doubt the disclosure or hold the survivor responsible for the rape, survivors will not only question the effectiveness of such services but also hesitate disclosing further or reaching out for help from anyone (Ahrens, 2006).

Survivors of CSA may have difficulty disclosing their abuse due to trust issues. Therefore, it is imperative that the service providers be aware of the barriers and facilitators of disclosure in order to offer appropriate services. A study by Teram, Schachter, and Stalker (1999) examined CSA survivor's interaction with physiotherapists. The sample population consisted of twenty-seven female survivors of CSA between the ages of 19- 62. The results show that awareness of the issues surrounding CSA can lead to maximizing the benefits of the treatment (Schachter, Stalker, & Teram, 1999).

Limitations of the Current Literature

The literature review reveals that to date there remains a paucity of research on CSA among male survivors. This may be due to underreporting by male CSA survivors, survivors' reluctance to seek medical or mental health services, incorrect assumptions about male CSA, and lack of awareness of male CSA. Although there is evidence indicating gender differences in terms of disclosure, there has been a consistent lack of research on factors concerning disclosure of CSA in males (Sorsoli et al., 2008). Studies that have included boys as part of their sample population tend to have disproportionate ratio of males to females. For example, a grounded theory study conducted by McElvaney, Greene, and Hogan (2014) to explore factors influencing disclosure included only six boys, amounting to only 27% of the study sample. Similarly, in a qualitative study conducted by Schönbucher et al. (2012), which explored disclosure in 23 adolescents, only 11% of the study sample included boys. A qualitative gender analysis study conducted by Alaggia (2005), which investigated the factors promoting and impeding disclosure amongst 30 adult survivors of CSA between the ages of 18 and 65,

included a male sample population of only 33%. Likewise, a quantitative study by Somer

and Szwarcberg (2001) which explored variables of disclosure of CSA in 42 adult

survivors of CSA also reported only 4% of their sample being men.

   The gender disparity present in the literature is problematic in many ways. The

lack of inclusion of males in CSA literature leads to incorrect assumptions about the

prevalence of male CSA survivors. In addition, including only females in CSA studies

that examine symptomology of CSA leads to a misconception about the generalizability

of the symptoms. Previous studies note the reported prevalence rate of male CSA is likely

not reflective of the true rate. Rationale for this discrepancy might be lack of a clear

definition about what constitutes as CSA, lack of standardized measures available,

sample types, methodological issues with the studies, as well as a delay in disclosure by

male CSA survivors. Similarly, many studies that look at effects of long term physical,

emotional and psychological effects of CSA also focus primarily on female population.

This is problematic since studies have found significant gender differences and as such

studies that lack an adequate male sample population cannot be generalized. While

studies have consistently shown that CSA is highly prevalent among females, with 1 in 3

females being at risk of CSA, prevalence studies on male CSA survivors indicate that the

prevalence rate of boys at risk of CSA may be much higher than what findings suggest

(Tang et al., 2008). High rates of non-disclosure amongst males have served to minimize

the actual prevalence rate of CSA among men. Studies that have explored disclosure of

CSA have also found significant gender differences in disclosure rates (Alaggia, 2005;

Hanson et al., 2003; Tang et al., 2008). Disclosure is an important part of accessing

health services. Men who do not disclose their sexual abuse history may not get proper

diagnosis or treatment for their sexual abuse. Research shows early intervention and prevention to be imperative in minimizing negative mental health issues in victims of CSA. However, there has been a distinct lack of literature on the topic of CSA leading to a gap in knowledge about the needs of this cohort and their experience of CSA and its impact on their health and quality of life.

Since service providers play an imperative role in the healing process, service providers are an important cohort to study. However, studies examining the perception and awareness of service providers who work with male CSA survivors are lacking. Therefore, studies that explore the perception of facilitators and barriers to disclosure of the workers who provider support to men are important in educating the service providers and informing the practice and policies of services that are available to men.

With the high nondisclosure rate amongst men and the lack of research on CSA in males, there is a false assumption about the true prevalence and the necessity for services that address the needs of men amongst the general public as well as policy and decision makers. Through the research on factors that facilitate and impede disclosure rates in men, I hope to highlight that "myths continue to permeate society and 'exacerbate the difficulties men have in disclosing the experience of sexual assault and increase their stigma while hindering the development of appropriate services and empirical research'" (Mcdonald & Tijerino, 2013, p. 7). In the following chapter, I provide a description of the qualitative methodology that guided my methods for completing my research study.

Chapter 3 Methodology

While quantitative and qualitative research both have their strengths and weaknesses, the purpose of each research methodology is inherently different. Al-Busaidi (2008) notes while quantitative research is preoccupied with trends and frequencies, qualitative research aims to report the lived human experience through exploring the meaning and values. As Bryman (1984) notes qualitative methodology strives to see the world through the "eyes of one's subject" (p. 78). Qualitative data provides cultural insights that cannot be captured with quantitative approaches such as structured surveys and experiments (Tracy, 2012). Similarly, Sofaer (1999) notes the capacity for qualitative research to provide rich description of the phenomenon under study. A qualitative approach allows for exploration of phenomena such as emotions, perception, presuppositions and assumptions (Al-Busaidi, 2008). Further, qualitative methodologies are ideal when the goal is to examine how individuals perceive a particular issue (Bricki & Green, 2009).

A qualitative descriptive research design was used to address this study's purpose as I sought to understand the barriers and facilitators regarding disclosure of male CSA from the perspective of service providers. In this chapter, I will describe the philosophical underpinnings for the study, the methodology used to conduct this study, sampling techniques, data collection and analysis and the measures taken to ensure that a rigorous process was followed throughout this study.

Positioning of the Study

The critical theory paradigm

Those who use the paradigm of critical theory view reality as being constructed by the interaction between society and factors including race, class, gender, education, economy, religion, and other social institutions (Asghar, 2013). Critical theorists view reality as being a construct of repeated social interactions rather than an intrinsic set of values. Critical theory "seeks human emancipation to liberate human being from the circumstances that enslave them" (Asghar, 2013, p.3123). The driving force of critical theory explores the inequities present in society and identifies possible solutions (Asghar, 2013). Moreover, the ideology of the critical paradigm is to offer "change in society through a normative thought process" (Asghar, 2013p. 3124). Critical theoretical paradigm is an appropriate choice to inform this particular study. The study seeks to uncover and understand the barriers and facilitators to disclosure of CSA among men and promote awareness so more male survivors will come forward to voice their past experiences without being restricted by sociopolitical values and norms, and further marginalized.

Study Methods

Sampling

Purposive sampling, as well as snowball sampling, were utilized to recruit participants for this study. Purposive sampling, according to Patton (1990), allows the researcher to select "information-rich cases", defined as participants from whom "one can learn a great deal about issues of central importance to the purpose of the research"

(p.169). Purposive sampling was used to ensure participants recruited for the study had the knowledge and experience of the phenomena of interest to provide rich data (Patton, 1990). Since the purpose of the study was to examine the attitudes and perceptions of service providers who work with male CSA survivors, only such participants were sought out and recruited for the study.

Snowball sampling is a method in which participants are asked to refer other individuals who meet the study criteria (Streeton, Cooke, & Campbell, 2004). Biernaki and Waldorf (1981) note snowball sampling is ideal in cases where the sensitivity of the topic may result in challenges to locate and contact potential participants (Streeton et al., 2004). Snowball sampling was extremely effective in recruiting service providers who had their own private practices due to the fact that many do not promote their practices widely and therefore have low visibility.

Inclusion criteria for the participants included: (1) a minimum of five years of providing counselling service to male victims of CSA; and (2) fluency in the English language. The rationale for the inclusion criteria of five years of work experience with male survivors was to ensure service providers have sufficient experience working in the field to be able to provide in-depth information about disclosure among male survivors of CSA. The reason for fluent comprehension of the English language was to receive informed consent as well as to ensure the participants understand the interview questions and are able to answer in a comprehensive manner.

Recruitment

Service providers were recruited from multiple organizations in order to increase the credibility of the study (Shenton, 2004) by facilitating site triangulation of data

sources(Patton, 1990). Recruitment and data collection took place over an eight-month

period beginning in fall of 2015 and ending in spring of 2016. Email addresses of

directors or managers of organizations that offered services for male CSA survivors were

obtained through the organizations' websites. Directors or managers of several

organizations in South and Central Ontario that offered services in relevant areas such as

children's mental health, child abuse, and survivors of abuse were either sent a

recruitment email (see Appendix A) or contacted by phone to inform them about the

study and ask for their support in recruitment. The recruitment email contained brief

information about the study and the researcher's contact information. The directors or

managers were requested to circulate the recruitment email to the staff within their

agency. A follow-up email (see Appendix B) was sent out two weeks after initial contact

to remind them about the study. All individuals were requested to forward the recruitment

email to anyone who might be interested in participating in the study. Interested

individuals contacted me directly by email or phone at which time I determined their

eligibility, explained the nature of the study in more detail, and answered any of their

questions. If they were interested in participating, I scheduled an interview date, time and

location that was convenient for the participant. Participants were sent an email reminder

one day prior to the interview to confirm and remind the participants of the upcoming

interview. Written informed consent (see Appendix C) was obtained from each

participant at the time of the interview.

According to Guest, Bunce and Johnson (2006), reaching data saturation is

considered the gold standard for determining the final sample size in qualitative research.

Morse (1995) defines data saturation as "collecting data until no new information is

obtained" (p. 147). Data saturation was determined by the researcher as the point at which no new information was emerging from the interviews and the themes that have emerged are well supported by the data (Zhang & Wildemuth, 2005). I determined data saturation after 11 participants had been recruited, and at that time ceased data collection . The final study sample consisted of 11 individuals recruited from diverse organizations providing mental health and counselling services to male CSA survivors.

Data collection strategies

Data was collected through semi-structured face-to-face in-depth interviews with each service provider on one occasion. Semi-structured interviews were considered ideal for this research study as they allow researchers to explore a topic in a manner that provides flexibility for participants and researchers to deviate from the initial interview questions while still providing guidelines on areas to be covered (Gill, Stewart, Treasure, & Chadwick, 2008). Interviews also provide a means to obtain in-depth understanding of the phenomenon of interest and are a useful method of data collection when exploring sensitive topics (Gill et al., 2008). The interview process involved an interview guide with open-ended questions and prompts were used where appropriate (see Appendix D). Open ended questions have been shown to be effective as they maximize the amount of information obtained during interviews (Hershkowitz, 2001). The interviews were conducted as a dialogue to assist the participants to discuss freely and share their experiences with the researcher. By using a conversational style, rich information about each participant's experience working with male survivors of CSA was obtained.

The majority of the interviews took place at the service provider's place of work and lasted approximately one hour. The interviews began once the service provider had

read the letter of information and signed the consent form. Each interview involved an in-depth exploration of the service provider's perception, attitude, and experiences regarding disclosure in male CSA survivors. The researcher asked participants questions that explored issues male CSA survivors deal with, societal attitudes of male CSA and male CSA disclosure, barriers and facilitators to disclosure, and services for male CSA survivors. Prompts, such as "can you expand on that a little more?" were used to further explore participants' answers and to clarify any aspect of their responses.

All the interviews were digitally audio-taped with the permission of the participant. Audio taping the interview allowed the researcher to be more attentive during the interview rather than being focused on taking notes. Additionally, audio recordings were instrumental during the transcribing process as they allowed the researcher to revisit the interview multiple times and to check for the accuracy of the transcripts. The audio recorded interviews were transcribed verbatim by the researcher.

Data Analysis

Thematic analysis as described by Braun and Clarke (2006) was the method used for data analysis. Thematic analysis is "a method for identifying, analyzing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.79). Thematic analysis is ideal for research that aims to explore participants' experiences, views, or perceptions (Braun & Clarke, 2006). Additionally, thematic analysis can be used with any type of qualitative data resulting from a researcher's interaction with a participant to provide rich description of the data set (Braun & Clarke, 2014). Data analysis followed the six steps of thematic analysis as outlined by Braun and Clarke's systematic guideline for identifying themes or

patterns in qualitative data (2006). Data analysis took place concurrently with data collection.

