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Exploring the Impacts of Childhood Sexual Abuse and Related
Adversities: A Multi-Study Analysis of Gendered Pathways in
Disclosure, Psychosocial, and Psychosexual Outcomes

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Dedication

To every survivor of CSA: May you find your voice, (re)connect with your feelings, and build a beautiful life. Like the courageous participants in this PhD, I hope you choose to share your story—a contribution that not only advances research but also helps build a better, more compassionate society.

Abstract

Childhood sexual abuse (CSA) is a pervasive and harmful experience with potentially long-term consequences for survivors. This thesis explored the impacts of CSA along with the presence of other adverse childhood experiences (ACE's), focussing on CSA disclosure, and behavioural, psychosocial, and psychosexual outcomes. Employing a multi-study approach that integrated quantitative and qualitative methodologies, the research investigated gendered pathways and the roles of contextual and interpersonal factors. Each of the three studies addressed distinct but interrelated aspects of CSA's aftermath, collectively contributing to a nuanced understanding of its complex effects.

The first study examined the relationships between the existence of childhood abuse (CA), as well as CA types specifically—CSA, childhood physical abuse (CPA), and childhood emotional abuse (CEA)—with outcomes including substance use disorder (SUD) patterns and self-directed violence (SDV). Using hierarchical multiple regression, the study identified significant associations between abuse types and maladaptive behavioural outcomes, highlighting the cumulative impact of abuse on risk behaviours. Notably, gender had no significant effect on the outcomes, underscoring shared underlying mechanisms while recognising potentially different contextual manifestations.

The second study explored the pathways linking CA types (i.e., CSA, CPA, and CEA) to sexual shame (SS) through structural equation modelling (SEM). This study investigated the mediating roles of disclosure experiences (DE) and contextual childhood adversities (CCA), as well as the moderating role of gender, to demonstrate how these factors influence psychosexual development. SEM revealed no significant mediating effects for DE, but identified significant mediating effects for CCA in some models. The study also found significant moderating effects for gender on SS in the CSA and CPA models, specifically that female participants were significantly more likely to experience higher levels of SS compared to male participants in these models. The findings emphasised the importance of social and environmental mediators in shaping long-term psychosexual outcomes for CSA survivors.

Building on the findings of these two studies, the third study employed Constructivist Grounded Theory (CGT) to further explore the lived experiences of CSA survivors, focussing on disclosure, recovery, and psychosexual development. Through in-depth semi-structured interviews, the study uncovered diverse trajectories shaped by barriers and incentives to disclosure, revealing the influence of attachment dynamics and societal constructs on the gendered experiences and outcomes of CSA survivors. The findings highlighted the pivotal role of disclosure as both a potential facilitator and barrier to recovery, offering critical insights into the relationship between personal and societal influences.

Synthesising findings across the three studies, this thesis underscores the complexity of CSA's impact and the critical role of contextual and gendered factors in shaping recovery and developmental trajectories. The research provides valuable insights of how disclosure experiences and contextual adversities influence behavioural and psychosexual outcomes, offering implications for practice and policy. Recommendations include fostering supportive disclosure environments, integrating psychosocial and psychosexual dimensions in intervention frameworks, and addressing gender-specific barriers to recovery. While limitations include the cross-sectional nature of two studies and potential contextual constraints, the findings provide a meaningful contribution to CSA research and support services, paving the way for further exploration into the long-term impacts of CSA.

Lay Summary

Childhood sexual abuse (CSA) is often a devastating experience that could have long-lasting effects on survivors' lives. This research explored how CSA, along with other negative childhood experiences, impacts the lives of survivors in areas such as mental health, coping behaviours, relationships, and personal recovery. By studying both men and women, the research aimed to understand how these experiences differ based on gender and how factors like support systems and life circumstances influence recovery.

The first part of the research looked at how different types of childhood abuse, including CSA, physical abuse, and emotional abuse, are linked to harmful behaviours like substance use, self-harm, and suicide. The study found that experiencing abuse increases the likelihood of these behaviours and showed that both men and women are affected in similar ways, even though the context of their experiences might differ.

The second part focussed on how CSA can lead to feelings of deep shame about one's sexuality, often called sexual shame. It examined how experiences of sharing the abuse (or not sharing it) with others, as well as the presence of other childhood difficulties, shape this shame. The research found that the environment and reactions from others play a big role in whether survivors experience more or less shame. Women were found to experience higher levels of shame than men in some cases.

The final part of the research involved in-depth interviews with survivors to hear their stories about disclosing the abuse, their recovery journeys, and how the abuse shaped their identities and relationships. The findings highlighted that opening up about abuse can be a turning point—either helping or hindering recovery—depending on the support survivors receive. Gender also shaped these experiences, with men often facing barriers to sharing due to societal pressures and stigma, while women's disclosures were sometimes met with disbelief or blame.

By bringing together the findings from these three parts, this research highlights the complex ways CSA affects survivors, including the different challenges faced by men and women. It

shows the importance of supportive environments and understanding individual needs in helping survivors heal. The insights from this work can help improve services and policies to better support those who have experienced childhood abuse, making recovery a more accessible and compassionate process for all.

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Frequently Used Acronyms

ACE	Adverse childhood experience
CA	Childhood abuse
CAPU	Cannabis and Polysubstance Use study
CCA	Contextual childhood adversity
CEA	Childhood emotional abuse
CEN	Childhood emotional neglect
CFA	Confirmatory factor analysis
CGT	Constructivist Grounded Theory
CPA	Childhood physical abuse
CPN	Childhood physical neglect
CSA	Childhood sexual abuse
CSB	Compulsive sexual behaviours
CTQ	Childhood Trauma Questionnaire
DE	Disclosure experience
DEneg	Negative disclosure experience
DEpos	Positive disclosure experience
EIPV	Exposure to intimate partner violence
HMI	Household mental illness
HMR	Hierarchical multiple regression
HSUD	Household substance use disorder
IP	Interpersonal sexual shame
MDE	Major depressive episode
NSSI	Non-suicidal self-injury
PD	Psychotic disorder presence
PI	Parental incarceration

PS	Parental divorce or separation
PSTB	Problematic sexual thoughts and behaviours
PSU	Polysubstance use
PTSD	Post-traumatic stress disorder
ROAR	Reducing Overdose and Relapse: Concurrent Attention to Neuropsychiatric Ailments and Drug Addiction study
RSB	Risky sexual behaviours
SA	Suicide attempt
SD	Self-directed sexual shame
SDV	Self-directed violence
SEM	Structural equation modelling
SRQ	Social Reactions Questionnaire
SS	Sexual shame
SUD	Substance use disorder
SUF	Substance use frequency
TA	“Turning against” disclosure experience
UA	“Unsupportive acknowledgment” disclosure experience
YASU	Youngest age of substance use

Chapter 1: Introduction

1.1 Background of overarching research objectives

Childhood sexual abuse (CSA) is a common and harmful problem that has potentially long-term repercussions for its victims (Easton & Kong, 2017; Hailes, Yu, Danese, & Fazel, 2019; Peltonen, 2014). CSA prevalence varies significantly worldwide, with notable differences across regions and between genders. Global estimates indicate that CSA exposure affects between 15.0% and 19.7% of girls and between 7.6% and 8.0% of boys (Sanjeevi et al., 2018), highlighting a higher rate among women. Variability in prevalence is influenced by differences in CSA definitions, reporting practices, and survey methodologies. For example, a recent Center for Disease Control and Prevention analysis found that including online sexual abuse in prevalence questions raised overall CSA rates from 13.5% to 21.7%, with female rates increasing from 19.8% to 31.6% and male rates from 6.2% to 10.8% (Finkelhor, Turner, & Colburn, 2024).

Differences in CSA definitions—whether limited to penetrative acts or expanded to include contact behaviours such as touching or fondling—also impact prevalence estimates (Petersson & Plantin, 2023). While most victims of CSA are girls, higher numbers of boys are found in particular contexts, such as situations involving street-living (ECPAT International, 2021), child labour (Kangaspunta et al., 2018), and child soldiers (Wessells, 2019), where sexual abuse is pervasive. In an effort to address the global situation of sexual exploitation of boys, ECPAT International co-authored an academic paper, which found that, although there is a burgeoning awareness of the sexual victimisation of boys, a dearth of research and services available in this area exists (Josenhans, Kavenagh, Smith, & Wekerle, 2020). Male CSA survivors are, moreover, significantly less likely to report or disclose their abuse experiences or to seek professional help, which complicates accurate estimation of male CSA rates across countries (Alaggia, Collin-Vézina, & Lateef, 2019; Briggs et al., 2021; Thomas & Kopel, 2023).

CSA can lead to extensive physical, psychological, and social issues that persist throughout life, including depression, anxiety, post-traumatic stress disorder (PTSD), shame, guilt, non-suicidal

self-injury (NSSI) or suicidality, substance use disorder (SUD), and relationship difficulties (Attrash-Najjar, Cohen, Glucklich, & Katz, 2023; Collin-Vézina et al., 2021; Drewitt-Smith & Marczak, 2023; Easton, Renner, & O’Leary, 2013; Grummitt et al., 2024; Hailes et al., 2019; Harb, Wart, Brzezinski, deRoon-Cassini, & Larson, 2024; Landa-Blanco, Vásquez, Portillo, Sproviero, & Echenique., 2024). These challenges may be further intensified by negative or absent disclosure experiences (Alaggia, 2010; Easton, 2013; Gemara & Katz, 2023; Marriott, Hamilton-Giachritsis, & Harrop, 2014; Weare et al., 2024). Given its sexual nature, CSA and the dynamics of disclosure can also significantly impact psychosexual development and influence later sexual experiences (Alley & Diamond, 2021; Ménard & MacIntosh, 2021; Vaillancourt-Morel et al., 2016). These lasting consequences underscore the profound impact of CSA on the individual.

Beyond the severe physical and psychological consequences for CSA survivors (Gemara & Katz, 2023; Hailes et al., 2019; O’Leary, Easton, & Gould, 2017; Weare et al., 2024), the economic impact of CSA on nations is immense, with billions lost due to reduced employment, higher healthcare expenses, and increased criminal justice involvement (Butchart & Mikton, 2014; Saied-Tessier, 2014; Radakin, Scholes, Soloman, Thomas-Lacroix, & Davies, 2021). Although global estimates vary due to methodological differences, the financial toll is significant. In the United States alone, CSA-related costs, including healthcare, lost productivity, and social welfare expenses, total over \$9 billion annually (Letourneau, Brown, Fang, Hassan, & Mercy, 2018). In the United Kingdom, recent estimates from the UK Home Office indicate that contact CSA incurs a yearly societal cost of approximately £10.1 billion (Radakin et al., 2021). Such national estimates reflect a broader global issue, as UNICEF and the World Health Organization highlight the cumulative effects of CSA on health, social services, and economic productivity worldwide (UNICEF, 2021). These findings underscore the need for global investment in CSA prevention and support measures to mitigate its extensive social and economic costs.

Given the profound and widespread consequences of CSA, both for survivors and society as a whole, a deeper understanding of its impact—including the underlying factors, such as the dynamics of disclosure and the contextual variables that can either mitigate or exacerbate its effects—is crucial for informing effective prevention, intervention, and support strategies that can alleviate its long-term social, psychological, and economic costs.

1.1.1 CSA background and sequelae

In exploring the sequelae and underlying factors of CSA, it is crucial to consider that this form of abuse frequently co-occurs with other adverse childhood experiences (ACE's¹), with numerous studies investigating CSA in relation to this wider context. Traumatic events are frequently interrelated, making it challenging to isolate the effects of one specific type of maltreatment (Amos, Cresswell, Hughes, & Bellis, 2023; Levenson, Willis, & Prescott, 2016). This complexity is especially relevant to CSA, which often exists alongside other ACE's (Vachon, Krueger, Rogosch, & Cicchetti, 2015). Childhood adversities, such as abuse, neglect, and household dysfunction, may increase a child's vulnerability to CSA, creating emotional and situational risks that lead to dependence on or increased exposure to the perpetrator (Attrash-Najjar et al., 2023).

Furthermore, the presence of CSA within the broader ACE context often amplifies its collective impact on the long-term mental health of victims (Amos et al., 2023; Levenson, Willis, & Prescott, 2016). Briggs, Amaya-Jackson, Putnam, and Putnam (2021) describe these interactions as “synergistic,” where certain ACE combinations within an overall ACE score elevate risk beyond the additive effects of each ACE alone. In a study characterising the unique, shared, and cumulative effects of childhood neglect and abuse on youth mental health, Amos et al. (2023) found that different types of maltreatment were highly interrelated, with symptom severity increasing linearly with the number of maltreatment types—supporting a cumulative impact on psychiatric symptoms. This cumulative nature of ACE's is further highlighted by recent findings from Landa-Blanco and colleagues (2024), demonstrating that the risk of adverse outcomes rises with each additional ACE.

One outcome commonly associated with CSA, particularly when other ACE's are not taken into account, is the later involvement in sexual or other forms of offending (Kirk-Provencher et al., 2022; Papalia, Ogloff, Cutajar, & Mullen, 2018; Turner et al., 2022). An Australian study found

¹ ACE's encompass childhood maltreatment or any number of childhood abuse (CA) types—CSA, childhood physical abuse (CPA) and childhood emotional abuse (CEA)—and household dysfunction/ childhood contextual adversity (CCA) types: childhood physical neglect (CPN), childhood emotional neglect (CEN), household mental illness (HMI), household substance use disorder (HSUD), parental incarceration (PI), exposure to intimate partner violence (EIPV), and parental divorce or separation (PS)).

that female CSA survivors exhibited an elevated risk of general or violent offending, and male survivors were more likely to commit sexual offences (Papalia et al., 2018). In a comprehensive review, however, Turner and colleagues (2022) suggest that the association between CSA and subsequent sexual offending may be mediated by various factors, such as attachment disruptions, childhood neglect, and early adverse environmental influences. Rather than indicating a direct causal link, this relationship likely reflects complex interactions among genetic and environmental factors, specific CSA characteristics, and potential mechanisms such as learned associations or conditioning, which remain speculative and warrant further investigation (Turner et al., 2022). Thus, in examining CSA, including its disclosure and sequelae, much research either analyses it within the context of other ACE's to identify unique pathways or omits consideration of additional ACE's—a limitation that may oversimplify CSA's outcomes and background. This is particularly important when CSA is experienced repeatedly by a victim, as it may reflect a broader ACE environment. To fully understand its impact, CSA must be contextualised within the broader ACE milieu when applicable.

Another crucial factor in evaluating the long-term outcomes of CSA is the type or nature of the abuse experienced, often framed in terms of severity. While the term “severity” can be subjective, it generally refers to CSA that is longer in duration, more frequent, more physically intrusive (e.g., penetrative CSA), and/or intrafamilial (Guiney et al., 2024; Vrolijk-Bosschaart et al., 2018). In an extensive five-decade longitudinal study, Guiney et al. (2024) explored the association between CSA severity and adverse adult outcomes, using varied CSA definitions to assess the impact of different abuse types on later life. Their findings demonstrated a consistent pattern: while all forms of CSA were linked to increased risks for adverse outcomes in adulthood, individuals exposed to more severe forms—such as penetrative abuse or forced intercourse—faced significantly higher risks across multiple domains, including physical, mental, sexual, interpersonal, economic, and antisocial aspects. These results align with previous studies, which have linked CSA severity to worsened mental health, greater engagement in sexual risk-taking, compromised physical health, and reduced socioeconomic well-being (Fergusson, McLeod, & Horwood, 2013; Vaillancourt-Morel et al., 2016; Vrolijk-Bosschaart et al., 2018). Collectively, these findings underscore the cumulative impact of CSA severity on long-term well-being, with more severe abuse experiences correlating with more profound and pervasive effects across life domains.

Survivors of CSA and other ACE's are often at increased risk of mental health disorders and, even without a formal diagnosis, may experience significant difficulties in later-life functioning (Talwar, Osorio, Appleton, & Billings, 2023). Research has shown that trauma-exposed youth, particularly those experiencing interpersonal violence, exhibit accelerated development of internalising symptoms compared to their non-exposed peers, heightening the risk of psychiatric disorders in adolescence and early adulthood (Russell, Heyn, Peverill, DiMaio, & Herringa, 2024). Aligned with these findings, Andreo-Jover and colleagues (2023) found that among 748 individuals with a history of suicide attempts, those with repeated attempts had significantly higher rates of various ACE's, including CSA, compared to those with a single attempt, illustrating a linear relationship between ACE frequency and suicide risk. Further emphasising the profound impact of childhood maltreatment on mental health, Grummitt et al. (2024) identified that 41% of suicide attempts and 39% of NSSI cases could be attributed to childhood maltreatment, with these experiences also accounting for 21% of depression, 27% of anxiety disorders, and 24% of SUD's. These findings underscore the substantial and lasting impact of CSA and ACE's on survivors, highlighting a strong association with adverse mental health outcomes across the lifespan.

Research consistently links CSA to SUD (Attrash-Najjar et al., 2023; Guo et al., 2018; Josenhans et al., 2020; LeTendre & Reed, 2017; Meng & D'Arcy, 2016), with this association being most pronounced when exploring the unique pathways of CSA in the context of other ACE's. In an umbrella review of meta-analyses evaluating the long-term psychiatric, psychosocial, and physical health outcomes of CSA, Hailes et al. (2019) identified SUD as the only psychosocial outcome consistently associated with high-quality assessment scores when CSA was disaggregated from other forms of childhood maltreatment. Additionally, Davis et al. (2019) investigated the relationships between various aspects of childhood victimisation—such as abuse type, poly-victimisation, relationships with perpetrators, perceived life threats, and social reactions to disclosure—and the development of SUD. Their findings highlighted a significant association between CSA, negative social reactions, and perceived life threats with SUD, emphasising the complex interplay of these factors in the development of substance use behaviours.

Furthermore, when CSA occurs alongside other ACE's, the combined effect may significantly increase the risk of adverse outcomes for survivors. Briggs and colleagues (2021) identified CSA as the most synergistically reactive ACE, producing the most severe outcomes (e.g., mental health challenges and SUD) when combined with other ACE's. Other studies comparing different ACE combinations—including those with and without CSA—indicate that CSA, either alone or alongside other ACE's, correlates with a notably elevated risk for a variety of mental health disorders and suicide attempts, underscoring CSA's uniquely detrimental impact (Andreo-Jover et al., 2023; Grummitt et al., 2024; Laporte, Ozolins, Westling, Westrin, & Wallinius, 2023; Turner, Taillieu, Cheung, & Afifi, 2017).

Several explanations have been proposed for the detrimental outcomes of CSA and other ACE's. From a psychobiological perspective, the relationship between childhood trauma and psychopathology may be linked to heightened crosswalk between peripheral inflammation and neural circuits, leading to chronic low-grade inflammation; This, in turn, could disrupt brain development, affect key behavioural domains, alter reactivity to stressors, and increase the risk of psychopathology (for a review, see Danese & Baldwin, 2017). Research also implicates alterations in various systems, including the endocrine and immune systems, as well as changes in DNA and chromatin, in the pathogenesis of medical disorders associated with CSA and ACEs (for a review, see Lo Iacono, Trentini, & Carola, 2021). These biological changes may contribute to the intergenerational transmission of CSA's effects (Lo Iacono et al., 2021). Supporting this, a systematic review by Soares, Rocha, Kelly-Irving, Stringhini, and Fraga (2021) found that ACE's are associated with significant biological changes in early life, including alterations in immune system biomarkers, DNA methylation, and telomere length. These changes may underlie the increased risk for mental health and physical disorders in individuals with a history of CSA and other ACEs (Danese & Baldwin, 2017; Lo Iacono et al., 2021; Soares et al., 2021).

From a psychological perspective, one explanation for the negative repercussions of CSA and other ACE's is the inhibition of mental state processing and somatic experiences due to dissociation, which may protect individuals from consciously recognising trauma-related emotions (Schimmenti & Bifulco, 2015; Schimmenti, Billieux, Santoro, Casale, & Starcevic, 2022). The dissociative processes induced by developmental trauma can contribute to the development of dissociative disorders or manifest variably across diagnostic categories,

complicating clinical presentations and worsening prognostic outcomes (Farina, Liotti, & Imperatori, 2019). In addition to dissociation, early traumatic events may trigger posttraumatic distress, which, when combined with maladaptive emotion regulation patterns, may contribute to several problematic behaviours (Greene, McCoach, Briggs-Gowan, & Grasso, 2021; Kirk-Provencher et al., 2022; Müller et al., 2015; Renaud, Jakubiec, Swendsen, & Fatseas, 2021).

A particularly significant maladaptive behaviour stemming from these emotion regulation difficulties is substance use and the development of SUD, a pattern commonly associated with CSA (Curran, Perra, Rosato, Ferry, & Leavey, 2021; Greene, McCoach, Briggs-Gowan, & Grasso, 2021; Müller et al., 2015; Renaud, Jakubiec, Swendsen, & Fatseas, 2021; Schimmenti et al., 2022; Snow et al., 2022). For example, men with histories of CSA often use emotion regulation strategies such as expressive suppression, rumination, and cognitive avoidance to cope with distress, and while NSSI and rumination are linked to internalising difficulties, self-medication is associated with externalising behaviours (Snow et al., 2022). Trauma-related dysregulation of mental and bodily states, often alleviated through substances that have an “anaesthetic” effect, may help explain the self-medication hypothesis (SMH), which posits that individuals with psychiatric disorders develop SUD’s to alleviate their symptoms (Khantzian, 1985; Robinson, Sareen, Cox, & Bolton, 2009). Schimmenti et al. (2022) support this model, suggesting that childhood neglect and abuse can lead to substance use as individuals attempt to self-regulate or soothe their internal states, often suppressing trauma-related emotions and memories from conscious awareness. These mechanisms of emotional dysregulation and coping strategies may also contribute to other behavioural patterns, including psychosexual behaviours, which will be explored in subsequent sections.

1.1.2 Gender patterns in CSA studies

Research indicates certain gender differences in the types and outcomes of CSA; however, these distinctions may be more perceptual than substantive. Gendered outcomes have been observed in areas such as physical aggression, NSSI, suicidality (Renner & Whitney, 2012; Xu et al., 2023; Zhu et al., 2015), risky or compulsive sexual behaviours (Abrams et al., 2019; Scheidell et al., 2017), substance misuse or SUD (Briggs et al., 2021; Guo et al., 2018; Meng & D’Arcy, 2016; Xu et al., 2023), and psychiatric disorders (Abrams et al., 2019; Briggs et al., 2021; Gokten et al.,

2016). These patterns, however, are likely influenced by methodological limitations and societal factors, rather than inherent gender-based differences in CSA's effects.

Some methodological factors may contribute to perceived gender discrepancies in CSA outcomes. For example, studies incorporating other forms of CA alongside CSA tend to report gender differences in behaviours such as NSSI and SUD; however, when CSA is isolated as a variable, these differences often diminish (Guo et al., 2018; Xu et al., 2023). Furthermore, Briggs et al. (2021) observed that CSA, in combination with other ACE's, produces distinct effects by gender: female CSA survivors are more susceptible to mental health issues, while male survivors exhibit higher risks of substance misuse, although the authors suggest that developmental stages may play a role in these gendered outcomes, underscoring the importance of age when assessing CSA's impact. Differences in developmental timing may also explain inconsistencies in gender-related attachment outcomes, as attachment styles in CSA survivors may vary based on the age at which the abuse occurred (Charest, Hébert, & Bernier, 2018; Ensink, Borelli, Normandin, Target, & Fonagy, 2020; Meyer, Cohn, Robinson, Muse, & Hughes, 2017). Additionally, differences in disclosure timing often correlate with abuse severity; for instance, male survivors tend to delay disclosure when experiencing severe CSA, such as penetrative abuse (Rosmarin et al., 2018), while female survivors may delay when their experiences are of higher severity than those of male survivors (Hemanth et al., 2024). Thus, co-occurring ACE's, developmental timing, and CSA severity may contribute to observed gender differences.

Societal misconceptions and gender norms also shape gendered patterns in CSA outcomes. CSA is often perceived as primarily affecting girls, while masculine ideals of strength and self-reliance may discourage male survivors from acknowledging its effects (Attrash-Najjar et al., 2023; Baidawi, Papalia, & Featherston, 2023; Easton, Kong, & McKetchnie, 2022; Gewirtz-Meydan & Finkelhor, 2020). For example, Gewirtz-Meydan and Finkelhor (2020) found that female survivors reported higher levels of fear related to their abuse, which may reflect male survivors' tendency to downplay trauma to align with traditional gender roles and avoid stigma associated with vulnerability. Consequently, studies that report gender differences in CSA outcomes suggest that these disparities often stem from cultural expectations and societal stigmas surrounding masculinity rather than from inherent differences in abuse experiences or impact (Attrash-Najjar et al., 2023; Baidawi et al., 2023; Gewirtz-Meydan & Finkelhor, 2020; Rosmarin

et al., 2018). These societal pressures may have long-term implications for male survivors, including delayed disclosures, an increased risk of self-medication behaviours, and impacts on psychosexual development, topics further explored in subsequent sections.

1.1.3 CSA disclosure

Many of the negative outcomes associated with CSA can be exacerbated by nondisclosure or delayed disclosure of the abuse (Alaggia, 2010; Easton, 2013; Gemara & Katz, 2023; Marriott, Hamilton-Giachritsis, & Harrop, 2014; Weare et al., 2024). Although it is not feasible to obtain participants who have never disclosed their abuse, studies examining first disclosures, delayed disclosures, and retrospective reasons for nondisclosure provide valuable insights. Barriers to disclosure include a lack of social support (Drewitt-Smith & Marczak, 2023; Humphries, Debowska, Boduszek, & Mattison, 2016), perceptions of non-caring or overprotective parents (Alyce, Taggart, & Turton, 2024; Priebe & Svedin, 2008), experiences of physiological pleasure during the abuse (Holmes, 2008; Swathisha & Deb, 2022; Thomas & Kopel, 2023), and feelings of complicity in the abuse (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Malloy, Brubacher, & Lamb, 2011; Thomas & Kopel, 2023). Additional barriers include higher abuse severity (Hemanth et al., 2024; Priebe & Svedin, 2008; Rosmarin et al., 2018), intrafamilial abuse (Gemara & Katz, 2023; Hemanth et al., 2024; Latiff et al., 2024), the presence of other ACE's (Attrash-Najjar et al., 2023; Gemara & Katz, 2023; Hemanth et al., 2024; Lahtinen, Laitila, Korkman, & Ellonen, 2018; Latiff et al., 2024), stigma surrounding victimhood (Kennedy & Prock, 2018; Lewis, Kiemle, Lowe, & Balfour, 2022; Vollman, 2021), fear of reprisals, blame, or disbelief (Drewitt-Smith & Marczak, 2023; Easton et al., 2014; Halvorsen, Harris & Dunn, 2018; Solberg & Stige, 2020; Sorsoli et al., 2008), and conflicting feelings toward the abuser, which complicate self-representation (Halvorsen, Harris & Dunn, 2018; Hemanth et al., 2024; Latiff et al., 2024).

For survivors of CSA, the reactions of disclosure recipients play a crucial role in helping them process distressing events and develop a more integrated and nuanced understanding of their experiences (Lassri & Gewirtz-Meydan, 2024; McElvaney, Monaghan, Treacy, & Delaney, 2023). Caregivers, particularly during childhood, are essential in both halting the abuse and supporting the child's recovery (Brennan & McElvaney, 2020; Manay & Collin-Vézina, 2021;

Gemara & Katz, 2023; Maleki, Damghanian, Rad, & Farnam, 2023). By fostering an environment where children feel safe to disclose their experiences, caregivers can help them recognize the moral transgression of the perpetrator, alleviating self-blame, and highlight the broader impact of the abuse (Gemara & Katz, 2023). Broman-Fulks et al. (2007) found that first disclosures to mothers were associated with significantly reduced risks of later PTSD, major depressive episodes, and delinquency. Other research has shown that mothers are the most common recipients of first CSA disclosures, particularly among male survivors (Edinburgh et al., 2006; Foster, 2017; Reitsema & Grietens, 2015). None of these studies have, however, examined whether participants who disclosed to their caregivers were victims of intrafamilial CSA or experienced other ACE's, factors that may influence disclosure outcomes.

Although disclosing CSA has the potential to reduce later psychological distress, the benefits are largely contingent on the responses of others. Compared to survivors of other types of trauma, CSA survivors are more likely to be disbelieved and stigmatised upon disclosing their victimisation (Davis et al., 2018; Glina, Carvalho, Barroso, & Cardoso, 2022; Ullman, Starzynski, Long, Mason, & Long, 2008). Negative reactions from listeners—such as accusatory, egocentric, controlling, or indifferent responses—can further exacerbate the negative impact of CSA and result in a disclosure experience that compounds the psychological consequences of abuse (Bi et al., 2018; Rees, Simpson, McCormack, Moussa, & Amanatidis, 2019; Relyea & Ullman, 2015; Tener, 2018). Such reactions can also discourage survivors from seeking additional help (Campbell & Raja, 2005; Kennedy & Prock, 2018; Mourtgos, Adams, & Mastracci, 2021) and contribute to the development of traumatic symptoms and self-blame (Hébert, Amédée, Théorêt, & Petit, 2022; Jouriles, Sitton, Adams, Jackson, & McDonald, 2022; Spaccarelli, 1994). Even when caregivers' responses are well-intentioned and protective, they may limit the child's activities following a disclosure (Bi et al., 2019; Gemara, Mishna, & Katz, 2023; Spaccarelli, 1994). For example, Gemara et al. (2023) found that children victimised by online sexual solicitation were less likely to disclose to parents due to fears of losing access to social media or having their internet usage restricted. This aligns with the findings of Bi et al. (2019), who reported that two-thirds of adolescent CSA survivors experienced a loss of social contact following disclosure, a change correlated with feelings of self-blame. Spaccarelli's (1994) transactional model suggests that reduced social contact may result from CSA's negative impact on the survivor's social environment, as caregivers limit social activities, or from the

survivor's internalised sense of shame (Attrash-Najjar et al., 2023; Feiring, Taska, & Chen, 2002). These reactions can exacerbate the survivor's negative internalisations from the abuse and, when disclosure occurs in childhood, may even contribute to the persistence of the CSA trauma.

Victims of intrafamilial CSA often face significant barriers to disclosing their abuse, either due to negative reactions or by withholding disclosure from family members altogether (Gemara & Katz, 2023; Hemanth et al., 2024; Latiff et al., 2024). In some instances, victims of intrafamilial CSA who do disclose may encounter accusatory responses or be coerced into maintaining secrecy, which can be linked to increased feelings of self-blame, suicidal ideation, and other mental health issues (Attrash-Najjar et al., 2023; Gemara & Katz, 2023; Rees, Simpson, McCormack, Moussa, & Amanatidis, 2019; Tener, 2018). More commonly, however, CSA victims may consciously or subconsciously choose not to disclose abuse, particularly when the perpetrator is a close family member (Bottoms et al., 2016; Brennan & McElvaney, 2020; Gemara & Katz, 2023; Kogan, 2004; Hemanth et al., 2024; Latiff et al., 2024; Leclerc & Wortley, 2015; Magnusson, Ernberg, & Landström, 2017; Morrison, Bruce, & Wilson, 2018; Priebe & Svedin, 2008). This decision is often rooted in fears of punishment, blame, perceived disloyalty, or the potential to destroy the family (Fisher, 2017; Gemara & Katz, 2023; Lemaigre, Taylor, & Gittoes, 2017; Tener, 2018). These victims frequently feel a sense of partial responsibility for the abuse, leading to concerns that disclosing the abuse could harm non-perpetrating family members (Gemara & Katz, 2023; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Malloy et al., 2011; Tener, 2018). Furthermore, disclosure within the family may threaten the child's attachment to the perpetrator, as well as their trust in and care for them (Alyce et al., 2024; Elfreich, Stevenson, Sisson, Winstead, & Parmenter, 2020; Gemara & Katz, 2023; Halvorsen, Solberg, & Stige, 2020; Latiff et al., 2024; Seto, Babchishin, Pullman, & McPhail, 2015). Consequently, the fear of damaging family bonds and the loss of trust in the family environment may make disclosure seem too dangerous or even unthinkable for many survivors of intrafamilial CSA.

Experiencing intrafamilial CSA often correlates with a broader family context marked by other ACE's. Even in the absence of intrafamilial CSA, exposure to other ACE's is associated with delayed or inhibited CSA disclosure (Attrash-Najjar et al., 2023; Gemara & Katz, 2023;

Hemanth et al., 2024; Lahtinen, Laitila, Korkman, & Ellonen, 2018; Latiff et al., 2024; Leclerc & Wortley, 2015; Tashjian, Goldfarb, Goodman, Quas, & Edelstein, 2016). Victims of CSA may predict a lack of parental support or doubt their parents' ability to respond appropriately to their disclosure, potentially due to prior experiences of hostility or maltreatment by those same parents (Lahtinen et al., 2018; Latiff et al., 2024; Mikulincer & Shaver, 2003; Tashjian et al., 2016). Furthermore, a lack of trust in caregivers often stems from a child's insecure attachment to a maltreating parent, which can further hinder disclosure (Drewitt-Smith & Marczak, 2023; Tashjian et al., 2016). When children do disclose CSA, the absence of support from non-offending caregivers may occur, particularly in households where other forms of abuse or neglect are present (Elliott & Briere, 1994; Latiff et al., 2024). The cumulative impact of CSA and other ACE's may thus be partially explained by these delayed or unsupported disclosures, which hinder the survivor's recovery and contribute to long-term psychological distress.

The process of disclosure for survivors of CSA is complex and heavily influenced by both individual and environmental factors. Barriers such as a lack of social support, fear of disbelief or reprisals, and confusion about the abuser often impede disclosure, particularly in cases of intrafamilial abuse. The reactions of disclosure recipients, particularly caregivers, play a critical role in either mitigating or exacerbating the psychological consequences of abuse. Supportive, non-judgmental responses can reduce the risk of trauma-related outcomes, whereas negative reactions can reinforce feelings of self-blame and hinder recovery. The presence of other ACE's within the family context further complicates disclosure, as survivors may lack trust in caregivers or fear the repercussions of revealing the abuse. Together, these factors underscore the importance of understanding disclosure not only as a personal experience but as a dynamic process shaped by familial, societal, and relational contexts, which can significantly affect the survivor's psychological trajectory.

1.1.4 Gender patterns in CSA disclosure

Gender has been identified as a significant factor in delayed disclosure of CSA. While male and female survivors experience comparable psychological effects from CSA (Gewirtz-Meydan, Walsh, Wolak, & Finkelhor, 2018), male survivors are considerably less likely to disclose their abuse (Drewitt-Smith & Marczak, 2023; Easton & Parchment, 2021; Edinburgh et al., 2015; Gewirtz-Meydan et al., 2018; Gill & Begum, 2023; Hounmenou, 2017; Latiff et al., 2024; Okur,

van der Knaap, & Bogaerts, 2017; Romano, Moorman, Ressel, & Lyons, 2019; Sølvsberg et al., 2023). This reluctance may be influenced by a lack of awareness that CSA can affect men, and insufficient resources and services tailored to male survivors, and societal pressures to conform to traditional masculine norms, which discourage vulnerability and disclosure.

The experiences of male CSA survivors and their unique challenges are often under-recognised. Societal misconceptions, such as the belief that CSA predominantly targets girls or that male victimisation is rare and less harmful, reinforce a harmful narrative that isolates male survivors and impedes their help-seeking behaviours (Alaggia, Collin-Vézina, & Lateef, 2017; Attrash-Najjar et al., 2023; Easton & Parchment, 2021; Easton et al., 2022). Compounding this issue is the erroneous assumption that women cannot perpetrate CSA, which discourages male survivors from labelling abusive experiences involving female perpetrators as such (Latiff et al., 2024; Thomas & Kopel, 2023; Weare, Hulley, & Craig, 2024). This societal denial of male victimhood not only silences survivors but also perpetuates myths that minimise the impact of abuse on men.

A significant barrier to addressing these misconceptions is the limited research and resources dedicated to understanding male CSA. Studies on female survivors—including those examining motherhood and intergenerational trauma—are extensive, yet equivalent research on male survivors, such as fathers with CSA histories, remains disproportionately scarce (for reviews, see Fatehi, Miller, Fatehi, & Mowbray, 2022; Stephenson et al., 2018). This imbalance in research reflects a broader lack of gender-sensitive support systems, leaving male survivors feeling unsupported and misunderstood by services that often prioritise female-centric experiences (Brown et al., 2022; Easton & Parchment, 2021; Sivagurunathan et al., 2019). Without tailored interventions, male survivors frequently face significant barriers in accessing the care they need, which exacerbates their feelings of alienation (Drewitt-Smith & Marczak, 2023; Easton et al., 2022).

Male survivors also encounter systemic barriers when attempting to disclose their experiences or seek support. Many report lower levels of perceived social support compared to their female counterparts, further diminishing their trust in healthcare and social services (Curran et al., 2021). The lack of gender-sensitive approaches in psychosocial interventions compounds this mistrust, as these services often fail to address issues such as male sexuality, identity, and the

unique challenges male survivors face in their recovery (Brown et al., 2022; Easton, 2020; Rapsey, Campbell, Clearwater, & Patterson, 2020). The lack of awareness around male victimisation not only restricts available interventions, but also limits public understanding of male survivors' experiences (Easton & Parchment, 2021; Latiff et al., 2024; Weare et al., 2024). Consequently, male survivors are less likely to disclose their abuse or seek professional help, perpetuating a cycle of unmet needs and unaddressed trauma (Attrash-Najjar et al., 2023; Easton et al., 2022).

The limited awareness, resources, and research concerning male CSA are further compounded by societal masculine norms, a critical factor that disproportionately influences male survivors compared to female survivors, often contributing to delayed or absent disclosures in childhood. Although gender ideals may also influence women in certain contexts (e.g., delaying CSA disclosure due to cultural beliefs surrounding reputation and marriageability in highly religious communities; Hemanth et al., 2024; Latiff et al., 2024; Mordi et al., 2022), they exert a particularly strong influence on men. Traditional masculine norms, such as stoicism, emotional restraint, and self-reliance, discourage men from seeking support or disclosing their experiences, as doing so is perceived as a violation of these ideals (Alaggia, 2005; Hlavka, 2017; Simon, Smith, Fava, & Feiring, 2015). These societal pressures are further compounded by cultural influences, such as fears of being perceived as homosexual (Easton, Leone-Sheehan, & O'Leary, 2019; Easton & Parchment, 2021; Foster, 2017; Vollman, 2021) or as potential perpetrators of abuse (Easton & Parchment, 2021; Von Hohendorff, Habigzang, & Koller, 2017). For instance, male CSA survivors of male perpetrators may feel more self-blame and greater anxiety toward disclosing the abuse, for fear of being blamed or judged because of their sexual orientation or perceived signalling (Easton & Parchment, 2021; Harris & Dunn, 2019).

Masculine socialisation teaches men to embody self-sufficiency and strength, often resulting in emotional suppression and denial of their experiences (Myrie & Schwab, 2023; Staiger et al., 2020). These norms vary across cultural and ethnic contexts, with research indicating that cultural expectations intersect with masculine ideals to further deter disclosure and help-seeking behaviours among male survivors (Curran et al., 2021; Levine, 2018; Myrie & Schwab, 2023; Sivagurunathan, Orchard, MacDermid, & Evans, 2019). For example, Myrie and Schwab (2023) found that African-Caribbean Black male CSA survivors, influenced by cultural norms of

stoicism and emotional control, often suppressed their emotions and avoided seeking support to avoid appearing vulnerable. Similarly, British South Asian male survivors face compounded stigma due to the intersection of cultural and gendered norms, which hinder their access to support services and willingness to report abuse (Gill & Begum, 2023).

These societal and cultural expectations contribute to a general reluctance among men to engage with mental health services, which is also reflected in the broader context of help-seeking behaviours. Men consistently access mental health services less frequently than women, a trend attributed to traditional masculine ideals that emphasise invulnerability and discourage reliance on external support (Curran et al., 2021; Sagar-Ouriaghli, Godfrey, Bridge, Meade, & Brown, 2019; Staiger et al., 2020; Wildey, Fox, Machnik, & Ronk, 2022). This reluctance is further reinforced by workplace stigma and societal attitudes that equate emotional expression with weakness, thereby prioritising independence and resilience over mental health support (Staiger et al., 2020). Curran et al. (2021) also observed that men reported significantly higher levels of self-stigma regarding help-seeking and held more negative perceptions of mental health services compared to women. These attitudes can lead to the misperception among healthcare providers that men are self-reliant and do not require support, particularly when men exhibit externalising behaviours that mask underlying issues, such as CSA-related trauma (Rapsey et al., 2020; Wildey et al., 2022).

Furthermore, societal perceptions of masculinity can overtly reinforce these barriers. Male CSA survivors who express intense emotions during disclosure or recovery are often viewed as failing to meet societal expectations of masculine strength.; such perceptions can impede their career advancement or fulfilment of traditional provider roles, further deterring emotional expression and help-seeking behaviours (Easton, Saltzman, & Willis, 2014; Evenson, Rhodes, Feigenbaum, & Solly, 2008; Myrie & Schwab, 2023; Staiger et al., 2020). In this way, societal norms not only discourage male survivors from seeking support, but also influence how others, including professionals and family members, perceive and respond to their needs.

The intersection of societal masculine norms and a lack of disclosure among male CSA survivors can contribute to a range of maladaptive coping behaviours. Male survivors, who often face lower levels of perceived social support than their female counterparts (Curran et al., 2021), may engage in self-medicating behaviours, including substance use, as a way of coping with their

trauma while conforming to masculine ideals of self-reliance and emotional restraint (Curran et al., 2021; Lavergne et al., 2022a). Studies indicate that male survivors are at an elevated risk of developing SUD (Information Service Division, 2020; Turner et al., 2018), which may serve as a maladaptive mechanism to suppress or manage symptoms associated with CSA and other ACE's (Snow, Moorman, & Romano, 2022). This behaviour aligns with broader findings that men often turn to externalising coping strategies, such as behavioural disengagement and substance misuse, rather than seeking professional help (Curran et al., 2021).

Masculine norms not only discourage emotional expression but also influence broader patterns of coping with CSA-related trauma, including suicidality. Research underscores the heightened risk of suicide attempts among men with CSA histories compared to men without (Blosnich et al., 2021; O'Gorman et al., 2024), which may partly stem from their reluctance to seek mental health support due to societal expectations prioritising strength and independence (Staiger et al., 2020). Additionally, coping mechanisms such as compulsive sexual behaviours or hypersexuality have also been observed among male CSA survivors, though the nuanced relationships between these behaviours, CSA severity, and societal pressures will be addressed in a subsequent section. The adoption of maladaptive strategies is reflective of the broader challenges male survivors face in reconciling their experiences with societal ideals of masculinity (Rapsey et al., 2020).

The reluctance among male CSA survivors to disclose their abuse and seek support is shaped by deeply ingrained societal masculine norms, a lack of recognition of male victimhood, and systemic barriers in healthcare and social support systems. These factors converge to create an environment in which male survivors are not only less likely to disclose their experiences but are also more prone to engaging in maladaptive coping mechanisms, such as substance use or externalising behaviours, to manage their trauma. These maladaptive responses not only perpetuate the cycle of unaddressed trauma but also intersect with challenges in psychosexual development, underscoring the complex and lasting effects of CSA on these survivors.

1.1.5 Psychosexual development

Because CSA, by nature, is a traumatic sexual experience in childhood and, therefore, often occurs during critical developmental stages, it can disrupt the victim's emerging sexual identity, desires, behaviours, and capacity for intimate relationships. Research consistently associates

CSA with problematic sexual thoughts and behaviours (PSTB), including unrestricted or forceful sexual fantasies (Gewirtz-Meydan & Opuda, 2023). Other documented outcomes include earlier sexual debut (Song & Qian, 2020; Tang, Qu, Li, & Tan, 2018; Williams-Butler, Howard, Anthony, & Duron, 2023) and risky sexual behaviours (RSB), such as extradyadic sexual involvement (Ménard & MacIntosh, 2021; Vaillancourt-Morel et al., 2016), unprotected sex² (Noll, Trickett, & Putnam, 2003; Tang et al., 2018), and sex trading (Scheidell et al., 2017). Additional behaviours often tied to CSA include using recreational substances to facilitate sexual activity (Alley & Diamond, 2021; Ménard & MacIntosh, 2021; Stavro et al., 2013; Williams-Butler et al., 2023) and compulsive sexual behaviours (CSB³; Gewirtz-Meydan & Godbout, 2023; Reed et al., 2022). PSTB excludes factors such as the number of sexual partners or experiences, as these may align with RSB or CSB, or—from an adaptive perspective—represent efforts to process and navigate the aftermath of abuse (Fava, Coxe, Fortenberry, & Bay-Cheng, 2024).

In addition to behaviours characterised by heightened sexual activity, CSA is also associated with PSTB comprising patterns of avoidance or inhibition. Survivors may exhibit sexual aversion or ambivalence (Borg, Both, ter Kuile, & de Jong, 2020; Labadie et al., 2018), or reduced sexual excitation (Kilimnik & Meston, 2016). PSTB among CSA survivors may reflect the complexity of trauma processing, shaping survivors' sexual and relational trajectories through patterns of compulsivity, risk behaviours, avoidance, inhibition, and attempts to manage the psychological consequences of abuse.

Several PSTB are found to be at higher risk among CSA survivors, particularly when the abuse is more severe, intrafamilial, or accompanied by other CA or ACE (Basting et al., 2024; Cassioli et al., 2024; Slavin et al., 2020b; Tang, Qu, Li, & Tan, 2018; Vaillancourt-Morel et al., 2016). These RSB or CSB often co-occur with other psychiatric disorders, such as PTSD and SUD. For

² This specifically refers to sex with increased exposure to unwanted pregnancies and/or STI's.

³ For the purpose of this study, CSB will encompass the terms sexual compulsivity (Coleman, 1987), sexual addiction (Carnes, 1991), and hypersexuality (Kafka, 2010). This terminology denotes a population experiencing difficulties with and repercussions from a perceived loss of control over their sexual thoughts and behaviours (Karila et al., 2014; Pistre, Schreck, Grall-Bronnec, & Fatseas, 2023; Reed et al., 2022; Stavro, Rizkallah, Dinh-Williams, Chiasson, & Potvin, 2013).

instance, Basting et al. (2024) found that adults with SUD who experienced a higher number of ACEs were at the greatest risk for both PTSD symptoms and CSB. Similarly, Giordano et al. (2024) found CSA to be the strongest predictor of sex addiction, followed by childhood emotional abuse (CEA), childhood physical abuse (CPA), and general childhood abuse (CA). These findings align with earlier research, which highlights the cumulative impact of CSA and other ACEs on RSB and CSB (Slavin et al., 2020b).

Motivation and incentives behind RSB and CSB in CSA survivors are important to understand. CSB and RSB may be linked to neurological traits in CSA, where biological adaptations foster survival and reproductive success in stressful environments. Alley and Diamond (2021) build on the life history theory (LHT), suggesting that childhood adversity is associated with later engagement in risky behaviours due to adaptations that promote survival and reproductive success in harsh environments. According to LHT, earlier sexual initiation, sexual maturation, and greater numbers of sexual partners may increase the risk of STI's and pregnancy, which could be adaptive for early reproduction (Alley & Diamond, 2021). In addition, Alley and Diamond (2021) propose *sexual reward sensitivity* as a mediator, suggesting that victims of early adversity may be more motivated to engage in high-risk sexual behaviours due to neurobiological and psychological sensitivity to immediate rewards, while disregarding long-term societal and physiological outcomes.

PSTB associated with ACE's, particularly CSA, have been linked to significant health consequences in survivors, including genitourinary symptoms and pregnancies in adolescent female victims (Noll et al., 2003; Tang et al., 2018; Vézina-Gagnon et al., 2021). Song and Qian (2020) investigated the effects of ACE's on adolescent sexual behaviours, finding that all ACE's were associated with earlier sexual initiation, inconsistent birth control use, and increased likelihood of teen motherhood; notably, these outcomes were more pronounced in CSA survivors, who also reported heightened preoccupation with sexual thoughts. Vézina-Gagnon et al. (2021) further examined the associations between CSA, psychiatric comorbidities, and genitourinary health in girls, revealing that CSA survivors were significantly more likely to be diagnosed with both urinary and genital diseases compared to their peers. This study suggests that psychiatric comorbidities partially mediate these associations, indicating that the adverse effects of CSA on genitourinary health may be driven by elevated psychiatric risks

(Vézina-Gagnon et al., 2021). These findings align with the adaptive framework proposed by LHT, suggesting that such sexual behaviours may reflect strategic responses to environmental and developmental conditions.

A similar neurobiological and psychological mechanism underlying sexual reward sensitivity in LHT may also help explain the overlap between substance use and PSTB (Golder et al., 2024; Stavro, Rizkallah, Dinh-Williams, Chiasson, & Potvin, 2013; Snaychuk, Dermody, Tabri, Basedow, & Kim, 2024). Both behaviours may stem from shared pathways of compulsivity or sensation-seeking tendencies, which are particularly pronounced in individuals with CSA histories (Ballester-Arnal, Castro-Calvo, Gimenez-Garcia, Gil-Julia, & Gil-Llario, 2020; Basting et al., 2024; Ménard & MacIntosh, 2021; Reed et al., 2022; Stavro et al., 2013; Turner et al., 2022). Research has suggested that neural plasticity in addiction-related circuitry may be induced by the natural reward system and/or a dysfunctional stress response (Jha & Banerjee, 2022; Nielsen, Mennies, & Olino, 2020; Petersson & Plantin, 2023; Turner et al., 2022). Substances may have disinhibitory effects on sexual behaviour, which may be perceived as enhancing sexual experiences and increase the likelihood of engaging in CSB or RSB (Bosma-Bleeker & Blaauw, 2018; Stavro et al., 2013; Turner et al., 2022). Additionally, psychological distress associated with PSTB may lead individuals to cope through substance use, or those with SUD and CSB may share common vulnerability factors that predispose them to both behaviours (Stavro et al., 2013; Golder et al., 2024). This connection further underscores the complexity of CSA survivors' coping mechanisms, where maladaptive behaviours such as substance use and PSTB are interlinked and often driven by similar neurobiological and psychological processes.

While the LHT provides a helpful framework for understanding the neurobiological and evolutionary mechanisms underlying RSB and CSB in CSA survivors, it may risk oversimplifying or overlooking the complexities of the mechanisms involved. Specifically, RSB and CSB have been linked to dissociation, body shame, emotional dysregulation, and sexual dysfunction (Brem et al., 2017; Cassioli et al., 2024; Petersson & Plantin, 2023). For instance, Cassioli and colleagues (2024) found that childhood trauma in men predicted CSB and erectile dysfunction (ED), mediated by body uneasiness and psychopathology. Additionally, CSA survivors may be more vulnerable to experiencing sexual aversion, inhibition, dysfunction, and

lower sexual excitation (Borg et al., 2020; Gewirtz-Meydan & Lahav, 2020; Jones & Lorenz, 2024; Kilimnik & Meston, 2016; Labadie et al., 2018).

In a systematic literature review, Bigras, Vaillancourt-Morel, Nolin, and Bergeron (2021) found that CSA survivors were significantly more likely to experience sexual aversion and avoidance behaviours, characterised by heightened sexual anxiety, fear, dissatisfaction, and difficulties with arousal, orgasm, and sexual self-esteem, compared to individuals without CSA histories. These sexual difficulties often contributed to conflicted feelings about sexuality and lower sexual satisfaction in adult relationships (Bigras et al., 2021). Furthermore, CSA has been associated with sexual dysfunction in domains such as orgasm, sexual drive, and relationship satisfaction (Cassioli et al., 2024; Cui et al., 2019; Gewirtz-Meydan & Opuda, 2022; Loeb et al., 2002; Petersson & Plantin, 2023; Swaby & Morgan, 2009; Thomas & Kopel, 2023). A recent systematic review and meta-analysis found that women with a history of CSA exhibited lower sexual function across multiple domains—including sexual arousal, desire, lubrication, and pain—and experienced increased sexual distress compared to those without CSA histories (Aşcı, Bal, & Koçoğlu, 2024). Mixed findings were reported for male CSA survivors, with some evidence of low sexual drive, arousal problems, and difficulties with orgasm and pain (Gewirtz-Meydan & Opuda, 2022).

Sexual aversion or avoidance may stem from anxiety and disgust associated with sexual activity (Jones & Lorenz, 2024; Lafortune et al., 2024), which could be rooted in prior traumatic sexual experiences. Interestingly, Jones and Lorenz (2024) found that heightened avoidance of sexual stimuli, rather than sexual disgust, was a greater contributor to sexual aversion in CSA survivors specifically. These findings underscore the complexity of sexual difficulties in CSA survivors, highlighting the need for a more comprehensive psychological explanation.

From a psychodynamic perspective on CSA and psychosexual development, Browning and Laumann (1997) propose a life-course model in which early sexual abuse fosters the development of inappropriate sexual behaviours, thereby increasing the likelihood of risky sexual behaviours in adulthood. Similarly, Finkelhor and Browne's (1985) traumagenic dynamics model identifies four key psychological outcomes of CSA: traumatic sexualisation, betrayal, powerlessness, and stigmatisation. Traumatic sexualisation involves the manipulation or

fetishisation of a child's sexual responses, shaping their sexual attitudes and behaviours inappropriately. Betrayal arises when a child is harmed by a trusted person, whether through active abuse or neglect, particularly when the relationship was initially perceived as safe and positive. Powerlessness is the result of repeated violations of personal boundaries, often reinforced by coercion and fear. Stigmatisation, on the other hand, entails the imposition of shame, guilt, and a sense of moral deficiency, affecting the survivor's self-concept.

The survivor's response to these dynamics can vary significantly, influenced by individual factors. Some may exhibit RSB and/or CSB as attempts to cope with or override the negative emotions stemming from their trauma (Finkelhor & Browne, 1985; Petersson & Plantin, 2023; Pulverman & Meston, 2020). Conversely, others may develop aversions toward sexual thoughts and activities, seeking to distance themselves from these negative emotions (Fava et al., 2024; Finkelhor & Browne, 1985; Noll et al., 2003). These divergent responses can lead to complex patterns of sexual behaviour, such as aversion to sexual activity or, paradoxically, a reenactment of situations reminiscent of the abuse itself (Cassioli et al., 2024; Gewirtz-Meydan & Opuda, 2022; Finkelhor & Browne, 1985).

Repeated exposure to sexualisation during abuse can extend to later intimate relationships, making it difficult for survivors to derive non-sexual rewards and potentially increasing the risk of engaging in risky sexual encounters (Cassioli et al., 2024; Finkelhor & Browne, 1985; Noll et al., 2003; Petersson & Plantin, 2023; Rettenberger, Klein, & Briken, 2016). Kilimnik and Meston (2016) found that while perceived sexual attractiveness was associated with sexual inhibition across all groups of female participants, it was specifically linked to sexual excitation only among women with a history of CSA. The intrusive nature of early sexual victimisation and subsequent stigmatisation can profoundly affect a survivor's self-concept, fostering feelings of moral deficiency and shame regarding sexual desire (Attrash-Najjar et al., 2023; Dorahy & Clearwater, 2012; Fava et al., 2024; Gewirtz-Meydan & Ofir-Lavee, 2020; Litam & Speciale, 2021; Schramm & Tapia, 2024; Pulverman et al., 2018). These feelings of shame can exacerbate negative self-beliefs and schemas, influencing sexual experiences and undermining both sexual functioning and psychological well-being (Cassioli et al., 2024; Cui et al., 2019; Healy, Lee, & D'Andrea, 2021). Anxiety, depression, and shame related to CSA have been shown to contribute to sexual dysfunction, including difficulties in achieving sexual climax or satisfaction, as well as

increased sexual compulsivity (Cassioli et al., 2024; Petersson & Plantin, 2023; Pulverman & Meston, 2020; Rendina, López-Matos, Wang, Pachankis, & Parsons, 2019; Swaby & Morgan, 2009). This may lead to a range of PSTB, such as sexual avoidance, risk-taking, compulsivity, or dysfunction.

PSTB in CSA survivors are often linked to relationship dissatisfaction. Petersson and Plantin (2023) found that compromised sexual identity, sexual dysfunctions and compulsions, emotional dysregulation, and body shame contributed to difficulties with intimacy in CSA survivors. Similar findings have highlighted that CSA often leads to challenges in forming and maintaining intimate relationships in adulthood (Attrash-Najjar et al., 2023; Gewirtz-Meydan & Lahav, 2020; Lewis, Kiemle, Lowe, & Balfour, 2022; Thomas & Kopel, 2023; Weetman, Kiemle, Lowe, & Balfour, 2022). These findings underscore the enduring impact of CSA on intimate relationships and sexual well-being.

Gender differences in PSTB among CSA survivors are well-documented, although the patterns and interpretations of these differences remain complex. Both female and male CSA survivors are more likely to exhibit PSTB compared to those without CSA histories (Alley & Diamond, 2021; Barker et al., 2022; Brem, Shorey, Anderson, & Stuart, 2017; Drewitt-Smith & Marczak, 2023; Meyer et al., 2017; Thomas & Kopel, 2023). Distinct gendered trends have been observed, however, particularly in the prevalence of CSB. Research indicates that men in the general population, regardless of CSA history, are more likely to engage in CSB compared to women (Briken et al., 2022; Reed et al., 2022), with male CSA survivors exhibiting the highest levels of CSB (Slavin et al., 2020a; Thomas & Kopel, 2023). Slavin et al. (2020a), in a large-scale Hungarian study, controlled for factors such as sexual orientation and relationship status, finding that men with CSA histories disproportionately reported elevated CSB, consistent with previous research (Meyer et al., 2017). In contrast, women with CSA histories tend to report lower levels of CSB and higher rates of sexual dysfunction, such as sexual inhibition and problematic pornography use, compared to their male counterparts (Gewirtz-Meydan & Godbout, 2023).

These observed gender differences may, in part, stem from methodological and societal factors. Methodological issues, such as a predominant focus on male samples in studies of CSA-related RSB and CSB, and an emphasis on female samples in research on sexual dysfunction, aversion,

or ambivalence, contribute to these discrepancies (Cavanaugh et al., 2015; Drewitt-Smith & Marczak, 2023; Giordano et al., 2024; Jones & Lorenz, 2024; Pulverman & Meston, 2020). Additionally, inconsistent definitions of CSA, recruitment biases, and unstandardised assessment methods further complicate comparisons (Gewirtz-Meydan & Opuda, 2022; Kilimnik et al., 2018; Ménard & MacIntosh, 2021).

Where gender differences do emerge, societal norms surrounding masculinity likely play a significant role. Constructs such as “hypermasculine” or “hypersexual” stereotypes may drive male CSA survivors toward compensatory behaviours, including increased CSB, as a maladaptive response to sexual trauma (Abrams et al., 2019; Attrash-Najjar et al., 2023; Thomas & Kopel, 2023). For male survivors abused by same-sex perpetrators, these norms may also exacerbate internalised stigma and complicate psychosexual development, particularly among those identifying as homosexual or bisexual, due to self-blame or fear of societal judgement (Alaggia, 2005; Easton & Parchment, 2021; Vollman, 2021). These findings underscore the methodological and societal influences, including inconsistent research practices and traditional masculine norms, that appear to shape these observed gender disparities.

The psychosexual development of CSA survivors is a complex process, shaped by both biological and psychological factors. The trauma of CSA can lead to a range of PSTB, including sexual compulsivity, dysfunction, and avoidance, which often reflect deeper issues of shame, anxiety, and emotional dysregulation. These difficulties are further complicated by gendered experiences, with male survivors exhibiting higher levels of CSB, while female survivors are more likely to experience sexual inhibition and dysfunction. Nevertheless, the complexity of these findings cannot be fully understood without considering methodological factors, such as sample biases and inconsistent research practices, as well as societal influences such as traditional gender norms. These factors not only shape survivors’ psychosexual responses but also influence their coping mechanisms and relationships, highlighting the lasting impact of CSA on sexual well-being and intimacy.

1.2 Overarching aims

The review of existing literature highlights critical gaps that inform the aims of this PhD. While extensive studies examine the long-term impacts of CSA on mental health, substance use, and

psychosexual development, much of the research either focusses on female survivors or generalises findings without accounting for gender-specific challenges. This oversight leaves male survivors' unique experiences underexplored, particularly the influence of societal masculine norms, limited disclosure, and the underrepresentation of male-specific outcomes. Furthermore, while research acknowledges the significance of CSA severity and disclosure experiences, there is limited integration of these factors with other ACE's to understand their compounded effects on developmental trajectories and coping mechanisms.

By incorporating diverse methodological approaches and examining a range of survivor experiences, this PhD offers a broader perspective to fill these critical gaps. It aims to provide a nuanced understanding of CSA's impact across genders, focussing on how abuse characteristics, disclosure experiences, and societal influences intersect to shape CSA survivors' psychosexual development, coping strategies, and broader life outcomes.

The aims of this PhD are to (a) explore gender differences in how victims experience and process CSA and its disclosure; (b) investigate how victims' experience of CSA as well as its disclosure contribute to their later psychosexual development, substance use patterns, and healing processes.

1.3 Scope and integration of empirical studies

The present thesis comprises three empirical studies, each presented in a dedicated chapter. The first study (Chapter 2) examines the relationship between childhood abuse (CA), including CSA, CPA, and CEA, and risk behaviours such as SUD patterns and self-directed violence (SDV). Using hierarchical multiple regression, the study explores how the presence of CA, as well as specific types of abuse, are associated with outcomes such as substance use frequency, polysubstance use, age of substance use initiation, and SDV behaviours, including non-suicidal self-injury (NSSI) and suicidality. Gender is included as a variable to examine its potential role in these associations.

This study aligns with the overarching aims of the dissertation by investigating the broader impacts of CSA and related forms of CA on behavioural and psychological outcomes. It reflects

the goal of contextualising CSA alongside other types of abuse to understand their unique and combined contributions to long-term sequelae, particularly in relation to SUD and SDV.

The second study (Chapter 3) examines the relationship between CA types—CSA, CPA, and CEA—and sexual shame (SS), employing structural equation modelling (SEM) to explore the pathways between these variables. SEM provides a rigorous methodological approach, enabling the examination of both direct and indirect relationships, including mediation effects such as the roles of disclosure experiences (DE) and contextual childhood adversities (CCA). The study uses data from the ROAR Canada project, focussing on individuals with concurrent SUD and psychiatric conditions, to investigate how CA influences psychosexual outcomes such as SS. Key measures include the Childhood Trauma Questionnaire, the Sexual Shame subscale, and the Social Reactions Questionnaire, which facilitate a detailed analysis of abuse types, disclosure quality, and associated psychosocial outcomes.

This study aligns with the overarching aims of the dissertation by exploring how CSA, alongside other abuse types, interacts with mediating factors such as the presence of DE, different DE types, and CCA to shape psychosexual development. The use of SEM allows for an in-depth understanding of these relationships, examining complex pathways and latent constructs that are critical to understanding the impact of CA on outcomes such as SS.

The third study (Chapter 4) employs Constructivist Grounded Theory (CGT) to explore the experiences of CSA disclosure, recovery, and their effects on psychosexual development among male and female survivors. It investigates the timing and nature of survivors' first disclosure experiences, barriers and incentives to disclosure, and how these factors influence recovery and sexual identity. Drawing on in-depth semi-structured interviews with survivors, the study examines the relationships between CSA, disclosure, and outcomes such as sexual identity formation, attachment dynamics, and interpersonal trust. Key themes include the role of supportive and unsupportive reactions to disclosure, the influence of societal norms, and the ways survivors navigate psychosexual development in the context of their abuse histories.

This study connects to the overarching aims of the dissertation by exploring the gendered dimensions of CSA disclosure and recovery processes. It examines how men and women's experiences differ or converge in terms of barriers to disclosure, perceived outcomes, and the

reconstruction of sexual identity and self-concept. By employing CGT, the study enables an in-depth exploration of these complex processes, with a focus on disclosure experiences as a pivotal point in survivors' journeys, aligning with the broader thesis' emphasis on understanding the intersections of CSA, psychosexual development, and recovery.

1.4 Theoretical framework

Ontology and epistemology are important in research, particularly as they reflect a shared belief system (i.e., a paradigm) that influences how the researcher determines from where knowledge stems, and subsequently reflects, articulates and justifies how knowledge is acquired (Creswell, 2013; Morgan, 2022). Ontology is concerned with what knowledge or truth the researcher believes exists, while epistemology is concerned with how the researcher believes s/he could gain knowledge. How data is obtained, analysed, and conveyed will be influenced by the researcher's epistemological stance (Al-Ababneh, 2020; Jones, Torres & Arminio, 2014). As a result, ontological and epistemological positions embedded within the researcher's perspectives may inform the methodological and interpretative decisions enacted (Hathcoat, Meixner, & Nicholas, 2019).

Concepts of reliability and validity traditionally stem from a positivist research paradigm, which are grounded on the notion that a single objective truth exists (Park, Konge, & Artino, 2020). Such a paradigm typically conveys a realist ontology, supporters of which believe that reality is not influenced by individuals (Rehman & Alharthi, 2016). Within the constructivist paradigm and relativist ontology, however, reality is assumed to be dependent on "social actors" (Lincoln, Lynham, & Guba, 2018; Pilarska, 2021; Poucher, Tamminen, Caron, & Sweet, 2020). A movement away from a dualistic perspective within these two paradigms has been less popular than the notion that reality may lie in between these two ontological assumptions (e.g., Burr, 1998; Lincoln, Lynham, & Guba, 2018; Van Poeck, 2019).

Critical realism is a paradigm that encompasses a realistic ontology with a relativist epistemology (Bhaskar, 1975). Bhaskar (1975), one of the founders of critical realism, postulates that critical realism moves away from a positivist paradigm to distinguish between the "real" and "observable" world. According to this paradigm, because the "real" world cannot be objectively

observed, the world according to human knowledge is constructed from the experiences and perceptions of social actors.

The current thesis aligns with the critical realist paradigm, where a single framework and methodology does not exist, but rather where both qualitative and quantitative methods are supported (Aspinall, Jacobs, & Frey, 2019). The tenets of critical realism are that of agency and structure, whereby social structures are a result of the actions of individuals (Bhaskar, 1975). These social structures may influence but not dictate an individual's behaviour (Aspinall et al., 2019). Critical realism, therefore, values, "*individual human experiences while investigating demi-regularities that might signify the actualisation of a causal mechanism*" (DeForge & Shaw, 2012, p. 85). Because the researcher does not espouse the belief that each individual's experiences signifies an idiosyncratic reality, but rather that some patterns exist in context-specific conditions, a relativist—specifically a constructivist—epistemological stance is undertaken. Critical realism accepts the notion that a constructivist or relativist epistemology is appropriate, given that the world is understood through the lens of the individual as a result of his/her experiences and social environment (Maxwell, 2012).

The multi-method approach in this thesis reflects the flexibility of critical realism, which supports the use of diverse methodologies to explore different dimensions of a complex phenomenon. Findings from the quantitative studies, such as those examining relationships between abuse types and behavioural outcomes, complement the qualitative insights into lived experiences and contextual influences. This integration exemplifies critical realism's emphasis on layered understanding, bridging measurable outcomes with nuanced personal narratives.

The researcher believes that it is not possible for her to be separate from her research. Interpretations are not self-evident, but rather interpretive according to the constructivist epistemology (Charmaz & Henwood, 2017). Thus, it highlights that meaning-making is subjective, but additionally embedded in and influenced by social contexts. A social constructivist perspective assumes that making meaning of experiences occurs through an interaction with others, as well as through historical and cultural norms within an individual's surroundings (Creswell, 2013). Consequently, this epistemology conceptualises the experiences of how CSA is perceived as subjective experiences impacted by participants' social environment,

and how the interaction between the participants and researcher result in co-constructed knowledge.