The transcripts were initially read through while listening to their audiotape to ensure completeness and accuracy. R *package* for Qualitative Data Analysis (RQDA) was used to manage the data set throughout the analysis process. The transcripts were imported into the RQDA to facilitate analysis. RQDA was an effective tool for organizing the textual data as it allowed data extracts to be tagged as single or multiple codes and automatically collated them into the appropriate code and category.

Phase one of thematic analysis consisted of the researcher familiarizing himself with the data through reading and re-reading of the transcripts (Braun & Clarke, 2006). Subsequently, each transcript was read through in its entirety once again to obtain a sense of its overall content and patterns of meaning.

The second phase of data analysis consisted of developing initial codes based on the transcripts. Initial coding involved the researcher reading through each transcript line by line and highlighting sections of text representing similar ideas and patterns. Each highlighted text was given a label or code to depict a pattern or meaning. Initial coding continued for each transcript and a 'master' code list was created in RQDA. The initial codes were re-applied to later segments of a transcript and to text of subsequent transcripts. This process of generating codes from the data extracts resulted in 61 initial codes. Each data extract was tagged as either a single code or multiple codes as relevant.

Once initial coding had been completed, phase three of the data analysis was undertaken. This phase consisted of examining the initial codes to identify significant broader patterns of meaning. Each code was examined to identify overarching themes

which were then grouped together into one or more themes while large and complex codes were developed as independent themes (Braun & Clarke, 2006). A code was determined to be large and complex when multiple instances of the code appeared in a single interview and multiple interviews contained the code, as well as when the code consisted of ideas that could not be broken into smaller parts without losing the context. For example, the theme 'Masculinity' consisted of ideas such as social attitudes about men and male sexuality, initiation into sex by older women, cultural expectations of men, and aggression.

Phase four consisted of reviewing and refining the themes. Data extracts within each theme were reviewed and their coherency was critically examined. This process consisted of examining each code individually and determining how often the codes were repeated across the transcripts. Codes that consisted of data extracts from no more than a single interview were considered to have inadequate data. In some cases, the codes were subsumed into other themes or abandoned because they were not considered part of emerging pattern while some thematic categories were collapsed into larger themes (Braun & Clarke, 2006). Data extracts were discarded from analysis in cases where the data did not fit into any of the themes and was not prevalent enough across the interviews to warrant a creation of a new theme (Braun & Clarke, 2006). Secondly, the transcripts were revisited and identified themes were checked against the transcripts to determine that the themes emerging from the analysis accurately represented the interviews (Braun & Clarke, 2006). This was done through re-reading a sample of interviews and examining whether the themes stay true to what the participants said.

Phase five consisted of further refining the themes and defining each theme. Four larger overarching themes emerged at this phase. Each theme was examined further and a detailed description of each theme was written. Each theme was also explored for any sub-themes that may be contained within. At the end of phase five, each theme was given a name and a concrete definition.

The final report consisted of data that was representative of the participants' experience while keeping the research questions in mind. The themes and codes that emerged through data collection and analysis were presented in a coherent and concise way. Descriptions of the theme that were written at the previous step were expanded upon and quotes that presented vivid examples of each theme and sub-themes were selected for use in describing the results (Braun & Clarke, 2006).

Establishing trustworthiness

Guba and Lincoln's (1985) four constructs- credibility, transferability, dependability and confirmability - were used to establish trustworthiness.

Credibility. Credibility refers to whether the results from the study provide plausible and accurate description of the phenomenon under study (Lincoln & Guba, 1985). Credibility was established through prolonged engagement, member checking, as well as site triangulation (Lincoln & Guba, 1985; Shenton, 2004). Prolonged engagement according to Lincoln and Guba (1985) involves "learning the culture" and building trust. My background which consists of clinical work in the mental health and social services field provided me with a unique opportunity to work first-hand with service providers as well as children and adults who have experienced CSA. Developing trust involved ensuring that the interviews were all held in a place that was safe and private. Most

participants met the researcher in their workplace, an environment that they were comfortable and familiar with. In addition, participant honesty was ensured through informing the participants of the independent nature of the researcher as well as their right to withdraw from the study at any point. Additionally, the process of site triangulation contributed to the study's credibility. Site triangulation refers to using participants from several organizations as a way to reduce the effect of particular local factors peculiar to one institution having a large effect on the study (Shenton, 2004). Member checking is the process of checking with the participants on the accuracy of the interpretation and conclusion (Lincoln & Guba, 1985). For the purposes of the current study member checking was an informal process which involved paraphrasing the participant's responses and asking participants for clarification during the interviews to avoid their responses being misinterpreted. Additionally, participants were asked to comment on responses provided by previous participants (Lincoln & Guba, 1985).

　　　　Transferability. Transferability refers to providing sufficient information to make it possible for the reader to make inferences about the fittingness of study findings to other similar situations or contexts (Lincoln & Guba, 1985). In order for transferability to be established, it is important for the researcher to provide a "thick description" or highly detailed description of the study so that the readers have sufficient information to make the inference (Lincoln & Guba, 1985). Shenton notes that information such as the number of organizations taking part in the study, the number of participants involved, the data collection methods that were employed, the number and length of the data collection sessions, and the time period over which the data was collected will all provide the reader with sufficient information so an attempt at transferability can be made (2004). Thick

detailed description of the sample entailed describing the relevant demographic

characteristics of the participants, which included their employment and educational

background without compromising anonymity (Ponterotto, 2006). Factors such as

location of the interviews, length of the interviews, and the interviewee's reaction to the

interview were also included (Ponterotto, 2006). Additionally, the results section includes

direct quotes from the participant in an attempt to provide rich descriptions of

participants experiences (Ponterotto, 2006).

      Dependability. Dependability provides the reader with the decision making

processes employed in the study so that future researchers can replicate the study

(Lincoln & Guba, 1985). A technique proposed by Guba and Lincoln (1985) to increase

dependability is the inquiry audit. This process involves the researcher accounting for all

research decisions regarding the data, findings, and interpretations. Attempt at

establishing dependability involved providing a highly detailed report of the research

design as well as the methods used for data collection and data analysis in the

methodology section of the thesis. The data collection and analysis were critically

examined by the thesis supervisor and the advisory committee members.

      Confirmability. Confirmability is the process in which steps are taken to ensure

that the findings presented in the study are as objective as possible (Shenton, 2004).

Objectivity is important as it ensures that the results are reflective of the participants'

experiences and not influenced by the researcher's bias. Confirmability was achieved

through reporting the researcher's values and biases as well as acknowledging any

weakness of the chosen methods and study procedures (Shenton, 2004). This was done

through the self-reflexive piece in the introduction chapter of the thesis as well as the

reporting of the limitations and weaknesses of the study in the discussion section of the thesis. In addition, reflexivity is an important aspect of any qualitative research. Reflexivity was maintained through reflective journaling during the data collection and research process where the researcher wrote down thoughts and questions that emerged throughout the study.

Ethics

Ethics approval was obtained through the Health Sciences Research Ethics Board (HSREB) at Western University prior to commencement of the study. The research study followed the three core principals of research ethics: *respect for persons*; *concern for their welfare*; and *justice*. Respect for persons "recognizes the intrinsic value of human beings and the respect and consideration that they are due."(NSERC, CIHR, & SSHRC, 2014). Respect for persons therefore included viewing each participant as a partner in the research project, respecting the autonomy of the participants and protecting those with diminished, impaired or developing autonomy (NSERC et al., 2014). By informing the participants of the purpose of the research as well as the risks and benefits associated with the study, participants were able to make an informed decision about participation in the study and to maintain autonomy. Before the interview began, the study's letter of information (see Appendix C) was discussed and any additional questions the participants had were answered. All participants were informed of the voluntary nature of the study and the option to refuse to participate or withdraw from the study, at any time, without penalty.

Concern for the participants' welfare was ascertained through procedures that ensured minimal physical and mental harm. The original proposal attempted to obtain

firsthand knowledge of the barriers and facilitators to disclosure by interviewing CSA survivors themselves. However, the ethics review board raised concerns regarding a high potential for such interviews to trigger or re-traumatize the male CSA survivors. Considering the potential mental harm such an interview process might have on the healing process and that the primary researcher's limited skill to deal with potential for re-traumatization, it was decided to explore these topics from the service providers' perspective. However, efforts were taken to minimize potentially triggering the service providers who participated in the study. Triggering is a process in which an individual recalls a previous traumatic event and result in psychological or physical distress in the individual (Sexual Assault Centre, 2016). Due to the sensitive nature of the study and the possibility of triggering the participants, close attention was paid to any sign of distress during the interview process. Additionally, each participant was provided with a resource package which included pamphlets on coping, and information about community resources such as counselling services. Counselling services included Toronto Health Unit, Family Services Toronto, Toronto Central Health Line, and mental health crisis lines.

CIHR Best Practices for Protecting Privacy in Health Research was used to ensure the participant's privacy (Canadian Institutes of Health Research Privacy Advisory Committee, 2005). To protect the participant's identity, only relevant personal identifiers were collected and all data was encrypted. Relevant personal identifiers included full name, telephone number, email, and date of birth. The personal identifiers were used for contacting and interview scheduling purposes as well as to ensure that participants meet inclusion criteria. Following completion of the interview process, all

personal identifiers were de-identified. Each transcript was read through and any mention of an individual's name or name of an organization was removed. The data collected for the study were stored on Western University hard drives as well as on a memory stick and all data were encrypted. The consent forms and data were stored separately in secured locked cabinets at an office located at Western University. The data was only accessible to the core members of the research team which included the researcher, thesis supervisor, and the members of the advisory committee. Audio recordings were erased once the interviews had been transcribed and checked for accuracy and consistency.

Summary

Qualitative methodology is an ideal approach to utilize when the study aims to understand the human experiences. Qualitative methodology is appropriate for current study as it asks 'how?' and 'what?' questions. Additionally, qualitative methodology allows for rich description of a complex and sensitive issue from the perspective of mental health providers. Due to the sensitive nature of the research topic, a quantitative approach which aims to quantify data would not be appropriate. The aim of the methods used in this study was to understand service providers' perspective of disclosure among male survivors of CSA. Purposive and snowball sampling methods were utilized in order to recruit service providers that had adequate knowledge of the phenomenon under study and are able to provide detailed description in response to researcher's questions. Eleven service providers took part in face to face semi-structured interviews that lasted approximately one hour.

Qualitative thematic analysis was used to reveal the barriers and facilitators to disclosure of male CSA as well as to identify gaps present in the services that are

available to male CSA survivors from the perspective of health service providers. The

data analysis included transcribing, open coding of text categorizing and development of

final themes. Throughout the data collection and analysis, emphasis was placed on

ensuing that the study met the ethical standards for research. The following chapter

describes the findings from the study followed by a chapter discussing the study findings.

Chapter 4 Findings

The purpose of this study was to explore the barriers and facilitators to self-disclosure of male survivors of child sexual abuse (CSA) from the perspective of health service providers and to identify gaps in services. This chapter details the findings that emerged throughout the data collection and data analysis process. The chapter begins with the description of the study participants followed by the main themes and sub-themes that describe service providers' perception of the facilitators and barriers to disclosure of male CSA and services for male CSA survivors.

Participant Demographics

A total of 11 service providers participated in this study. The service providers were from eight different organizations or agencies that provide services to male CSA survivors in two cities located in southern Ontario. To protect the participants' identities, the names as well as the organizations in which they were employed or volunteered have been kept confidential. Each participant was provided with arbitrary initials which are used for cited comments. Each participant had on average five years of experience working with male CSA survivors. The participants included Trauma Coaches, Registered Social Workers, Registered Psychotherapists, and Counsellors. Four participants were male and seven were female. All participants were Caucasian. Seven participants were employed by large agencies, two had their own private practice and the remaining two were employed at an agency in addition to having their own practice.