This critical realist stance additionally enables the derivation of practical recommendations for interventions, bridging measurable outcomes with individual experiences. For example, the quantitative studies provide insights into broad patterns and causal mechanisms, while the qualitative study captures the lived realities that contextualise these patterns. This dual lens ensures that the research not only advances theoretical understanding but also informs actionable strategies to effectively support CSA survivors.

Chapter 2: Childhood Abuse and Risk Behaviours in Substance Use Disorder – Study I

2.1 Introduction: Study I

2.1.1 Background

Childhood sexual abuse (CSA), often co-occurring with other forms of childhood abuse (CA), is associated with a wide range of risk behaviours in survivors. These behaviours include substance use or substance use disorder (SUD; LeTendre & Reed, 2017; Mishra et al., 2022; Parisi, Jordan, Jensen, & Howard, 2022; Schückher, Sellin, Engström, & Berglund, 2019), as well as self-directed violence (SDV), which encompasses non-suicidal self-injury (NSSI) and suicidality, such as suicidal ideation, attempts, and/or completed suicide (Angelakis et al., 2020; Cantón-Cortés et al., 2020; Eisenberg et al., 2007; Goldberg et al., 2019). Additionally, CSA survivors may exhibit both SUD and SDV concurrently (Curran et al., 2021; Di Nicola et al., 2024; Landa-Blanco et al., 2024; McCabe et al., 2022). The consequences of these risk behaviours are significant, resulting in profound costs at both individual and societal levels.

In 2018, Health Canada estimated that the healthcare, criminal justice, unemployment, and other societal costs associated with SUD totaled \$38.4 billion for that year alone (Stockwell et al., 2018). Suicide accounted for approximately 1.5% of global mortality in 2016 (Naghavi, 2019), with these figures rising during the COVID-19 pandemic (Zalsman et al., 2020). Additionally, suicide attempts (SA) are estimated to occur at a rate roughly twenty times higher than completed suicides (Moreno et al., 2022). Understanding the mechanisms by which CA contributes to SUD and/or SDV is therefore essential in efforts to prevent or mitigate these outcomes.

The presence of ACE's has been consistently identified as a significant risk factor for maladaptive behaviours. Extensive evidence supports the association between ACE's and SDV,

including both NSSI and SA's (Andreo-Jover et al., 2023; Angelakis et al., 2019; Baldwin et al., 2023; Icick et al., 2022; Landa-Blanco et al., 2024; Zatti et al., 2017). Similarly, ACE's have been linked to early initiation of substance use and the subsequent development of SUD (Beal et al., 2023; Capusan et al., 2021; Cicchetti & Handley, 2019; Hagborg et al., 2020; Proctor et al., 2017; Tonmyr et al., 2010). Early substance use is particularly concerning, as SUD in adulthood has been associated with the onset of substance use at a younger age (Han et al., 2019; Millar et al., 2021; Nuño & Herrera, 2022; Richmond-Rakerd et al., 2017; Volkow et al., 2021), and with more frequent substance use during adolescence (Johnston et al., 2021; Johnston et al., 2016; Substance Abuse and Mental Health Services Administration, 2020). Additionally, ACE's have been significantly correlated with polysubstance use, further compounding the risk of adverse outcomes (Beal et al., 2023; Clark et al., 2023; DiGuseppi et al., 2020; Hagborg et al., 2020).

The early use of substances poses considerable risks, leading to physical, neurological, and mental health consequences (Fishbein et al., 2016; Mishra et al., 2022; Schulte & Hser, 2013). These risks are especially pronounced among individuals with a history of ACE's, who are more vulnerable to engaging in SDV, including SA's and NSSI, alongside SUD (Grummitt et al., 2024; Icick et al., 2022). The significant role of ACE's in shaping these interconnected risk behaviours highlights their pervasive impact on long-term mental and physical health outcomes.

ACE's have also been found to contribute to higher relapse rates of SUD's and exacerbate symptoms associated with SDV. For instance, one study revealed that childhood maltreatment significantly increased the likelihood of SA's in individuals with Major Depressive Disorder, even after controlling for other risk factors and potential confounders; This association was particularly prominent among female patients (Goldberg et al., 2019). Similarly, research on women with alcohol use disorder (AUD) demonstrated that female patients with a history of CA were significantly less likely to maintain abstinence both immediately after treatment and 12 months post-treatment, compared to those without a history of CA, despite both groups being matched for social stability, education, partnership, and employment (Schückher, Sellin, Engström, & Berglund, 2019).

Nevertheless, not all findings are consistent. A systematic literature review and meta-analysis reported a non-significant trend indicating that survivors of sexual victimisation had slightly lower odds of completing SUD treatment than their non-CSA counterparts (Parisi et al., 2022).

Such inconsistencies may be attributed to variations in the types and severity of abuse, which can lead to disparate outcomes across studies.

While individual ACE's have been linked to substance use and SDV, their cumulative effects demonstrate stronger associations across various studies (Amos et al., 2023; Andreo-Jover et al., 2023; Di Nicola et al., 2024; Icick et al., 2022; Landa-Blanco et al., 2024). In a large, representative UK study involving 21,716 participants, Amos et al. (2023) provided robust evidence of the cumulative impact of ACE's on risk behaviours, including binge drinking, cannabis use, smoking, and mental health diagnoses. Other studies similarly found that repeated SA's and suicidality (Andreo-Jover et al., 2023; Berardelli et al., 2022; Werbart Törnblom, Sorjonen, Runeson, & Rydelius, 2020) or substance use (Afifi et al., 2020b; Davis et al., 2019) were significantly associated with individual ACE's, with the cumulative impact of multiple ACE's presenting even greater odds of these outcomes.

While cumulative ACE's are consistently linked to increased risk behaviours, CSA, as an individual ACE, appears to have a particularly strong influence. Landa-Blanco et al. (2024) observed a significant inverse relationship between the number of ACE's and mental health outcomes, such as suicide ideation and alcohol use, with forced childhood intercourse exerting a more profound impact on these negative outcomes than other individual ACE's. Angelakis et al. (2020) similarly reported in their systematic review and meta-analysis that childhood sexual, physical, and emotional abuse could increase the likelihood of suicide ideation by 2.5 times; Notably, CSA alone was linked to a fourfold increased risk of suicide plans. These findings align with those of Hailes et al. (2019), who reported CSA to exert a stronger influence on SUD compared to other forms of CA.

Mishra et al. (2022) further examined the differential effects of various forms of CA on substance use patterns, considering genetic predispositions. They found that CA combinations were linked to substance use, but notably, two distinct sub-groups exhibited the most rapid increases in substance use: one with high exposure to sexual abuse and the other with high exposure to physical abuse. Interestingly, while the physical abuse sub-group exhibited these results when paired with a high genetic risk for substance use, the sexual abuse sub-group showed similar patterns despite only a medium to low genetic predisposition (Mishra et al.,

2022). These findings underscore the unique role of CSA in predicting substance use, independent of high genetic susceptibility.

CSA demonstrates higher predictive odds than other ACE's and has been identified as one of the most synergistically reactive forms of childhood trauma in forecasting both suicidality (Andreo-Jover et al., 2023; Berardelli et al., 2022; Grummitt et al., 2024; Laporte et al., 2023) and SUD (Briggs et al., 2021), as well as their co-occurrence (Di Nicola et al., 2024). These findings suggest that the circumstances surrounding and following CSA may have a more substantial influence on the development of substance use than other types of childhood maltreatment (Angelakis et al., 2020; Hailes et al., 2019; Landa-Blanco et al., 2024; Mishra et al., 2022). Further empirical research is essential to clarify the distinct developmental pathways from CSA, both in isolation and in combination with other forms of CA, leading to substance use and SDV.

Several explanations and theories underpin why CSA and other forms of CA may serve as precursors to various risk behaviours. One perspective focusses on the role of substances, which are often associated with a deterioration in coping mechanisms and problem-solving abilities, the onset of substance-induced depression, a decline in social relationship quality, and impaired academic or occupational performance. These factors can exacerbate psychological distress and impulsivity, thereby increasing susceptibility to SDV (Chai et al., 2022; Gupta, Narnoli, Das, Sarkar, & Balhara, 2019; Laporte et al., 2023; Rioux et al., 2021). Conversely, engaging in SDV may precipitate substance use or SUD through self-medicating behaviours, wherein individuals seek temporary relief from emotional or psychological pain (Auger, Chadi, Ayoub, Brousseau, & Low, 2022; Iorfino et al., 2018; Rioux et al., 2021).

A compelling alternative explanation suggests that these risk behaviours may exist bidirectionally, with transactional relationships in which each behaviour increases vulnerability to the other. This bidirectionality indicates that maladaptive behaviours, such as substance use and SDV, may co-occur as a result of shared underlying factors, including broader psychopathological issues and early life trauma (Di Nicola et al., 2024; Rioux et al., 2021; Shamabadi, Ahmadzade, Pirahesh, Hasanzadeh, & Asadigandomani, 2023). These shared factors may not only contribute to the development of both behaviours but also reinforce their

persistence, further entangling the relationship between CA and subsequent maladaptive outcomes.

From a neurobiological standpoint, the impact of early trauma offers further insight into these pathways. Chronic early-life stressors, particularly those experienced over extended periods, have been shown to dysregulate the hypothalamic-pituitary-adrenal (HPA) axis. This dysregulation leads to sustained stress responses and alterations in cortisol levels, which are closely associated with the development of psychopathology, including suicidality and substance use (Danese & Baldwin, 2017; Lippard & Nemeroff, 2023; Malhi et al., 2019; O'Connor, Green, Ferguson, O'Carroll, & O'Connor, 2018; Papalia, Ogloff, Cutajar, & Mullen, 2018). The resulting neurobiological changes, particularly within neural circuits responsible for emotional regulation and executive functioning, contribute to long-term impairments in emotion processing and impulse control (Lippard & Nemeroff, 2023; Pirnia et al., 2020). These alterations not only heighten the risk of engaging in maladaptive behaviours, such as substance use or SDV, but also help explain the observed relationship between childhood trauma and suicidal behaviours in individuals with SUD (Allen et al., 2021).

From a psychological perspective, these risk behaviours are often employed as maladaptive strategies to regulate emotions, cope with trauma, or escape distressing internal states. Dysfunction in emotion regulation—manifesting as deficits in cognitive regulatory strategies, non-acceptance of emotional responses, and difficulty accessing adaptive strategies—has been associated with childhood trauma, particularly CSA (Khosravani, Ardestani, Bastan, Mohammadzadeh, & Amirinezhad, 2019; Mohammadzadeh, Ganji, Khosravani, Ardakan, & Amirinezhad, 2019). The *Cry of Pain* model (Williams, 2001) and the interpersonal theory of suicide (Van Orden et al., 2010) highlight that feelings of entrapment, perceived burdensomeness, and thwarted belongingness—rooted in ACE's—can lead to suicidality. Similarly, NSSI has been theorised as a coping mechanism to reenact trauma, regulate dissociation, express overwhelming emotions such as shame and anger, or regain a sense of control (Connors, 1996a). For substance use, the SMH (Khantzian, 1985) posits that substances serve as external regulators for unprocessed distress stemming from trauma-induced dysregulated mental and bodily states. This aligns with trauma models of substance use (Schimmenti et al., 2022), which identify direct pathways, such as substance use as an immediate

emotional regulator, and indirect pathways, such as dissociation stemming from childhood maltreatment.

SUD and SDV may, therefore, be closely linked to dysregulated emotional processing, often exacerbated by trauma-induced dissociation. This dissociation impairs the integration of distressing experiences and inhibits adaptive emotion regulation (Berardelli et al., 2022; Bikmazer et al., 2023; Di Nicola et al., 2024; Öztürk & Erdoğan, 2021; Rossi et al., 2019; Schimmenti & Bifulco, 2015; Snow et al., 2022). According to Di Nicola et al. (2024), individuals with CSA histories, SUD, and SA's experience heightened difficulties in several dimensions of emotion regulation, including engaging in goal-directed behaviours under emotional distress, controlling impulses, and accessing effective coping strategies. Studies have shown that maladaptive strategies such as emotional suppression, rumination, and low adaptive reappraisal play distinct roles in suicidality (Colmenero-Navarrete, García-Sancho, & Salguero, 2022). In this context, suicidality may result from a combination of dysregulated emotional processes and impulsive tendencies in the presence of heightened affective states (Allen et al., 2021; Clapham & Brausch, 2024). Furthermore, impulsivity and limited access to regulatory strategies are particularly prominent in individuals with SUD, which exacerbates their difficulties in managing emotional distress and increases their reliance on substances or SDV (Weiss et al., 2022; De Berardis et al., 2020).

Additionally, trauma-induced emotion dysregulation has been found to indirectly link to suicidal behaviours through internalising symptoms such as anxiety and depression, as well as externalising features such as aggressive behaviours and substance use (Laporte et al., 2023; Mohammadzadeh et al., 2019). These overlapping internalising and externalising patterns reflect the complexity of the pathways from childhood trauma to SDV and SUD, reinforcing the multifaceted nature of the underlying mechanisms (Clapham & Brausch, 2022; Mohammadzadeh et al., 2019). Dysfunctional coping mechanisms stemming from CA can not only impair individuals' ability to manage emotional distress but also amplify that distress, thereby creating a cyclical vulnerability to both substance use and SDV.

Ultimately, CSA and other CA disrupt emotional regulation processes and reinforce dissociative states, increasing vulnerability to both SDV and SUD (Cicchetti & Handley, 2019; Curran et al.,

2021; Di Nicola et al., 2024). These maladaptive behaviours may arise from a dynamic interaction of neurobiological, cognitive, and emotional factors, all of which are shaped by early traumatic experiences. Substances may temporarily alleviate intrusive trauma-related memories or foster a sense of social belonging, while SDV may act as a coping mechanism to regulate dissociation or overwhelming emotions, underscoring their dual roles as maladaptive strategies for self-regulation and distress alleviation (Rioux et al., 2021; Schimmenti et al., 2022). Ultimately, both risk behaviours may represent attempts to navigate the long-term emotional and neurobiological consequences of CSA and other ACE's.

Gender differences in the literature:

Gender differences in outcomes related to CSA and other CA types, particularly regarding substance use or SUD and SDV, have yielded mixed results. While some studies have found that men are more likely to engage in substance use and self-medicating behaviours (Bolton, Robinson, & Sareen, 2009; Curran et al., 2021; Thompson et al., 2021; Turner et al., 2018), others report that women may be more prone to these behaviours, especially in response to emotional distress (Buckner, 2013; McKee & McRae-Clark, 2022; Van Gils, Dom, Dierckx, Van Alphen, & Franck, 2023; Wallis et al., 2022). Likewise, findings on gender differences in SDV, including suicide attempts, are inconsistent. Studies have reported higher rates of suicide attempts among men (Chang, Yip, & Chen, 2019; Liddon et al., 2018; ONS, 2015; WHO, 2017), while others have found higher rates among women, particularly in the context of CSA and other forms of CA (Armoon et al., 2021; Carr et al., 2016; Di Nicola et al., 2024; Knipe, Padmanathan, Newton-Howes, Chan, & Kapur, 2022; WHO, 2022).

The variability in these findings may be attributed to methodological issues, particularly the failure to control for key factors, such as different types of childhood abuse, age at the time of abuse, and the presence of co-occurring conditions. Several studies fail to distinguish between CSA and other ACE's, such as CPA or CEA, which may differentially impact men and women (Benedini & Fagan, 2020; Bikmazer et al., 2023; Hébert, Amédée, Blais, & Gauthier-Duchesne, 2019; Penning & Collings, 2014). For instance, Yue et al. (2023) found that female adolescents with mood disorders who experienced CEA were more likely to engage in NSSI than their male counterparts, but that gender differences were less significant when mood disorders were

accounted for. Other factors, such as impulsivity (McMahon et al., 2018), depression (Choi et al., 2023), peer relationships, and behavioural problems (Frobel et al., 2022), have also been identified as key mediators in the relationship between CA and risk behaviours. Additionally, cultural context, sexual orientation, and socioeconomic factors can further influence these outcomes (Dowling et al., 2023; Hughes et al., 2014; Khan, Dar, Bano, & Iqbal, 2021; Johnson & Zaidi, 2021).

Beyond methodological challenges, societal stigma may also play a significant role in shaping gender differences in SUD and SDV outcomes. Men, for example, are often subject to societal pressures that discourage emotional vulnerability and help-seeking, which may lead them to adopt maladaptive coping strategies, such as substance use, in response to trauma (Parent et al., 2018; Staiger et al., 2020; Wildey et al., 2022). Curran et al. (2021) found that men with CSA histories and low social support demonstrated a stronger correlation between trauma and SUD than women, highlighting the role of social isolation in their maladaptive coping behaviours. Conversely, women with SUD may face heightened societal stigma. Russell, Gajwani, Turner, and Minnis (2022) found that women with SUD, particularly those who also exhibited suicidality, experienced harsher outcomes and stigma compared to men, suggesting that societal perceptions may exacerbate their vulnerability and hinder recovery efforts. Thus, gender differences in CSA and other forms of CA on SUD, and SDV are complex and influenced by multiple factors, including methodological inconsistencies and societal pressures.

2.1.2 Research aim and research questions:

2.1.2.1 Research aim

The existing literature has identified important associations between CA, including CSA, CPA, and CEA, and increased engagement in risk behaviours such as SUD and SDV. While substantial evidence underscores the impact of childhood trauma on the development of these behaviours, gaps remain in understanding the differential effects of various types of CA and the mechanisms through which these behaviours manifest. Specifically, while many studies have examined the relationship between CA and risk behaviours, there is a lack of consensus regarding which forms

of abuse (i.e., CSA, CPA, CEA) are most strongly associated with particular outcomes, such as SUD patterns and SDV. In addition, gender differences in these associations have been inconsistently reported, with some research suggesting that men and women may experience different pathways to these risk behaviours, yet methodological inconsistencies and the failure to account for mediating factors complicate these findings.

The current study seeks to address these gaps by investigating the specific associations between CA and its forms—CSA, CPA, and CEA—with increased engagement in SUD patterns and SDV among individuals with SUD. Additionally, it aims to explore potential gender differences in these associations, providing a clearer understanding of how these dynamics may vary based on the characteristics of the abuse experienced. By addressing these research questions, this study will contribute to a more nuanced understanding of the complex relationships between childhood trauma and risk behaviours, while accounting for potential gendered differences. The findings will help clarify the relative influence of different types of abuse and further illuminate the factors that exacerbate vulnerability to these potentially harmful behaviours in individuals with SUD.

2.1.2.2 Research questions

1. Is childhood abuse (CA) associated with increased engagement in risk behaviours: substance use disorder (SUD) patterns (i.e., greater frequency, existence of polysubstance use, and younger age of initiation) and self-directed violence (SDV; i.e., non-suicidal self-injury (NSSI) and suicidality) in individuals with SUD?
2. Is the degree of childhood sexual abuse (CSA), childhood physical abuse (CPA), and childhood emotional abuse (CEA) in individuals with SUD differentially associated with increased engagement in risk behaviours (i.e., SUD patterns and SDV)?
3. Is gender a significant predictor of any of the outcomes?

2.1.2.3 Research hypotheses

Based on the research aims and the specific research questions outlined in the previous sections, the following hypotheses are proposed:

Hypothesis 1: *It is hypothesised that CA will be associated with increased engagement in SUD patterns and SDV in individuals with SUD.*

Hypothesis 2: *It is hypothesised that CSA, CPA, and CEA will exhibit differential associations with increased engagement in SUD patterns and SDV among individuals with SUD. Specifically, it is anticipated that CSA will demonstrate stronger associations with these outcomes.*

Hypothesis 3: *It is hypothesised that gender will not be a significant predictor of the outcome variables.*

These hypotheses are informed by previous research that has suggested a link between childhood abuse and risk behaviours (i.e., SUD patterns and SDV), as well as potential gender differences in these associations.

2.2 Methods: Study I

2.2.1 Ethical considerations

Ethical considerations play a crucial role in conducting research studies, ensuring the protection of participants' rights, privacy, and confidentiality. In line with these principles, the current study obtained ethical approval from the University of British Columbia's Clinical Research Ethics Board (UBC CREB), the British Columbia Mental Health and Substance Use Services (BCMHSUS) Research Committee, and the University of Edinburgh's School of Health and Social Science Ethics. Please see the proof of ethical approval in Appendices A and B.

To ensure that potential participants had the necessary information to make an informed decision about participating in the study, a comprehensive recruitment process was implemented. Willing participants were provided with a consent form (see Appendix C) that outlined the study's purpose, procedures, potential risks and benefits, confidentiality measures, and the participants' rights. The study recruiter ensured that potential participants fully understood the study's purpose, procedures, and associated risks and benefits. Any queries or concerns regarding the consent form were addressed by the study coordinator during the scheduling call or by the interviewer during the participation session.

Participants were given adequate time to review the consent form and were afforded the flexibility to schedule their participation session at their convenience, allowing ample opportunity for careful consideration. Scheduling a session did not imply an assumption of consent, and participants were under no obligation to sign the consent form immediately upon arrival. Participants retained their autonomy in making an informed decision and could either provide their consent to participate or choose not to consent and terminate the session. Study results will not be communicated directly to participants, but interesting aggregate findings will be published as a profile sheet of clientele and distributed to the treatment centres where participants may have access.

Accessibility accommodations were made for participants with specific needs. Sight-impaired participants had the option to request that the consent form be read to them by the facilitator. Similarly, participants who were not comfortable using computers or tablets were provided with the opportunity to have the consent form read to them. Resources for translated consent forms or in-interview translators, however, were not available.

Throughout the study, the interviewer returned all consent forms and questionnaires to the study coordinator at UBC, ensuring the secure handling and storage of participant-related materials. To protect the privacy and confidentiality of participants, their identities were safeguarded through the utilisation of anonymous and unique study IDs. These IDs were not derived from or linked to any personally identifiable information, such as names, social insurance numbers (SINs), personal health numbers (PHNs), hospital numbers, dates of birth (DOBs), addresses, or unique characteristics. The crosswalk document, which connected participant IDs to personal identifiers, was securely stored separately from the data on the Provincial Health Services Authority (PHSA) server and encrypted to maintain confidentiality. Access to this document was restricted to specific members of the research team, excluding the principal investigator and the current PhD researcher. The PHSA administrator only had access to the folder containing the identifiers.

Participants in this study provided consent for the review of their medical records at their current treatment centre, covering the preceding 12 months. Chart data was accessed via the CST Cerner system by a designated member of the research team. Access to CST Cerner was granted either on-site at the Redfish Healing Centre/Burnaby Centre for Mental Health and Addictions or remotely at the UBC office through secure remote access.

To ensure the security of the data, both physical and digital measures were implemented. Data was stored in secure, Canadian-based servers with password protection and encryption. The research team, comprising the principal investigator, co-investigators, and designated research assistants, were the sole individuals with access to the collected data. The names of study personnel were maintained in a study file to ensure transparency and accountability.

Consent forms, whether in paper or digital format, were securely stored at the Burnaby Centre for Mental Health and Addictions in a locked filing cabinet within the principal investigator's locked office or the locked interview room. Data collected through chart reviews and questionnaires were stored separately on the PHSA-approved survey system, BCCHR REDCap, and UBC Qualtrics, respectively. When data analysis commenced, the information was encrypted and transferred to the UBC TeamShare server. The storage of physical and digital data was protected to prevent unauthorised access and maintain participant confidentiality.

The retention and disposal of data were carefully managed to adhere to data protection principles. Paper data was retained until the conclusion of data collection and subsequently shredded and destroyed after being digitally entered. Digital data will be retained for a minimum of five years after publication or presentation, after which the crosswalk file will be destroyed. De-identified data exported from Qualtrics and REDCap was retained only if necessary for further analyses, such as in the current study. The current study's (de-identified) raw data was stored on the password-encrypted Microsoft's OneDrive and the University of Edinburgh's DataSync. These are two separate and distinct cloud-based services, which hold data centrally, but can be accessed from anywhere in the world. Using these two distinct services ensured information was backed. No paper or hard copies were transferred from Canada.

2.2.2 Participants

This study involved a secondary analysis of data derived from the cross-sectional version of the Cannabis and polysubstance use (CAPU) study conducted by the University of British Columbia (UBC) Behavioural Reward Affect and Impulsivity Neuroscience (BRAIN) Lab, which aimed to evaluate cannabis use among polysubstance users in treatment. The study reached its targeted sample size of 380 participants.

CAPU was conducted by profiling clients with SUD from three treatment centres in the Vancouver area: the Burnaby Centre for Mental Health and Addiction (BCMHA), the Assertive Community Treatment (ACT) Teams, Coast Mental Health, and Richmond Addiction Services.

The inclusion criteria for this study were as follows: participants had to be patients at BCMHA, ACT Team, Coast Mental Health, or Richmond Addiction Services; be aged 19 (the legal age of an adult in British Columbia, Canada) or older; be proficient in English; demonstrate stable medications in the month preceding study entry; and have the capacity to provide informed consent.

2.2.3 Recruitment and data collection

Volunteer research assistants acted as survey facilitators and recruiters, approaching clients during their free periods or after appointments, offering information about the study and a consent form to interested clients. Caseworkers and service providers may have assisted volunteers on a voluntary basis by helping with patient scheduling conflicts and introducing them to potential participants. Each treatment centre informed its patients about the study, and interested participants could contact the study coordinator for further information.

The recruiter provided clients with a consent form and contact information for the study. Willing participants who were proficient in reading and writing English—in order to understand the consent form and survey tools—contacted the study coordinator.

Upon contacting the study coordinator, potential participants scheduled an interview appointment at or near the treatment centre, lasting approximately 60-90 minutes, which comprised a consent form and various questionnaires. The facilitator provided the participant with a consent form (if not previously provided), allowed them time to review it, answered any questions, and obtained the participant's signature. Participants had ample time to review the form beforehand, as they were offered a copy by the recruiting case worker. A copy of the consent form was provided to participants for their records. By signing the consent form, participants agreed to be re-contacted with information about future related studies. Participants were then provided with a \$20 honorarium in the form of a gift card, independent of whether or not they completed the study.

Furthermore, participants were notified (both verbally and in the consent form) that study results could be used for various substudies and by trained researchers within the lab. The name of the PhD researcher for the current substudy (Asaly Skrenes) was, therefore, added to the CAPU application, an amendment that was approved by all necessary ethics boards. Participant personal information (i.e., names, contact information, addresses) were removed from the data, and replaced with an ID number; all researchers of substudies, including the current PhD researcher had access to only this ID number, along with corresponding additional raw data (i.e., answers to the various desired questionnaires). The PhD researcher of the current study has participated and audited courses, such as the University of Edinburgh’s Research Skills in the Social Sciences: Data Collection; the data protection training on the self-enrolment page of Learn; as well as the UBC online tutorial TCPS 2: CORE (Course on Research Ethics).

2.2.4 Measures

2.2.4.1 Demographics

This questionnaire obtained basic demographic information. Questions pertaining to the current study comprised the following: gender (man/woman/other); age (in years); ethnicity (Caucasian, Asian, African, South East Asian, First Nations, Latin American, Other, Mixed Ethnicity, Not Documented); presence of psychotic disorder (“PD”; i.e., schizophrenia, schizoaffective disorder, psychotic disorder NOS, mood disorder NOS with psychosis, or substance induced psychosis); history of substance use (type(s) of substance(s), age of first use, date of last use, frequency of use, amount used per day, routes of use); number of overdoses prior to admission; number of overdoses after admission; reported history of self-harm and suicide attempts; DSM-V diagnosis of opioid use disorder.

2.2.4.2 Childhood Trauma Questionnaire–Short Form (CTQ-SF)

The Childhood Trauma Questionnaire–Short Form (CTQ-SF; Bernstein et al., 2003) is a 28-item retrospective self-report questionnaire assessing and characterising childhood and adolescent trauma, and includes 6 subscales: physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, and the minimization-denial scale. Items are presented using a 5-point Likert scale, which ranges from “never true” to “very often true” in the context of “when

you were growing up”. Scores of 5 to 25 for each trauma subscale are produced, with scores representing four categories: none to low trauma exposure, low to moderate trauma exposure, moderate to severe trauma exposure and severe to extreme trauma exposure. The three questions representing the minimization/denial scale (three questions) assess the likelihood of underreporting traumatic experiences.

In diverse clinical and nonreferred samples, the CTQ subscale scores were found to have good test-retest reliability, with coefficients between .79 and .86; high internal consistency, with coefficients between .66 to .92; and good interrater reliability with coefficients of 0.9 to 1.0 (Bernstein et al., 2003; Bernstein, Ahluvalia, Pogge, & Handelsman, 1997). Dovran and colleagues (2013) assessed the CTQ-SF in populations with SUD and high-risk behaviour, and found this scale to have excellent internal consistency, with coefficients of 0.96 for sexual abuse, 0.90 for physical abuse, 0.86 for emotional abuse, 0.90 for emotional neglect, and 0.79 for physical neglect. Furthermore, the CTQ-SF was found to have a Cronbach's alpha of .91 in a sample of CSA survivors who had been sexually revictimised later in life (Wilson, Kimbrel, Meyer, Young, & Morissette, 2015). Lastly, in a similar study assessing childhood abuse and substance misuse problems among South African adolescents, Hogarth, Martin, and Seedat (2019) used only the three abuse subscales and obtained Cronbach's alpha's of .72, .77 and .80 for the CEA, CPA, and CSA respectively. Other studies have demonstrated good psychometric properties of the CTQ-SF (for reviews, see Georgieva, Tomas, & Navarro-Pérez, 2021; Saini, Hoffmann, Pantelis, Everall, & Bousman, 2019). The CTQ-SF has additionally been utilised in studies assessing social support (Zhou et al., 2019), and validated across various populations, including adolescents and adults, in various languages (Georgieva et al., 2021; Liebschutz et al., 2018; Saini, Hoffmann, Pantelis, Everall, & Bousman, 2019; Zhang et al., 2020). In the current study, internal consistency was found to be good across the CTQ as a whole ($\alpha = .929$), along with each subscale—CSA ($\alpha = .931$), CPA ($\alpha = .878$), and CEA ($\alpha = .872$). Values exceeding 0.7 are typically deemed indicative of adequate reliability levels (Field, 2018).

In this study, the CTQ was employed in two distinct manners. Initially, the questionnaire was operationalised CSA, CPA, CEA through a dichotomous approach. Specifically, a score of 0 to a maximum of 5 in the CSA category, 7 in the CPA category, and 8 in the CEA category denoted the absence of abuse (coded as '0'), whereas scores ranging from above these respective scores

through to 25 indicated the presence of abuse (coded as '1'). These indicators were aggregated to construct a composite 'Childhood Abuse' (CA) variable. Within this variable, a cumulative score of '0' represented the absence of any form of childhood abuse, while a score ranging from 1 to 3 will be recoded as '1', signifying the presence of CA. Secondly, the CTQ was used according to its original design, whereby each of the CSA, CPA, and CEA categories or variables retained their original scoring range.

2.2.4.3 Maudsley Addiction Profile (MAP)

The Maudsley Addiction Profile (MAP; Marsden et al., 1998) is a 60-question assessment, which stands as a pivotal instrument in the evaluation of substance use disorders, offering a detailed examination across four domains: substance use, health risk behaviours, physical and psychological health, and social functioning. This tool is organised into modules that allow for independent domain scoring. The focus of the present study lies within Section B, the substance use module, which measures substance consumption patterns through (a) frequency of use over the past 30 days, (b) quantity used on a typical day within the same timeframe, and (c) modes of administration for a range of substances relevant to the location or population of a particular study. The substances used in CAPU include alcohol, cannabis, opioids (heroin, non-prescribed methadone, or non-prescribed opioids), cocaine (powder or crack cocaine), amphetamines (amphetamines or crystal methamphetamines), and a non-prescribed benzodiazepine and 'other' category. For the purpose of the current study, only (a) and (b) of Section B of the MAP were used; the route of administration was not relevant to the study, as the frequency (a) and amount (b) of substances used are related to substance use patterns and dependence, whereas type and administration (c) of substances is not.

The MAP has been found to have good test-retest reliability, with average intraclass correlation coefficients of 0.94 and 0.81 across eight substances (Marsden et al., 1998). Using the MAP's section B on a sample of substance users, Higgins, Smith, and Matthews (2022) found the MAP to demonstrate good internal consistency (Cronbach's $\alpha=.88$). In the current study, internal consistency was found to be low across the MAP ($\alpha = .584$).

In terms of validity, studies have explored the MAP's sensitivity and specificity in identifying substance use patterns, particularly in populations using cannabis and those diagnosed with

opioid use disorder. Rosic et al. (2021) and Zielinski et al. (2017) highlighted the MAP's capability to accurately detect substance use with a sensitivity of 79.9% and a specificity of 80.0%, as confirmed through comparison with biochemical verification methods such as urinalysis. These figures suggest that the MAP accurately classifies individuals according to their substance use status, making it a reliable tool for both clinical assessment and research purposes.

Beyond its reliability and validity, the MAP's utility in assessing substance use patterns has been further demonstrated through its application in various research contexts. Some studies have assessed patterns and problems associated with various substances through looking at past 90-day consumption, and 'intensity' of consumption—combination of recent frequency and dose for each drug type (or total amount consumed) for the 3 months prior to interview (Boys et al., 2003). The MAP uses a 30-day window to avoid shorter windows where failing to capture episodic substance use and other behaviour occurs, and longer periods where participant recall problems may exist (Marsden et al., 1998). Some studies use the MAP substance use section categorically, such as categorising substance use into mild, moderate, and heavy past use, according to a designated threshold of substance use within the 30-day timeframe (De Burca, Miles, & Vasquez, 2013; Wheatley, 1998). Higgins, Smith, and Matthews (2022), however, used the MAP, *inter alia*, with an exploratory means to determine factors related to the direction of the causal relationship between opioid use disorder and chronic pain. The researchers used univariate ANOVA to assess group differences the frequency of substance use (i.e., the number of days in the month a selection of substances are taken in the past 30 days), the dosage amount (i.e., the amount of substance used on a typical day in the past 30 days), and existence of multiple substance use (Higgins, Smith, & Matthews, 2022), a method similar to that used to assess substance use in a previous study (Manhapra, Sullivan, Ballantyne, MacLean, & Becker, 2020). Other studies have used the MAP to assess substance use (frequency, dosage, etc.) as a continuous variable (Rosic et al., 2021; Zielinski et al., 2017). A previous study using the CAPU data and assessing homeless populations experiencing SUD has, moreover, utilised the MAP (Schütz et al., 2019).