Barriers and Facilitators to Disclosure of Male CSA

The barriers and facilitators to disclosure of child sexual abuse among male survivors from the perspective of health service providers fell within four primary themes: (a) personal characteristics (b) interpersonal, (c) institutional, and (d) societal. While each theme and their sub-themes are presented as independent elements for the ease of reporting the findings, it is important to note the inter-relationship among each of the themes and sub-themes.

Personal Characteristics.

The theme, personal characteristics, consisted of barriers and facilitators to self-disclosure that are present at the individual level. This theme reflects a person's own personal values regarding male CSA, how they view society, and their place in it. This theme consists of five subthemes: (a) emotions, (b) denial, (c) sexual orientation, (d) acknowledgement, and (e) inner strength.

Emotions. The service providers described male survivors of CSA as experiencing numerous emotions which can function as barriers to self-disclosure of sexual abuse. Participants mentioned fear, embarrassment, guilt, and shame as key barriers to disclosure among male CSA survivors.

Fear. Regarding self disclosure, many service providers mentioned that male CSA survivors were fearful of further violence, of potentially re-triggering the trauma, or of being perceived as different. As one participant noted "they'll say all kinds of things (…) to scare them or threaten or (…) prevent them from telling about the abuse so *um* I think probably fear and is a big reason in children to not disclose." (Participant F. Q.) Another participant speaking about the men's fear of being re-traumatized remarked:

I think it's fear; we touched on it a little bit. when a person is harmed sexually especially a boy they're at a very vulnerable time in their life…to be vulnerable again as an adult is a very difficult thing for a male to do because they go back into that pain, they go back into that weakness. (Participant C. X.)

Additionally, participants suggested that the males may also fear becoming abusers themselves. Some service providers commented that some male survivors of CSA become reluctant to have children due to their fear of possibly continuing this cycle of abuse with their own children.

Guilt. The service providers commented that many male survivors of CSA also feel a deep sense of guilt, shame or self-blame regarding the child sexual abuse. They remarked that due to the men's physiology and the way the male body responds to stimulation men may feel an additional sense of guilt in cases where the abuse "felt good" at the time. One participant mentioned that the men may be left feeling they had wanted it:

They often feel like they somehow they, well, they just feel that they were somehow a part of it somehow complicit. Especially if they reached an erection or they ejaculated they feel like they must have wanted it on some level, so there's a lot of self-blame on that area. (Participant E. W.)

Additionally, service providers mentioned that in cases where the abuse happens over an extended period of time the survivors may feel guilt for not stopping the abuse immediately or seeking help earlier.

Denial. Denial that the sexual abuse ever happened was mentioned as a barrier to disclosure by many of the service providers. Participants expressed that abuse survivors used multiple forms of denial. Some stated that denial may take the form of simple denial in which the survivor may consciously deny the abuse took place and "kind of shove things aside and say this never happened." (Participant K. A.) Participants noted that male CSA survivors may also minimize the event and its impact on their life, not

recognizing the way in which the abuse may contribute to their maladaptive behaviours, such as substance abuse or relationship issues. Regarding minimization as a coping strategy one participant expressed: "They might have an addiction or they might have a mental health issues they're really under aware of and it's really only when things kind of go off the rails that they realize maybe, maybe there's a connection." (Participant I. C.) Participants also mentioned that in some cases the brain may unconsciously be blocking the fact that the abuse occurred as a way to help the male survivor cope. One participant remarked: "I'm not remembering this right. right? so this is a psychological protection you know sometimes the way the brain protects us from trauma right so, so, so, that's, that can, that's a huge barrier." (Participant K. A.)

Sexual Orientation. Service providers mentioned that male survivors of CSA question their sexual orientation which can further hinder self-disclosure. For example, participants commented that in cases of male-on-male sexual abuse the survivor may question his sexual orientation and worry about whether he had unconsciously invited the abuse. One participant stated: "[…] maybe he is gay and he gave messages to that and that's why the perpetrator sought him out." (Participant E. W.). However, this "*confusion*" of sexual orientation may not be limited to heterosexual males who are abused by males. Homosexual males may also have questions surrounding their sexual orientation. In case of homosexual males who have been abused by men, participants mentioned that male survivors may question whether the abuse made them homosexual "[…] if the *uh* person, the victim was gay he may have wondered if that's why he is gay, did that make him gay? *um* if he, so he'll have confusions around that." (Participant E. W.). Participants also mentioned that the males may also have confusion surrounding

their sexual orientation when the abuser is a close relative, such as, a parent or a sibling. One participant expressed that the abuse may also lead to circumstances in which heterosexual male survivors of abuse may "*cruise*" or seek out homosexual encounters in public places.

Acknowledgment. Service providers noted that male CSA survivors not acknowledging their past experience of child sexual abuse may also be a barrier to self-disclosure. Participants remarked that the lack of acknowledgement may take two forms; in some cases, the men are not aware of how prevalent male child sexual abuse is in the general society, and in other cases the men may be unaware of the situation surrounding their own specific abuse. Service providers remarked that men may believe the perpetrator is only abusing them or that their abuse is a unique situation such that they are the only one who has been sexually abused as a child. As one participant stated: "Every single time someone discloses it's big new my phone ring. They say "I thought I was the only one" (Participant E. W.). Conversely, service providers commented that when male survivors of CSA acknowledge that they were abused and not the only one who has had this experience, either as a result of education or through disclosure of CSA by other men, they are more likely to come forward and disclose their own childhood sexual abuse.

Inner strength. Service providers identified that men's inner strength was an important facilitator to disclosure of child sexual abuse. Service providers expressed that disclosing one's personal CSA history to others required a tremendous amount of "*courage*" and "*strength*" due to associated stigma. As one service provider stated: "I think it takes so much courage to and this I specific to men *um* I, definitely for men I

guess that it's a little bit more harder because there's a stigma or perception that you know out there" (Participant J. B.). One participant mentioned that in addition to disclosing the abuse, the men needed courage to seek appropriate service to deal with the aftermath of CSA. The service providers described that while females also experience barriers to disclosure, CSA males face additional stigma and shame and expressed that a tremendous amount of courage is needed for a male survivor to come forward.

Interpersonal

The interpersonal theme consisted of barriers and facilitators related to the male survivor's interaction with family, friends and peers and consists of six sub-themes: (a) social rejection, (b) relationship issues, (c) perpetrator characteristics, (d) becoming a "Hero", (e) "Crisis", and (f) reaction to disclosure by others.

Social Rejection. Service providers noted that male CSA survivors might be afraid of social rejection. The concern about being socially rejected in turn, could hinder the male CSA survivor's disclosure of sexual abuse to others. Concerns of social rejection included (a) negative social repercussion, (b) labelled as a pedophile, and (c) labelled as "gay".

Negative social repercussion. Fear of negative social repercussions was a significant barrier to disclosure for male CSA survivors as described by service providers. The providers mentioned that men are concerned about being fired from their job, being seen as "damaged", not being believed, being blamed for the abuse, being perceived as "less than a man", or being abandoned by their loved ones. Participants noted that the male survivors might feel that by disclosing the abuse their friends, family, or spouses may leave them, or judge them in a negative light. Fear of being abandoned by

their loved ones following disclosure was a consistent response amongst the participants. As one participant voiced: "They think that you know their wife is going to automatically leave them, or their husbands are going to leave them because you're abused, you're a horrible person, or you did some kind of crime, or whatever." (Participant B. Y.).

   Labelled as a pedophile. Service providers indicated that many male survivors were aware of the "vampire myth" or the notion that males who are sexually abused as children will grow up to become abusers themselves. Participants stated that while only a small percentage of CSA survivors go onto becoming abusers themselves this myth is common and serves to further silence survivors and functions as a barrier to disclosure. Participants suggested male survivors of CSA choose not to disclose due to their concern of being judged as potential threat or a predator by those in their social circle. As one participant remarked: "I've encountered that with men who have been abused they are afraid that people will think that they are a pedophile" (Participant D. W.)

   Labelled as "Gay". Another issue that service providers suggested as a barrier to disclosure amongst male CSA survivors was being labelled as "gay" or having their sexuality questioned by others. One service provider talking about a client explained "[…] this man when he was young he grew up with the belief that if your sexually abused that makes you gay […]" (Participant I. C.). Similarly, another participant commented that one of the young clients from a minority ethnicity was worried about whether the abuse means that he is gay and what it would mean to his family if he was labelled as such.

   Relationship Issues. Service providers noted that many men experience negative relationship issues compounded by trust issues following child sexual abuse. According

to service providers, these relationship issues may involve encountering challenges in forming new relationships or maintaining current relationships. Participants mentioned that experiencing child sexual abuse had resulted in many men dissolving their marriages. One participant stated that the abuse may make men to feel vulnerable and thus difficult for them to feel safe in an intimate relationship. Service providers observed that the difficulties encountered by these men to form trusting relationships are not limited to just sexual or romantic relationships; it extends to forming any type of bond whether it be a friendship or even relationship with a health service provider. One participant, who had been abused himself, expressed that he was not able to perform a simple social interaction such as watching a sport with other males and bonding over their shared interest, noting, "Emotionally, well physically, emotionally it disallowed me to have relationships as I stated from the beginning whether they be in intimate level or friendship level not being able to trust anybody." (Participant D. W.) Another service provider stated that these relationship issues can result in feelings of "*isolation*" in which the male survivor feels unable to tell any one that they are "*different*".

Service providers remarked that for many male CSA survivors the relationship issues impact their ability to trust others, especially in cases when the abuser is someone who the survivor had previously respected or who they had trusted, such as a parent, close relative, religious figure, or a coach. One service provider stated that the child sexual abuse may create a lifelong distrust of authority figures, leading to trouble working for others as well as trusting law enforcement officials and even service providers. Conversely, service providers stated that males are more likely to disclose when they feel that they can trust the individual. For example, group therapy was

mentioned as creating an environment in which the males may form trusting relationships with other male CSA survivors and feel comfortable enough to disclose their own abuse. As one service provider remarked: "they are seeing they're are not alone, they are hearing stories and share each other, they become really close. so it creates an ongoing community for, for a trust, a trust that they wish they always probably had" (Participant A. K.)

Perpetrator Characteristics. Characteristics of the perpetrator, such as their gender, relationship to the survivor, social standing, and professional status, were mentioned as additional barriers to self-disclosure. Service providers remarked that there are multiple factors that may lead to non-disclosure in cases where the abuser was related to the victim. The child may feel that by disclosing the abuse they will cause the family unit to fall apart. Additionally, the child may have had previously respected and *looked up* to the family member and may continue to feel that they need to protect the abuser even following the abuse. One participant discussing a specific client explained: "[…] he loved his brother and he really looked up to him and he and I don't know if he was like entirely sure if what was going on between them is okay or not okay" (Participant F. Q.). Additionally, one participant stated that when the abuser is a close relative the child may feel that they are part of the problem, that they had some how invited the sexual abuse leading to further silence.

Participants noted that the abuser's gender may also play a significant role in non-disclosure. Participants mentioned that the general society views females as being incapable of being an abuser. Service providers remarked that society's perception of who can be a perpetrator or victim of CSA may lead to males feeling more reluctant to

come forward in situations where the abuser is a female due to the fear of not being

believed. Furthermore, some service providers stated that there is an additional shame

associated with being abused by a female for a male survivor of child sexual abuse.

Speaking in regards to the disbelief and shame faced by men who are abused by females,

one participant expressed:

> If it's a female that did the abusing they feel like they won't be believed and they often if they don't want to go forward to the police they don't want to make a formal complaint, because they feel like they won't be believed and they will be shame and embarrassed. (Participant E.G.)