Importantly, the MAP has been integral in studies addressing the effects of childhood abuse on later substance use behaviours. While the specific studies mentioned (Elhammady et al., 2014; Freeman & Fowler, 2009; Agnihotri et al., 2022; Lee-Cheong et al., 2021; Perrenoud et al., 2021;

Vogel et al., 2021) do not directly provide psychometric properties of Section B, they collectively affirm the instrument's relevance in capturing the nuances of substance use in populations exposed to early adversities.

This study will employ an exploratory analysis using the MAP to investigate group differences in substance use patterns. Specifically, it aims to examine substance use frequency and existence of polysubstance use, and their associations with childhood trauma. Substances were classified into five categories: alcohol, cannabis, opioids, stimulants, and others. For each category, usage frequency were recorded up to a maximum of 30 days per month. These frequencies were aggregated to formulate a composite measure, termed substance use frequency (“SUF”), capped at 30 days to represent the total monthly usage across all substances. In addition, for the analysis of polysubstance use (“PSU”), each substance category was dichotomized based on usage: “0” representing no use (0 days per month) and “1” indicating any use (1-30 days per month). These binary indicators were summed to generate an ordinal variable, “PSU”, ranging from 0 to 5, to reflect the breadth of substance use diversity within the sample.

2.2.4.4 Addiction Severity Index (ASI)

The Addiction Severity Index (ASI; McLellan et al., 1992), is a seminal structured interview tool designed to assess multifaceted problems across seven domains: health, drug use, alcohol use, family and social functioning, employment, legal issues, and psychological distress. This instrument quantifies the severity of an individual's substance use and related problems by generating a composite score within each domain, based on symptom number, duration, frequency, and intensity, observed over the preceding 30 days. Scores range from 0, indicating no problem, to 1, denoting the highest level of severity (McLellan et al., 1992). Subsequent investigations into the ASI's psychometric properties have consistently demonstrated its robustness and reliability. For instance, studies have reported inter-rater reliability coefficients between 0.86 and 0.96, alongside a test-retest reliability of 0.92, underscoring the tool's precision and stability over time (Alterman, Brown, Zaballero, & McKay, 1994; McLellan et al., 1992; Samet, Waxman, Hatzenbuehler, & Hasin, 2007).

The ASI's utility extends beyond assessment of substance use severity, and has been used to explain relationships between substance use disorders and various psychosocial factors,

including childhood trauma and abuse. For example, Heath, Torrie, and Gill (2019) utilised the ASI to demonstrate a significant relationship between higher composite scores in anxiety or mood disorders and histories of childhood sexual and physical abuse among Cree communities in the Canadian province of Quebec. In addition, the instrument's inclusion of questions related to childhood abuse and demographic factors—such as sex, age, education, and employment—has facilitated in-depth analyses of polysubstance abuse among individuals with a history of sexual abuse in alcohol, drug, and gambling addiction treatment centers in Greenland (Leth, Bjerrum, & Niclasen, 2021).

Similarly, a systematic review and meta-analysis conducted by Parisi, Jordan, Jensen, and Howard (2022) synthesised findings from studies employing the ASI, offering compelling evidence of the negative impact of sexual victimisation on substance use disorder treatment outcomes. This analysis aligns with other research endeavours that have investigated the intersection of substance use disorders (SUD) and childhood trauma, further utilising tools such as the Childhood Trauma Questionnaire (CTQ) to deepen our understanding of these complex relationships (Lotzin, Haupt, von Schönfels, Wingenfeld, & Schäfer, 2016; Melchior et al., 2019; Sidelì et al., 2019).

In the present study, the ASI was employed to assess a range of variables including gender, age, employment status, reported self-directed violence (SDV), and youngest age of substance use (YASU), thereby contributing to a more comprehensive understanding of the multifaceted nature of substance use disorders.

2.2.5 Data analysis

All analyses, including data cleaning, preliminary analyses, and hierarchical multiple regression analyses, were carried out using IBM SPSS Statistics version 29.

2.2.3.1 Preliminary analyses

The initial step comprised undertaking data cleaning, for which erroneous (“invalid” out of range) responses were screened. Individual response patterns within and across the MAP, ASI, and CTQ questionnaires were examined for a zero score variability, such as the consistent use of the same score for each item within a single questionnaire. This observation served as an

indicator of unengaged and repetitive response patterns. The questions (i.e., SDV, PD, etc.) were not screened, as a pattern could not exist with individual questions. Unengaged participants were removed from the remaining study analyses. Furthermore, as the CAPU study is long and requires participants to answer several questionnaires, where the MAP had several non-responses, these were cross-checked with the ASI. For instance, where a participant was not reported to be engaged with a particular substance, and this response was left blank on the MAP, this was replaced with a zero. If the substance was reported in the ASI but left blank on the MAP, this was reported as missing.

In accordance with the methodology proposed by Little and Rubin (1987), Little's Missing Values Analysis was utilised to ascertain the nature of missing data, distinguishing between “missing completely at random” (MCAR), “missing at random” (MAR), and “missing not at random” (MNAR). This analysis informed the selection of the most suitable technique for handling missing data. Little's Missing Values Analysis was conducted for all variables exhibiting a missing rate of 0.01% or higher.

Descriptive statistics were generated to examine sample characteristics. Statistical assessments pertaining to normality and z scores concerning skewness and kurtosis may yield significance even in instances of minimal departure from normality (Field, 2018). Hence, an assessment of normality was conducted by examining the absolute magnitudes of skewness and kurtosis, alongside the visual representation of data distributions. Instances where absolute skewness values exceeded 1 or -1, and absolute kurtosis values surpassed 3 or -3, were deemed indicative of non-normally distributed data, in accordance with the criteria outlined by Bowen and Guo (2011).

For ordinal and skewed continuous variables, the median (Mdn) and interquartile range (IQR) were employed as the most suitable measures of central tendency and dispersion, respectively, as opposed to the mean (M) and standard deviation (SD). Correlations and between-group tests were employed to evaluate the associations among study variables and to pinpoint potential control variables for inclusion in the primary analyses. Variables that demonstrated significant relationships in the bivariate analyses were controlled for in the subsequent multivariate regression analyses. To examine gender differences in CA, a Chi-square test of independence

was conducted. In all analyses, statistical inference was conducted through a two-sided significance test, with the significance threshold established at $p < .05$.

Each regression underwent scrutiny to ensure adherence to regression assumptions, including checks for multicollinearity, homoscedasticity, linear associations between predictor and outcome variables, and the normal distribution of residuals, according to Field (2018). The assumption of normally distributed residuals was explored through observing histogram and normal probability plots for standardised residuals, as well as standardised residual is $< +/-3$.

Scatterplots of and values for standardised residuals versus the predicted values were checked for assumptions of linearity and homoscedasticity. In the case of all regressions, at least one normality assumption was violated, which resulted in bootstrapping all regressions.

Bootstrapping, moreover, provided more rigorous results for these regressions.

2.2.3.2 Bootstrapping

Bootstrapping was used across preliminary and main study analyses. In order to assess the variability of the correlation estimate and to construct confidence intervals (95%) for the true population correlation when the underlying distribution of the data, bootstrapped correlation coefficients were used. Bootstrapping was additionally used during hierarchical multiple regression to assess the variability of the regression coefficients and to construct more reliable confidence intervals for the model parameters. The use of p-values to assess significance is contingent upon the presence of multivariate normality (Oppong & Agbedra, 2016). Initial tests assessing skewness and kurtosis, as well as regression assumptions found the data to not be normally distributed. The utilisation of bootstrap confidence intervals was, therefore, employed for statistical inference as a more suitable, non-parametric method to assess the presence of direct effects, without the necessity of meeting the normality assumption (Yung & Bentler, 2013).

Bootstrapping is a resampling technique that is used for estimating the sampling distribution of a statistic and for obtaining more reliable estimates of the variability of a statistical estimator, particularly when the underlying distribution of the data is unknown or when the assumptions of parametric methods are not met (Simar & Wilson, 2000). This resampling technique entails the iterative extraction of samples, each of size n corresponding to the original sample size (Yung &

Bentler, 2013). Within every iteration of the bootstrapping process, individual data points are selectively drawn with replacement, whereby each individual score is returned to the original dataset after being drawn; Consequently, a particular score within a specific bootstrap sample has the potential to be replicated multiple times or never (Cheung, Pesigan, & Vong, 2023). The calculation of the test statistic in each bootstrap sample facilitates an empirical approximation of the sampling distribution of said test statistic. This process also facilitates the construction of confidence intervals around the test statistic through the distribution of bootstrap test statistic estimates. Statistical significance is deduced when zero is excluded from the confidence intervals' lower and upper bounds (Cheung, Pesigan, & Vong, 2023).

2.2.3.3 Hierarchical multiple regression

Hierarchical multiple regression (HMR) was the statistical method used in the following study to assess statistical assumptions and characteristics related to the data, including multivariate normality, linearity, collinearity, and heteroscedasticity. This method was, moreover, employed in the main analysis to investigate the unique contribution of the predictor variables to the variance in each dependent variable, while accounting for the effects of other predictors and control variables.

Separate HMR analyses were employed to assess each outcome variable (i.e., SUF, PSU, YASU and SDV); specifically, the relative ability of CA, CSA, CPA, and CEA to predict SUF, PSU, YASU and SDV. Predictors (i.e., CA, CSA, CPA, and CEA) were entered into the regression equation in blocks in a stepwise manner. Demographic variables that demonstrated a significant impact on the variability of outcomes in preliminary analyses (i.e., covariates) were included in the first block of the analysis (Step 1), while the main predictor (i.e., CA, CSA, CPA, and CEA, depending on the regression model) was entered into the second block (Step 2). This process allows for the evaluation of the incremental variance in the outcomes to be explained by each set of predictors (Ross & Willson, 2017). HMR is particularly beneficial when there is theoretical or empirical justification for the order in which predictors are entered, and when a desire to understand the specific impact of different sets of variables on the outcome exists (Richardson, Hamra, MacLehose, Cole, & Chu, 2015).

2.3 Results: Study I

2.3.1 Data cleaning & missing value analysis

Missing data items were assessed. Only variables that were entered in the main analyses were used in the missing values analyses. Fifteen cases (4.9% of the initial sample, $N = 305$) were initially removed from analyses due to completely missing or all but one to two scores missing from the total dataset. Results and information subsequently provided is drawn from the remaining 290 participants.

The percentage of missing data exceeded 10% for several items, two of which (“other substance frequency” and “YASU”) exceeded 20%. Although Cohen and Cohen (1983) recommend excluding variables missing beyond 10% data, these items were retained. Due to the length of time required to complete the CAPU survey, it is likely that participants chose to not complete items that were not applicable; specifically, the “other substance frequency” may not have been completed because participants might have only provided information for substances they had consumed. YASU was retained because it was the only item in the three SUD patterns variables that related to substance use behaviour within the lifetime.

Approximately 16.7% of cases were missing $\geq 20\%$ values across survey items. These variables are indicated in the demographics section (see Table 2.1). Variables heavily missing in data points ($> 20\%$) were used in analyses for this study.

Little’s Missing Completely at Random (MCAR) Test indicated significance ($p < 0.05$) for all individual subscales and the entire dataset ($\chi^2 (2138) = 2296.72, p = .009$). Robust missing values techniques were, therefore, used to carry out analyses, specifically multiple imputation, which has been found to be more rigorous than listwise deletion or other missing data handling techniques (Van Ginkel, Linting, Rippe, & van der Voort, 2020).

Although it might not yield the extensive richness of output typically associated with alternative methods, multiple imputation, currently regarded as among the most reputable method for addressing missing data, has the advantage of not necessitating the assumption of MCAR, and possibly MAR, and is applicable to various forms of Generalised Linear Model (GLM) analyses, including regression (Tabachnick & Fidell, 2019). To provide estimates of variables with missing

data, multiple imputation involves generating m random samples with replacement from the distribution of each variable with missing data, resulting in m complete datasets (Jakobsen, Gluud, Wetterslev, & Winkel, 2017; Li, Stuart, & Allison, 2015; Tabachnick & Fidell, 2019). Typically, the default accepted number is $m = 25$, as there is minimal benefit in further increasing m beyond this threshold (Van Buuren, 2018). This process allows for the assessment of the uncertainty associated with the missing values and the construction of accurate confidence intervals and significance tests for the quantities of interest; the imputed datasets can then be analysed, and the results can be combined to provide a comprehensive understanding of the relationships and associations within the data (Jakobsen, Gluud, Wetterslev, & Winkel, 2017; Li, Stuart, & Allison, 2015).

2.3.2 Participant characteristics

Percentages are reported in approximation. For more details on sample characteristics see Tables 2.1 to 2.3.

2.3.2.1 Demographic and clinical characteristics

Participants' age ranged between 19 and 66 years (Mdn = 36, IQR = 17). The genders with which participants identified were male (33%), female (65%), and transsexual (1%). Participants self-identified as Caucasian ($n = 160$), Indigenous ($n = 65$), East Asian ($n = 7$), South Asian ($n = 7$), Black ($n = 6$), Southeast Asian ($n = 1$), West Asian ($n = 1$), mixed ethnicity ($n = 19$), other ($n = 18$), or not declared ($n = 6$). Over half had completed secondary education (28%), and completed trade school (4.5%) or higher education (college or university; 22%). The majority of participants were single (68%), and, prior to admission, reported unemployment (80%), and living in shelters, supportive housing, or other treatment centres (67%); 3% lived with family, whereas 29% lived in an owned or rented apartment/house. Under half of the participants reported living in the lowest (17%) or second lowest (26%) quintile groups, with the majority living in the middle quintile group (28%). Allegations of legal infractions were filed or in the process of being filed against (43%) of participants, while 41% of participants had no reported legal charges.

All participants were diagnosed with complex concurrent disorders, which included schizophrenia or PD's (82%). As the study took place in a treatment centre, all participants had SUD, and over half had a reported history of overdose (55%). Within 30 days of receiving treatment, participants had consumed non-prescribed stimulants (75%), alcohol (57%), cannabis (55%), opioids (54%), and/or other non-nicotine substances (38%).

Table 2.1: Demographic characteristics

Numerical	Range	Mdn	IQR	Skewness	Kurtosis	Missing (%)
Age	19–66	36	10.94	0.49	3.552	15 (5.2)
Categorical	N (%)		N (%)		N (%)	
Gender		Housing Situation		Legal Charges		
	Female	189 (65.2)	Institution/ supportive housing	146 (50.3)	None listed	118 (40.7)
	Male	96 (33.1)	Own/rented house/apartment	84 (29.0)	Past	76 (26.2)
	Transsexual	3 (1.0)	Street/ shelter	47 (16.2)	Present	44 (15.2)
	Missing	2 (0.7)	Family member's house	8 (2.8)	Pending	6 (2.1)
		Missing	5 (1.7)	Missing	46 (15.9)	
Ethnicity		Neighbourhood Income		Employment Status		
	White (European, Caucasian)	160 (55.2)	Middle quintile	80 (27.6)	Unemployed	123 (42.4)
	First Nations/Inuit/Métis	65 (22.4)	Second lowest quintile	74 (25.5)	Disabled/unable to work	110 (37.9)
	Mixed	19 (6.6)	Lowest quintile	49 (16.9)	Employed	38 (13.1)
	Other	13 (4.5)	Second highest quintile	42 (14.5)	Student	8 (2.8)

East Asian	7 (2.4)	Highest quintile	19 (6.6)	Retired	7 (2.4)
South Asian	7 (2.4)	Missing	26 (9.0)	Missing	4 (1.4)
Black, African-Canadian	6 (2.1)	Relationship Status		History of overdose	
Missing	6 (2.1)	Single	197 (67.9)	Yes	160 (55.2)
		Divorced/separated	33 (11.4)	No	92 (31.7)
Highest Level of Education		Partnered	27 (9.3)	Missing	38 (13.1)
Less than secondary	121 (41.7)	Married/common-law	8 (2.8)	Substance use	
Secondary	82 (28.3)	Widowed	6 (2.1)	Stimulant use	218 (75.2)
Higher education	64 (22.1)	Missing	19 (6.6)	Alcohol use	166 (57.2)
Trade school	13 (4.5)	PD		Cannabis use	159 (54.8)
Missing	10 (3.4)	Yes	238 (82.1)	Opioid use	156 (53.8)
		No	52 (17.9)	Other non-nicotine substances	110 (37.9)

Notes. Substance use = Non-prescribed substances used in the preceding 30 days.

2.3.2.2 Risk behaviours characteristics

The majority of participants had engaged in SDV (63%; male = 62%, female = 62%), with suicide attempt without NSSI being the most common method (37%; male = 31%, female = 39%).

Within 30 days of receiving treatment, the majority of participants had consumed substances every day (71%; male = 67%, female = 72%), with 80% (male = 83%, female = 78%) engaging in PSU; the most common form of PSU was the consumption of four drug categories (27%). Participants' YASU ranged from 4 to 23 years of age (Mdn = 14, IQR = 4).

Table 2.2: Risk behaviours characteristics

Numerical	Total (N=290)	Male (N=96)	Female (N=189)
YASU			
Range	4-23	7-23	4-23
Median	14	14	14
IQR	4	2.89	3.14
Skewness	0.65	-	-
Kurtosis	1.61	-	-
Missing (%)	0 (0.0)	0 (0.0)	0 (0.0)
SUF			
Range	4-30	4-30	4-30
Median	30	30	30
IQR	7.15	8.01	7.15
Skewness	-2.15	-	-
Kurtosis	3.13	-	-
Missing (%)	25 (8.6)	10 (10.4)	15 (7.9)
Categorical	Total N(%)	Male N(%)	Female N(%)
SDV			
NSSI only	22 (7.6%)	8 (8.3%)	12 (6.3%)
Suicide attempt only	106 (36.6%)	30 (31.3%)	74 (39.2%)
NSSI and suicide attempt	54 (18.6%)	21 (21.9%)	32 (16.9%)
PSU			
1 substance	33 (11.4%)	6 (6.3%)	27 (14.3%)
2 substances	51 (17.6%)	16 (16.7%)	35 (18.5%)

3 substances	75 (25.9%)	28 (29.2%)	47 (24.9%)
4 substances	76 (26.2%)	26 (27.1%)	50 (26.5%)
5 substances	25 (8.6%)	10 (10.4%)	15 (7.9%)
Missing	25 (8.6%)	10 (10.4%)	15 (7.9%)

2.3.2.3 Childhood abuse characteristics

A history of CA was prevalent among participants (89%; male = 91%, female = 88%), with specific forms of CA comprising CEA (70%), CPA (56%), and/or CSA (53%). See Table 2.3 for details.

Over half of the male participants had experienced CSA (64%), while under half of the female participants had experienced CSA (46%). Among both these genders, the most prevalent form of CSA experienced was severe to extreme (male = 40%, female = 22%). CPA was experienced by over half of both male (58%) and female (55%) participants. Severe to extreme CPA was the most common form experienced by both genders (male = 34%, female = 34%). Most male and female participants had experienced CEA (70% each gender). Whereas severe to extreme forms of this abuse was most common among male participants (28%), moderate forms of CEA were most prevalent among female participants (24%).

Table 2.3: Childhood abuse characteristics

Numerical	Group	Range	Mdn	IQR	Skewness	Kurtosis	Missing (%)
CSA	Total	20	6	9	1.133	0.434	0 (0.0)
	Male	20	10	9.91	0.771	-0.352	0 (0.0)
	Female	20	5	7	1.412	1.3	0 (0.0)
CPA	Total	18	9	8.73	0.693	-0.622	0 (0.0)
	Male	18	8.96	8.89	0.734	-0.627	0 (0.0)
	Female	18	9	8.73	0.669	-0.64	0 (0.0)
CEA	Total	20	12	8	0.305	-0.721	0 (0.0)
	Male	20	13	8	0.376	-0.665	0 (0.0)
	Female	17	11	8	0.184	-1.014	0 (0.0)

Categorical	Total N(%)	Male N(%)	Female N(%)
CA presence	259 (89.3%)	87 (90.6%)	167 (88.4%)
CSA presence	153 (52.8%)	61 (63.5%)	87 (46.0%)
CSA Severity			
None	137 (47.2%)	35 (36.5%)	102 (54.0%)
Low	18 (6.2%)	3 (3.1%)	15 (7.9%)
Moderate	51 (17.6%)	20 (20.8%)	31 (16.4%)
Severe	84 (29.0%)	38 (39.6%)	41 (21.7%)
CPA presence	196 (67.6%)	62 (64.6%)	130 (68.8%)
CPA Severity			
None	127 (43.8%)	40 (41.7%)	85 (45.0%)
Low	31 (10.7%)	13 (13.5%)	18 (9.5%)
Moderate	33 (11.4%)	10 (10.4%)	22 (11.6%)
Severe	99 (34.1%)	33 (34.4%)	64 (33.9%)
CEA presence	248 (85.5%)	83 (86.5%)	160 (84.7%)
CEA Severity			
None	86 (29.7%)	29 (30.2%)	57 (30.2%)
Low	62 (21.4%)	18 (18.8%)	43 (22.8%)
Moderate	70 (24.1%)	22 (22.9%)	46 (24.3%)
Severe	72 (24.8%)	27 (28.1%)	43 (22.8%)

2.3.3 Preliminary analyses results

2.3.3.1 Normality

Parametric assumptions, specifically skewness, kurtosis, and outliers, were assessed in the two continuous outcome variables (i.e., *SUF* and *YASU*) in an effort to avoid missing deviations from normality. Both visual inspection of P-P & Q-Q plots and significance in both the Shapiro-Wilk and Kolmogorov-Smirnov tests indicated that both outcome variables were non-normally distributed. In addition, negative skewness was observed in *SUF*, while positive kurtosis was observed in *SUF* and *YASU*, according to Field's (2018) suggested absolute values greater than +/- 1.96 at $p < 0.05$. See Table 2.2 for more details. Transformations such as log differences, the square root method, and the inverse method continued to yield non-normal data distributions.

Univariate outliers were identified through the interquartile range (IOR) and box plots. These outliers were winsorized, where extreme scores with z-scores greater than positive or negative 3.29 were replaced by scores 3 standard deviations from the mean, as suggested by Field (2018).

2.3.3.2 Correlation analyses

A correlation matrix was computed for model variables, where demographic variables were used to identify potential control variables. Due to a low endorsement of the demographic categorical variable for gender (i.e., only three participants identified as neither female nor male), this variable was collapsed into a binary variable. In order to identify potential control variables for the subsequent HMR, correlation analyses using bootstrapped t-tests and Pearson correlations, specifically using BCa bootstrap confidence intervals, were conducted. For an overview of the correlation matrices between model variables, see Tables 2.1 to 2.2 in Appendix D. Separate two-tailed bootstrapped t-tests were conducted to compare age, gender, and PD with SUF, PSU, YASU, and SDV. Significant relationships were found between SUF and PD (mean difference = -0.133, 95% CI: -.258, -.020); SUF and PSU (mean difference = 0.415, 99% CI: 0.309, 0.523); PSU and age (mean difference = -0.278, 99% CI: -0.394, -0.161); PSU and PD (mean difference = -0.190, 99% CI: -.063, -.313); PSU and YASU (mean difference = -0.143, 95% CI: -0.245, -0.031); SDV and PD (mean difference = -0.133, 95% CI: -0.258, -0.020), and gender and PD (mean difference = -0.173, 99% CI: -0.272, -0.069).

Significant relationships with the demographic variables, gender, age, and PD, suggested that they be controlled for in hierarchical regression analyses, where SUF, PSU, YASU, and SDV were dependent variables, particularly where they had empirical evidence or accounted significantly for model variance. Gender was, moreover, retained as a covariate, because of its theoretical justification.

Bootstrapped Pearson correlations were utilised to investigate the relationships among CA, CSA, CPA, CEA, SUF, PSU, YASU, and SDV. Statistically significant positive relationships were observed between CA and SDV ($r = 0.131$, 95% CI: 0.014, 0.240), CPA and SDV ($r = 0.159$, 99% CI: 0.043, 0.259), and CEA and SDV ($r = 0.273$, 99% CI: 0.170, 0.369).

2.3.4 Hierarchical multiple regression assumptions testing and overview

In order to assess the hypotheses, separate HMR models were conducted to investigate the predictive capacity of CA, CSA, CPA, and CEA (i.e., predictor variables) on each of SUF, PSU, YASU, and SDV (i.e., outcome variables). Covariates that were checked included gender, age, and the PD.

Prior to hypothesis testing, assumptions of linearity, multicollinearity, normality of residuals, and homoscedasticity were assessed across all regression models. Linearity was evaluated through inspection of scatterplots between predicted values and residuals, which indicated non-linearity in some of the SUF regressions only. Multicollinearity was considered non-problematic in all regressions, according to the VIF and tolerance. Evidence suggested deviations from normality and the presence of heteroscedasticity in all regressions, as indicated by visual inspection of P-P plots and residual scatterplots. Consequently, bootstrap procedures with 2000 samples were employed to provide bias-corrected and accelerated (BCa) confidence intervals, thereby mitigating the impact of these assumption violations.

For the SUF regressions, 30 multivariate outliers were removed, reducing the sample to N=260. For the PSU regressions, 40 multivariate outliers were removed, resulting in N=250. For YASU, five multivariate outliers were excluded in the CA and CPA regressions (N=285), while 17 were removed in the CSA and CEA regressions (N=273), both through listwise deletion. Lastly, five multivariate outliers were excluded in each SDV regression, reducing the sample to N=285 via listwise deletion.

2.3.4.1 Hypothesis 1 results

It is hypothesised that CA will be associated with increased engagement in SUD patterns (i.e., greater frequency, existence of polysubstance use, and younger age of initiation) and SDV (i.e., NSSI and suicidality) in individuals with SUD.

To address Hypothesis 1, the relationship between CA and the four outcome variables were examined. The results provide partial support for Hypothesis 1. Table 2.4 provides details.

CA was found to be a significant predictor of SDV ($\beta = 0.140$, $p < .05$, BCa 95% CI [0.058, 0.713]), with an explained variance of 1.9% (R^2 adjusted = 0.03, $F(1,281) = 5.73$, $p = .02$).

CA was not a significant predictor for any other outcome variables. For SUF, CA did not significantly predict the outcome ($\beta = -0.049$, BCa 95% CI [-2.783, 1.206]). The model explained a negligible amount of variance, with an adjusted R^2 of -0.004 and an F change of 0.632 ($p = .472$). In the PSU model, CA again did not emerge as a significant predictor ($\beta = 0.057$, BCa 95% CI [-0.192, 0.522]). The model including CA explained 9.9% of the variance (adjusted $R^2 = 0.085$, $F(3,245) = 8.678$, $p < .001$), with most of this variance accounted for by covariates. Lastly, for the YASU, CA did not significantly predict the outcome ($\beta = 0.085$, BCa 95% CI [-0.204, 1.510]). The model did not explain a significant amount of variance in this outcome variable.

Table 2.4: CA bootstrapped hierarchical multiple regressions

Regressions		Step 1		Step 2	
		B (SE B) (95% BCa CI)	β	B (SE B) (95% BCa CI)	β
SUF	Constant	26.234 (0.803) (24.47, 27.92)		26.945 (1.202) (24.34, 29.116)	
	Gender	0.612 (0.982) (-1.167, 2.588)	0.039	0.611 (0.983) (1.208, 2.633)	0.039
	CA			-0.899 (1.131) (-2.783, 1.206)	-0.049
PSU	Constant	3.830 (.371) (3.089, 4.551)		3.735 (.367) (2.942, 4.486)	
	Gender	-.157 (.152) (-.443, .123)	-0.063	-.158 (.153) (-.448, .126)	-0.064
	Age	-.027 (.007) (-.039, -.013)	-.245**	-.027 (.007) (-.040, -.014)	-.249**
	PD	.341 (.086) (-.065, .719)	0.117	.325 (.187) (-.069, .700)	0.083
	CA			.161 (.172) (-.192, .522)	0.057
YASU	Constant	14.063 (.312) (13.522, 14.626)		13.550 (.475) (13.522, 14.626)	
	Gender	-.053 (.383) (-.760, .631)	-0.008	-.044 (.383) (-.746, .643)	-0.007
	CA			.640 (.447) (-.204, 1.510)	0.085

SDV	Constant	1.813 (.204) (1.443, 2.192)		1.520 (.237) (1.069, 1.998)	
	Gender	-.081 (.147) (-.384, .222)	-0.033	-.080 (.146) (-.380, .230)	-0.032
	PD	-.489 (.182) (-.803, -.206)	-.161**	-.522 (.181) (-.823, -.245)	-.172**
	CA			.403 (.168) (.058, .713)	.140*

Notes. * $p < .05$; ** $p < .01$. 95% BCa CI = 95% bias-corrected and accelerated bootstrap confidence intervals.

2.3.4.2 Hypothesis 2 results

It is hypothesised that CSA, CPA, and CEA will exhibit differential associations with increased engagement in SUD patterns and SDV among individuals with SUD. Specifically, it is anticipated that CSA will demonstrate stronger associations with these outcomes.

To address Hypothesis 2, relationships between CSA, CPA, and CEA and the outcome variables were examined. The results provided partial support for Hypothesis 2, demonstrating that different forms of CA are differentially associated with SUD patterns and SDV (for thorough details, see Tables 2.5 to 2.7).

CPA emerged as the only significant predictor for SUF among the specific forms of CA ($\beta = 0.121$, BCa 95% CI [0.038, 0.328]). CPA, moreover, significantly predicted SDV ($\beta = 0.144$, $p < .01$, BCa 95% CI [0.008, 0.059]), with CPA explaining 2.1% of variance (R^2 adjusted = 0.04, $F(1,281) = 6.11$, $p = .01$). CEA emerged as the strongest predictor of SDV among the specific forms of CA ($\beta = 0.265$, $p < .01$, BCa 95% CI [0.035, 0.085]), explaining 7% of variance (R^2 adjusted = 0.09, $F(1,281) = 21.67$, $p < .001$).

For the PSU and YASU models, CSA, CPA, or CEA were not found to be significant predictors ($p > .05$). Notably, CSA was not found to be a significant predictor of any of the outcome variables ($p > .05$). It is worth noting that age consistently demonstrated a robust negative relationship with PSU across all models (β ranging from -0.277 to -0.289, $p < .001$), as well as a

significant predictor of the YASU in the CPA and CEA models ($\beta = 0.033$, $p < .05$, BCa 95% CI [0.002, 0.066]).

Table 2.5: CSA bootstrapped hierarchical multiple regressions

Regressions		Step 1		Step 2	
		B (SE B) (95% BCa CI)	β	B (SE B) (95% BCa CI)	β
SUF	Constant	26.234 (0.803) (24.353, 27.974)		25.922 (1.008) (23.061, 28.231)	
	Gender	0.612 (.981) (1.353, 2.634)	0.039	0.681 (1.004) (1.202, 2.665)	0.043
	CSA			0.029 (0.086) (-0.143, 0.188)	0.021
PSU	Constant	4.249 (.263) (3.732, 4.779)		4.084 (.289) (3.507, 4.681)	
	Gender	-.204 (.153) (-.501, .083)	-0.082	-.160 (.156) (-.458, .136)	-0.064
	Age	-.030 (.007) (-.042, -.017)	-.277**	-.031 (.007) (-.042, -.019)	-.285**
	CSA			.018 (.013) (-.007, .043)	0.086
YASU	Constant	12.891 (.677) (11.577, 14.191)		12.595 (.750) (11.059, 14.123)	
	Gender	-.033 (.317) (-4.277, .065)			
	Age	-.124 (.397) (-.882, .627)	-0.117	-.042 (.407) (-.851, .743)	-0.006
	CSA		-0.019	.031 (.010) (-.002, .064)	0.112
SDV	Constant	1.813 (.204) (1.421, 2.181)		1.596 (.244) (1.114, 2.052)	
	Gender	-.081 (.147) (-.359, .192)	-0.033	-.030 (.150) (-.313, .257)	-0.012
	PD	-.489 (.182) (-.799, -.164)	-.161**	-.503 (.181) (-.803, -.181)	-.165**
	CSA	1.813 (.204) (1.421, 2.181)		.021 (.013) (-.004, .045)	0.098

Notes. * $p < .05$; ** $p < .01$. 95% BCa CI = 95% bias-corrected and accelerated bootstrap confidence intervals.

Table 2.6: CPA bootstrapped hierarchical multiple regressions

Regressions	Step 1		Step 2		
	B (SE B) (95% BCa CI)	β	B (SE B) (95% BCa CI)	β	
SUF	Constant	26.234 (0.803) (24.340, 27.842)		24.462 (1.907) (21.796, 27.003)	
	Gender	0.612 (0.981) (-1.232, 2.556)	0.039	0.622 (0.976) (-1.205, 2.548)	0.039
	CPA			0.177 (0.091) (0.038, 0.328)	0.121*
PSU	Constant	4.249 (.263) (3.729, 4.735)		4.087 (.284) (3.483, 4.633)	
	Gender	-.204 (.153) (-.497, .107)	-0.082	-.202 (.152) (-.497, .106)	-0.081
	Age	-.030 (.007) (-.043, -.016)	-.277**	-.031 (.007) (-.045, -.017)	-.289**
	CPA			.021 (.014) (-.006, .047)	0.091
YASU	Constant	12.891 (.677) (11.552, 14.096)		12.937 (.741) (11.434, 14.308)	
	Gender	-.124 (.397) (-.915, .711)	-0.019	-.126 (.398) (-.928, .704)	-0.019
	Age	-.033 (.317) (.003, .067)	-0.117	-.033 (.017) (-.002, .066)	-.118*
	CPA			-.006 (.038) (-.084, .070)	-0.009
SDV	Constant	1.813 (.204) (1.421, 2.181)		1.483 (.242) (1.003, 1.946)	
	Gender	-.081 (.147) (-.359, .192)	-0.033	-.072 (.146) (-.345, .198)	-0.029
	PD	-.489 (.182) (-.799, -.164)	-.161**	-.501 (.181) (-.802, -.177)	-.165**
	CPA			.033 (.014) (.008, .059)	.144**

Notes. * $p < .05$; ** $p < .01$. 95% BCa CI = 95% bias-corrected and accelerated bootstrap confidence intervals.

Table 2.7: CEA bootstrapped hierarchical multiple regressions

Regressions		Step 1		Step 2	
		B (SE B) (95% BCa CI)	β	B (SE B) (95% BCa CI)	β
SUF	Constant	26.234 (.803) (24.353, 27.974)		26.208 (1.030) (22.947, 28.987)	
	Gender	.612 (.981) (-1.354, 2.634)	0.039	0.614 (0.985) (-1.324, 2.634)	0.039
	CEA			0.002 (0.001) (-0.181, 0.183)	0.023
PSU	Constant	4.249 (.263) (3.732, 4.779)		4.032 (.305) (3.431, 4.686)	
	Gender	-.204 (.153) (-.501, .083)	-0.082	-.193 (.152) (-.494, .097)	-0.077
	Age	-.030 (.007) (-.042, -.017)	-.277**	-.030 (.007) (-.042, -.018)	-.283**
	CEA			.020 (.014) (-.010, .047)	0.085
YASU	Constant	12.891 (.677) (11.603, 14.220)		12.879 (.790) (11.240, 14.489)	
	Gender	-.124 (.397) (-.860, .596)	-0.019	-.123 (.384) (-.878, .621)	-0.019
	Age	.033 (.017) (.002, .066)	0.117	-.033 (.017) (-.002, .066)	.117*
	CEA			.001 (.037) (-.079, .079)	0.002
SDV	Constant	1.813 (.204) (1.435, 2.212)		1.013 (.262) (.519, 1.541)	
	Gender	-.081 (.147) (-.386, -.206)	-0.033	-.018 (.152) (-.317, -.276)	-0.007
	PD	-.489 (.182) (-.811, -.162)	-.161**	-.454 (.176) (-.761, -.155)	-.149**
	CEA			.061 (.013) (.035, .085)	.265**

Notes. * $p < .05$; ** $p < .01$. 95% BCa CI = 95% bias-corrected and accelerated bootstrap confidence intervals.

2.3.4.3 Hypothesis 3 results

It is hypothesised that gender will not be a significant predictor of the outcome variables.

Gender did not account for significant variance in any of the regression models ($p > .05$). Tables 2.4 to 2.7 provide details.

A Chi-square test of independence was conducted to examine the relationship between gender and CA presence (dichotomous). To further determine whether a gender difference existed, gender was retained as a covariate in each regression. The results provide support for Hypothesis 3.

The results indicated no significant association between gender and CA presence, $\chi^2(1, N = 285) = 0.073$, $p = .787$, Cramer's $V = .016$. The proportion of men who experienced CA (80.2%, $n = 77$) did not significantly differ from the proportion of women who experienced CA (78.8%, $n = 149$). See Table 2.8 for more details.

Table 2.8: Chi-Square test for gender and childhood abuse

Statistic	Value	df	p-value
Pearson Chi-Square	0.073	1	0.787
Likelihood ratio	0.073	1	0.786
Linear-by-linear association	0.073	1	0.787
N of Valid Cases	285	-	-

Notes. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 19.87.

2.4 Discussion: Study I

This study aimed to examine the relationships between CA and its specific forms—CSA, CPA, and CEA—with risk behaviours, specifically SUD patterns (i.e., SUF, PSU, and YASU) and SDV (i.e., NSSI and suicidality). Additionally, it explored whether gender differences in these risk behaviours are contingent upon differences in CA experiences.

The study revealed that CA was a significant predictor of SDV, consistent with the broader literature indicating that childhood trauma often contributes to NSSI and suicidality (Baldwin et al., 2023; Gong & Zhang, 2024; Liu et al., 2017; Zatti et al., 2017). Among the specific abuse types, CEA emerged as the strongest predictor of SDV, with CPA also demonstrating a significant association. These findings echo those from previous studies, where CEA has

consistently been highlighted as a critical risk factor for SDV (Yue et al., 2023; Thomassin et al., 2016). Thomassin and colleagues (2016) reported that poor emotional expressivity mediates the relationship between CEA and NSSI, emphasising the significance of emotional regulation issues linked to CEA. Conversely, CSA did not emerge as a significant predictor of SDV, which diverges from findings in some prior research suggesting CSA is strongly linked to suicide plans and attempts (Angelakis et al., 2020; Stea et al., 2023). Nilsson et al. (2022), however, found no significant relationship between CSA, CPA, or childhood neglect and SDV, supporting the current study's findings. This discrepancy may stem from varying sample characteristics, methodological differences, or the smaller effect size of CSA compared to CEA or CPA (Klonsky & Moyer, 2008; Yue et al., 2023).

Regarding SUD patterns, CPA was the sole significant predictor of SUF, supporting the hypothesis that certain forms of CA, particularly CPA, are linked to specific substance use outcomes. This aligns with prior research indicating a strong relationship between CPA and increased substance use (Mishra et al., 2022; Benedini & Fagan, 2020). Benedini and Fagan (2020) found that physical abuse directly affected adolescent SUF, mediated by internalising problems and anger. These findings underscore the lasting impact of CPA on maladaptive coping mechanisms, such as substance use. Nevertheless, CSA and CEA were not significant predictors of SUF, PSU, or YASU, which contrasts with studies suggesting that childhood maltreatment broadly contributes to substance use initiation and escalation (Beal et al., 2023; Carliner et al., 2016; Cicchetti & Handley, 2019). This lack of association could indicate that the relationship between CSA and substance use may be moderated by other factors, such as emotional dysregulation or additional trauma exposure (Mandavia et al., 2016; Schimmenti et al., 2022). Additionally, PSU and YASU were not significantly related to any form of abuse, diverging from previous research indicating that early maltreatment is linked to PSU and earlier substance initiation (Capusan et al., 2021; Huang et al., 2021). This discrepancy may reflect the influence of unmeasured mediators or sample-specific characteristics, such as having a population already diagnosed with SUD.

The absence of gender as a significant predictor of substance use patterns and SDV contrasts with some literature emphasising gender-specific trajectories following CA (McKee & McRae-Clark, 2022; Meng & D'Arcy, 2016; Serafini et al., 2017; Thompson et al., 2021). One

plausible explanation for these mixed findings is the failure to control for key variables in gender-specific analyses. For instance, studies that do not differentiate between CSA, CPA, and CEA may obscure the unique impact of each abuse type on men and women (Benedini & Fagan, 2020; Bikmazer et al., 2023; Hébert, Amédée, Blais, & Gauthier-Duchesne, 2019; Penning & Collings, 2014). Similarly, other mediating or contextual factors have been found to further complicate the gendered impact of childhood trauma on SUD and SDV (Choi et al., 2023; Dowling et al., 2023; Frobel et al., 2022; Khan, Dar, Bano, & Iqbal, 2021; Johnson & Zaidi, 2021). Controlling for key covariates may elucidate more precise gender-specific pathways linking CA forms to risk behaviour.

Furthermore, the absence of significant gender differences in the current study may be attributed to several factors, including the lack of significant gender differences in CA exposure and the sample's clinical nature, where all participants presented with SUD. In populations where SUD is prevalent, gender differences in coping strategies and risk behaviours may be less pronounced, or substance use itself may mask these differences. In addition, the atypical finding that more men than women in the sample reported CSA deviates from typical epidemiological trends (Finkelhor et al., 2024; Johnson & Zaidi, 2021), possibly influencing the absence of gender-specific effects.

2.4.2 Conclusion and future research

The current study provides valuable insights into the complex relationships between forms of CA—including CSA, CPA, and CEA—and risk behaviours, namely SUD patterns (SUF, PSU, YASU) and SDV (NSSI and suicidality), in individuals with SUD's. By controlling for gender, age, and the presence of psychotic disorders, this study offers a clearer understanding of how CA and its subtypes relate to these risk behaviours. The significant findings, particularly the associations between CPA and SUF and between CA, CPA, and CEA with SDV, underscore the importance of considering specific abuse types rather than treating CSA or CA as homogenous constructs. These findings enhance the understanding of CA's role in the development of maladaptive behaviours in SUD populations, offering a foundation for future research and clinical interventions.

Despite these contributions, several limitations must be acknowledged. The reliance on self-report measures introduces potential biases, such as recall and social desirability biases, which could affect the accuracy of reported abuse experiences and associated behaviours. Furthermore, the secondary nature of the CAPU dataset limited variable control, particularly regarding the inclusion of only specific abuse measures and predictors and risk behaviours, which may have excluded other relevant factors. The cross-sectional design is another limitation, as it precludes any determination of causality. Longitudinal research would be essential to unravel the temporal and potentially causal relationships between CA and the emergence of SUD and SDV. Furthermore, the sample's clinical nature, composed of individuals entering SUD treatment programs, may limit the generalisability of the findings to broader, non-clinical populations. The unexpected gender distribution, where more male participants reported CSA despite the higher proportion of female participants overall, also raises questions about gender-specific reporting patterns and requires further exploration.

The study's strengths, however, should not be overlooked. The use of bootstrapping techniques to estimate associations between CA predictors and risk behaviours enhances confidence in the robustness of the findings. This approach mitigates some of the limitations associated with sample size and variability, providing more reliable estimates, particularly in the significant relationships observed between CPA and SUF and between CA, CPA, and CEA with SDV. By focussing on specific forms of abuse and controlling for key demographic variables, this study offers a nuanced perspective that contributes to the broader discourse on trauma and its long-term behavioural outcomes.

Future research should build on these findings by exploring more complex pathways and mediating factors that may influence the relationship between CA and risk behaviours. The inclusion of additional ACE's or childhood contextual factors could offer deeper insights into how broader environmental and familial conditions interact with specific abuse types to shape outcomes. Furthermore, the exploration of CSA disclosure experiences could elucidate how disclosure dynamics influence behavioural and psychological outcomes, particularly in populations with SUD. Given that CSA did not emerge as a significant predictor in this study, future research should examine whether certain contextual or relational factors impact CSA on outcomes that may be more pertinent to sexual trauma.

In addition, the use of more complex and advanced statistical techniques could enhance future research by allowing for a more comprehensive examination of direct and indirect pathways linking CSA and CA forms to later outcomes. This could help delineate the complex interactions between different types of abuse, mediators such as familial adversity, and various behavioural outcomes. This approach could address some of the limitations of the current study by incorporating multiple pathways and mediating variables, thus providing a more holistic understanding of the sequelae of childhood trauma.

Finally, qualitative research approaches could offer an in-depth exploration of the dynamic and subjective experiences of individuals with histories of CSA and CA forms. Given the complexity and relative under-researched nature of gender differences in these contexts, qualitative studies could reveal nuanced insights into how gender, societal stigma, and individual experiences of abuse intersect to influence various outcomes. By integrating qualitative perspectives, future research can deepen an understanding of the lived experiences behind statistical findings and develop more tailored, gender-sensitive interventions.

While the current study highlights significant associations between CA and risk behaviours in individuals with SUD, it also opens avenues for further exploration. Future research should continue to refine our understanding of these complex relationships, incorporating more sophisticated methodologies and broader contextual factors to inform more effective prevention and intervention strategies. These efforts are critical in advancing both clinical practice and public health initiatives aimed at mitigating the long-term impact of childhood trauma.

Chapter 3: Childhood Abuse and Sexual Shame: Exploring Pathways of Disclosure Experiences, Contextual Adversities, and Gender through Structural Equation Modelling – Study II

3.1 Introduction: Study II

3.1.1 Background

ACE's, particularly CSA as an early traumatic sexual experience, may profoundly impact survivors' psychosexual development, influencing their later sexual and intimate desires and experiences (Alley & Diamond, 2021; Barker, Volk, Hazel, & Reinhardt, 2022; Drewitt-Smith & Marczak, 2023; Ecott, Aiolfi, & Ó Ciardha, 2020; Gewirtz-Meydan & Godbout, 2023; Giordano, Hedden, Kim, Lundeen, & Lu, 2024). As previously noted, CSA and other ACE's are strongly associated with substance use and SUD's (Beal et al., 2023; Capusan et al., 2021; Clark et al., 2023; Cicchetti & Handley, 2019; Hagborg, Christie, & Rice, 2020; Thomas & Kopel, 2023; Thorvaldsson, & Fahlke, 2020). This relationship is particularly pertinent given the frequent co-occurrence of SUD's and problematic sexual behaviour (Basting et al., 2024; Garner, Shorey, Anderson, & Stuart, 2020; Golder et al., 2024; Meyer et al., 2017; Ménard & MacIntosh, 2021; Stavro et al., 2013).

Many negative outcomes associated with CSA may be compounded by nondisclosure or delays in disclosing the abuse (Alaggia, 2010; Easton, 2013; Gemara & Katz, 2023; Marriott, Hamilton-Giachritsis, & Harrop, 2014; Weare et al., 2024). These delays or nondisclosures have been found to be more common among male survivors than female survivors (Drewitt-Smith & Marczak, 2023; Easton, 2013; Edinburgh et al., 2015; Gewirtz-Meydan et al., 2018; Gill & Begum, 2023; Hounmenou, 2017; Latiff et al., 2024; Okur, van der Knaap, & Bogaerts, 2017; Romano, Moorman, Ressel, & Lyons, 2019; Sølvsberg et al., 2023). Nevertheless, gender differences in CSA disclosure timing and duration may vary across contexts, cultures, and abuse severity (Hemanth et al., 2024; Latiff et al., 2024; Mordi, Katz, Tener, & Savaya, 2022).

The quality and level of support during the disclosure experience are critical, as these factors can either facilitate or hinder recovery from trauma. Early and supportive disclosure, particularly during childhood, may prevent the internalisation of the abuse or halt the abuse itself (Bi et al., 2018; Mourtgos et al., 2021). Conversely, unhelpful or detrimental disclosure experiences can involve negative reactions. Relyea and Ullman (2015) identified two types of negative social reactions to sexual assault disclosure: “turning against” (TA) and “unsupportive acknowledgment” (UA). TA responses involve blaming, stigmatising, or infantilising the survivor, while UA responses are characterised by distracting, controlling, or egocentric behaviours. Survivors who experienced TA reported greater social withdrawal, increased self-blame, and decreased assertiveness, whereas those who experienced UA—found to be more common—engaged in greater maladaptive and adaptive coping strategies (Relyea & Ullman, 2015).

Variability in responses to and outcomes of disclosures may arise from personal, familial, and societal factors (Drewitt-Smith & Marczak, 2023; Gemara & Katz, 2023; Humphries et al., 2016). For instance, parental support can create an environment where children better comprehend the gravity of the abuse and feel safe disclosing their experiences (Gemara & Katz, 2023; Maleki et al., 2023). In many cases, however, these factors contribute to nondisclosure during childhood (Drewitt-Smith & Marczak, 2023; Gemara & Katz, 2023; Humphries et al., 2016), particularly in instances of intrafamilial CSA (Gemara & Katz, 2023; Hemanth et al., 2024; Latiff et al., 2024). Even in the absence of intrafamilial CSA, the presence of other ACE’s, such as neglect or household dysfunction, has been shown to further impede disclosure (Attrash-Najjar et al., 2023; Gemara & Katz, 2023; Hemanth et al., 2024; Lahtinen, Laitila, Korkman, & Ellonen, 2018; Latiff et al., 2024; Leclerc & Wortley, 2015; Tashjian, Goldfarb, Goodman, Quas, & Edelstein, 2016).

Barriers to disclosure also include feelings of shame, perceptions of shared responsibility, stigma surrounding sexual orientation or preferences, refusal to label the experience as abuse, and a lack of supportive resources (Depraetere, Vandeviver, Vander Beken, & Keygnaert, 2020; Gerke et al., 2023; Kennedy & Prock, 2018; Priebe & Svedin, 2008). These barriers to disclosure and the resulting negative experiences often contribute to the internalisation of shame and maladaptive coping mechanisms. Such outcomes can have lasting impacts on survivors’ psychological

well-being and psychosexual development. The relationships between CSA, ACE's, and these coping mechanisms may help explain the emergence of problematic sexual thoughts and behaviours (PSTB).

CSA, particularly when combined with other ACE's, has been linked to the development of problematic sexual thoughts and behaviours (PSTB) through neurobiological, psychological, and maladaptive coping mechanisms (Alley & Diamond, 2021; Golder et al., 2024). PSTB can encompass a wide range of sexual activity, from avoidance of sexual intercourse to engaging in risky sexual behaviour (RSB) or compulsive sexual behaviour (CSB) (Cassioli et al., 2024; Fava et al., 2024; Petersson & Plantin, 2023; Pulverman & Meston, 2020).

Although several methodological issues persist in studies examining gendered psychosexual outcomes—such as those using single-gender samples and generalising findings to all individuals of that gender—some trends have emerged regarding gender differences among CSA survivors (Gewirtz-Meydan & Opuda, 2022; Kilimnik et al., 2018; Ménard & MacIntosh, 2021). Male survivors appear more likely to engage in CSB and RSB (Slavin et al., 2020a; Thomas & Kopel, 2023), while female survivors report higher rates of sexual inhibition and dysfunction (Gewirtz-Meydan & Godbout, 2023). Despite these observed patterns, the underlying mechanisms driving these behaviours among CSA survivors, including potential gendered trends, may share substantial similarities.

These PSTB, despite varying in manifestation (e.g., avoidance versus CSB), may share similar underlying mechanisms. Early sexual traumatisation often results in negative emotions surrounding sex (Fava et al., 2024; Noll et al., 2003), including sexual disgust (Jones & Lorenz, 2024; Lafortune et al., 2024), or the internalisation of inappropriate sexual behaviours, as outlined by the life-course and traumagenic dynamics models (Browning & Laumann, 1997; Finkelhor & Browne, 1985). Such mechanisms may lead to PSTB serving as a means of either reenacting or suppressing trauma-related distress (Cassioli et al., 2024; Fava et al., 2024; Petersson & Plantin, 2023; Pulverman & Meston, 2020). Trauma-related negative emotions, such as depression, have been closely linked to feelings of shame and sexual preoccupation (Gewirtz-Meydan & Lassri, 2023; McHugh & Weiss, 2019; Rudenstine, Espinosa, & Kumar, 2020). Shame, in particular, may foster maladaptive self-schemas that perpetuate psychological

distress (Healy, Lee, & D'Andrea, 2021; McElvaney, Lateef, Collin-Vézina, Alaggia, & Simpson, 2022).

In a thematic analysis of CSA disclosure narratives, McElvaney and colleagues (2022) identified three central themes: languaging implicit shame, avoiding shame, and reducing shame. Their findings indicated that shame, often expressed through feelings of being “dirty” or “disgusting” and a fear of judgment, led to avoidant coping strategies and difficulties verbalising abuse, which in turn contributed to negative self-concepts and hindered disclosure. These negative self-concepts and feelings of shame among CSA and ACE survivors have been associated with increased difficulties in recovery from psychological and sexual challenges (Dorahy & Clearwater, 2012; Feiring & Taska, 2005; Feiring, Taska, & Chen, 2002; Litam & Speciale, 2021; Schramm & Tapia, 2024; Pulverman & Meston, 2020). For instance, shame and maladaptive self-schemas have been shown to exacerbate sexual dysfunction, further compromising survivors’ psychological well-being and sexual experiences, which may, in turn, amplify sexual shame (SS; Cassioli et al., 2024; Cui et al., 2019).

Gewirtz-Meydan and Godbout (2023) identified CSA as a significant risk factor for sexual difficulties in adulthood; Their findings revealed that heightened levels of sex-related guilt and shame were linked to greater sexual dysfunction and moderated the relationship between CSA and compulsive sexual behaviour disorder in both women and men. Similarly, studies have found that SS mediates the relationship between a history of CSA and sexual functioning among women (Pulverman & Meston, 2020) and men (Petersson & Plantin, 2023; Rendina et al., 2019). These findings suggest that while the expression of sexual behaviours may differ between genders, the underlying psychological motivations, including SS, may be comparable for male and female CSA survivors.

Factors contributing to feelings of shame often include the severity of CSA, the closeness of the survivor-perpetrator relationship, and the presence of additional CCA's (Basting et al., 2024; Cassioli et al., 2024; Ciocca et al., 2023; Finkelhor & Browne, 1985; Giordano et al., 2024; Noll et al., 2003; Vaillancourt-Morel et al., 2016; Tang et al., 2018). These feelings of shame and self-blame are frequently compounded by nondisclosure or delays in disclosure, which are often driven by the anticipated or actualised negative reactions of others upon disclosure (Bi et al.,

2018; Drewitt-Smith & Marczak, 2023; McElvaney et al., 2022; Relyea & Ullman, 2015; Weare et al., 2024). Together, these intersecting variables may have profound implications for psychosexual development, particularly in fostering SS.

3.1.2 Research aims

Despite extensive research on the impacts of CSA and other ACE's, significant gaps remain in understanding the nuanced pathways linking childhood abuse, disclosure experiences, and psychosexual development outcomes such as SS. Much of the existing literature overlooks the differential effects of abuse severity across various abuse types (CSA, CPA, and CEA), as well as the mediating and moderating roles of contextual factors such as disclosure experiences and sex. Additionally, findings regarding gender differences in SS and psychosexual development remain inconclusive, with limited studies directly comparing male and female survivors, particularly in the context of varying abuse severities and disclosure experiences. Furthermore, while the influence of CCA on disclosure and recovery has been acknowledged, their specific role in shaping the quality and outcomes of disclosure experiences remains underexplored. These gaps are particularly evident in populations with SUD's, who may experience compounded vulnerabilities due to co-occurring problematic sexual behaviours and substance-related stigma. By addressing these gaps, this study aims to elucidate the complex relationships between childhood abuse types, disclosure experiences, contextual adversities, gender, and SS, providing a more comprehensive understanding of these interactions within individuals with SUD.

3.1.2.1 Research questions and hypotheses

Drawing on theoretical frameworks and existing empirical evidence, this study seeks to address the following research questions and test the corresponding hypotheses.

Research question 1: Is the severity of childhood abuse (i.e., sexual, physical, or emotional) in individuals with SUD differentially associated with levels of sexual shame?

Hypothesis 1: The severity of CA types will be differentially associated with levels of SS in individuals with SUD, with higher CSA severity predicting significantly higher SS compared to high CPA and/or CEA severity.

Research question 2: Does disclosing childhood sexual abuse (CSA) in childhood mediate the relationship between childhood abuse types and sexual shame in individuals with SUD?

Hypothesis 2: Childhood disclosure of CSA will significantly mediate the relationship between childhood abuse types (i.e., CSA, CPA, and CEA) and SS in individuals with SUD.

Research question 3: Do different CSA disclosure experiences in childhood (i.e., positive or negative) mediate the relationship between childhood abuse types and sexual shame in individuals with SUD?

Hypothesis 3: Positive CSA disclosure experiences (DE positive) in childhood will significantly mediate the relationship between childhood abuse types (i.e., CSA, CPA, and CEA) and SS, with positive disclosure experiences associated with lower SS.

Hypothesis 4: Negative CSA disclosure experiences (DE negative) in childhood will mediate the relationship between childhood abuse types (i.e., CSA, CPA, and CEA) and SS, with negative disclosure experiences associated with higher SS.

Research question 4: Do instances of contextual childhood adversities (i.e., physical neglect, emotional neglect, household mental illness, household substance use disorder, parental incarceration, exposure to intimate partner violence, parental divorce or separation) mediate the relationship between childhood abuse types and CSA disclosure experiences in individuals with SUD?

Hypothesis 5: CCA will mediate the relationship between childhood abuse types (i.e., CSA, CPA, and CEA) and DE in individuals with SUD, with higher instances of CCA associated with lower rates of disclosure or more negative DE's.

Research question 5: Does sex (i.e., female or male) moderate the relationship between childhood abuse types and sexual shame in individuals with SUD?

Hypothesis 6: Sex will not significantly moderate the relationship between childhood abuse types and SS in individuals with SUD.

It is anticipated that greater severity of CSA will be associated with higher levels of SS, as the sexual nature of CSA may uniquely contribute to shame tied to sexuality, more so than CPA or

CEA (Finkelhor & Browne, 1985; Gewirtz-Meydan & Godbout, 2023). Disclosure of CSA during childhood is expected to mediate the relationship between abuse types and SS, with survivors who disclosed experiencing lower SS due to opportunities for processing and support. Additionally, the type of DE is predicted to play a critical role: positive DE's are expected to reduce SS by fostering validation and support, while negative DE's are likely to exacerbate SS by reinforcing self-blame and shame (McElvaney et al., 2022; Relyea & Ullman, 2015). Higher instances of CCA are hypothesised to mediate the relationship between abuse types and DE's, as adverse environments may discourage disclosure or increase the likelihood of negative DE's (Gemara & Katz, 2023; Latiff et al., 2024). Finally, no significant sex differences in SS are expected when controlling for CSA severity, other forms of abuse, CCA, and DE's—factors uniquely examined in this study to provide a better understanding of these complex relationships.

3.2 Methods: Study II

3.2.1 Sample

3.2.1.1 ROAR background

The current study is a substudy of the larger Reducing Overdose and Relapse: Concurrent Attention to Neuropsychiatric Ailments and Drug Addiction (ROAR CANADA or "ROAR") study, conducted by the University of British Columbia's (UBC) Behavioural Reward Affect and Impulsivity Neuroscience (BRAIN) Lab. Participants were receiving treatment for concurrent disorders, defined as a diagnosis of both a substance use disorder (SUD) and one or more other psychiatric conditions. All participants of ROAR are patients at four centres in Canada that specialise in treating mental health and addiction: Red Fish ("Red Fish") Healing Centre (formerly titled Burnaby Centre for Mental Health and Addiction), Heartwood Centre for Women ("Heartwood"), BC Forensic Psychiatric Hospital (FPH), and St. Joseph's Healthcare Hamilton (SJHH). Only Red Fish and Heartwood collected data for substudies, such as the current CSA substudy.

ROAR is a 5-year longitudinal study over four time points (spanning an average of 7-14 months between each) that aims to gather 1500 participants. The purpose of ROAR is to better understand the transition process of patients from the treatment facilities to the community by

assessing various health outcomes and service utilisations pre- and post-discharge. More specifically, the objectives of ROAR are the following:

- *To describe a large sample of people with severe concurrent disorders, including: a) demographic profiles, including items like age, ethnicity, sex, gender, and education; b) types of substance use and mental disorders, and how they have been treated; c) shared histories, including experiences of social support, housing and homelessness, criminal justice involvement, physical health, trauma, and positive experiences in childhood; d) how their sleep may function as an important predictor for relapse and mental health*
- *To develop an evidence-based model of care for treating people with severe concurrent disorders.*
- *To disseminate knowledge acquired from the research to patients, families, treatment providers and researchers, to reduce overdoses and relapses, and specifically during service transitioning.*
- *To establish sustained knowledge dissemination structures to secure future easy access and improved dissemination of advances in the field locally, nationally, and internationally.*

This information will assist in the modification of current integrated treatment programs, as well as the development of new facilities locally, nationally, and internationally.

3.2.1.2 Participants

Participation in this substudy was voluntary and contingent upon participants having completed ROAR. Participants aged 19 years or older (i.e., the legal age of an adult in the Canadian province of British Columbia) with no known discharge plans for the following month, and who were sufficiently fluent in English were included in the study. Furthermore, due to the nature of ROAR, only those participants who were deemed stable enough to participate were included. This was achieved through the assessment and recommendation of their care provider (e.g., the patient's nurse or Patient Care Coordinator), as well as their ability to respond to seven questions about the study, ensuring adequate informed consent (i.e., evidence of fluency in English and a capacity to adequately understand the purpose of and their involvement in the study). Lastly, all

participants in the current study must have confirmed their experience of CSA prior to completing the questionnaires.

3.2.2 Recruitment and data collection

Recruitment for ROAR included patients at Red Fish, Heartwood, FPH, or SJHH at the time of the baseline study session. No existing records are used to identify participants. Potential participants are recruited opportunistically while RA's are on treatment centre grounds, not based on any review of patient files. Recruitment information is provided in two modes:

- Recruitment Flyers: Flyers were posted on bulletin boards, digital information displays, and in common areas.
- In-Person Recruitment:
 - Recruitment Talks: Research assistants (RA's) made regular announcements at the end of group therapy sessions and other group activities, with the permission of site staff. RA's were, moreover, available in common areas to answer questions and provide information about the study and/or consent forms. Due to the nature of the treatment centres, it is not possible to reach all potential participants solely through group recruitment talks or flyers. Furthermore, because the treatment centre requested that congregating in common areas be avoided, additional recruitment strategies were implemented.
 - Initial Contact: Research coordinators and assistant coordinators shared general information about the study with potential participants for ROAR at the centre. Measures to ensure no undue influence on participants were taken: a) the restriction of both the number and type of research personnel who can make initial contact with prospective participants, and b) the encouragement of interested patients to discuss whether or not participating in this study would be a good fit with their circle of care at the treatment centre. Research coordinators and assistant coordinators were given permission from the treatment centres to share study information with the patients with this approach.

- Site Staff Training/Pocket Protocol: Site staff were required to recruit for the study; however, as members of the circle of care, they were able to make initial contact with prospective participants. The study was described to staff during staff meetings, and all staff were offered a laminated pocket protocol. This pocket protocol briefly outlined the study and provides staff with contact information for interested patients.

A patient was able to review the consent form as long as they wished. If the patient decided to enrol into ROAR, they were invited to a quiet, private room to review and subsequently sign the consent form. The CSA substudy was embedded into the consent contract; therefore, if a participant was interested and eligible for ROAR, they had the opportunity to check off their consent into this substudy, provided they were CSA survivors. Prior to a potential participant's admission into ROAR, an RA administered a brief consent confirmation interview. This interview comprised seven questions about the nature of the study and the role of participants. A participant had to answer all questions correctly to demonstrate their understanding of English and ability to adequately provide informed consent. All participants were offered a copy of the consent form, and were able to request new copies in the future if they lost the original form.

Once the participant provided consent, they completed 6 sessions across 4 timepoints during and after treatment. Participants previously consenting to any substudies, such as the CSA substudy, were provided with the additional relevant questionnaires following the first time point (T1). The total time to complete ROAR was 5-7 hours, whereas the CSA substudy took 5-10 minutes. A mixture of structured interview tools and self-administered surveys were utilised, with RA's available to support those requiring assistance. The Sexual Shame (SS) subscale and Social Reactions Questionnaire (SRQ), added exclusively for CSA substudy, were self-administered.

Regardless of completion, at each session, remuneration was offered in the form of gift cards, vouchers, or direct bank deposits, depending on the treatment centre's guidance and ROAR time point. Participants who enrolled into substudies, such as the current CSA, received \$5 at T1.

3.2.3 Ethical considerations

3.2.3.1 Ethical procedure

In addition to the ethical considerations outlined in the recruitment process (e.g., measures to ensure no undue influence on participants, unlimited time to review the consent form, the consent confirmation interview, etc.), other ethical precautions were followed.

After each time point in ROAR, participants were reminded that potential support was provided in the resource flyer (see Appendix G), that the site's coordinator or principal investigator (PI) could discuss questions or concerns with them, and that they could discuss any part of the study with their circle of care. They were provided with a list of web- and phone-based resources, along with a copy of the consent form. If the participant had provided an email address, all documents were emailed to them.

No treatment was linked with ROAR; hence, the risk of harm, discomfort, and incapacity was minimal. Questions asked of participants during the study sessions might have been personal or sensitive (e.g., questions about sexual shame, history of trauma, CSA disclosure, depressive symptoms, etc.). Participants were reminded that all questions were optional, that they could withdraw from the study at any point prior to analyses, and were encouraged to speak with their care providers about any feelings or reactions towards the study.

ROAR participants provided consent for the review of their medical and police records at their current treatment centre, covering the preceding 12 months. Signed consent forms were stored at Red Fish or Heartwood in a locked filing cabinet in the PI's locked office or the research team's locked office. The PhD researcher for the current substudy (Asal Skrenes) did not have access to these consent forms.

Participants were assigned an anonymous and unique study ID number that was used on all study documents. Personal identifiers collected for ROAR included the Personal Health Number (PHN) and Provincial Corrections Number (PCN). These identifiers were collected from the participant during the interview and chart review to retrieve administrative data from PopDataBC and the Canadian Police Information Centre (CPIC). Once extracted, PopDataBC and CPIC removed identifiers from the dataset before granting access to the research team. Each type of

data collected was stored separately and linked only by study ID; these IDs were not derived from or linked to any personally identifiable information, such as names, social insurance numbers (SINs), PHNs, hospital numbers, dates of birth (DOBs), addresses, or unique characteristics. Identifiers were stored in a separate database from all self-report, chart review, and administrative data. All linkage between datasets (including linking self-report, chart review, and administrative data, as well as linking data from the research sites) was made with the participant's study ID.

The crosswalk document, which connected participant IDs to personal identifiers, was securely stored separately from the data on the Provincial Health Services Authority (PHSA) server and encrypted to maintain confidentiality. Access to this document was restricted to the PHSA administrator and specific members of the research team—only those with access to the server on-site at PHSA-governed locations—and excluded the PI and the current PhD researcher.

The self-report questionnaire and interview responses collected by the research team were entered into REDCap, a secure web application for building and managing online surveys and databases. All REDCap data was stored on secure servers at the BC Children's Hospital. Information from charts was collected via CST Cerner by one designated RA. Data pulled from chart review was entered into REDCap. The RA did not retain access to full charts after chart review. CST Cerner was accessed either on-site (i.e., Red Fish/Heartwood) or off-site at the UBC office through remote access.

All data was stored in secure, Canadian-based servers and was password-protected and encrypted. No paper copies existed for participants for the CSA sub-study (i.e., ROAR participants at Red Fish or Heartwood). Following data collection, the de-identified data was moved to UBC TeamShare. The name of the PhD researcher for the current sub-study was added to the ROAR application, an amendment that was approved by all necessary ethics boards. The PhD researcher had access to only de-identified data pertinent to the CSA sub-study via a BRAIN Lab RA (Izzy Yu).