The perpetrator's social standing or professional status was also identified by

service providers as a barrier to disclosure. One participant suggested that men who have

been abused by clergymen, coaches or teachers are reluctant to disclose because of the

belief that abuse would not happen in a place of worship or a school. One participant

voiced the reluctance of men of certain ethnic backgrounds to come forward with

allegations of sexual abuse from an imam because of the respect that such a position

entails. This participant remarked; "Muslim men who have been abused with the mosque

by their imam and they couldn't tell anybody and they were saying how this could happen

within the mosque." (Participant E.G.). Similarly, another participant discussing a client

who had been abused by a teacher commented:

> In his culture it was a teacher and teachers were held in the utmost of regard *um* so it was *um* he, he feels so it was, there was, there was supposed to be a respect there so *um* disclosing that was felt, he felt, I think that was a hard thing to do it was too hard to do, *um* I don't think he has disclosed to anyone. (Participant J.B.)

Becoming a "Hero". Participants commented that disclosure by male CSA

survivors encourages and motivates others to come forward and talk about their own

experience of child sexual abuse. One service provider noted that by coming forward

with their abuse the men become a "*hero*" to others who may not be able to speak "that

five or nine year old child that's being hurt right now at the moment" (Participant A. Z.).

Another service provider discussing the impact of disclosure on other male CSA

survivors stated: "I think when men you know raise their hand and acknowledge the

sexual abuse *um* you know gives strength to other men to come forward to maybe pursue

pressing charges or just asking for help." (Participant I. C.)

Service providers indicated that this effect is not limited to initial disclosure but

can also influence their decision in other situations. In group therapy settings, service

providers mentioned that males are more likely to share their experience of abuse

following the disclosure by other males. One participant expressed that when one

individual decides to open up about their own CSA experiences it shows other male CSA

survivors that there are other individuals who they can relate to and people who have

been in similar situation and understand their experience. As one participant remarked:

> So what I do is I disclose about my own abuse and once they see that I am a
> survivor and that that's the beginning of starting trust, and then what usually
> happens ninety percent of the time I won't say hundred percent of the time but
> ninety percent of the time the other participants the male participants will disclose
> just as I have. (Participant D. W.)

"Crisis". Participants in the study mentioned experiencing a crisis acts as a

facilitator for disclosure of male CSA. Participant stated *"crisis"* or critical events or

triggers may prompt individuals to revaluate the impact of the abuse on their lives and

their decision to disclose. Service providers stated that *"crisis"* for male survivors may

take the form of emotional triggering caused by social media's depiction of child sexual

abuse in movies, television shows, newspaper articles or advertisements; negative life

events such as getting fired from a job or losing the house; relationship issues; depressive

symptoms; and disruptive coping mechanisms such as alcohol and substance abuse

issues. Participants noted that, in some instances, male celebrities who come forward

with their own sexual abuse stories can be emotionally triggering for some male

survivors of CSA. Speaking about crisis in the male survivor's lives, one participant

commented:

> […] I've seen men whose lives are actually going pretty well they're able to keep busy and they might be workaholics, but their life is kind of good enough. Its moving along, they're working they have relationships they're kind of coasting just above the threshold but then something happens there's layoffs or they get in a car accident or they have an injury and that sends their lives off the rails (Participant I. C.)

Participants stated that whatever form the *"crisis"* may take once the men realize

that they need help, they start reflecting on the events from their past and realize the

connection between their childhood sexual abuse and their current problems. One

participant noted: "things that are triggering and emotionally distressing to male

survivors and really prompts some distress and really point them towards "whoa maybe

this is Impacting me, maybe I should see services" (Participant I. C.) The service

providers noted that these critical life events and subsequent behaviours can function as

catalyst for disclosure. One participant expressed that following the crisis men may

finally come to terms with the impact of CSA and the way it has shaped their entire lives

and begin to seek help. Commenting on a *crisis* as a catalyst to disclose and seek help,

the participant remarked:

> […] they might have an addiction or they might have a mental health issues they're really under aware of and its really only when things kind of go off the rails that they realize maybe, maybe there's a connection. They seek help and then they begin to see and understand the way its impacted them and that they can change so yeah. (Participant I. C.)

Reaction to disclosure by others. Service providers stated that male survivors

are more likely to make further attempts at self-disclosure when they receive positive

reactions from others following disclosure, such as being believed or receiving

compassion, empathy and emotional support. Conversely service providers commented

that when the disclosure is followed by negative reactions, such as denying or not

believing that the abuse took place, minimizing or dismissing the abuse, and actively

trying to silence the disclosure, males are less likely to attempt further disclosure.

Participants noted that having the experience of child sexual abuse believed by others

plays a key role in whether or not males will attempt further disclosure. One service

provider described the importance of child sexual abuse being believed as:

> […] important thing is that the child is believed *um* so that there's someone
> believing them […] treatment also is very important obviously but I think before
> treatment safety and having someone believe, I think those two things sort of
> should happen before treatment. (Participant F. Q.)

Many service providers also mentioned that, in some cases, the parents of the

male CSA survivors may minimize the situation or actively discourage disclosure for

various reasons, whether it be because the perpetrator is a relative or the parents may fear

being judged or blamed for not protecting the child. In such cases, the parents were

described as either trying to silence the child or encouraging the victim not to get help.

One participant stated:

> Some family members will say you know don't talk about this, don't go forward
> don't put it in the newspapers you know parents may feel especially mothers that
> they didn't protect their child and they'll be blamed so there's a lot of, they're not
> encouraged, the victim is not encouraged to get the help they he needs because the
> family members will feel like somehow they did something (Participant E. W.).

Participants stressed the need to promote a safe environment in which the males

feel comfortable enough to discuss their CSA history. The service providers expressed

that creating a safe place may facilitate further disclosure among male survivors. One

service provider remarked that being empathetic to what the survivor has gone through

opens the lines of communication and promotes a relationship in which the male survivor

feels safe. One participant discussing the impact of positive reaction to disclosure expressed:

> Being supportive and not being judgmental about anything that the man says in the disclosure […] make sure the environment they are saying it in feels safe to them, feels welcoming to them, […] we don't make statements like "oh, that was like 30 years ago, don't you think it's time to get over it." Because that is again a reinforcer of let's not talk about that, you know. No matter what it is they can say it in this space because it is safe to do so. (Participant B. Y.)

Institutional

The institutional theme consisted of barriers and facilitators related to funding and situations created by organizations that may facilitate or hinder disclosure by male CSA. Institutional theme consisted of three sub-themes (a) services, (b) barriers to accessibility, and (c) education.

Services. Health services that offer support to male CSA survivors were mentioned as playing a key role in facilitating or hindering disclosure. Participants remarked there are limited health programs available to male CSA survivors and a lack of awareness among service providers and the general public about specific programs that are available.

Lack of programs. Service providers stated that there is a lack of adequate support services available to male CSA survivors. One participant noted that in some smaller communities there is no services available for men who have experienced male CSA. Another service provider speaking about the current services available to men stated:

> There's lack of, there's a lack of, there's far from being enough support. Toronto, Calgary, Ottawa, Montreal our Vancouver our big centers that I'm aware of that there's any kind of centers, and its grossly inadequate. I think Toronto probably has the most out of all of them but they're all grossly inadequate. (Participant D. W.)

Additionally, service providers expressed the need for adequate programs available in each type of counselling modality. For example, participants stated that individual counselling, group counselling, and gender-specific services each cater to different individuals during different stages of the healing process. Speaking about the services that offer options in terms of counselling modalities one participant remarked: "group services and group based services are very powerful very effective they're more cost effective and they're very healing in a very different way than individual services *uh* they complement each other" (Participant G. E.).

Service providers also remarked that some men may feel more comfortable accessing gender specific services similar to abuse centres that only cater to females, especially in cases where the perpetrator of the CSA was a female. However, many participants stated that only a few larger communities offer male specific programs such as the Men's Project in Ottawa. Additionally, many participants stated there is a lack of committed weekly support group meetings for male survivors of CSA. One participant expressed that a single service provider serves various counties meaning that group sessions may only be hosted in one county once every couple of weeks.

Lack of awareness about programs. Service providers commented that when counselling programs are available there is a lack of awareness amongst male CSA survivors and even amongst service providers about them. Many service providers stated that the lack of inter-agency communication prevents collaboration and referrals. The service providers commented that many services are not adequately promoted in the community. the lack of awareness about programs may lead to men not accessing services that are in their community as well as service providers not being able to provide

referrals to services. Additionally, some participants mentioned there is a lack of a cohesive network that service providers and male CSA survivors can access to find services that meet the needs of these men. Participants mentioned services such as 211, which provides information and referrals to community and social services, do not adequately meet the needs of male survivors because either they are not aware of the services for male CSA or they do not promote privately run services. One service provider speaking about her agency expressed: "we are accessed for free and easily by the community but I don't know that everyone knows about us." (Participant F. Q.).

Barriers to Accessibility. Participants mentioned numerous barriers in accessing needed services including (a) physical, (b) communication, (c) systemic and (d) attitudes. These four barriers prevent males from accessing services available to them.

Physical. Physical barriers can be defined as environmental features that impede access to services. Service providers stated that many male survivors have to travel long distances to access needed services due to the lack of programs available in their local communities. One participant mentioned that services are only offered in one place in many of the surrounding counties and when the counties are large geographically men might be required to travel a large distance to access this service dependent on where they live. This issue of access to services is compounded when the individual has a disability related to mobility or has limited funding for transportation as described by one participant:

> I've had men on disability who tried we tried to advocate with disability to try provide some money for transportation *um* and because were not we don't have a psychologist or a psychiatrists associated with our program cause were a community based service they only have funds for programs where there's a psychologist or psychiatrist signing off on treatment *um* so that's been a barrier (Participant I. C.)

Communication. The participants mentioned a large number of males with a history CSA do not access services because of language barriers. Specifically, service providers stated that individuals whose first language is not English may have a hard time accessing service or disclosing their CSA experience. Participants mentioned that interpreters may offer help but that their help is limited when dealing with a sensitive issue such as sexual abuse. As one participant voiced: "[…] if their first language isn't English…what we'll do is hire an interpreter. That can be kind of difficult when you're talking about something so sensitive […]" (Participant F. Q.).

Additionally, language barriers were not limited to those individuals who are not fluent in English. Service providers noted that many organizations do not accommodate individuals who have disabilities related to communication. One service provider noted that individuals with trouble reading smaller fonts, or an individual who has auditory issue, or an individual with dyslexia have special needs that many organizations do not try to accommodate. Participants commented that, in many cases, organizations are not capable of adapting to meet the special needs of these males who have communication related disabilities.

Systemic. Systemic barriers are the result of an organization's policies, protocols and practices that restrict certain individuals from accessing the services. Specific to male CSA survivors accessing services, waitlists, verification of disclosure, requiring a referral, and fee for service were mentioned as systemic barriers to access to care.

Service providers expressed that many male survivors of CSA are placed on a long waiting list before they are able to access health services and treatment. Participants mentioned that programs are often full and new clients need to wait for a spot to become

vacant, or in some cases (e.g., group therapy sessions) a certain number of males must sign up for a session before a new group is created. Additionally, the lack of qualified staff to provide the counselling services to current male clients was identified as contributing to new clients being placed on a waitlist. As one participant described: "That's another barrier having these waiting lists because people are waiting for *uh* another maybe staff position to open up for whatever reason." (Participant B.Y.) One participant stated that men may be put on a waitlist for as long as six months in some cases.

Being referred to treatment was also mentioned as impacting male survivors' access to services. Many organizations require that the males receive a referral from a family physician or from a child welfare agency before they provide treatment. One participant indicated that having a formal referral process that requires paperwork from a family physician creates additional frustrations that prevent males from seeking help. Another participant expressed:

> we don't have a formal referral process, sometimes that can, that can even be a hindrance. If somebody has to call into an agency to then be told 'oh, your doctor has to fax us some form' they have to go to the doctor. (Participant B.Y.)

Additionally, participants expressed that many first responders, whether it is a law enforcement officer or a family physician, may not be knowledgeable about the impact that child sexual abuse. Service providers noted this may result in CSA not receiving a referral to services that can help with the impact of the abuse.

Participants commented that organizations that deal with abuse victims may also have a policy of not serving male CSA survivors. One participant noted that one of his clients had reached out to a crisis hotline that deals with abuse only to be told that they do not serve males.

Service fees can also create an additional barrier to accessing treatment and health services. One service provider commented that many of the adult mental health and adult counselling services are offered on a fee-for-service basis. Similarly, one service provider expressed:

> You know I'm a private practitioner, I'm not a non-profit, I am but not by design, *um* so, some men can't afford to see people like me. They can go to the gatehouse that's free buts that a limited, it's a very limited 12, 15 weeks, so it costs, it costs money. OHIP doesn't cover my services, right. OHIP will cover a doctor or psychiatrists who might not have the skills I have, who often don't have the skills I have at this stage in my life (Participant E. W.)

Participants noted that many of the services that are offered for free have a very limited amount of sessions. One participant noted that this may create unrealistic expectations about the healing process.

Attitudes. Attitudinal barriers refer to attitudes or behaviours of providers that are dismissive or patriarchal and can alienate an individual seeking service. Participants mentioned that some service providers may attempt to maintain a power dynamic when establishing a relationship, decreasing the likelihood that the male CSA survivors will feel comfortable enough to disclose. One participant noted that as a service provider being vulnerable themselves allows the male survivors to be vulnerable as well. As one participant remarked: "the more vulnerable you are as a facilitator will allow others to be vulnerable as well cause they'll see that they're not alone and they'll see that somebody understands" (Participant D. W.). However, when the service provider tries to establish a professional distance an unfavourable environment for the healing process is created. As one service provider remarked about the negative effect of the power dynamic: "if I'm sitting above somebody on a pedestal that you know can't relate then why would they

ever want to share with me the stuff that's you know *um* most vulnerable to them."
(Participant K. A.)

Service providers also stated that some mental health providers may be dismissive
of the child sexual abuse. In describing when the male survivors attempt to disclose their
abuse or access service, one participant expressed: "*um*, I've even heard professional
doctors say 'well you know in your best interest to try and forget it and get over with' as
if as if they choose not to be able to get over it." (Participant E. W.). The participant
noted that this dismissive attitude further silences the male CSA survivor and prevents
them from seeking additional service or attempting to disclose. This is because "when a
professional like a doctor says 'it's in your best interest to get over it' they, they feel, they
get silenced. Which keeps them suffering in silence." (Participant E. W.)

Additionally, service providers stressed the importance of providing culturally
sensitive health services. One participant speaking about the importance of ensuring
cultural sensitivity remarked: "it really would be helpful if they were treated within their
ethnic community with someone that understands their ethnicity." (Participant E. W.)
However, service providers noted that many male CSA victims face additional barriers
and stigma in their own communities and may seek out services from individuals outside
of their communities. As one participant mentioned "they've come here because they
don't they're worried about the native community finding out that they are seeking
therapy for whatever it is that they are seeking therapy for." (Participant H. D.)

Education. Education also functions as a barrier or facilitator for disclosure
amongst male CSA survivors. Participants mentioned two key issues with the education:

lack of education for service providers and lack of education for the general public about male child sexual abuse.

  Education for service providers. Many service providers commented on the lack of information available to service providers pertaining to CSA among males in the current formal education programs as well as ongoing professional development. Participants stated that the education offered in graduate or clinical programs for health care and service providers either focus on working with females with a brief overview about the males or do not address the topic of working with the male CSA survivors at all. Service providers indicated that this lack of education results in service providers not having the necessary knowledge and skills to effectively work with male clients. One participant voiced that inadequate formative training not only effects how they offer services to males with CSA history but may also lead to misdiagnosing the symptoms of childhood sexual abuse. As one participant noted regarding the assessment of male survivors of CSA:

> Let's say someone goes for addiction treatment and there's a high correlation between addiction of all different kinds and childhood sexual trauma … so if they go if their presenting issue is not the history of childhood sexual abuse, if that has not been identified as a key issue *uh* they may or may not have their initial encounter with a professional who is got some sensitivity training or experience at responding to that or asking the right questions. (Participant G. E.)

  Similarly, another service provider remarked that insufficient knowledge could result in service providers medicating clients for symptoms of the presenting issue such as PTSD or alcoholism instead of providing treatment for the underlying CSA trauma, which acts as impediment to males receiving the appropriate mental health treatment. Service providers mentioned that this lack of education is not specific to just social workers or mental health workers who work with male CSA survivors. For example, one

participant mentioned there is a lack of training about male child sexual abuse for law enforcement and judicial workers.

Service providers expressed that professional development opportunities and ongoing training on working with male CSA survivors are limited in comparison to training on other topics or training that focus primarily on working with female sexual abuse or assault. Additionally, participants also mentioned workshops or training that are offered have high fees that service providers are required to pay out of pocket for, which serves as a further barrier.

Education for general public. Participants stated that education aimed at raising awareness of male CSA among the general public plays a crucial role in facilitating disclosure among male survivors. Service providers stated that education in any forum whether it be in the school system, in religious settings, or through public service announcements and media coverage all function as facilitators of male CSA survivors' disclosure. Service providers pointed out an increase in clients who seek help following media coverage of child sexual abuse allegations from male celebrities or following movies on sexual abuse among boys. However, many participants expressed the paucity of information about male sexual abuse and its prevalence being provided currently in school systems and community settings, such as religious congregations, as well as to the general public. One participant noted that schools are reluctant to have service providers come into the schools to talk with students and faculty about sensitive topics like child sexual abuse or even topics on safety and boundaries:

> there was some resistant from the school board, particularly catholic school board where and sometime it was the teacher that felt uncomfortable with the topic and that children having this conversation in class or the principle. (Participant F. Q.)

Another participant stressed the importance of educating children about sexual abuse since it can take different forms and may elicit various emotional responses, noting:

> I think there's something that there has to be something in our middle school and our primary schools available to kindergarten up to grade eight on how *um* you can be a voice or educate yourself on what all abuse is cause abuse can feel good and you don't even know that it can come from someone you are supposed to trust. So you really want to be aware and educated on what abuse is and I think the middle schools and primary schools have to have something about it. (Participant A. Z.)

Participants also discussed the reluctance amongst religious communities to educate their congregations on the topic of child sexual abuse. One participant commented on the importance of having an open conversation about the topic of child sexual abuse in general and male child sexual abuse in particular while observing the reluctance that many religious leaders have in doing so. In addition to the importance of having a supportive religious environment, participants also noted the importance of having discussions about sex and sexual health in the family unit as a facilitator to disclosure. According to many service providers, such discussions within the family unit create an environment in which a child will feel comfortable in discussing their sexual abuse. Participants noted that it might be difficult for the child to come forward or disclose about a sexually inappropriate behavior to the parent in families where the topic of sex is not discussed. Additionally, one participant mentioned that having open conversations about sex teaches children the *"basic life skills"* (Participant G. E.) needed to recognize interactions that may be inappropriate.

Societal

The societal theme consisted of barriers and facilitators that are formed by the larger collective group. In comparison to the interpersonal and institutional categories which consisted of variables related to the individual's immediate social group (e.g., family, friends, co-workers and health providers), the societal category consists of values and norms about masculinity, gender, and sexuality created by the broader societal factors that function to facilitate or impede disclosure in male CSA survivors. The sub-themes include: (a) masculinity, (b) attitude around sex and sexual abuse, and (c) funding

Masculinity. Societal norms of what it means to be a man were identified by the study participants as major barriers to disclosure for male survivors of CSA. Service providers indicated that men are socialized to be strong providers, not to be victims, to be able to protect themselves, to not talk about their emotions, to not show vulnerability, and to just deal with abuse and move on. As one participant remarked: "societal attitudes that men are not supposed to be victims. Men are supposed to be able to protect themselves. Man, being a victim and being a man is almost like *uh* a contradiction in terms." (Participant E. W.) Participants noted that these beliefs, attitudes, and norms can make it difficult for men to disclose their sexual abuse. One participant stated that men who disclose their abuse are considered be weak or being less than a man, "*a wimp*" (Participant H. D.) when they come forward about their abuse. They are seen as having allowed the abuse to take place because they either wanted it or invited the abuse by being vulnerable. In some cases, when the abuse occurs the gender identity of the survivor is taken away and this leads to questioning their sense of self, as one participant remarked:

> The expectation is that going back to what I just said there, that to be a man means to be a certain way, which typically means in our and many societies ad cultures around the world that it means to man up and be strong, carry the weight, don't show you emotion or you appear weak, you're to be the stronghold *uh* the pillar of the family so when that is taken away it can feel like the *um* the inner part of the man is being stripped (Participant C. X.)

Service providers remarked that disclosure reinforces the feelings of vulnerability, as one participant noted the males re-live the pain and weakness they felt when they were being abused as child. One participant commented that the male survivor may feel that they are not fulfilling the roles that's set out for them. One service provider commented that male CSA survivors may feel they are letting somebody down – whether it be the society, their family, or their children –by disclosing their most vulnerable moment. Participants noted that men may try to disconnect themselves from the abuse and the feelings of being a victim by behaving more "*macho*" either through overly aggressive or hyper-sexual behaviour. One participant speaking about the hyper-sexuality that stems from CSA expressed:

> […] because we socialize men to like sex and to imagine themselves to be powerful and men are not victims these are a lot of the stereotypes that impact men adversely when there's sexual abuse. They might not feel manly enough so they might become hypersexual, try to have sex with a lot of people as a way of proving that they are manly […] (Participant I. C.)

Additionally, participants mentioned that there is a double standard when it comes to sexual abuse. One participant spoke about media portraying male child sexual abuse as glorious introduction of young boys to sex by older women while the same depiction would be more like to be considered "rape" if media portrays a younger girl and older man. Another participant stated:

> […] young man who was coming out of a bar and three women *um* offered him a ride and then they took him somewhere and sexually abused him, and when he went forward in the newspaper and in, they, everybody laughed at him and said this is every man's dream and how can you complain and that's the case with *uh*

lot of young *uh* lot of men if they are sexually abused by women they will feel that they, they all their friends and family members will say "ooh lucky you". (Participant E. W.)

Another service provider remarked that society tends to minimize or normalize the abuse, ignoring the trauma of CSA experience by boys. Service providers noted that social attitude about female perpetrators and how males should react to abuse by females results in further reluctance by male CSA survivors to disclose their abuse when the abuser is a woman.

Service providers noted that the ethnicity of the males may also play a significant role in perpetuating the idea of the "*man box*" (Participant G. E) - a box in which all emotions should be put and stored away. Participants remarked that males from ethnic minority communities feel additional pressure to live up to the social standards of being a male. Participants commented that many ethnic communities have much more stringent expectations of what it means to be a man and are faced with much more social stigma and social rejection when they do not conform to these social expectations. Service providers noted that some cultures are more likely to glorify the "sexual initiation" of male children by older women and sexual objectification as well as emphasizing male sexual prowess. As one participant noted:

> African American community for example I think *um* in many corners within that community *uh* particularly in some of the underprivileged urban ghetto areas there is *uh* and its not exclusive to them but it is a factor I think there's a much stronger the man box is stronger right? (Participant G. E.)

Attitude around sex and sexual abuse. Stigma around sex and sexual abuse was also mentioned by participants as a barrier to disclosure. One service provider commented that child sexual abuse is not a topic that the general society talks about or thinks about. Specifically, there is a stigma attached to this topic and this stigma is

compounded when the victim of child sexual abuse is a male. Another participant noted

that society has certain beliefs about sex and when an incident, such as CSA, takes place

it disrupts societies' norms and values and therefore considered taboo. One participant

talking about the discomfort felt by individuals when talking about the topic of CSA

commented:

> Boards of trustees in the school system *uh* or, or, Ministry of Education at the
> governmental levels *uh* a lot of them are personally very uncomfortable *uh* or feel
> accountable to constituencies, voters, *uh* members of the community whomever
> they feel accountable to *uh* who are, many of whom are very uncomfortable
> talking about these issues (Participant G. E.)