The PhD researcher participated in and audited courses, such as the University of Edinburgh's Research Skills in the Social Sciences: Data Collection; the data protection training on the self-enrolment page of Learn; as well as the UBC online tutorial TCPS 2: CORE (Course on

Research Ethics). The current substudy's de-identified data was stored on the password-encrypted Microsoft's OneDrive and the University of Edinburgh's DataSync. These were two separate and distinct cloud-based services, which held data centrally but could be accessed from anywhere in the world. Using these two distinct services ensured information was backed up.

All data will continue to be stored, as described above, for a minimum of 5 years after publication. When data is destroyed, all files will be deleted from the secure REDCap servers and other digital repositories. An intention was made to share aggregate findings with patients and other stakeholders to inform existing treatment programs, as well as the development of additional integrated programs for individuals with concurrent disorders. Study results will, therefore, be made available for participants and family members via the study's website (to be developed later). Study results will also be presented in a report to the funder and via academic publications. Participants who provided email addresses will have the opportunity to register to have study results emailed to them. The PhD researcher did not have direct contact with the participants; therefore, if this study is published in a journal or conference, it may be available to participants through the UBC Brain lab.

3.2.3.2 Ethical approval

Ethical approval was obtained by the University of Edinburgh's School of Health in Social Science Research Ethics board, the University of British Columbia's Clinical Research Ethics Board (UBC CREB), the Provincial Health Services Authority (PHSA) Ethics, and the BC Mental Health and Substance Use Services (BCMHSUS). See Appendices E and F.

3.2.4 Measures

Measures detailed in the current section are presented according to order of administration. The demographics, Adverse Childhood Experiences (ACE), Mini International Neuropsychiatric Interview (MINI) for Psychotic Disorders Studies, and Childhood Trauma Questionnaire (CTQ) were part of the larger ROAR study. The Social Reactions Questionnaire-Shortened (SRQ-S) and Sexual Shame (SS) subscale were added exclusively for this substudy.

3.2.4.1 Demographics

This questionnaire obtained basic demographic information, including sex, gender, age, and major depressive episode. See table 3.1, Appendix I for details.

3.2.4.2 Adverse Childhood Experiences (ACE)

The Adverse Childhood Experiences (ACE) questionnaire is a widely used tool in research and clinical settings to identify the presence and impact of childhood adversity. The original 10-item questionnaire was developed by Felitti and colleagues (1998) and aimed to identify adverse childhood experiences such as abuse and neglect that may increase the risk of negative health outcomes later in life. The ACE questionnaire consists of ten statements that describe various types of adversity, including verbal abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, parental separation or divorce, intimate partner violence towards the mother, household substance use disorder, household mental illness or suicide, or household incarceration. Participants are asked to respond "yes" or "no" to each statement, reflecting whether they experienced that particular type of ACE in childhood. Each item was coded dichotomously based on the presence (coded as 1) or absence (coded as 0) of the childhood experience; higher scores (i.e., closer to the maximum number of ACE's–10) indicated greater numbers of ACE's.

Regarding its psychometric properties, the ACE questionnaire has demonstrated good validity and reliability in several studies. Chapman et al. (2004) found that higher ACE scores were associated with higher rates of depressive disorders in a sample of 6460 adults. Other studies have reported associations between ACE scores and increased risk of daily stress as an adult, physical symptoms resulting from stress, and reports of poor negative affect in adulthood (Mosley-Johnson et al., 2021), as well as higher depression rates and more frequent suicidal ideation among Chinese adolescents (Chen et al., 2022). Additionally, Dong et al. (2004b) found that higher ACE scores were associated with a higher risk of ischemic heart disease.

Furthermore, retrospective reports of ACEs had good to excellent test-retest reliability (Dube et al., 2003), and the ACE questionnaire has demonstrated good internal consistency with Cronbach's alphas of 0.67 (Folayan et al., 2020) and 0.88 (Murphy et al., 2014). The measures used to assess ACEs were highly interrelated and correlated (Dong et al., 2003; Dube et al.,

2003). Using the coefficient omega (ω) to evaluate the construct reliability of the ACE, Mei et al. (2022) found this questionnaire to obtain an acceptable level of reliability, which passed the threshold of 0.65 for multidimensional measures ($\omega = 0.906$).

The ACE questionnaire has also been adapted and modified for use with different populations and purposes. Although the original questionnaire—used in the current study—was designed for use with adults, there are now versions for use with children and adolescents, as well as different versions for different languages and cultures (Dong et al., 2003; Dube et al., 2003; Folayan et al., 2020; Mei et al., 2022). These adaptations have allowed for broader use of the ACE questionnaire across diverse populations and settings.

3.2.4.3 Mini International Neuropsychiatric Interview (MINI)

The Mini International Neuropsychiatric Interview (MINI) is a widely used structured clinical interview for the assessment of psychiatric disorders based on the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association [APA], 2013) and the International Classification of Diseases (ICD; World Health Organization [WHO], 2018) criteria. Developed by Sheehan and colleagues (1998), the MINI provides a brief, standardised, and valid instrument for use in both clinical practice and research. The MINI covers 17 of the most common psychiatric disorders, including mood, anxiety, psychotic, substance use, and personality disorders.

The MINI has undergone extensive evaluation for its psychometric properties and has been found to have good validity, reliability, and clinical utility. Studies have reported high levels of agreement between MINI diagnoses and clinical diagnoses based on the DSM and ICD criteria, demonstrating good diagnostic accuracy (Högberg et al., 2019; Lecrubier et al., 1997; Mosner et al., 2019). The MINI has, moreover, demonstrated good interrater reliability, with high levels of agreement between different interviewers (Lecrubier et al., 1997; Mukhtar et al., 2012). Good internal consistency has been reported, as evidenced by its Cronbach's alpha coefficients, indicating high levels of internal reliability (Högberg et al., 2019; Hyphantis et al., 2011; Lecrubier et al., 1997; Sheehan et al., 1997). Sheehan et al. (1997) reported Cronbach's alpha coefficients above 0.75 for most modules and diagnoses.

Furthermore, the MINI has proven to be a valuable tool in both research and clinical settings. In research settings, the MINI has been utilised to evaluate the prevalence and correlates of psychiatric disorders in various populations, including children and adolescents, college students, and clinical samples (Högberg et al., 2019; Mosner et al., 2019; Sheehan et al., 1998). In clinical settings, the MINI has been used to assist in diagnostic decision-making, treatment planning, and monitoring treatment outcomes (Timko et al., 2021).

3.2.4.4 Childhood Trauma Questionnaire–Short Form (CTQ-SF)

The Childhood Trauma Questionnaire–Short Form (CTQ-SF; Bernstein et al., 2003) is a 28-item self-report questionnaire widely used to assess experiences of childhood trauma, specifically emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. The CTQ-SF uses a five-point Likert scale, with response options ranging from "never true" to "very often true," and scores for each subscale are calculated by summing the item responses.

Several studies have demonstrated good psychometric properties of the CTQ-SF (Liebschutz et al., 2018; Saini, Hoffmann, Pantelis, Everall, & Bousman, 2019), with good interrater reliability (kappa of 0.9 – 1.0), good internal consistency coefficients (Cronbach's alpha values ranging from .66 to .92) across initial validation samples, and good test-retest reliability (intraclass correlation coefficients ranging from .79 to .86 (Bernstein et al., 2003; Bernstein, Ahluvalia, Pogge, & Handelsman, 1997). In a study involving individuals either infected with or at risk for HIV, Spies, Kidd, and Seedat (2019) reported reliability coefficients for three subscales of the CTQ-SF—Emotional Neglect (EN), Physical Abuse (PA), and Sexual Abuse (SA)—which ranged from good to excellent. Conversely, the reliability coefficients for Physical Neglect (PN) and Emotional Abuse (EA) were found to be less than acceptable, with values below 0.70; Specifically, the Cronbach's α coefficients for all CTQ-SF subscales were as follows: PN ($\alpha = 0.64$), EA ($\alpha = 0.67$), EN ($\alpha = 0.83$), PA ($\alpha = 0.78$), and SA ($\alpha = 0.89$) (Spies et al., 2019). No items regarding inter-item correlations, however, exceeded a coefficient of 0.80, indicating the absence of multicollinearity; all corrected item-total correlations were above 0.30, indicating acceptable inter-item correlations (Spies et al., 2019).

The CTQ has also been validated across various populations, including adolescents and adults, and has been translated into different languages (Georgieva, Tomas, & Navarro-Pérez, 2021;

Liebschutz et al., 2018; Saini, Hoffmann, Pantelis, Everall, & Bousman, 2019; Zhang et al., 2020).

3.2.4.5 Social Reactions Questionnaire-Shortened (SRQ-S)

The Social Reactions Questionnaire-Shortened (SRQ-S; Ullman, Relyea, Sigurvinsdottir, & Bennett, 2017) is a 16-item self-reported retrospective measure that assesses disclosure experiences using three subscales, with two assessing negative experiences and one evaluating positive disclosure experiences. The two negative subscales include Turning Against (TA), which consists of six items that measure the degree to which individuals experienced stigmatisation, blame, and infantilization after disclosing; and Unsupportive Acknowledgement (UA), which includes four items assessing the extent to which individuals received egocentric or controlling responses when they disclosed. The third subscale is Positive Reaction (PR), consisting of four items measuring the degree to which individuals received emotional support and tangible aid after disclosing. According to Ullman et al., (2017), participants assess their experiences using a Likert scale, ranging from 0 (never) to 4 (always). The score for each subscale is determined by summing the scores of the individual items within that subscale. Higher scores on subscales measuring positive reactions indicate more supportive social responses, while higher scores on subscales measuring negative reactions indicate more detrimental or harmful social responses.

The SRQ-S has demonstrated good construct validity, internal consistency, and reliability in previous studies (Bernstein & Newins, 2022; Salim, Eshelman, & Messman, 2022; Ullman et al., 2017). According to Ullman et al. (2017), the internal consistency of the SRQ-S was found to be good to excellent across multiple samples (TA: $.82 \leq \alpha \leq .90$; UA: $.64 \leq \alpha \leq .81$; and PR: $.74 \leq \alpha \leq .88$). In addition, Bernstein and Newins (2022) found that the SRQ-S demonstrated good internal consistency ($\alpha \geq .77$) in a sample of women measuring sexual assault acknowledgment and psychological symptoms.

3.2.4.6 The Sexual Shame (SS) subscale

The Sexual Shame (SS) subscale is an 8-item self-reported subscale that assesses feelings of shame related to sexual thoughts, feelings, and behaviours. This subscale is derived from the

Sexual Shame and Pride Scale (SSPS; Rendina, López-Matos, Wang, Pachankis, & Parsons, 2019), which uses a 5-point Likert scale, ranging from 0 (indicating not true at all) to 4 (indicating completely true). The SSPS has no overall score, and therefore, the eight sexual shame (SS) and eight sexual pride (SP) items are averaged separately to form two subscales (Rendina et al., 2019).

The SS subscale contains four questions that appear to be relevant to self-directed shame (SD; *'I often feel embarrassed by the sexual activities that I like'; 'I tend to feel bad or dirty after sex'; 'Shortly after sex, I'm often ashamed of what I have just done'; 'I am ashamed by my sexual capabilities'*), and four that appear to be more relevant to the interpersonal shame (IP; *'I'd be ashamed if people knew the kinds of things I have done sexually'; 'I'm often embarrassed to tell my sexual partners about my sex life'; 'I'm often embarrassed about the people who I have sex with'; 'I often try to hide the people I have sex with or keep them a secret'*). Gilbert (1998) proposed internal shame to be a different cognition from external shame. Internal shame reflects a negative evaluation of the self, whereby the individual perceives him-/herself to fail to remain congruent with his/her internal standard (Gilbert, 1998). External shame, however, implies importance the individual places on the views and judgments of others on his or her actions and behaviour (Gilbert, 1998). Although oftentimes highly correlated, internal and external shame are found to be mutually exclusive (Gilbert, 1998; Proeve & Howells, 2002). Consequently, in an effort to capture the two distinct domains of shame, the current study categorised SD and IP into a two-factor model.

The SSPS has demonstrated good psychometric properties. The internal consistency of the SS subscale was found to be good, with Cronbach's alpha for the subscale at $\alpha = .74$ at a single time point, and $\alpha = .83$ three months later, indicating test-retest reliability (Rendina et al., 2019). SS was significantly positively correlated with both general mental health (i.e., anxiety and depression, emotion dysregulation) and sexuality-specific mental health (i.e., sexual compulsivity, maladaptive cognitions about sex) outcomes, and also positively correlated with internalised homonegativity, indicating good validity (Rendina et al., 2019).

Additionally, the SS subscale was found to predict additional variability over and above other constructs that have been empirically validated as contributing to sexual compulsivity (Pachankis et al., 2015; Pachankis, Rendina, Ventuneac, Grov, & Parsons, 2014). In a sample of men who

have sex with men (MSM), high levels of SS were associated with decreased frequency of sexual partners and sexual acts across all four analyses, including the number of sexual partners, number of first-time sexual partners, number of anal sex acts, and number of condomless anal sex acts (Rendina & Parsons, 2019).

3.2.5 Data analysis

Data analysis was conducted in Statistical Package for Social Science (SPSS) Version 29.0.1.0 and JASP (v0.13.1.0). SPSS was primarily used to generate descriptive data and correlations for all variables, whereas JASP was used to handle missing data, conduct confirmatory factor analysis, structural equation modelling, and create visualisations of the findings.

3.2.5.1 Descriptive statistics

Descriptive statistics were analysed for all variables using SPSS Version 29.0.1.0. Means, standard deviations, skewness, kurtosis, and Shapiro-Wilk normality tests were reported for each scale and relevant subscale. Bivariate correlations were calculated for all variables; frequency and percentages were reported for categorical variables. For correlational analyses, Kendall's Tau was conducted, which is robust against outliers and violations of normality.

3.2.5.2 Reliability tests

Reliability tests were conducted using Cronbach's alpha coefficients (α). Values exceeding 0.7 are typically deemed indicative of adequate reliability levels (Field, 2018).

3.2.5.3 Missing data

Missing value analysis was conducted in SPSS using the Missing Value Analysis feature. Data was assessed for the amount of missing data (%). Following Little and Rubin's (1987) recommendations, Little's Missing Values Analysis (Little, 1988) was employed to identify whether values were Missing Completely at Random (MCAR) or Missing at Random (MAR), or Not Missing at Random (NMAR);

3.2.5.4 Structural equation modelling and confirmatory factor analysis

Structural equation modelling (SEM) is a statistical technique employed in testing complex relationships among variables in a study. Unlike traditional approaches, such as cluster analysis, SEM can incorporate latent variables and non-linear relationships in a probabilistic framework (Magidson & Vermunt, 2002). By using SEM, researchers can investigate relationships among multiple continuous or categorical independent and dependent variables, while reducing the number of measured variables to a few latent variables. This approach enables researchers to test hypotheses, directionality, and statistical significance in complex relationships (Schreiber, Nora, Stage, Barlow, & King, 2006).

SEM consists of two main components: measurement models and structural models (Schreiber et al., 2006). The measurement model identifies the relationships between latent variables and their corresponding indicators using factor analysis (FA). The structural model identifies the relationships among latent variables, independent variables, and dependent variables using path analysis (Schreiber et al., 2006).

The grouping of observed variables within FA is based on their shared variance, and the factors are latent variables—generally continuous—that can explain the patterns of correlations among the observed variables (Brown, 2015). FA assumes homogeneity within a population, specifically that individuals in the population come from the same population, and, thus, have similar underlying factor structures, but may differ in the specific levels of each factor (Clark et al., 2013). Factor scores for individuals are then calculated based on their response patterns, and compared to those of others in the sample. All individual factor scores together lead to an approximation to the sample distribution of the factor (Brown, 2015; Clark et al., 2013). The assumption of homogeneity may not, however, hold in all populations, and may lead to inaccurate model parameters and biased conclusions (Muthén, 1989). This could include not considering different backgrounds or characteristics of individuals, and may impact the efficacy of treatments or programs for a population (Muthén, 1989).

Confirmatory factor analysis (CFA), on the other hand, is a theory-driven technique that specifies the number of latent factors and their relationships to the observed variables *a priori* (Schreiber et al., 2006). CFA is used to confirm or test a specific hypothesis or theory about the underlying

factor structure, rather than to explore the data for the most appropriate factor structure. More specifically, CFA establishes a measurement model that evaluates the construct validity of the observed variables by testing the hypothesised relationships among them and the underlying latent variables (Anderson & Gerbing, 1998; Brown & Moore, 2012). This enables the evaluation of the fit between the hypothesised model and the observed data. Although deviations from the specific *a priori* structure may not be detected in CFA, the model fit can be determined through a process of specification and estimation; it could then be revised and retested to avoid model misfit and non-convergence problems until a satisfactory fit to the sample data is accomplished (Mueller & Hancock, 2008). The evaluation of model fit can be accomplished through various fit indices, which will be described in the subsequent subsections.

The data analysis procedures were performed to derive optimal structural models for the population survivors of CSA with SUD, which were employed in the SEM analysis. The models assessed both the entire sample, including those with and without disclosure experiences in childhood (DE), as well as the impact of different forms of DE only among those with DE's. The SEM was designed to test the hypothesised relationships based on the results of the qualitative study and relevant literature. To ensure optimal fit, an *a priori* approach was employed for this sample. Following the two-step approach by Anderson and Gerbing (1988), CFA was first utilised to examine the dimensional structure of the measures (i.e., the measurement model), followed by SEM to establish the structural model. Specifically, CFA assessed the indicators on the following latent variables: 1. the predictor/exogenous variable, childhood abuse, which was a second-order latent variable contributing to the three childhood abuse latent variables (i.e., CSA, CPA, and CEA) and their indicator variables; 2. the outcome latent variable, SS, contributing to the self-directed and interpersonal indicator variables; 3. the main mediator, DE, which was a dichotomous variable in the first models (i.e., the existence or absence of DE), and, in the subsequent, latent variables contributing to the indicators, PS, TA, and UA; and 4. the second mediator, CA, which was a latent variable contributing to indicator variables, PS, EIPV, PI, HSUD, HMI, CPN, and CEN. CFA was used to determine the accurate measurement of the components in each model and their underlying constructs by evaluating the intercorrelations among the indicators in each scale.

In order to ensure valid results when specifying, identifying, estimating, and evaluating SEM models, several factors must be considered, such as the model complexity, selection of appropriate fit indices, and sample size adequacy, as well as potential issues such as multicollinearity and non-normality of variables (Bollen, 1989; Schumacker & Lomax, 2010; Ullman, 2006). According to Ullman (2006), the SEM procedure follows four steps: model specification, model estimation, model evaluation, and model modification. The current study followed all four steps to ensure the validity and robustness of the SEM analysis.

3.2.5.4.1 Model specification

In this initial stage of SEM, the hypothesised model is specified in both written equation and diagrammatic forms. This process involves identifying any assumptions that SEM and CFA may have, as well as statistically evaluating the model. JASP (Version 0.18.3; JASP Team, 2024), which uses the "lavaan" coding from R (Rosseel, 2012) was used for SEM model specification, while SPSS was used for descriptive statistics.

3.2.5.4.1.1 Sample size

Although calculating the correct sample size in CFA and SEM is difficult *a priori* in order to allow adequate statistical power that yields meaningful results, a large sample size is generally required depending on the number of resultant variables and indicators (Quintana & Maxwell, 1999; Ullman, 2006). Generally, 10 observations/participants per variable in the model is suggested (Barclay, Higgins, & Thompson, 1995; Bentler & Chou, 1987; Schreiber et al., 2006). Bentler and Chou (1987) have suggested as few as 5 participants per estimated parameter in cases where a large number of indicators per latent construct exist and/or their associated factor loadings are large. Nevertheless, while sample sizes of only 100 participants could result in some statistical indices, such as goodness of fit, performing adequately, sample sizes of at least 200 have been recommended to reach more stable and sufficient results (Boomsma, 1985; Quintana & Maxwell, 1999). A sample size of approximately 300 minimum has even been suggested when the model contains a large number of manifest variables and latent constructs, and when the data do not adhere to multivariate normality (Comrey & Lee, 2013; Quintana & Maxwell, 1999; Tabachnick & Fidell, 2013; West, Finch, & Curran, 1995). Conversely, according to their guidelines developed using mathematical and statistical theory foundations for calculating power

based on the goodness-of-fit index, Root Mean Square Error of Approximation (RMSEA, Steiger & Lind, 1980), MacCallum, Browne, and Sugawara (1996) posit that complex relative to less complex models require smaller sample sizes. This is because models containing more manifest and latent variables have larger degrees of freedom in comparison to models with fewer manifest and latent variables, which results in more power to reject null hypotheses (MacCallum et al., 1996).

The current study's sample size was based on Westland's (2010) software, where a benchmark small effect size (0.20) according to Cohen (1988), and a 0.80 power and 0.05 significance level is used. In addition, the number of latent variables would be 6, and the number of observed variables would be 18. The resultant desired sample size that would detect an effect would be 403 participants, with 200 participants being the minimum sample size for the model structure.

3.2.5.4.1.2 Handling missing data and outliers

Missing data was imputed using the Full Information Maximum Likelihood (FIML) technique, which is a default setting within JASP (Version 0.18.3; JASP Team, 2024). Here, available data are used to compute maximum likelihood estimates. FIML is a direct model-based method that is flexible and powerful because it uses all available and complete data, including the covariance matrix, to estimate the model parameters of the implied values of the missing data, thus retaining the power of the data (Newman, 2014; Schlomer et al., 2010). Compared to traditional methods, such as listwise deletion, mean substitution, and expectation maximisation, FIML has been shown to provide better statistical power and less biased estimates and results (Newman, 2014). Additionally, even in cases with a moderate number of missing data and/or relatively small sample sizes, FIML produces comparable results with other sophisticated methods, such as multiple imputation (Rubin et al., 2007; Newman, 2014).

3.2.5.4.1.3 Multivariate normality

Assumption of normality is crucial in CFA and SEM, as it facilitates the parametric test of the distributions of all the measured variables. To assess normality, various statistical tools were utilised. For univariate normality, Shapiro-Wilk normality tests (1965), where normality was deemed problematic when z scores exceeded +/- 1.96 (Field, 2018) were used. Additionally, skewness and kurtosis, where absolute skewness values exceeded 1 or -1, and absolute kurtosis

values surpassed 3 or -3, were deemed indicative of non-normally distributed data (Bowen & Guo, 2011).

Non-normal variables were not excluded from the CFA and SEM analyses. One of the significant advantages of SEM is its flexibility in handling non-normal data. Specifically, the non-normality of the data is not problematic in SEM, as it allows the selection of robust estimators, which can handle non-normality efficiently. Hence, when the normality assumption was violated, alternative methods were considered during model estimation, which are discussed later in this section.

3.2.5.4.1.4 Multicollinearity

Multicollinearity, which refers to a situation where two or more variables are highly correlated with each other, can have an effect on discriminant validity, and potentially lead to larger standard errors of parameter estimates. To ensure the absence of multicollinearity, variance inflation factor (VIF) was computed using the VIF function in JASP. According to Field (2012) and Kennedy (2008), a VIF of less than 10 is generally considered an acceptable threshold. Prior to conducting the CFA, VIF and tolerance statistics were examined to ensure that the factor loadings were within acceptable limits. The results of the VIF analysis revealed that all VIF values were below 10, indicating no evidence of multicollinearity in this study.

3.2.5.4.1.5 SEM models

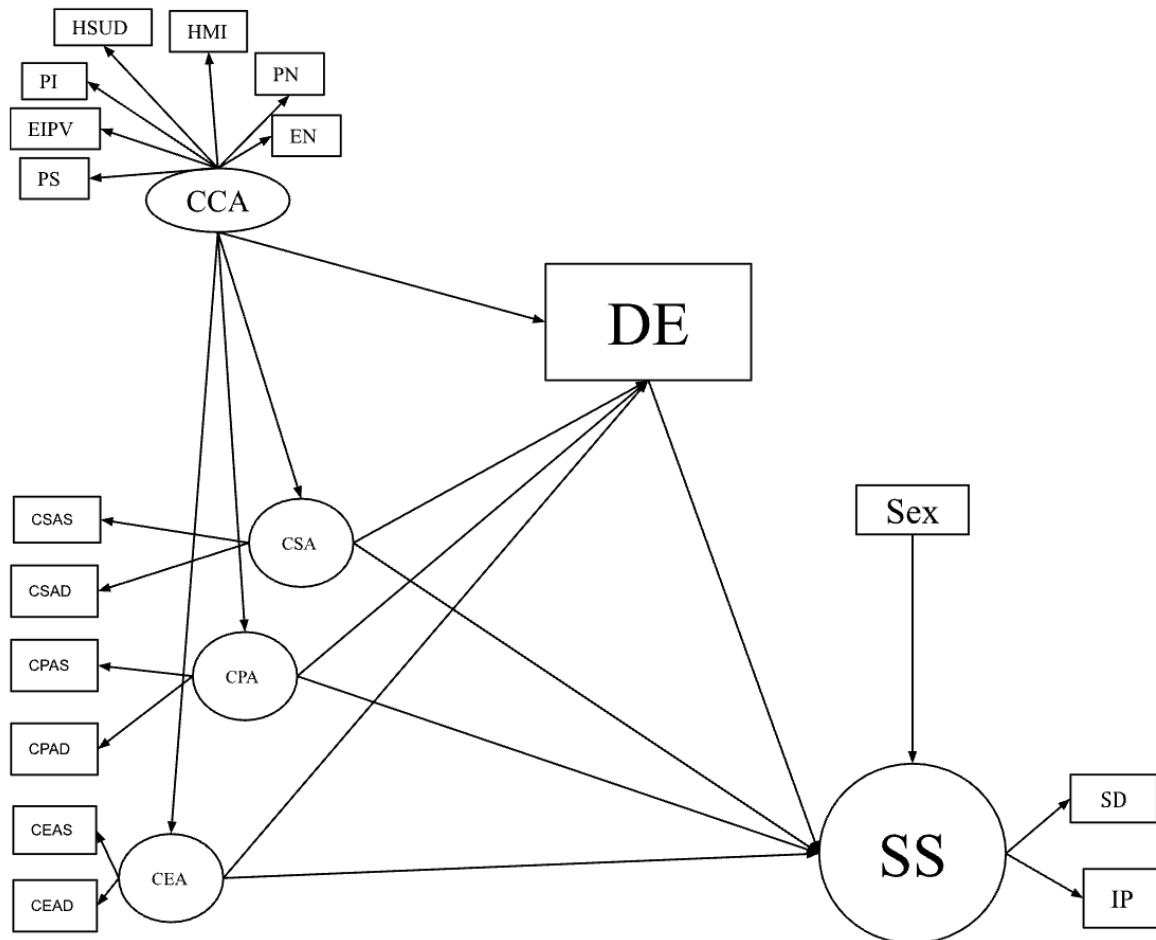
When specifying a structural equation model (SEM), it is essential to clearly articulate the underlying hypotheses of the models, typically presented diagrammatically. This is achieved through the use of a standard procedure for displaying SEM in a figure format, such as the example shown in Figure 3.1. The model consists of two components: the measurement model, which depicts the relationship between latent variables and their observed/indicator variables, and the structural model, which represents the relationships between latent variables. The hypothesised models were tested by combining the measurement models with the structural models.

In the following study, four reflective measurement models exist within each structural model. Because each of the measures cover subcategories of what they are measuring (e.g., self-directed

and interpersonal each cover partial aspects of sexual shame), and demonstrate good internal consistency, latent variables are assumed to be reflective, meaning they cause the observed indicator variables. This could be seen by the arrows moving from the latent (oval shapes) to indicator (rectangular shapes) variables in Figure 3.1. In Models 1, 2 and 3 (figures 3.1, 3.2, and 3.3, respectively), the second-order predictor or exogenous latent variable, childhood abuse (CA), explains the latent variables CSA, CPA, and CEA, which predict each of their two childhood abuse indicator variables—CSAS, CSAD, CPAS, CPAD, CEAS, and CEAD. The latent outcome or endogenous variable, sexual shame (SS), explains the indicators, self-directed sexual shame (SD) and interpersonal sexual shame (IP) in both models. In Model 1, the main mediator latent variable, disclosure experiences (DE), predicts a dichotomous indicator variable—(0) no existence of DE, and (1) an existence of DE; in Models 2 and 3, DE is a latent variable that is positive (Model 2) or negative (Model 3). For the positive DE, the categories of indicator variables include emotional support (ESD) and tangible aid (TD). For negative DE, the categories of indicator variables include turning against (TAD), and unsupportive acknowledgment (UAD). Finally, in all models, the mediator latent variable, contextual childhood adversities (“CCA”), causes the seven indicator variables, childhood physical neglect (CPN), childhood emotional neglect (CEN), household mental illness (HMI); household substance use disorder (HSUD), parental incarceration (PI), exposure to intimate partner violence (EIPV), and parental divorce or separation (PS).

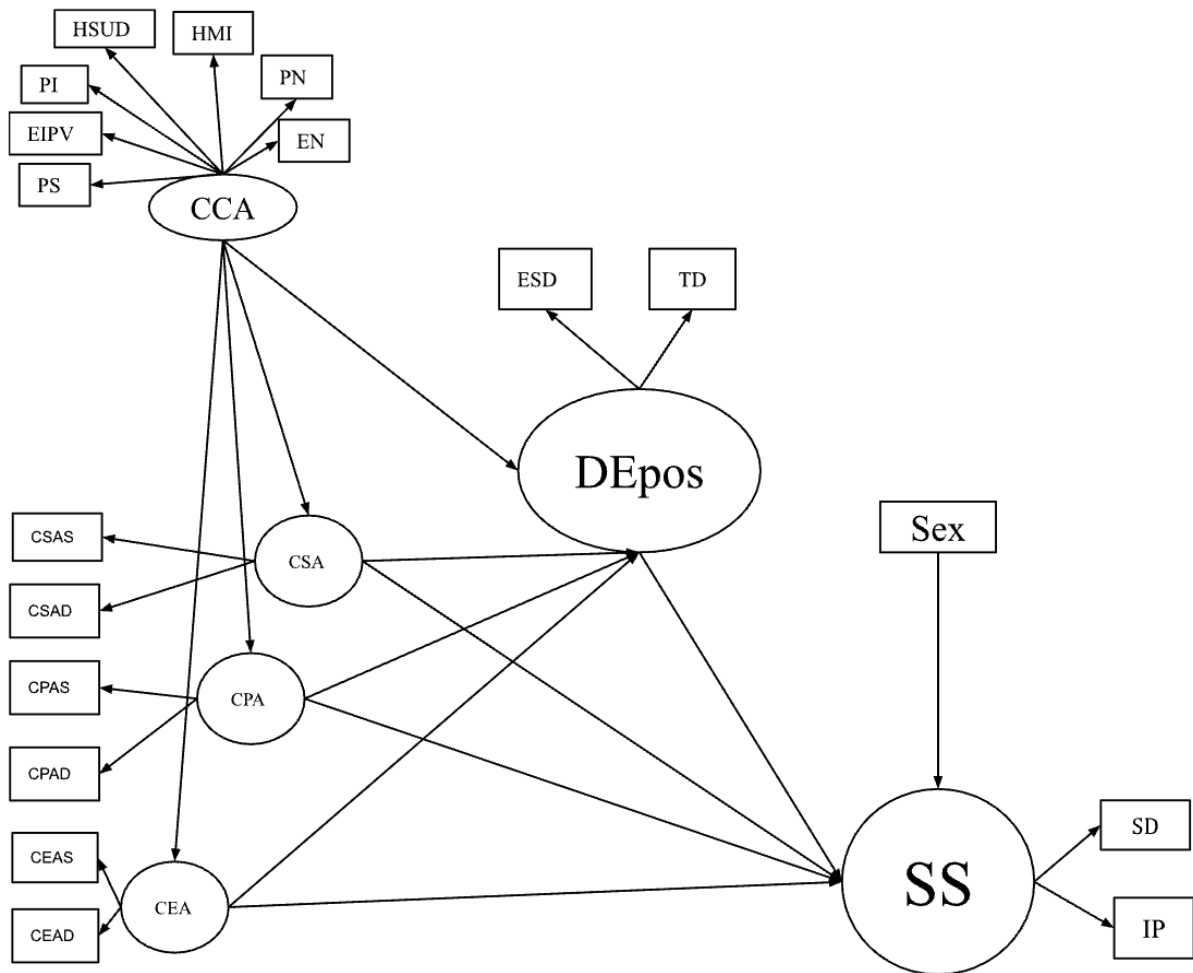
Typically, double-headed arrows indicate correlations between variables, although the current models do not have these relationships. Single-headed arrows indicate causal relationships between variables; a single-headed arrow pointing to a variable indicates that this variable is dependent or endogenous. In model 1, for instance, CA types is predicted to have a causal relationship with SS, the latter of which being endogenous.

Figure 3.1: Hypothesised model for the relationships between childhood abuse types, contextual childhood adversities, presence of disclosure experience(s) in childhood, sexual shame, and sex



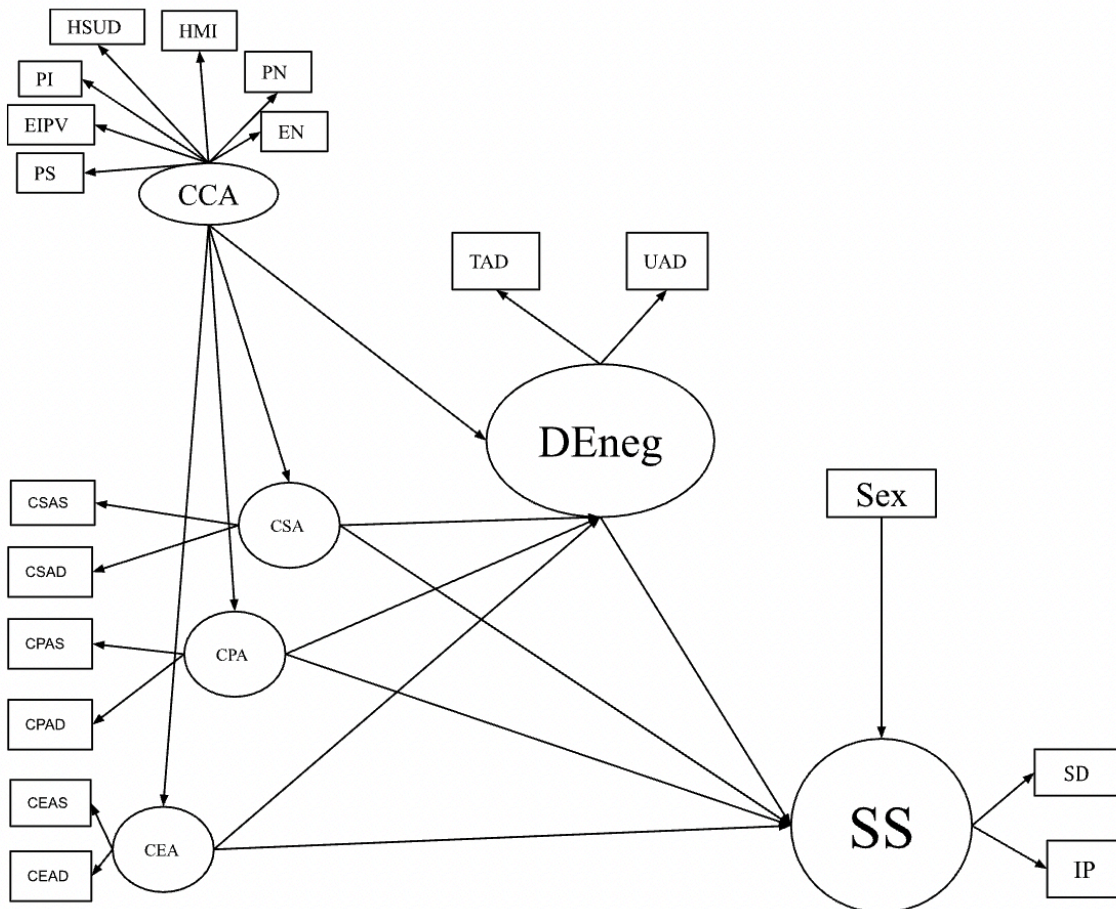
CSA = childhood sexual abuse; CSAS = CSA severity from the CTQ; CSAD = CSA dichotomous from the ACE's questionnaire; CPA = childhood physical abuse; CPAS = CPA severity from the CTQ; CPAD = CPA dichotomous from the ACE's questionnaire; CEA = childhood emotional abuse; CEAS = CEA severity from the CTQ; CEAD = CEA dichotomous from the ACE's questionnaire; CCA = contextual childhood adversities; CPN = childhood physical neglect; CEN = childhood emotional neglect; HMI = household mental illness; HSUD = household substance use disorder; PI = parental incarceration; EIPV = exposure to intimate partner violence; PS = parental divorce or separation; DE = presence of disclosure experience(s) (dichotomous) in childhood; SS = sexual shame; IP = interpersonal SS; SD = self-directed SS; Sex= sex/gender

Figure 3.2: Hypothesised model for the relationships between childhood abuse types, contextual childhood adversities, positive disclosure experience(s) in childhood, sexual shame, and sex



CSA = childhood sexual abuse; CSAS = CSA severity from the CTQ; CSAD = CSA dichotomous from the ACE's questionnaire; CPA = childhood physical abuse; CPAS = CPA severity from the CTQ; CPAD = CPA dichotomous from the ACE's questionnaire; CEA = childhood emotional abuse; CEAS = CEA severity from the CTQ; CEAD = CEA dichotomous from the ACE's questionnaire; CCA = contextual childhood adversities; CPN = childhood physical neglect; CEN = childhood emotional neglect; HMI = household mental illness; HSUD = household substance use disorder; PI = parental incarceration; EIPV = exposure to intimate partner violence; PS = parental divorce or separation; DEpos = positive disclosure experience(s) in childhood; ESD = emotionally supportive DEpos; TD = tangible aid DEpos; SS = sexual shame; IP = interpersonal SS; SD = self-directed SS; Sex= sex/gender

Figure 3.3: Hypothesised model for the relationships between childhood abuse types, contextual childhood adversities, negative disclosure experience(s) in childhood, sexual shame, and sex



CSA = childhood sexual abuse; CSAS = CSA severity from the CTQ; CSAD = CSA dichotomous from the ACE's questionnaire; CPA = childhood physical abuse; CPAS = CPA severity from the CTQ; CPAD = CPA dichotomous from the ACE's questionnaire; CEA = childhood emotional abuse; CEAS = CEA severity from the CTQ; CEAD = CEA dichotomous from the ACE's questionnaire; CCA = contextual childhood adversities; CPN = childhood physical neglect; CEN = childhood emotional neglect; HMI = household mental illness; HSUD = household substance use disorder; PI = parental incarceration; EIPV = exposure to intimate partner violence; PS = parental divorce or separation; DEneg = negative disclosure experience(s) in childhood; TAD= turning against DEneg; UAD= unsupportive acknowledgement DEneg; SS = sexual shame; IP = interpersonal SS; SD = self-directed SS; Sex= sex/gender

3.2.5.4.2 Model estimation

Model estimation is a crucial step in SEM, and the selection of an appropriate estimation technique depends on the sample size and distributional characteristics of the data. Maximum

likelihood estimator (ML) is a commonly used estimation method in SEM, as it yields precise parameter estimates, and maximises any differences between factors (Ullman, 2006).

Multivariate violations of normality, outliers, and other distributional assumptions may, however, lead to biased estimates (Hox et al., 2010). To address these issues, a robust ML method was used for the SEM analyses, which employs FIML imputation to account for missing data, and provides more accurate estimates of standard errors, model fit, and statistical significance (Enders, 2010; Kline, 2015).

In cases where data was not normally distributed in the structural models, including mediation effects, a bootstrapping method was employed. Bootstrapping is a resampling method that provides an empirical approximation of the sampling distribution of the test statistic (and estimation of indirect effects), and the construction of confidence intervals by randomly sampling from the original dataset with replacement (Mooney et al., 1993; Ng & Lin, 2016; Preacher & Hayes, 2004). In this study, 5000 bootstrap samples were used to compute the structural models, including mediation effects, as is recommended by Preacher and Hayes (2004). Both the percentile bootstrap and bias-corrected (BC) bootstrap were used, the latter of which being important in correcting for any bias in the bootstrap estimate, especially in cases where the sample size is small or when the bootstrap distribution is skewed (Chen & Fritz, 2021; Diccio & Romano, 1988). Bootstrapping has several advantages over other techniques, such as the Baron and Kenny (1986) procedure and the Sobel test, as it does not rely on assumptions of normality, homoscedasticity, and standard error estimates, and it can be used with small sample sizes (Preacher & Hayes, 2008). The use of bootstrapping provides a more robust test of indirect effects and enhances the validity of the findings.

3.2.5.4.3 Model evaluation

After the model has been specified and estimated, it must be evaluated to determine whether the hypothesised model should be accepted or rejected, that is, to assess the fit between the model and the data collected (Mueller & Hancock, 2006).

When estimating the measurement models (CFA's), several aspects of model evaluation measures were addressed. Measures of indicator reliability, which signify the extent to which observed indicators capture variance attributable to the latent variable, alongside composite

reliability, which reflects the internal consistency of the latent factors are reported. Convergent validity assesses the extent to which observed variables are consistent in measuring the same underlying construct; in other words, it examines whether various measures intended to capture the same construct demonstrate positive correlations with one another. Thus, the statistical significance of standardised factor loadings was examined. Additionally, the average variance extracted, which reflects convergent validity by determining whether the variance captured by the indicators due to the latent construct exceeds measurement error was assessed. Although there is no agreed threshold in the literature, it is generally suggested that the value of a factor loading be greater than 0.4 or 0.5 for interpretation purposes (Cheung, Cooper-Thomas, Lau, & Wang, 2023).

In order to prevent ambiguity between constructs, and ensure that each latent variable in the model is distinct from others (i.e., factors load more strongly on their respective latent factors), discriminant validity was assessed. This was achieved by ensuring that cross-factor loadings—loadings of an indicator on a factor other than its designated one—were below 0.5.

The estimated correlations between factors were analysed. Both the pattern matrix containing factor loadings and, where relevant, factor correlation matrices are considered and presented in the analyses. In the correlation matrix of latent factors, values below the main diagonal are constrained to remain below 0.7. This constraint is implemented to mitigate excessive overlap of variance between factors. A strong positive correlation coefficient greater than 0.7 suggests a high degree of overlap between the constructs, and may indicate the potential for multicollinearity. This, in turn, suggests that the constructs are potentially measuring the same underlying concept, and as a result, their discriminant validity may be compromised (Zainodin, Noraini, & Yap, 2011).

CFA and SEM require a number of fit indices for the tested models, and researchers are advised to use multiple indices to avoid bias towards a favourable index (Brown & Moore, 2012; Schreiber et al., 2006; Schumacker & Lomax, 2010; Shook, Ketchen, Hult, & Kacmar, 2004). Several cut-off criteria have been suggested for various fit indices, including the scaled Chi-square test (Schreiber et al., 2006). This is the most commonly used fit statistic with a null hypothesis that the model specifications are valid, and a higher associated probability indicates a better model fit. A non-significant Chi-square result, therefore, indicates a well-fitted model with

the optimal associated probability existing between 2df and 3df ($2df < \chi^2 \leq 3df$; Schermelleh-Engel et al., 2003). The Chi-square test statistic, however, is highly sensitive to sample size and variable distribution, resulting in significant Chi-square tests being widely accepted, provided other fit indices thresholds be satisfied (Rose, Markman, & Sawilowsky, 2017). Decisions made in this study were primarily based on other fit indices. The majority of these indices should be at an acceptable threshold in order for the model to be deemed a good fit (Schreiber et al., 2006).

Fit indices can be categorised into incremental and absolute fit indices. Incremental fit indices, such as the Comparative Fit Index (CFI; Bentler, 1990) and Tucker Lewis Fit Index (TLI; Tucker & Lewis, 1973), assess the improvement in model fit compared to the baseline or null model that assumes no associations between variables. These indices provide insight into the degree to which the hypothesised model fits relative to a more restricted model. Conversely, absolute fit indices, such as Root Mean Square of Approximation (RMSEA; Steiger & Lind, 1980) and the Standardised Root Mean Square Residual (SRMR; Hu & Bentler, 1998; 1999), assess how well the model fits the observed data without comparing it to a baseline model (Byrne, 2011).

The CFI is a normed index with a range of 0 to 1, where values closer to 1 indicate a better fitting model. In contrast, TLI is a non-normed index, and its values can extend outside the range of 0 to 1; however, like CFI, values close to 1 are interpreted as indicating a better fit. TLI has an advantage over CFI as it is sensitive to complex models, and its value takes into account the parameters included in the model that contribute minimally to improving model fit. A CFI and TLI value of 0.90 or above is generally considered as an indication of an adequate fit, with a value of 0.95 or higher being desirable (Bentler, 1992; Hu & Bentler, 1999; Kline, 2004).

RMSEA assesses the degree to which the hypothesised model fits the fully saturated model (i.e., a model that comprises a maximal number of pathways and estimated parameters). A RMSEA value of below .08 is generally considered acceptable, with a value below .05 indicating a good fit (Browne & Cudeck, 1993; Steiger, 1990). The SRMR is the average difference between the observed and predicted correlations, and provides an overall estimate of the model's ability to explain the data. A value of 0.08 or less is considered an indicator of a well-fitted model (Hu & Bentler, 1998), although some sources suggest that values below 0.05 may be more indicative of a good fit (Byrne, 2011).

The Akaike Information Criterion (AIC) and the Bayesian Information Criterion (BIC) are important criteria for model selection in cases where two models are compared. They provide a balance between the goodness of fit and the complexity of the model, favouring parsimonious interpretations of the data. Lower AIC and BIC values indicate better-fitting models relative to their complexity (Schreiber et al., 2006). AIC and BIC penalise complexity, where models may not generalise well to new samples or populations. Consequently, given the complexity of the current models, the AIC and BIC were considered alongside other fit indices.

In addition to examining overall model fit, it is important to evaluate the significance of the estimated parameters. In CFA, they typically refer to the magnitude of factor loadings, specifically, the strength of the relationship between latent variables and their observed indicators. In SEM, parameter estimates encompass the strength of the relationships between latent variables themselves, as well as the strength of the regression pathways, which comprises a broader range of coefficients, including factor loadings, regression coefficients, and error variances. Values closer to +1 or -1 (specifically above +0.5 or below -0.5) indicate stronger relationships between variables, while values between +/- 0.2 and +/- 0.5 are considered moderate. In the context of mediation effects, bias-corrected 95% confidence intervals are often used to assess the significance of parameter estimates (Preacher & Hayes, 2004). The significance of a parameter estimate is determined by examining whether the confidence interval includes zero. If the confidence interval does not contain zero, the effect is considered statistically significant at a predetermined level, typically $p < .05$. This signifies that, for instance, the hypothesised mediation is unlikely to have arisen by chance at the pre-specified level of confidence (e.g. $p < .05$), as outlined by Hayes (2018). The JASP output from the CFA functions provide both unstandardised and standardised parameter estimates. When the model is estimated using the ML method, adjusted χ^2 , CFI, TLI, RMSEA and SRMR will be reported as evaluation measures (Hu & Bentler, 1999).

Furthermore, the application of the BC bootstrap technique involved modifying the confidence interval by displacing it through an adjustment that was contingent on the divergence between the sample statistic and the mean value of the bootstrap distribution (Chen & Fritz, 2021; Diccio & Romano, 1988). The percentile and BC bootstrap confidence intervals were selected as the preferred approach due to their superior performance in terms of power and control over

Type I error, particularly in models with multiple mediators, even in small to moderate samples (Falk & Biesanz, 2015; Preacher & Hayes, 2008). The use of these bootstrap methods in conjunction with adjustments to the confidence interval provides a robust approach to testing the proposed models and their indirect effects (Carpenter & Kenward, 2012).

As recommended by Preacher and Kelley (2011), reporting measures of effect size alongside confidence intervals is essential to fully understanding the magnitude of the effects observed in the model. Thus, for each model, the index of the explained variance, R-squared (R^2), which represents the proportion of variance in the dependent variable that can be explained by the independent variables included in the model is reported. Following the guidelines proposed by Jackson, Gillaspay Jr, and Purc-Stephenson (2009), path coefficients (standardised regression coefficients – β), which indicate the direction and strength of the relationship between the independent and dependent variables, along with the standard errors (SE) of the path coefficients, which provide an estimate of the precision of the coefficients have additionally been reported. To assess the goodness-of-fit of the model, measures of measurement and residual errors have been reported. These measures provide an indication of how well the model fits the observed data, and can help identify potential sources of model misspecification (Ullman, 2006).

In the model diagrams, standardised regression coefficients are used to show the direction and strength of the relationships between the factors and indicators. It is, moreover, crucial to consider the measurement error, which is represented by arrows pointing towards the variables, and the residual error, which is shown by arrows pointing towards the latent variables. One important metric to assess the model's performance is the coefficient of determination, or R^2 —a measure of model fit that represents the proportion of variance in an indicator that is accounted for by its associated latent factors (Byrne, 2011).

3.2.5.4.4 Model modification

The chosen theoretical model may not always fit the data in SEM, resulting in an unacceptable model fit (Ullman, 2006). In such cases, modifications to the model are often made to improve its overall fit (Schumacker & Lomax, 2010). Some scholars contend that revisions to the theoretical model or data collection process may be more appropriate to better align with the observed data, as poor model fit may signify fundamental flaws in these areas (Antonakis,

Bendahan, Jacquart, & Lalive, 2010; Marsh, Hau, & Wen, 2004). Others argue that modification of the model should be carried out as an exploratory technique, with proposed modifications grounded in theory and subjected to sensitivity analyses to assess the robustness of the findings to alternative model specifications (Kline, 2015; Whittaker, 2012). This ensures that the modifications are not only statistically significant but also theoretically meaningful and justifiable (Schumacker & Lomax, 2010).

Thus, forcing the model to fit the data through modification is cautioned against; instead, addressing model complexity, measurement error, or other factors that may contribute to poor model fit is advised (Bollen & Curran, 2006; Whittaker, 2012). Fit indices and modification indices must act as guidelines for creating alternative, post-hoc SEM models. It is essential to ensure that these modifications are consistent and aligned with both model fit indices, and the theoretical and conceptual assumptions underlying the original model (Bollen & Curran, 2006; Hu & Bentler, 1999; Kline, 2015; Marsh, et al., 2004).

Model misspecification may arise when parameters are either misspecified or omitted entirely. In such cases, researchers should first review the original model theory and consider investigating more relevant theories to improve the model specification (Mueller & Hancock, 2006).

Consequently, modifications resulting from problematic factor loadings, average variance extracted, discriminant validity, pattern matrices, factor correlation matrices, Chi-square tests, fit indices (i.e., CFI, TLI, RMSEA, SRMR), and AIC/BIC, in addition to all modifications made to the model using modification indices were theoretically grounded. This helped to avoid the risk of overfitting, where the model is too closely tailored to the sample data, and may not generalise well to new data (Kline, 2015). All excluded items and decisions related to modifications were reported.

When the *a priori* model did not fit the data, modifications to the model were made to improve the overall model fit. To identify potential areas for model modification, two commonly used measures were employed: the modification indices (MI) and the standardised expected parameter change (SEPC), both of which are available in JASP using the *modification indices* function. MI is a useful tool for identifying parameters that could be added or removed from the model to improve its fit through evaluating the difference between the expected and observed covariance matrices from the model (Bollen & Curran, 2006; Kline, 2015; Whittaker, 2012). Conversely,

SEPC values—standardised versions of the commonly used expected parameters change (EPC)—indicate the potential size of the effect of a particular parameter on the model's overall fit, as well as on the relationships between other parameters; it measures the change in standardised parameter estimates when specific data points are omitted from the analysis (Bollen & Curran, 2006; Kline, 2015; Whittaker, 2012). As their interpretation may depend on various factors such as sample size, model complexity, and parameter estimates, a consensus on the best cut-off values for MI and SEPC has not been reached in the literature (Kline, 2015; Moshagen & Musch, 2014; Saris, Satorra, & Van der Veld, 2009; Schreiber et al., 2006). Nevertheless, parameters with the largest MI and positive SEPC values were targeted for modification (Brown, 2015; Kline, 2015). Specifically, a large MI was considered to be above 10, and a large SEPC was considered to be above .2, in line with commonly used values in the literature (Saris et al., 2009; Whittaker, 2012). Modifications were informed by theoretical considerations, as MI and SEPC values alone may not be sufficient to determine appropriate modifications. Furthermore, model fit was examined through comparing the reduction in chi-square statistic resulting from the modifications. Incremental fit indices were additionally evaluated to ensure that the modifications did not adversely affect the overall model fit (Byrne, 2011).

3.3 Results: Study II

All preliminary tests and analyses were conducted in SPSS (v 29.0.1.0).

3.3.1 Descriptive Statistics

Descriptive statistics were determined using SPSS, and are described below in Tables 3.1 to 3.6.

3.3.1.1 Demographic characteristics

Of the total sample (N = 140), 48 participants (34.3%) reported being born male, while 92 participants (65.7%) reported being born female. Gender identities reported included male (N = 45; 32.1%), female (N = 87; 62.1%), two-spirit (N = 5; 3.6%), questioning (N = 1; 0.7%), and other (N = 1; 0.7%). Participants' ages ranged between 19 and 66 years (Mdn = 37.5, IQR = 28.25 to 47.0).

A history of overdose was reported by 75 participants (53.6%), while 65 (46.4%) reported no overdose experience. Racial and ethnic backgrounds included White (European, Caucasian; N = 80; 57.1%), First Nations/Inuit/Métis (N = 44; 31.4%), Black or African-Canadian (N = 5; 3.6%), East Asian (N = 3; 2.1%), West Asian (N = 2; 1.4%), Hispanic/Latin American (N = 2; 1.4%), and Southeast Asian (N = 2; 1.4%). Regarding relationship status, 103 participants (73.6%) were single, 22 (15.7%) were partnered, and 11 (7.9%) were married or cohabitating. For additional demographic information, see Appendix J, Table 3.1.

3.3.1.2 Trauma experiences and diagnoses

A total of 98 (73.7%) participants responded affirmatively to a CSA-related question in the CTQ or ACE, including 27 (57.4%) male and 71 (82.6%) female participants. All participants reported experiencing CSA as a prerequisite for the current study, though it is noteworthy that 26.3% of the CSA-related CTQ and ACE questions did not reflect this form of abuse. It is possible that the CTQ and ACE CSA-related questions did not reflect some participants' experience of this form of abuse. Thus, this study will assume that all participants have experienced CSA. In addition to CSA, 136 (100.0%) participants reported experiencing CPA, and 135 (99.3%) reported experiencing CEA.

Regarding disclosure experiences, 49 (39.2%) participants reported having disclosed CSA during childhood (9 [22.0%] male, 40 [47.6%] female). Among them, 40 (81.6%) participants reported a positive experience only, 43 (87.8%) a negative experience only, and 45 (91.8%) reported a combination of both positive and negative disclosure experiences. See table 3.1 for details. Descriptive statistics for the Childhood Trauma Questionnaire–Short Form (Table 3.2), Social Reactions Questionnaire-Shortened (Table 3.3), and the Sexual Shame subscale (Table 3.4) are reported below.

Table 3.1. Frequencies for trauma experiences and diagnoses

Variables	Total N(%)	Male N(%)	Female N(%)
CSA	98 (73.7%)	27 (57.4%)	71 (82.6%)
CPA	136 (100.0%)	47 (100.0%)	89 (100.0%)
CEA	135 (99.3%)	47 (100.0%)	88 (98.9%)
CPN	54 (39.7%)	12 (25.5%)	42 (47.2%)

CEN	80 (59.3%)	19 (41.3%)	61 (68.5%)
Other ACE's	124 (91.9%)	39 (84.8%)	85 (95.5%)
DE	49 (39.2%)	9 (22.0%)	40 (47.6%)
PS DE	40 (81.6%)	8 (88.9%)	32 (80.0%)
TA DE	43 (87.8%)	9 (100.0%)	34 (85.0%)
UA DE	45 (91.8%)	9 (100.0%)	36 (90.0%)
MDE	63 (62.4%)	14 (45.2%)	49 (70.0%)

Notes. CSA= childhood sexual abuse; CPA = childhood physical abuse; CPN = childhood physical neglect; CEN = childhood emotional neglect; DE = presence of disclosure experience(s) in childhood; PS= positive DE; TA= negative turning against DE; UA= negative unsupportive acknowledgment DE; MDE = major depressive episode

Table 3.2. Descriptive statistics for childhood abuse and neglect as measured by the Childhood Trauma Questionnaire–Short Form

	CPN 1	CP N 2*	CE A1	CP N3	CE N 1*	CP N4	CE N 2*	CE A2	CPA 1	CPA 2	CPA 3	CE N 3*	CE A3	CPA 4	CPA 5	CE A4	CE N 4*	CS A1	CS A2	CS A3	CS A4	CE A5	CPN 5*	CS A5	CEN 5*
Valid	136	136	136	136	136	136	136	136	136	136	136	136	136	136	136	136	136	135	135	135	135	135	135	135	135
Missing	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	5	5	5	5	5	5	5
Mean	1.96	2.7	2.85	2.22	2.63	1.8	2.6	2.23	1.55	1.99	2.38	2.86	2.95	2.57	1.72	2.99	3.1	2.53	1.81	2.22	2.67	3.34	2.17	2.9	3.13
Median	1	3	3	1	3	1	2.5	2	1	1	2	3	3	2	1	3	3	2	1	2	2	3	2	3	3
Std. Deviation	1.282	1.37	1.47	1.47	1.39	1.24	1.26	1.38	1.06	1.24	1.43	1.36	1.43	1.64	1.22	1.57	1.34	1.56	1.38	1.48	1.67	1.53	1.284	1.7	1.335
Skewness	1.005	0.33	0.14	0.79	0.30	1.42	0.32	0.76	1.92	0.92	0.51	0.11	-0.0	0.43	1.61	0.01	-0.0	0.50	1.45	0.87	0.33	-0.3	0.984	0.0	-0.119
Std. Error of Skewness	0.208	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.209	0.2	0.209
Kurtosis	-0.33	-1.0	-1.3	-0.8	-1.1	0.84	-0.9	-0.7	2.66	-0.3	-1.1	-1.2	-1.2	-1.4	1.41	-1.5	-1.1	-1.2	0.55	-0.7	-1.5	-1.3	-0.079	-1.7	-1.012
Std. Error of Kurtosis	0.413	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.414	0.4	0.414
Shapiro-Wilk	0.348	0.18	0.16	0.30	0.18	0.36	0.18	0.26	0.42	0.32	0.26	0.17	0.15	0.25	0.39	0.17	0.14	0.24	0.40	0.27	0.24	0.21	0.249	0.2	0.166
P-value of Shapiro-Wilk	<.001	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.00	<.001	<.0	<.001
Minimum	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Maximum	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5

Notes. * reverse-coded

Table 3.3. Descriptive statistics for positive supportive (PS), turning against (TA) and unsupportive acknowledgment (UA) self-directed (SD) disclosure experiences as measured with the Social Reactions Questionnaire–Shortened

	TA 1	PS 1	TA 1	UA 1	PS 2	UA 1	UA 1	UA 2	TA 2	PS 3	UA 2	UA 2	TA 2	TA 1	PS 4	TA 2
Valid	48	49	49	49	49	49	49	49	49	49	48	49	49	49	49	49
Missing	92	91	91	91	91	91	91	91	91	91	92	91	91	91	91	91
Mean	1.63	1.8	1.67	2.24	1.61	1.61	1.61	1.47	1.35	1.22	1.98	1.1	1.43	1.53	1.2	1.43
Median	2	2	2	2	2	2	2	2	1	1	2	1	2	1	1	1
Std. Deviation	1.347	1.291	1.144	1.422	1.304	1.272	1.255	1.226	1.362	1.141	1.36	1.229	1.208	1.371	1.354	1.258

Skewness	0.24	0.034	0.163	-0.408	0.243	0.276	0.196	0.215	0.62	0.589	0.145	0.711	0.285	0.464	0.768	0.43
Std. Error of Skewness	0.343	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.343	0.34	0.34	0.34	0.34	0.34
Kurtosis	-1.094	-1.013	-0.631	-1.062	-0.905	-0.756	-0.864	-0.83	-0.801	-0.39	-1.055	-0.633	-0.705	-0.959	-0.692	-0.899
Std. Error of Kurtosis	0.674	0.668	0.668	0.668	0.668	0.668	0.668	0.668	0.668	0.668	0.674	0.668	0.668	0.668	0.668	0.668
Shapiro-Wilk	0.18	0.175	0.177	0.207	0.188	0.176	0.177	0.224	0.222	0.2	0.175	0.282	0.218	0.196	0.259	0.198
P-value of Shapiro-Wilk	<.001	<.001	<.001	<.001	<.001	<.001	<.001	<.001	<.001	<.001	0.001	<.001	<.001	<.001	<.001	<.001
Minimum	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Maximum	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4

Table 3.4. Descriptive statistics for self-directed (SD) and interpersonal (IP) sexual shame (SS) as measured by the Sexual Shame subscale

	SS SD 1	SS SD 2	SS SD 3	SS SD 4	SS IP 1	SS IP 2	SS IP 3	SS IP 4
Valid	120	122	122	121	122	121	122	122
Missing	20	18	18	19	18	19	18	18
Mean	1.49	1.25	1.07	1.16	1.54	1.51	1.17	1.24
Median	2	1	0	0	2	1	0	1
Std. Deviation	1.489	1.433	1.389	1.544	1.527	1.539	1.43	1.432
Skewness	0.412	0.841	1.066	0.934	0.416	0.444	0.847	0.774
Std. Error of Skewness	0.221	0.219	0.219	0.22	0.219	0.22	0.219	0.219
Kurtosis	-1.228	-0.691	-0.205	-0.702	-1.267	-1.301	-0.649	-0.727
Std. Error of Kurtosis	0.438	0.435	0.435	0.437	0.435	0.437	0.435	0.435
Shapiro-Wilk	0.817	0.788	0.744	0.713	0.818	0.814	0.765	0.786
P-value of Shapiro-Wilk	<.001	<.001	<.001	<.001	<.001	<.001	<.001	<.001
Minimum	0	0	0	0	0	0	0	0
Maximum	4	4	4	4	4	4	4	4

3.3.1.3 Reliability analyses

Single-test reliability analyses were conducted for the reflective (CSA, CPA, CEA, DE positive, DE negative, and SS) variables. Internal consistency was not calculated for the dichotomous disclosure experiences (DE) question, the dichotomous CCA questions, and the major depressive episode (MDE) questions, as these measures have only one total score each. For the reflective variables, CSA, CPA, CEA, SS, DE positive, DE negative, and SS, the internal consistency was acceptable (Table 3.5).

Table 3.5. *Internal consistency for the reflective variables*

Scale	Reflective variable	Cronbach's alpha	Number of items
CTQ	CSA	0.848	5
	CPA	0.837	5
	CEA	0.86	5
	CPN	0.764	5
	CEN	0.813	5
SRQ-S	PS DE	0.832	4
	TA DE	0.805	6
	UA DE	0.763	6
SS	SD SS	0.865	4
	IP SS	0.813	4

3.3.1.4 Missing values and outliers

Missing values and outliers were analysed in SPSS. Values were inspected for CSA, CPA, CEA, and CCA (CTQ subscale total scores and ACE's total scores), CSA disclosure experiences (SRQ-S positive subscale and SRQ-S negative ("turning against") subscale only), and sexual shame (the total scores for each of the SD and IP subscales of the SS). Little's Missing Values Analysis (Little, 1988) was not significant, indicating that the pattern of missing data may not be MCAR ($\chi^2 = 211.283$; Df = 215; $p = .559$). The highest percentage of missing data was 14.9%, which was the case for the SD subscale of the SS.

Furthermore, extreme values were identified using the interquartile range (IQR) method. Extreme values were defined as cases outside the range of $Q1 - 1.5 \times IQR$ and $Q3 + 1.5 \times IQR$. No cases of extreme low values existed in the data. Conversely, the following variables had notable extreme high cases: SRQ turning against stigmatise 1 (1 case); CTQ CPA 1 (10 cases) CPA 5 (12 cases), and CSA 2 (17 cases). As no explanation was available for the extreme high values, these values were retained.

3.3.1.5 Correlation

Correlations between the sum scores for CSA, CPA, CEA, DEpos, DEneg, SS, and sex are presented in table 3.6. Notably, all CA types were all significantly correlated with each other

($p < .001$). In addition, sex was found to be negatively significantly correlated with CA types (i.e., CSA, CPA, and CEA), with $p < .001$.

Table 3.6. Kendall's Tau correlations for childhood sexual abuse, childhood physical abuse, childhood emotional abuse, positive disclosure experience, turning against disclosure experience, unsupportive acknowledgment disclosure experience, self-directed sexual shame, interpersonal sexual shame, and sex

Variable		CSA (CTQ)	CPA (CTQ)	CEA (CTQ)	PS (SRQ)	TA (SRQ)	UA (SRQ)	SD (SS)	IP (SS)	Sex
CSA (CTQ)	Kendall's Tau									
	B	1								
	p-value	.								
	N	136								
CPA (CTQ)	Kendall's Tau									
	B	.289**	1							
	p-value	<.001	.							
	N	136	136							
CEA (CTQ)	Kendall's Tau									
	B	.314**	.494**	1						
	p-value	<.001	<.001	.						
	N	136	136	136						
PS (SRQ)	Kendall's Tau									
	B	0.071	0.188	0.186	1					
	p-value	0.502	0.079	0.075	.					
	N	49	49	49	49					
TA (SRQ)	Kendall's Tau									
	B	-0.141	-0.105	-.293**	-0.072	1				
	p-value	0.175	0.322	0.005	0.495	.				
	N	49	49	49	49	49				
UA (SRQ)	Kendall's Tau									
	B	-0.154	-0.021	-.261*	.226*	.409**	1			
	p-value	0.137	0.84	0.012	0.033	<.001	.			
	N	49	49	49	49	49	49			
SD (SS)	Kendall's Tau									
	B	-.276**	-.261**	-.308**	-0.085	.247*	0.181	1		
	p-value	<.001	<.001	<.001	0.435	0.021	0.091	.		
	N	122	122	122	47	47	47	122		
IP (SS)	Kendall's Tau									
	B	-.324**	-.178**	-.271**	-0.188	.287**	0.183	.626**	1	
	p-value	<.001	0.008	<.001	0.085	0.008	0.091	<.001	.	
	N	122	122	122	47	47	47	122	122	
Sex		-.315**	-.149*	-.257**	-0.063	.172	-.011	.238**	.325**	1*

<.001	.044	<.001	.612	.161	.928	.002	<.001	.
136	136	136	49	49	49	122	122	140

Notes. ** Correlation is significant at $p < 0.01$; * Correlation is significant at $p < 0.05$ level

3.3.1.6 Correction for non-normality of the variables

None of the items on the variables for CSA, CPA, CEA, DE positive, DE negative, CCA, and SS ($p < 0.05$) were normally distributed, according to the Shapiro-Wilk and Kolmogorov-Smirnov tests.

Non-normality of variables could result in biases in model fit indices, the Chi-square statistic, and standard errors of the parameter estimates. Consequently, a bias-corrected (BC) bootstrap method was used for confirmatory factor analyses and structural equation modelling (Chen & Fritz, 2021; Preacher & Hayes, 2004), which was applied in JASP (version 0.13.1.0).

3.3.2 Measurement models/ Factor analysis

The structure of the latent variables was investigated with confirmatory factor analyses (CFA) for items on the CTQ, ACE's, SRQ-S and SS. All analyses were applied with JASP software (v0.13.1.0). For CFAs, a bias-corrected (BC) bootstrap method was used, and missing cases were excluded pairwise. Following the initial CFA on each measurement model, dimension reduction was conducted when it aligned with both theoretical considerations and empirical evidence. For Models 2 and 3, the information for each latent variable represented total weighted scores; no analyses could be conducted to determine their dimensionality. Nevertheless, the weighted scores of each measurement model in Models 2 and 3 was calculated only for the (reduced) indicators used in Models 1.