Another participant expressed that social success is measured by conforming to

traditional views of sexuality. "You're supposed to be a man, a woman, have children,

have two and a half kids, a dog and a white picket fence this is the idea of success"

(Participant C. X.). Participants remarked that any event, such as child sexual abuse, that

disrupts the social measures of success is stigmatized. The service providers mentioned

that many men feel reluctant to come forward in cases where the abuser is a male due to

society's negative attitude around homosexuality and homosexual relationships.

Additionally, society's response to sexual abuse allegations was also considered to be an

impediment to disclosure by participants. One participant suggested that sexual crimes

often define the victim is the one to be blamed for the abuse, noting that when a victim

comes forward society tends to respond with an attitude of "how could you let this

happen" (Participant H. D.). Additionally, service providers remarked that in cases when

the sexual abuse takes place over a prolonged time frame the victim is blamed for not

disclosing sooner.

Funding. The lack of adequate funding for services that cater to the needs of male

CSA survivors was a major issue highlighted by many of the participants. The service

providers noted that there is a significant lack of focus on male survivors of CSA when it comes to funding at all governmental levels. Participants mentioned that the Canadian government is less likely to fund programs and organizations that offer services to male CSA survivors. One participant stated that while funding for sexual abuse is limited for both females and males, the government is more likely to pay for '*crisis*' health care rather than chronic health care, and male CSA programs are far less likely to be funded than programs that service female CSA survivors. One participant noted:

> […] The Ministry of Health here in Ontario provides funding for therapeutic agencies in the communities to provide services to women who are sexually abused as children but I understand when that decision was made the decision was made to exclude men from that service […] (Participant I. C.)

Summary

The findings illustrate various barriers and facilitators that impact disclosure and function on four levels: (a) personal, (b) interpersonal, (c) institutional, and (d) societal. Multiple factors were identified as influencing the male survivors' decision to disclose about child sexual abuse, preventing or precipitating the disclosure dependent on each individual's context. The participants identified more barriers than facilitators, indicative of the various constraints faced by male CSA survivors. While some of the barriers for disclosure mentioned are common to all child sexual abuse survivors regardless of gender, the participants described additional complexities and unique barriers that male child sexual abuse victims deal with in comparison to female survivors. The following chapter will discuss the study's findings in relation to previous research on male child sexual abuse as well as outline implications for practice and areas of future research.

Chapter 5 Discussion

Findings from this study indicated that male child sexual abuse (CSA) survivors'

decision to disclose their abuse history is influenced by complex set of factors. Thematic

analysis was conducted and four themes - personal, interpersonal, institutional and

societal - were identified that describe the facilitators and barriers to self disclosure

among male survivors of CSA. In this chapter, I will discuss the study's findings and

outline implications for health providers offering services to male CSA survivors,

educators in the school system, policy makers in addressing issues regarding male CSA,

and future research on this topic. I will also offer recommendations to promote disclosure

of CSA in male survivors. Strengths and limitations of the study will also be discussed.

Facilitators and Barriers to Disclosure

The male survivor's decision to disclose CSA is highly complex, influenced by

multiple barriers and facilitators that exist on four different yet interrelated levels. The

barriers and facilitators to self-disclosure identified by the service providers are

congruent with those reported by male CSA survivors in other studies (Alaggia, 2005;

Easton et al., 2014; Schonbucher, Maier, Mohler-Kuo, Schnyder, & Landolt, 2012;

Sorsoli et al., 2008). The revelation that our findings were very similar to previous

research on male CSA survivors is encouraging and indicates that there is a high level of

awareness or insight present among service providers about the barriers and facilitators

that impact self-disclosure among male CSA survivors. Health providers' astute

awareness of these factors may have been precipitated through their experience working

with male CSA survivors. In addition, service providers were acutely aware of the service gaps present in the community to help meet the needs of male CSA survivors.

At the personal level, barriers for disclosure included emotions, denial, questions about sexual orientation and lack of acknowledgement while facilitators included acknowledging male CSA as an issue and inner strength. Our findings suggest emotion played a major role in male CSA survivors' decision to disclose their CSA. The list of emotions mentioned by service providers as being a factor in disclosure included fear, shame, guilt, self-blame. The results from the current study confirm what has been reported in previous research that has examined disclosure amongst male CSA survivors (Finkel, 2012; McElvaney et al., 2014; Sorsoli et al., 2008). For example, a study by McElvaney et al., (2014) which examined informal disclosure amongst 22 youths and 14 parents through semi-structured interviews found shame and fear to be major barriers to disclosure.

In addition to emotions, questions about sexual orientation also emerged as a barrier to disclosure. The service providers in the current study noted that CSA led to men questioning their sexual orientation and as a result being reluctant to disclose their CSA. These results are similar to previous studies such as the one by Easton et al. (2014) which involved 487 men who completed a survey on barriers to disclosure. The Easton et al. (2014) study indicated that due to sexual orientation being a core part of one's nature questioning their sexual orientation may be highly disturbing to the individuals and function as barrier to disclosure.

The interpersonal theme consisted of barriers and facilitators to disclosure that emerge through male CSA survivor's interaction with their immediate social circle.

Barriers at the interpersonal level included fear of social rejection, relationship difficulties and trust issues, perpetrator characteristics, as well as negative response by others following disclosure. In contrast, disclosure by other male CSA survivors, crisis, and positive reaction to disclosure all functioned as facilitators.

The results of the study showed that men's interactions with their social environment play a major role in disclosure and could function as either a barrier or a facilitator. Stigma surrounding male CSA was considered a significant barrier to disclosure; participants noted fear of negative social repercussions, being labelled as a pedophile and gay prevent male CSA survivors from disclosing. Similar results have been found by previous studies with stigma surrounding male CSA playing a key role in male CSA decision to not disclose (Alaggia, 2005; Easton, 2013; Easton et al., 2014). Myths associated with male CSA further marginalizes male CSA survivors. These myths include belief that male CSA survivors are or will become "gay" or will go onto become abusers.

While negative social interactions including stigma and active silencing can function as barriers to disclosure, positive social interactions such as empathetic social reaction following disclosure and disclosure by other male CSA survivors may all encourage disclosure in male CSA survivors. Results from the current study indicate non-judgmental reactions following disclosure or not minimizing the experience functions as a facilitator, encouraging further disclosure.

The institutional theme consisted of barriers and facilitators that are formed through the male CSA survivor's interaction with institutional agencies as well as with individuals who work within the agencies and ultimately function as the face of the

organizations or services being offered. Barriers included issues such as lack of available programs, lack of awareness of available programs, attitudinal barriers such as service providers being dismissive or minimizing the abuse, and lack of education about male CSA. Facilitators included increased public education and culturally sensitive service provision. Raising awareness about CSA through education was identified as key to encourage male survivors to disclose about CSA. Our results note the importance of education about sexual abuse for children, adults who come into contact with children, the general public, as well as service providers. Findings from our current study indicate that change in social attitudes and more understanding of the concept of CSA precipitated through education will lead to an environment that is conducive to children disclosing their CSA.

Previous studies have indicated that victimization prevention programs increase self-disclosure of sexual abuse (Finkelhor, Asdigian, & Dziuba-Leatherman, 1995; Gibson & Leitenberg, 2000; Wise, 2015). Sexual abuse and awareness programs have been successful in raising awareness of CSA among children as well as teaching them self-protection skills (Finkelhor et al., 1995; Gibson & Leitenberg, 2000; Wise, 2015). A study conducted by Sorensen and Snow (1991) examined disclosure of CSA amongst 116 children between the ages of 3 and 17 with 38% of the sample being males. The results indicated that school programs focusing on topics such as touch prevention, divorce and social skills groups contributed to purposeful disclosure in 24% of the sample population (Sorensen & Snow, 1991). Similarly, another study by Finkelhor at el. (1995) examined the effect of victimization prevention program on 2000 children between the ages of 10 and 16. The study results showed that disclosure significantly increased following such

programs (Finkelhor et al., 1995). Additionally, the study found children were less likely to blame themselves for the abuse (Finkelhor et al., 1995). However, results from the current study indicate, many schools and school administrators are reluctant to bring the topic of CSA into the school education policies. This is extremely problematic since this sends a message that CSA is a topic that is not open to discussion, further stigmatizing the issue and preventing children from disclosing. Education about CSA in the school system may encourage both boys and girls to ask questions and create an environment in which children will come forward when an abuse has taken place**.**

Results from the current study also suggest the reluctance to discuss sexual abuse in school systems and religious institutions, such as churches and mosques, is due to societal attitude about sex as well as the stigma attached to sexual abuse of males. current study note emphasis should also be placed on educating the religious authorities in the minority communities and religious authorities from such communities should be encouraged to promote awareness of the issue. The result about the importance of educating the religious authorities on the topic of male CSA might be due to the high amount of influence religious authorities have in ethnic communities as well as high accessibility to children.

Our findings suggest that further education directed at the general public as well as parents, family members and close acquaintances is of utmost importance and has a positive impact on disclosure. A qualitative study by Alaggia (2010) which examined disclosure of CSA noted that males described their community as not being knowledgeable on how to handle their disclosure or their behavior following the abuse. Males may be more reluctant to disclose their CSA because of the perception that they

won't receive help from the society. Therefore, more public awareness on how to handle disclosure and the impact and behaviours that stem from CSA is needed. More public awareness and open discourse about the issue of male CSA may encourage men to tell their stories.

Public Service Announcements (PSA) aimed at educating the general public on male CSA can be beneficial. However, the participants in the current study expressed that public awareness campaigns fall short in their attempt to raise awareness on this topic. Public awareness campaigns tend to overlook the issues faced by CSA survivors following the abuse and focus primarily on identification of child abuse victims and reduction of risks for abuse (Broman-Fulks et al., 2007). Our results show that more robust public awareness campaigns that deal with male CSA and its impacts on male survivors is needed. Additionally, the results from the current study show PSA focused on reaching minority ethnic populations is imperative.

Access to health services and service providers are also imperative to encourage male disclosure of CSA and assist with the healing process. Results from the current study note the distinct lack of service available to male CSA survivors. A qualitative study by McDonald and Tijerino (2013) examined the experiences of 59 male CSA survivors which included supports available for male along with effects of CSA, coping strategies, and reporting of CSA. The results showed that males in the study felt there's a distinct lack of services available to male CSA survivors (Mcdonald & Tijerino, 2013). Congruent with the results from previous studies. Similarly, a study on rape victims have shown that survivors may choose to not disclose because they are not aware of the

services available to them or feel there is no available services resulting in a feeling of lack of options (Ahrens, 2006).

In addition to the lack of treatment programs to male CSA survivors, service providers in the current study indicated there are multiple barriers to accessing services, such as language issues, lack of services for individuals with disabilities, negative responses from service providers, limited referrals, lack of cultural sensitivity, and long wait lists. Additionally, accessibility issues due to lack of cultural sensitivity in treatment programs was found in the current study. Similar results were found in a previous UK study by Allnock et al. (2012) who found that children with disabilities and children from black, Asian ethnic minority and refugee background have a harder time accessing services in cases of CSA (Allnock et al., 2012). The results from the current study indicate that majority of the clients that utilize the services of the participants in the current study are primarily of Caucasian descent. However, the lack of service utilization by ethnic minorities does not mean ethnic minorities are not experiencing CSA. Rather that this cohort might be more reluctant to disclose or utilize the services available to them due to more traditional beliefs about sexuality and sex, resulting in ethnic male CSA survivors feeling more marginalized and more reluctant to come forward with their disclosure of CSA.

In addition to the service gaps, service providers also mentioned the lack of education available to mental health providers who work with male CSA survivors. These results are similar to the findings from the study by Lab et al. (2000) which examined attitudes and practices of mental health service providers (55 psychologists and 84 nurses) who deal with male CSA survivors. The study found 2/3 of the mental health

service providers mentioned receiving no training in the area of assessment/treatment of sexual abuse (Lab et al., 2000). Additionally, only 30.8% of the study population felt they had received sufficient training to inquire about sexual abuse histories in men (Lab et al., 2000).

At the societal level, barriers for disclosure included stigma surrounding the notions of masculinity as well as attitude around sex and sexual abuse. Studies on stigma have consistently shown it to be a major barrier in disclosure as well as service utilization. A mixed-methods study by Niang et al. (2006) examined topics of stigma, violence and HIV vulnerability in men who have sex with men in Senegal. The study showed that men are reluctant to seek services for anal symptoms due to the fear of revealing their homosexuality (Niang et al., 2003). The results from Niang and colleagues' study (2003) suggested that societal attitudes and views regarding masculinity function as a barrier to disclosure. Previous research has explored the effect of social values in regards to masculinity and its effect on disclosure among male survivors of CSA (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Easton et al., 2014; Fontes & Plummer, 2010; Spataro et al., 2001). Societal views become internalized and may function as a barrier and further marginalize males who have been sexually abused as children. The societal judgement regarding male CSA might enhance the men`s fear of social rejection by their social circle. Our findings indicate that males often feel the pressure to live up to the standards set by their social groups and society at large. These findings are similar to other studies that explore CSA amongst males (Kia-Keating et al., 2005). Similar to previous studies, our findings suggest that social norms result in a dichotomy between being a male and being a victim (Fontes & Plummer, 2010; Mendel,

1995; Spataro et al., 2001). As Fontes and Plumer (2010) stated: "admission [of CSA] requires 'confessing' to having been victimized, which is a blow to their masculine image" (p. 498).

In addition to males feeling pressured to conform to social notions of masculinity, males must face additional issues following disclosure. Results from the current study show many male CSA survivors also experience active silencing or unsympathetic reactions following their disclosure. Similar results have been found in previous studies which show when males come forward with allegations of abuse, society is much less sympathetic towards their experience in contrast to female allegations of CSA (Ullman & Filipas, 2005). Secondly, our results indicate that the gender of the perpetrator also leads to additional shame and stigma. Results in the current study show that in the case of abuse by a male perpetrator there is a fear of being labelled gay. Therefore, fear of judgement of one's own sexuality by others served as an impediment to disclosure amongst men. In addition to fear of being labelled as gay, social responses to homosexuality and social views of homosexual community also serves to silence the men. However, results indicate when the perpetrator is a female the social norms dictates that the male should enjoy the abuse and feel honoured to be initiated into sex in this way. Therefore, males may feel heightened shame associated with disclosing the abuse by female perpetrators.

Males from ethnic communities face additional pressure due to much more stringent expectations to conform to the masculine norms. Consistent with previous studies (Hanson et al., 2003; Kellogg & Huston, 1995; Kia-Keating et al., 2005), findings from the current study indicate that ethnic men were much less likely to disclose their

CSA. Our findings suggest that compared to males who are not part of the visible

minority males from ethnic minorities are much more reluctant to come forward with

their disclosure due to the fear of violating masculine norms. Additionally, our findings

note that men from ethnic minorities were more prone to acting tough through increased

aggressive behaviour and hyper-sexuality in an attempt to detach themselves from the

role of a victim.

The current study identified several key issues that are novel in the area of male

CSA. The service providers noted ethnicity of the service provider plays a complex role

in mental health service utilization of male CSA survivors. One participant stated that

male CSA survivors from ethnic communities may feel reluctant to meet with a service

provider from their own community due to fear of being judged. However, other

participants also mentioned that being familiar with the ethnicity of the male CSA would

allow them to understand the issues from the cultural context and relate to the client in a

more enriched capacity. These results are similar to the study by Cinnirella and

Loewenthal (1999) who examined impact of religious and ethnic group on mental health

treatment strategies among 52 participants from five religious and ethnic groups. Results

showed that the relationship between service providers' ethnicity had an impact on the

individuals' decision to seek help from specific mental health service provider (Cinnirella

& Loewenthal, 1999).

The finding that "crisis" or critical events could act as a catalyst for male CSA

survivor's decision making regarding disclosure was novel. The definition of crisis often

has a negative connotation attached to it. However, Merriam-Webster dictionary defines

crisis as simply a turning point or a decisive moment, a moment which may either be

positive or negative. Participants indicated that critical events may facilitate disclosure in male CSA by forcing them to rethink the impact of the abuse on their life and also causing them to reach out for services prompting disclosure as a method to access service. Our findings suggest that crisis may take many forms, from relationship issues to negative coping strategies as well as triggering led by media and disclosure of other male CSA survivors. Previous studies on critical events on behavioral change have found similar results. Studies on critical events or "teachable moments" and their effect on negative health behaviours such as smoking have been well established. A meta-analysis by McBride, Emmons, and Lipkus (2003) found factors such as pregnancy, hospitalization and disease diagnosis resulted in high rate of smoking cessation (McBride, Emmons, & Lipkus, 2003). Similar effects may be contributing to male CSA survivors' decisions to disclose following life-events such as re-triggering or loss of relationships.

Recommendations for Future Research

Although awareness of CSA among males continues to grow, research on the topic remains relatively limited in scope and quantity. Even as allegations of CSA of boys continue to take the limelight, services that meet the needs of men seem to be woefully inadequate at best (Mcdonald & Tijerino, 2013). Therefore, further research is needed to identify the barriers and facilitators of CSA among males as well as the services that are available for such men. Future studies exploring teachers', parents', religious authority figures' views, knowledge, and awareness of male CSA are needed to help inform relevant education programs regarding male CSA and CSA in general in schools, religious communities and families.

In addition, more research on stigma attached to CSA particularly with male survivors is an important area of research. While there is stigma attached to sexuality and sexual abuse, social ideas about masculinity and victimization of males tend to further marginalize male CSA survivors. Therefore, further research on stigmatization of male CSA and social attitudes about masculinity is needed.

In addition to raising awareness of the issue of male CSA, it is also imperative to focus on the perpetrators. Participants mentioned that many funding organizations and policy makers are reluctant to create or fund services that are aimed at perpetrators of CSA. Studies on why the perpetrators offend or go from fantasizing about CSA to making it a reality are important in understanding the dynamics that play a role in the crime and may shed light on ways in which such abuse can be prevented. While studies have examined subset of victims who go onto offend against children (Craissati, McClurg, & Browne, 2002; Glasser et al., 2001), further research on this population is needed.

More research on services providers of male CSA is also needed. Service providers play a large role in the aftermath of allegations of CSA and contribute to the healing process of the survivors. Therefore, it is imperative to further examine the understanding, perceptions, and attitudes of the service providers regarding disclosure of CSA amongst males. Additional benefits of such research include identifying educational needs of the service providers to enhance their interactions with this male group and to inform educational programs and mental health services for service providers.

Additionally, future research should include ethnically diverse service providers in order to gain a more diverse understanding of unique issues faced by ethnic service

providers as well as males who access service. It may also be possible that service providers who are from an ethnic minority may have unique experiences and worked with a different group of male CSA survivors than their Caucasian counterparts.

Recommendations for Practice

In addition to future research, the study also has several implications for practice. educators in the school system, especially those who are teaching children in the primary and secondary grades, need to create an environment in which children specifically male children are comfortable enough to discuss issues such as inappropriate interactions amongst peers or between an adult and children. Education should focus on achieving two goals: (a) what CSA might look like due to the varied nature of CSA and (b) the various responses it can elicit. Sex education classes should not simply focus on teaching children about human development and sexual health, but should also include topics on what inappropriate interactions and situations look like as well as to how to respond in such circumstances. While the current Ontario curriculum update touches on topics such as inappropriate touching and naming body parts, further emphasis should be placed on topics of child abuse particularly sexual abuse. Additionally, guest speakers such as mental health workers should be invited into the school system to speak to youth as they may have much more experience working with male CSA survivors and be more knowledgeable on topics such as CSA in comparison to educational staff.

Graduate level curriculums for clinicians who may be dealing with male CSA in their practice should also be re-examined. Service providers expressed there is very little training or courses offered at the graduate level for mental health and health care workers that address the topic of male CSA. This results in service providers having insufficient

skills and experience to work with male CSA who have unique and complex needs in comparison to female CSA survivors. Additionally, the lack of education on this topic may lead to service providers making incorrect assumptions about the prevalence rate of male CSA. These incorrect assumptions may lead to service providers not asking the correct questions during assessment and in turn lead to misdiagnosing the symptoms of CSA amongst male patients in mental health settings.

To address the general public's lack of recognition of male CSA, more public service announcements (PSA) geared at raising awareness of the issue should be disseminated. Raising awareness of male CSA serves multiple functions. Awareness seems to play a key role in male CSA survivor's decision to disclose. The notion of "I'm the only one" functions as a barrier to disclosure and an increased awareness of male CSA serves to change the notion and help promote disclosure rate. PSA shed light on the issue, leading to increased awareness of male CSA amongst the general public. By promoting awareness of male CSA, it will serve to limit misconceptions about the prevalence rate of male CSA. Furthermore, increased awareness and education will serve to potentially reduce the stigma around male victimization resulting in an environment in which open conversations can take place. Studies have shown education to have a positive impact on stigma (Pinfold et al., 2014; Tanaka, Ogawa, Inadomi, Kikuchi, & Ohta, 2003). PSA would bring the issue of male CSA to the forefront and into the consideration of policy makers and service providers leading to possible increase in funding and increase in creation of services for male CSA survivors.

In terms of clinical practice, services must be more accessible. These include more staff and programs being offered for male CSA survivors. There must be more local

or communal services made available to male CSA in order to reduce travel times and travel costs. More gender specific services are also imperative. Additionally, referrals should not be a mandatory requirement for accessing services as it may function as a barrier to accessing service. Services being offered should also be culturally sensitive, by taking a "one shoe fits all" approach services may not be meeting the needs of male CSA from ethnic minority communities. Male CSA survivors from ethnic communities may have additional or unique barriers such as increased shame as well as language issues and cultural norms that further functions to marginalize male CSA survivors.

At the governmental level, financial aid to cover the expenses of counselling and travel costs should be provided to male CSA survivors. Additionally, more funding for organizations that deal with male CSA is required.

Strengths and Limitations

This study has several strengths. First, to my knowledge, relatively few studies have explored the topic of CSA among males from the perspective of the service providers. Since service providers play a pivotal role in the healing process, understanding their perspective lends insight into the experiences of men who have been sexually abused as children. Additionally, by focusing on the service providers, service gaps were identified, ultimately resulting in better services to facilitate the healing process and to inform existing counselling programs to meet the needs of male CSA survivors. The study also contributes to the body of knowledge on self-disclosure amongst male CSA survivors. The majority of studies on CSA, to date, has focused on female sexual abuse and have had a predominantly female participant pool. Finally, the

findings of this study identified facilitators that might promote disclosure rate in males who are experiencing or have experienced CSA.

There are limitations to this study that need to be acknowledged. One limitation was that the service providers were all recruited from one specific region of Ontario. In addition, the ethnic makeup of the participant pool consisted of only Caucasian service providers. It might be possible that service providers from an ethnic minority population would have different experiences and may be more likely to be working with non-Caucasian client population than their Caucasian counterparts. Finally, the study only examined facilitators and barriers to disclosure from service providers' perspective, not from the perspective of the male CSA survivors themselves. Therefore, the results may not reflect the male CSA survivor's innermost feelings or barriers and facilitators they might not have felt comfortable discussing with the service providers.

Conclusion

In conclusion, the study results support many of the findings about facilitators and barriers for disclosure of male CSA reported in previous studies. While other findings revealed additional information to help further understand challenges male survivors experience regarding disclosure of CSA as well as the gaps in services available to the males CSA survivors. Disclosure of childhood sexual abuse is a complex process with multiple barriers and facilitators influencing the male CSA survivor's decision to come forward with their abuse. Current study shows that barriers such as notion of masculinity, guilt, shame and stigma all play a large role in a male CSA survivor's decision to withhold their disclosure. On the other hand, experiencing a positive response to disclosure, increase social awareness, and education about male CSA and access to

services all serve as facilitators for disclosure. In addition to the barriers and facilitators, the current study highlights some of the gaps that are present in terms of the services available to men. This indicates that not only are service providers aware of the additional factors associated with being a male CSA survivor but are also perceptive in regards to the service gaps. Some recommendations are provided in an attempt to ensure that services provided to the men adequately address some of the unique barriers faced by males including the notions of the masculine, heightened shame and stigma, and social attitudes. Males face unique barriers that need to be acknowledged and addressed, at the same time facilitators need to be strengthened.

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Appendices

Appendix A:Email Recruitment

Email Subject Line: Invitation to Participate in a Research Study

Body of Email Script

Dear Colleague:
We are seeking to understand from the service provider perspective the issues surrounding disclosure and non-disclosure of child sexual abuse amongst male child sexual abuse survivors. The aim of this study, **Exploring issues related to disclosure and non-disclosure in males: Service provider perspective** is to obtain input from mental health service providers on personal, interpersonal and systemic barriers and facilitators to disclosure as experienced by male child sexual abuse survivors.

We would like to invite any health care provider involved in providing care male child sexual abuse survivors to participate in this study which will involve engaging in two sessions of one on one interviews lasting approximately one hour each. Individuals who are interested in participating in this study are asked to reply by email to Marudan Sivagurunathan for additional information. If you have any questions about the study, please do not hesitate to contact one of the research team members noted below.

Thank you,

Dr. Marilyn Evans, MN, PhD
Associate Professor
University of Western Ontario

Marudan Sivagurunathan, M. sc.,
Health and Rehabilitation sciences
University of Western Ontario

Appendix B: Reminder Email

Email Subject Line: Invitation to Participate in a Research Study

Body of Email Script

Dear Colleague:
you {indicate how long ago it was sent} (weeks / days) ago and we wanted to send you a quick reminder about our study.
We are seeking to understand from the service provider perspective the issues surrounding disclosure and non-disclosure of child sexual abuse amongst male child sexual abuse survivors. The aim of this study, **Exploring issues related to disclosure and non-disclosure in males: Service provider perspective** is to obtain input from mental health service providers on personal, interpersonal and systemic barriers and facilitators to disclosure as experienced by male child sexual abuse survivors.

We would like to invite any healthcare provider involved in providing care male child sexual abuse survivors to participate in this study which will involve engaging in two sessions of one on one interviews lasting approximately one hour each. Individuals who are interested in participating in this study are asked to reply by email to Marudan Sivagurunathan for additional information. If you have any questions about the study, please do not hesitate to contact one of the research team members noted below.

Thank you,

Dr. Marilyn Evans, MN, PhD
Associate Professor
University of Western Ontario

Marudan Sivagurunathan, M. sc.,
Health and Rehabilitation sciences
University of Western Ontario

Appendix C: Letter of Information

Project Title: Exploring issues related to disclosure and non-disclosure in males: Service provider perspective
Principal Investigator:
Dr. Marilyn Evans, Associate Professor, RN PhD, Nursing, Western University Room
Marudan Sivagurunathan, M.Sc., Health and Rehabilitation, Western University,

<u>**Letter of Information**</u>

1. **Invitation to Participate**

   You are being invited to take part in a research study on the perspective of service providers on child sexual abuse disclosure amongst males. You are being asked to volunteer because you are a service provider who has experience working with males who have been sexually abused as children.

2. **Purpose of the Letter**
   The purpose of this letter is to provide you with information required for you to make an informed decision regarding participation in this research. Please take the time to read and feel free to ask any questions.

3. **Purpose of this Study**
   The purpose of this study is to explore the perceptions, attitudes, and experiences of service providers who work with male victims of child sexual abuse. The focus of the study will be on self-disclosure of child sexual abuse amongst youth.

4. **Inclusion Criteria**
   Individuals over the age of 30 who have worked with male child sexual abuse victims in a clinical capacity for more than 5 years.

5. **Exclusion Criteria**

   Individuals under the age of 30 with less than 5 years experience working with male victims of child sexual abuse or those without clinical experience are not eligible to participate.

6. **Study Procedures**
   If you agree to participate, you will be asked to complete interview session with the student investigator. The interview will be on an individual basis and in person. It is anticipated that the entire task will take two hours, over two sessions. The interview will be conducted in a mutually agreed place that is both convenient to the participant and safe. There will be a total of 15 participants in the study. With your permission the interview will be audio taped, if you choose to not be audio taped you can still participate in the study but the interviewer will be taking notes.

7. Possible Risks and Harms

The possible risks and harms to you include possible psychological and emotional distress. You may recall traumatic events and experience difficult memories and emotions. If a participant indicates any signs of distress during the interview process the interview will be terminated immediately and if appropriate rescheduled for a later date. Resources that address their need will be provided, including pamphlets on coping, and referral to community resources such as counselling services. Potential counseling services include, Toronto Health Unit, Family Services Toronto, Toronto Central Health Line and Mental health crisis line. The researcher will conduct a follow-up phone call on the following day to check on your health and mental well-being.

8. Possible Benefits

You may not directly benefit from participating in this study but information gathered may provide benefits to society as a whole which include increase in knowledge in the area of child sexual abuse in males. Additional benefits include identifying needs of providers to enhance their interactions with this male group as well as Informing educational programs for service providers The interview may also prove to be therapeutic to some individuals. By talking about things that have happened you might begin to understand them in new or different ways.

9. Voluntary Participation

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future health and wellbeing or your employment. However, if the participant wishes to withdraw from the research after data analysis begins, the participant cannot remove his/her data from the collection undertaken in this research project as it is not possible to withdraw individual data following data analysis. If participants withdraw consent prior to data analysis all raw data obtained from the participant will be removed and destroyed. All personal identifiers collected will be removed from any of the analyzed data.

10. Confidentiality

We will respect your privacy. All data collected will remain confidential and accessible only to the investigators of this study. The data will be encrypted and stored safely. If the results are published, your name and other identifying data will not be used. All data will be destroyed at the completion of the study. Representatives of The University of Western Ontario Health Science Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research. The Data collected will be saved for 5 years, at the end of the 5 year period all data will be will be shredded (if hard copy) and permanently removed (if on electronic file).

We will ensure none of your personal information is given to anyone without your permission, unless required by law. We would be required to inform the authorities if there is indication of ongoing child abuse, or there is a risk of suicide. Additionally we may be requested by the court to give them the study papers. Signing the consent form does not constitute a waiving of your legal rights. While total confidentiality cannot be guaranteed investigator will do the upmost to maintain throughout the research process.

11. Contacts for Further Information

If you require any further information regarding this research project or your participation in the study you may contact Marudan Sivagurunathan.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics (519) 661-3036, email: ethics@uwo.ca.

12. Publication

If the results of the study are published or presented, your name will not be used. If you would like to receive a copy of any potential study results, please contact Marudan Sivagurunathan.

This letter is yours to keep for future reference.

Consent Form

Project Title: Exploring issues related to disclosure and non-disclosure in males: Service provider perspective.

Study Investigator's Name: Marudan Sivagurunathan

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Agree to be audio taped: Yes ☐   No☐

Participant's Name (please print): _____

Participant's Signature: _____

Date: _____

Person Obtaining Informed Consent (please print):   _____

Signature: _____

Date: _____

Appendix D: Semi-Structured Interview Guide

Introduce the study

you have volunteered for this study about service providers perspective on child sexual abuse amongst males. You may begin wherever you like and say as much or as little you want.

Opening Questions:
1. How are you feeling about taking part in this study?
   a. what were some of your thoughts and feelings about coming today
   b. What made you decide to participate in this study? Probe
2. Perhaps we could begin by you telling me a little about yourself :
   a. Tell me about credentials
   b. What is your degrees/ education level? What is your profession? ie. What is the title of your job?
   c. How long you have been in the field?
   d. Can you tell us about the type of settings that you have worked in?

Child Sexual abuse Questions:
1. Now I'm interested in knowing a little about your past experience working with male youth who have experienced child sexual abuse:
   a. What are the main issues you encounter when you become involved with male youth who have experienced child sexual abuse?
      i. What are the social attitudes and ideas that emerge?
2. What are you perception regarding child sexual abuse amongst males? Specifically in regards to disclosure.
   a. What are your feelings/ views in regards to disclosure?
   b. What do you think are the needs of male child sexual abuse survivors?
3. What in your opinion are the main barriers facilitators to disclosure of male child sexual abuse.
   a. How can these barriers be overcome?
   b. Are there ethnic differences that you have come across when dealing with the youth?
   c. Do ethnic youth have special concerns and barriers to disclosure?
   d. Do they have different facilitators to disclosure?
4. What in your opinion are the main facilitators to disclosure of male child sexual abuse
5. What is the impact on the families; is there any social support available?
6. How do you feel about the services that are available to male child sexual abuse victims?
   a. Some feel that services that address the needs of male victims of child sexual abuse are inadequate, how do you feel about that?
      i. Tell me about the experiences of survivors from ethnic communities when trying to access services.

      ii. Do you feel that programs tailored for specific ethnic groups or culturally sensitive programs would better facilitate access to services and disclosure?

    iii. Lets talk about the education available to service providers and communities

Closing Questions:

1. Personal feelings now after the end of the interview?
2. Is there anything else you would like to share with me that we haven't addressed?

Appendix E: Ethics Approval

Western Research

Research Ethics

Western University Health Science Research Ethics Board
HSREB Delegated Initial Approval Notice

Principal Investigator: ███████████
Department & Institution: Health Sciences\Nursing,Western University

Review Type: Full Board
HSREB File Number: 106962
Study Title: Exploring issues related to disclosure and non-disclosure in males: Service provider perspective

HSREB Initial Approval Date: September 09, 2015
HSREB Expiry Date: September 09, 2016

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Western University Protocol	Received 21Aug15	
Advertisement	Reminder email	2015/08/17
Letter of Information & Consent	Letter of Information clean version	2015/08/13
Other	resource one- Looking for Mental Health Services? (received 21Aug15)	
Other	Quick Guide Mental Health Resources Serving Toronto (Received 21Aug15)	
Other	Stress brochure (received 21Aug15)	
Other	Trauma brochure (Received 21Aug15)	
Instruments	Interview Guide (Received 08Jul15)	
Advertisement	Email ad	2015/08/17

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

HSREB approval for this study remains valid until the HSREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice Practices (ICH E6 R1), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health Canada Medical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

Members of the HSREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Ethics Officer, on behalf of ████████████ HSREB Chair

Ethics Officer to Contact for Further Information

This is an official document. Please retain the original in your files.

Curriculum Vitae

Name: Marudan Sivagurunatha

Post-secondary   McMaster University
Education and   Hamilton, Ontario, Canada
Degrees: 2008-2012 B.A.

                    The University of Western Ontario
                    London, Ontario, Canada
                    2014-2016 M.A.

Honours and   Western Graduate Research Scholarship (WGRS)
Awards: 2014-2015, 2015-2016, 2016- 2017

Related Work   Teaching Assistant
Experience   The University of Western Ontario
                    2015, 2016

Conference:

1. (2015, February). *Factors of disclosure in boys aged 13-24 who were sexually abuse as children*. Lecture presented at the Health and Rehabilitation Sciences Graduate Research Conference, The University of Western Ontario, London, Canada.
2. (2016, February). *Exploring issues related to disclosure and non-disclosure in males: Service provider perspective*. Lecture presented at the Health and Rehabilitation Sciences Graduate Research Conference, The University of Western Ontario, London, Canada.
3. (2016, March). *Exploring issues related to disclosure and non-disclosure in males: Service provider perspective*. Poster presented at the Western Research Forum, The University of Western Ontario, London, Canada.