A fundamental requirement of CFA entails establishing a fixed pathway in the factor loadings for the items, serving as a benchmark against which subsequent calculations are performed. In JASP, when conducting CFA, the software automatically sets the first indicator for each latent variable as the reference indicator with a fixed loading of 1. Because fixing pathways has a potential effect on the model fit of the CFA or explained variance of the items, sensitivity analyses were conducted by fixing different indicators within each CFA to determine if any change in model fit

indices (CFI, TLI, RMSEA, SRMR) resulted. No change occurred in the fit indices, and the indicators with the highest factor loadings remained as the fixed pathways in each CFA.

3.3.2.1 Childhood abuse

Originally, a second-order model for childhood abuse (CA) was tested. The model comprised a total of three first-order latent variables (CSA, CPA, and CEA). In total, the tested model consisted of 15 measured variables/indicators (each latent variable contributing to five indicators) and 49 free parameters. This model, however, had poor fit indices, and resulted in non-significant ($p > 0.5$) parameter estimates for all five CEA indicator variables within the CEA latent variable. Consequently, model modification ensued, and three alternate CFA's were tested, each testing one of the latent variables: CSA, CPA, and CEA. Each CFA consisted of one factor. See table 3.7.

Table 3.7. *Items of the Adverse Childhood Experiences questionnaire and Childhood Trauma Questionnaire–Short Form that were included in the analyses for CA types*

Item (scale)	Item reflecting	Factor loadings (standardised)	Explained variance by item	Error variance
CSA 1 (CTQ)	Someone tried to touch me in a sexual way, or tried to make me touch them.	1.411	0.816	0.184
CSA 2 (CTQ)	Someone threatened to hurt me or tell lies about me unless I did something sexual with them.	0.934	0.457	0.543
CSA 3 (CTQ)	Someone tried to make me do sexual things or watch sexual things.	1.222	0.683	0.317
CSA 4 (CTQ)	Someone molested me.	1.38	0.683	0.317
CSA 5 (CTQ)	I believe I was sexually abused.	1.369	0.639	0.361
CPA 1 (CTQ)	I got hit so hard by someone in my family that I had to go see a doctor or go to the hospital.	0.678	0.412	0.588

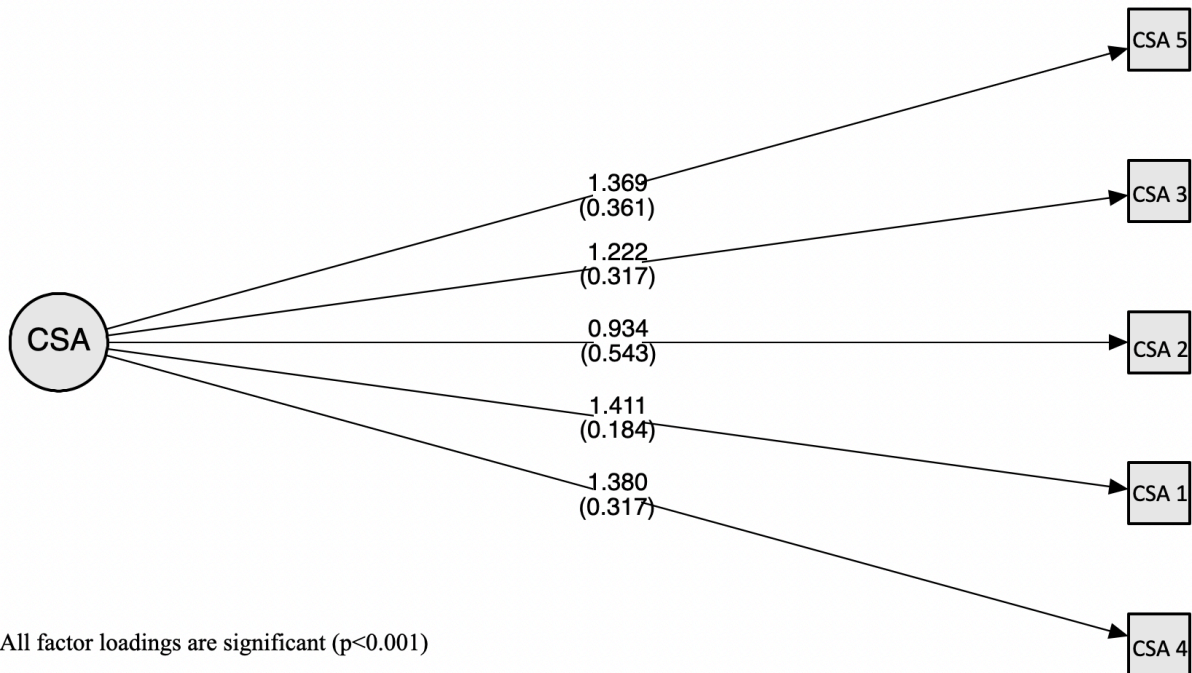
CPA 2 (CTQ)	People in my family hit me so hard that it left me with bruises or marks.	1.115	0.809	0.191
CPA 3 (CTQ)	I was punished with a belt, a board, a cord, or some other hard object.	0.926	0.423	0.577
CPA 4 (CTQ)	I believe that I was physically abused.	1.199	0.538	0.462
CPA 5 (CTQ)	I got hit or beaten so badly that it was noticed by someone like a teacher, a neighbour, or doctor.	0.852	0.49	0.51
CPA (ACE)	Did a parent or other adult in the household often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	0.344	0.474	0.526
CEA 1 (CTQ)	People in my family called me things like 'stupid,' 'lazy,' or 'ugly.'	1.101	0.559	0.441
CEA 2 (CTQ)	I thought that my parents wished I had never been born.	0.883	0.408	0.592
CEA 3 (CTQ)	People in my family said hurtful or insulting things to me.	1.192	0.699	0.301
CEA 4 (CTQ)	I felt that someone in my family hated me.	1.21	0.597	0.403
CEA 5 (CTQ)	I believe that I was emotionally abused.	1.125	0.539	0.461
CEA (ACE)	Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	0.265	0.317	0.683

Notes. ACE= *Adverse Childhood Experiences questionnaire*; CTQ= *Childhood Trauma Questionnaire–Short Form*

The CSA model included five indicators. Sixteen free parameters existed in the CFA. The model fit was good: $\chi^2(4) = 8.91$, $p = .063$, CFI = 0.989, TLI = 0.973, RMSEA = 0.095, SRMR = 0.022. All parameter estimates were significant ($p < .001$), with factor loadings ranging from 0.934 to 1.411. The factor loading for the ACE CSA indicator variable was < 0.4 (0.304), and was noted for (and subsequently omitted from) the SEM models. with R^2 values explaining 45.7% to 81.6% of the variance (see Figure 3.4). The error term between CSA Q4 (“*Someone molested me.*”) and

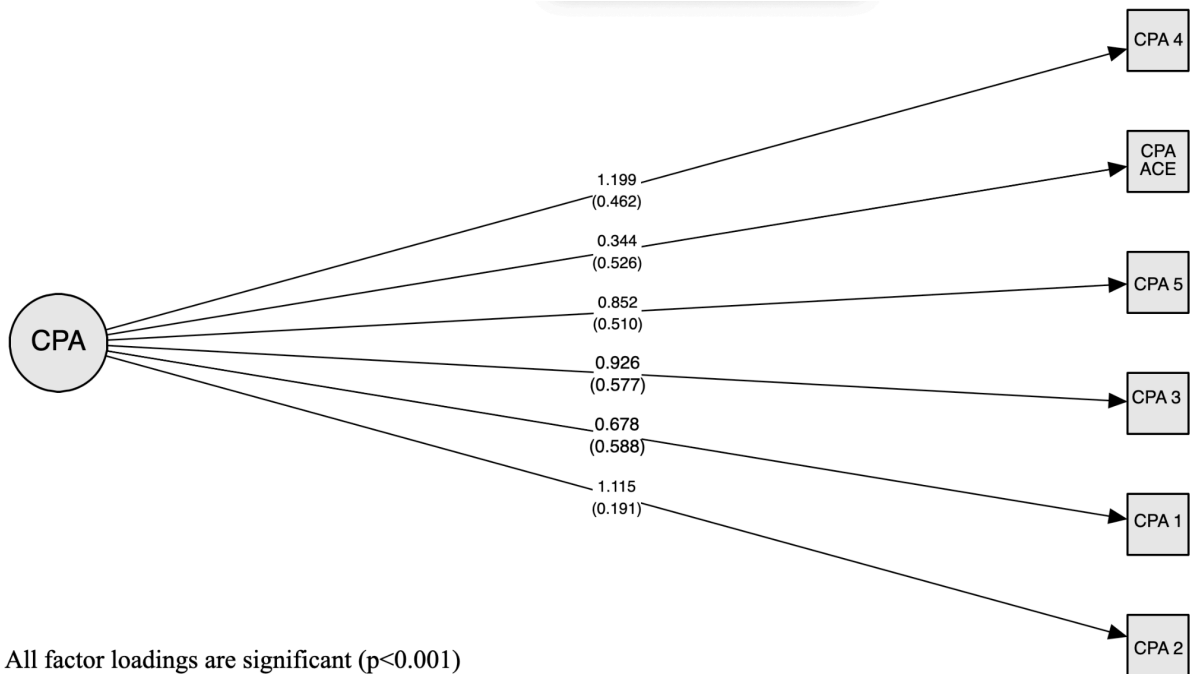
CSA Q5 (“I believe I was sexually abused.”) of the CTQ was relaxed, given that both were conceptually similar and with high covariances.

Figure 3.4. Measurement model for the CSA latent variable from the CTQ. Standardised beta coefficients are displayed and error terms appear in parentheses.



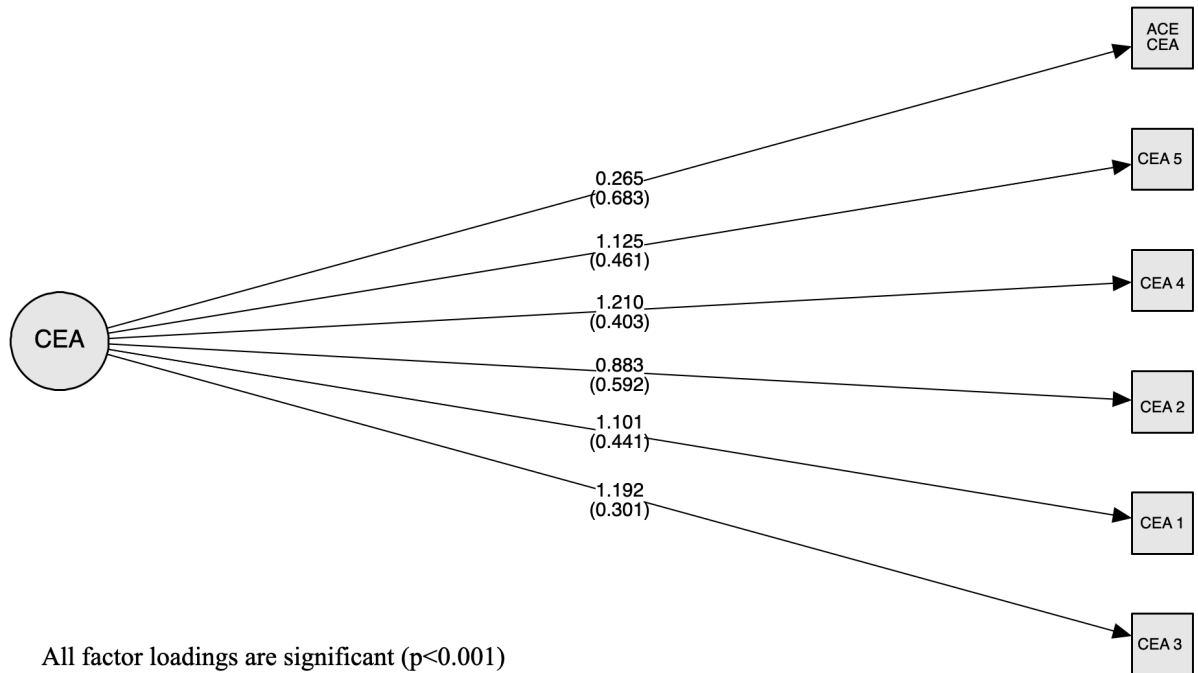
The CPA model included six indicators. Eighteen free parameters existed in the CFA. The model demonstrated excellent fit: $\chi^2(9) = 11.17$, $p = .264$, CFI = 0.994, TLI = 0.989, RMSEA = 0.042, SRMR = 0.030. Factor loadings ranged from 0.344 to 1.199, with R^2 values from 41.2% to 80.9%. (Figure 3.5).

Figure 3.5.. Measurement model for the CPA latent variable from the CTQ and ACE. Standardised beta coefficients are displayed and error terms appear in parentheses.



The CEA model included six indicators. Eighteen free parameters existed in the CFA. Model fit was acceptable: $\chi^2(9) = 18.31$, $p = .032$, CFI = 0.973, TLI = 0.954, RMSEA = 0.087, SRMR = 0.036. Factor loadings ranged from 0.265 to 1.192, explaining 31.7% to 69.9% of the variance (Figure 3.6).

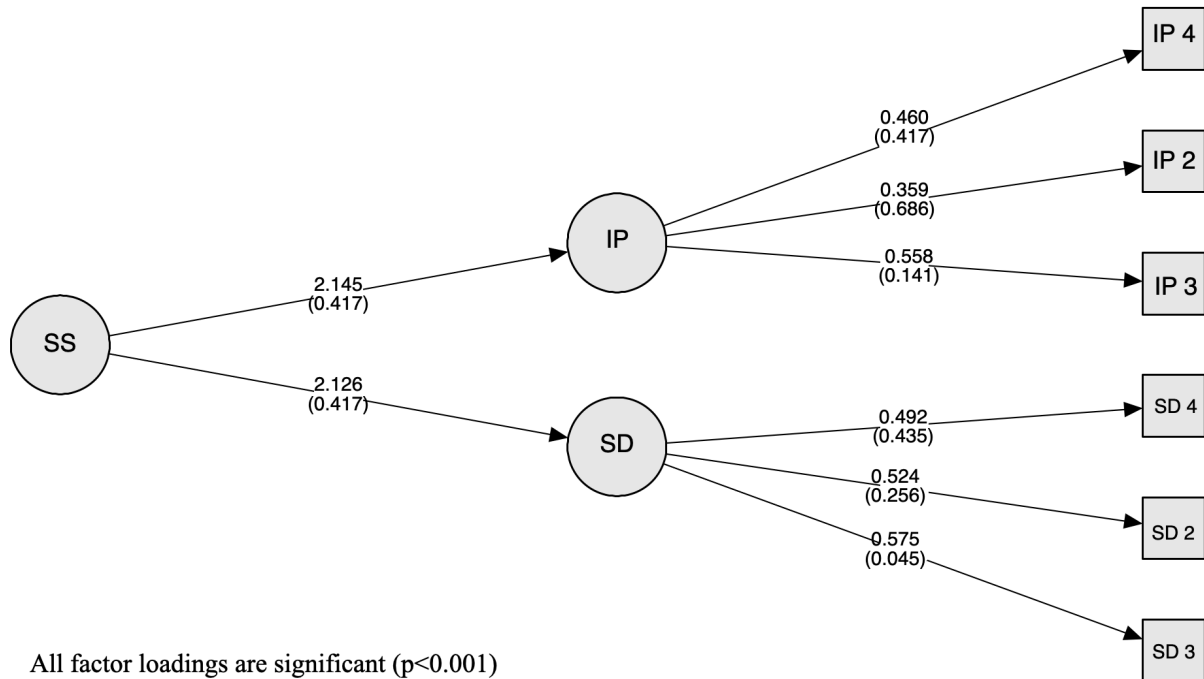
Figure 3.6. *Measurement model for the CEA latent variable from the CTQ and ACE. Standardised beta coefficients are displayed and error terms appear in parentheses.*



3.3.2.2 Sexual shame

A second-order model for the SS was evaluated, which specified a two-factor structure for each SS category. One factor comprised three self-directed (SD) indicator variables, and the other comprised three interpersonal (IP) indicator variables. Twenty one free parameters existed in the CFA (Figure 3.7).

Figure 3.7. Measurement model for the SS latent variable from the Sexual Shame (SS) subscale. Standardised beta coefficients are displayed and error terms appear in parentheses.



Two (SD Q1 and IP Q2) were omitted due to their low parameter estimates/ factor loadings (< 0.4) and lowering of the overall fit indices; these questions were, moreover, not essential to the latent variable, as their meaning could be captured by the remaining indicator variables. The error term between SD Q4 (“*I am ashamed by my sexual capabilities.*”) and IP Q2 (“*I am often embarrassed to tell my sexual partners about my sex life*”), was relaxed, as the residual covariances were high, and the content and wording were similar for each.

The model fit was strong: $\chi^2(6) = 14.56$, $p = .024$, CFI = 0.982, TLI = 0.956, RMSEA = 0.108, SRMR = 0.038. Factor loadings ranged from 0.492 to 0.575, explaining 31.4% to 95.5% of the variance (Table 3.8).

Table 3.8. Items of the Sexual Shame subscale that were included in the analyses for SS

Item number	Item reflecting	Factor loadings (standardised)	Explained variance by item	Error variance
SD 2	I tend to feel bad or dirty after sex.	0.524	0.744	0.256

SD 3	Shortly after sex, I am often ashamed of what I have just done.	0.575	0.955	0.045
SD 4	I am ashamed by my sexual capabilities.	0.492	0.565	0.435
IP 2	I am often embarrassed to tell my sexual partners about my sex life.	0.359	0.314	0.686
IP 3	I am often embarrassed about the people who I have sex with.	0.558	0.859	0.141
IP 4	I often try to hide the people I have sex with or keep them a secret	0.46	0.583	0.417

Notes. *SS*= sexual shame; *SD*= self-directed *SS*; *IP*= interpersonal *SS*; All factor loadings are significant ($p < 0.001$)

3.3.2.3 Disclosure experiences

Because the initial SEM analysis comprised disclosure experiences (DE) as a dichotomous variable, a CFA was not possible or required. For the second SEM analysis (i.e., for Models 2 and 3), CFA's for DE positive and DE negative (disclosure experiences) were tested.

One CFA (DE positive) comprised four positive (PS) indicator variables, and the other comprised five negative "turning against" (TA) indicator variables (Table 3.9).

Table 3.9. *Items of the Social Reactions Questionnaire-Shortened that were included in the analyses for disclosure experience(s)*

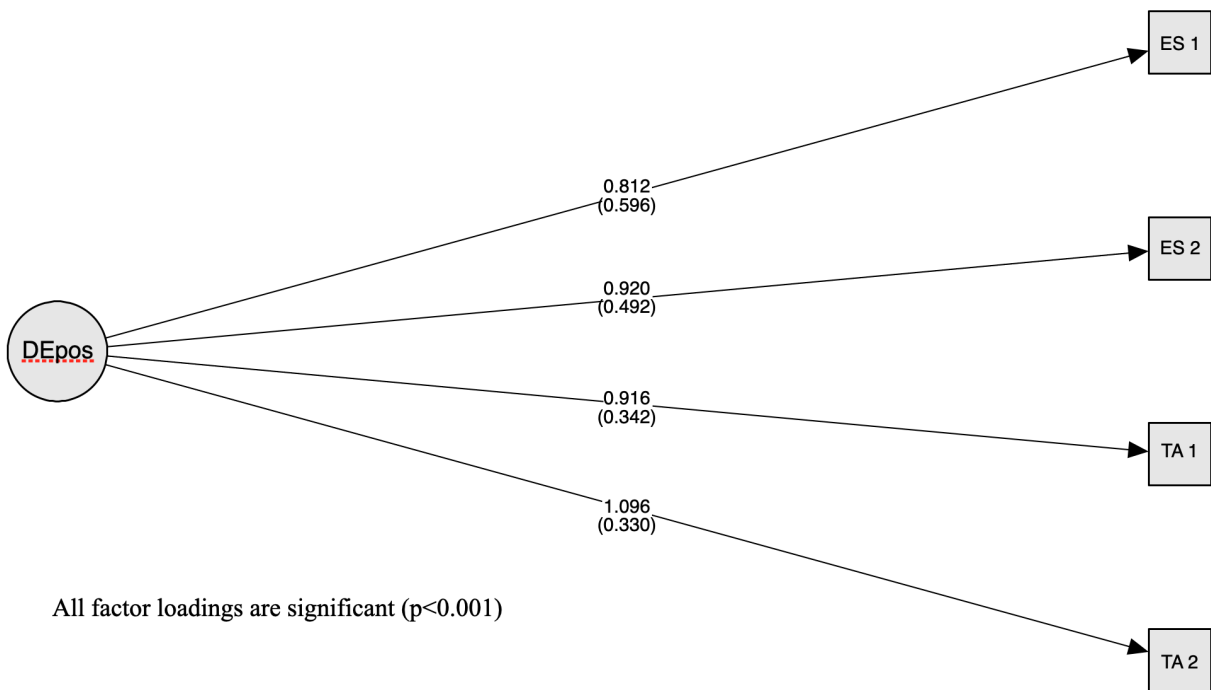
Item	Item reflecting	Factor loadings (standardised)	Explained variance by item	Error variance
PS emotional support 2	Comforted you by telling you it would be all right or by holding you.	0.92	0.508	0.492
PS tangible aid 1	Provided information and discussed options.	0.916	0.658	0.342
PS tangible aid 2	Helped you get information of any kind about coping with the experience.	1.096	0.67	0.33
PS emotional support 1	Reassured you that you are a good person.	0.812	0.404	0.596
TA stigmatise 1	Treated you differently in some way than before you told them that made you uncomfortable.	0.67	0.351	0.649
TA stigmatise 2	Avoided talking to you or spending time with you.	0.801	0.449	0.551
TA infantilise 1	Treated you as if you were a child or somehow incompetent.	0.997	0.54	0.46

TA infantilise 2	Made you feel like you didn't know how to take care of yourself.	0.96	0.594	0.406
TA blame 1	Told you that you were irresponsible or not cautious enough.	0.99	0.556	0.444

Notes. DE= disclosure experience(s) PS= positive DE; TA= negative DE

Twelve free parameters existed in the CFA for DE positive model, which achieved a good fit: $\chi^2(2) = 4.79$, $p = .091$, CFI = 0.962, RMSEA = 0.169, SRMR = 0.041. Factor loadings ranged from 0.812 to 1.096 (Figure 3.8).

Figure 3.8. Measurement model for the DE positive latent variable from the SRQ-SF subscale. Standardised beta coefficients are displayed and error terms appear in parentheses.

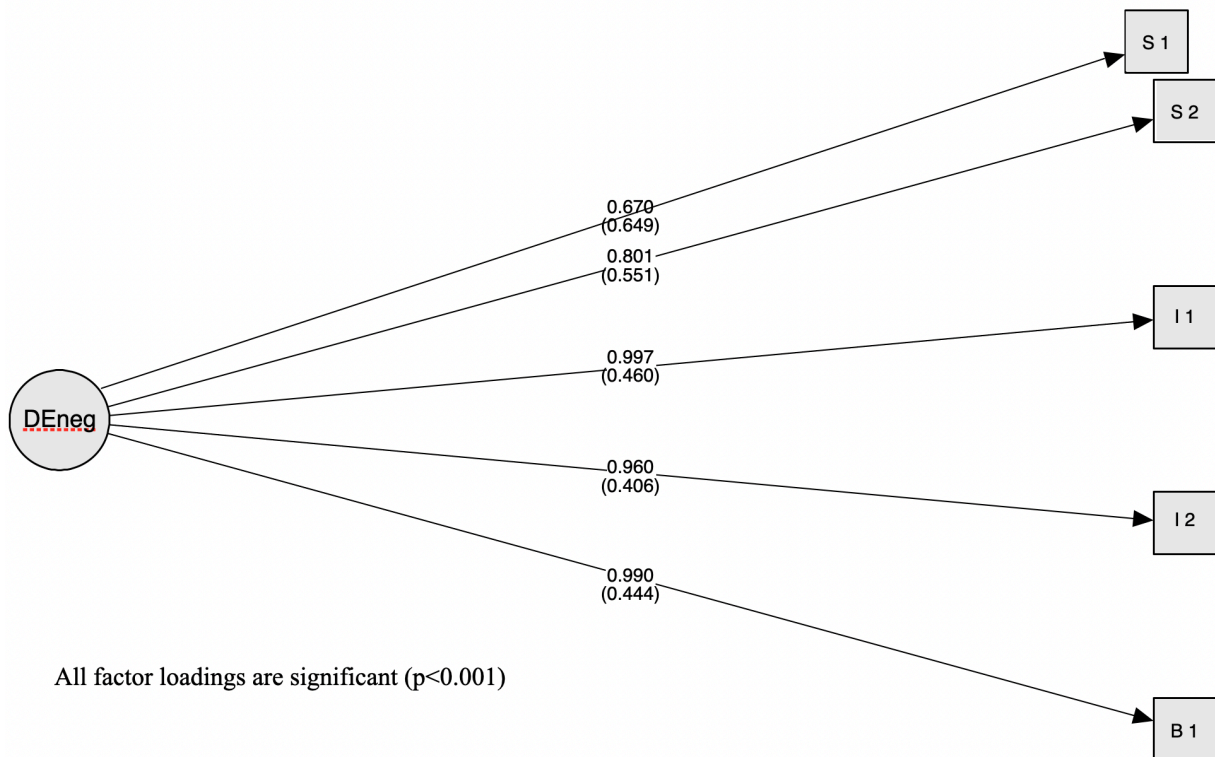


In the other CFA (DE negative model), four of the negative “unsupportive acknowledgment” (UA) indicator variables were removed due to their low parameter estimates/ factor loadings (< 0.4), lack of significance, and poor fit indices for the CFA model. This decision was, additionally, theoretically appropriate, as UA indicator variables did not appear to be explicitly

negative in nature. One TA indicator variable (TA blame Q2) was removed, as it did not have significant parameter estimates and resulted in poor fit indices for the CFA model; this indicator variable was, moreover, conceptually captured in the TA blame Q1 question, which was included.

For DE negative, fifteen free parameters existed. The model fit was excellent: $\chi^2(5) = 5.92$, $p = .314$, CFI = 0.988, RMSEA = 0.061, SRMR = 0.038, with loadings from 0.670 to 0.990 (Figure 3.9).

Figure 3.9. Measurement model for the DE negative latent variable from the SRQ-SF subscale. Standardised beta coefficients are displayed and error terms appear in parentheses.



3.3.2.4 Contextual childhood adversities

A second-order model for CCA was evaluated, consisting of two factors: Childhood Physical Neglect (CPN) and Childhood Emotional Neglect (CEN). The CFA consisted of 12 indicator variables/ indicators and 29 free parameters. One factor comprised seven childhood physical

neglect (CPN) and other contextual adversity indicator variables, one five childhood emotional neglect (CEN) indicator variables. CPN Q1 and Q2 from the CTQ, and the CPN, CEN and parental separation (PS) questions from the ACE, were omitted from the CFA removed. These indicator variables had poor parameter estimates/ factor loadings and resulted in poor fit indices for the CFA model; PS, moreover, did not have significant factor loadings. This decision was theoretically appropriate, as the meaning of each of the CPN and CEN indicator variables could be captured by the remaining indicator variables. All four non- CPN and CEN CCA indicators had factor loadings < 0.4 . Because the CFA model demonstrated acceptable fit, the items were retained in the model to maximise information on CCA as this was essential to addressing the research questions (Table 3.10).

Table 3.10. *Items of the Adverse Childhood Experiences questionnaire and Childhood Trauma Questionnaire–Short Form that were included in the analyses for CCA*

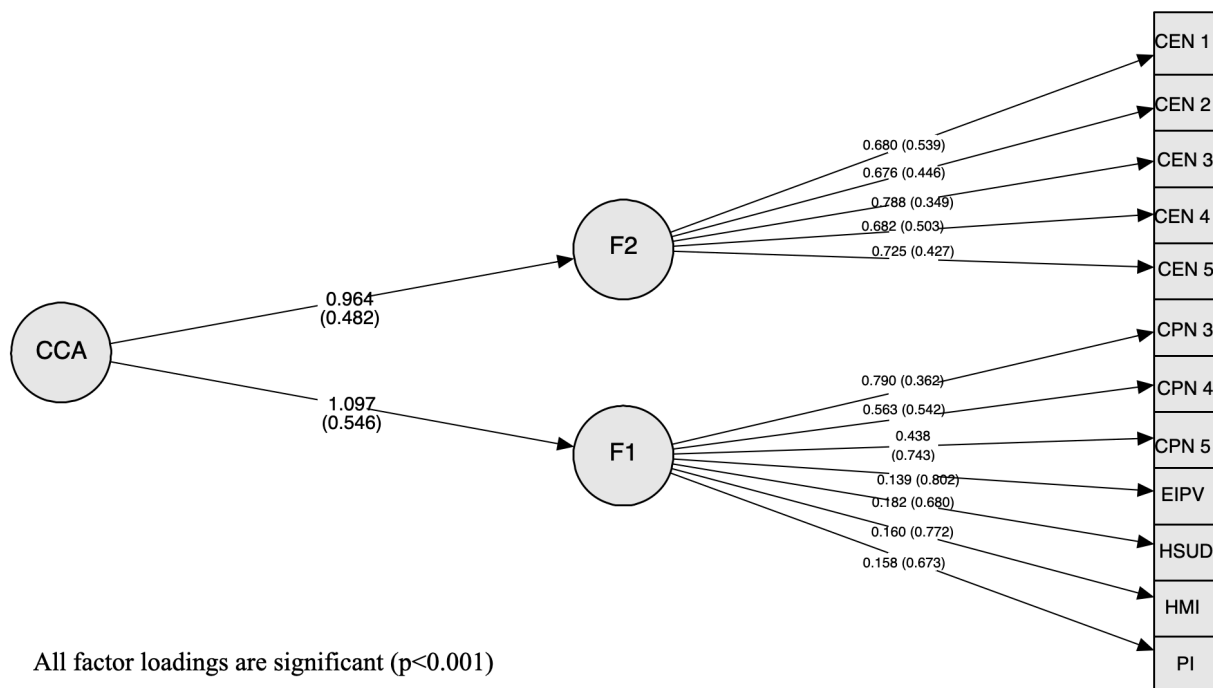
Item (scale)	Item reflecting	Factor loadings (standardised)	Explained variance by item	Error variance
CPN 3 (CTQ)	My parents were too drunk or high to take care of the family.	0.79	0.638	0.362
CPN 4 (CTQ)	I had to wear dirty clothes.	0.563	0.458	0.542
CPN 5* (CTQ)	There was someone to take me to the doctor if I needed it.	0.438	0.257	0.743
EIPV (ACE)	Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	0.139	0.198	0.802
HSUD 1 (ACE)	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	0.182	0.32	0.68
HMI (ACE)	Was a household member depressed or mentally ill or did a household member attempt suicide?	0.16	0.228	0.772
PI (ACE)	Did a household member go to prison?	0.158	0.327	0.673
CEN 3* (CTQ)	People in my family looked out for each other.	0.788	0.651	0.349
CEN 4* (CTQ)	People in my family felt close to each other.	0.682	0.497	0.503

CEN 5* (CTQ)	There was someone to take me to the doctor if I needed it.	0.725	0.573	0.427
CEN 1* (CTQ)	There was someone in my family who helped me feel that I was important or special.	0.68	0.461	0.539
CEN 2* (CTQ)	I felt loved.	0.676	0.554	0.446

Notes. *reverse-coded; ACE= Adverse Childhood Experiences questionnaire; CTQ= Childhood Trauma Questionnaire–Short Form

The model demonstrated good fit: $\chi^2(52) = 83.41$, $p = .004$, CFI = 0.940, TLI = 0.924, RMSEA = 0.067, SRMR = 0.063. Factor loadings ranged from 0.139 to 1.223, with R^2 values from 19.8% to 65.1% (Figure 3.10).

Figure 3.10. Measurement model for the CCA latent variable from the ACE and CTQ. Standardised beta coefficients are displayed and error terms appear in parentheses.



3.3.3 Structural Equation Models

Three different models were created for each CA type, specifically, the latent predictor variables—CSA, CPA, and CEA. As a result, RQ's and hypotheses in this study were addressed using nine SEM's. This section will initially provide details around the Chi-square statistic, fit indices, and other techniques for estimating SEM's for each of the Models 1, Models 2, and Models 3 with each latent predictor variable (i.e., CA types). The section will, subsequently, address the RQ's with their corresponding hypotheses, drawing on the findings of the relevant models.

3.3.3.1 Models 1

The initial analyses assess the relationship between CA types and SS, with DE as a dichotomous mediating variable, and CCA as a mediating latent variable between the CA types and DE (dichotomous) relationships. These analyses are referred to as Models 1. Models 1 were conducted with each CA type—specifically, CSA, CPA, and CEA—as a latent predictor variable within each model. The specific Model 1 analyses are referred to as CSA Model 1, CPA Model 1, and CEA Model 1.

The details of each Model 1 are outlined below. The sample size for all three models was $N = 140$. Consistent with the CFA analyses, the error terms for SD 4 and IP 2 were relaxed in all models. Although not all direct regressions were significant within each of the CSA, CPA, and CEA Models 1, all fit indices were acceptable, with overall significance levels of $p = 0.030$, 0.002 , and 0.005 , respectively.

CSA Model 1

The hypothesised CSA Model 1 had 24 measured variables (indicators), 3 continuous latent variables, and 83 free parameters. The model fit statistics were as follows: $\chi^2(265) = 367.593$, $p < .001$; RMSEA = 0.055, 90% CI [0.041, 0.069]; CFI = 0.934; TLI = 0.920; SRMR = 0.046. These indices indicated an acceptable model fit.

As stated in the previous CFA sections, the error terms for the CTQ's CSA Q4 and Q5 were relaxed. Because the factor loading for the CSA ACE question was < 0.4 , and the R^2 corresponding to this indicator was low and, thus, the fit indices were reduced, this indicator

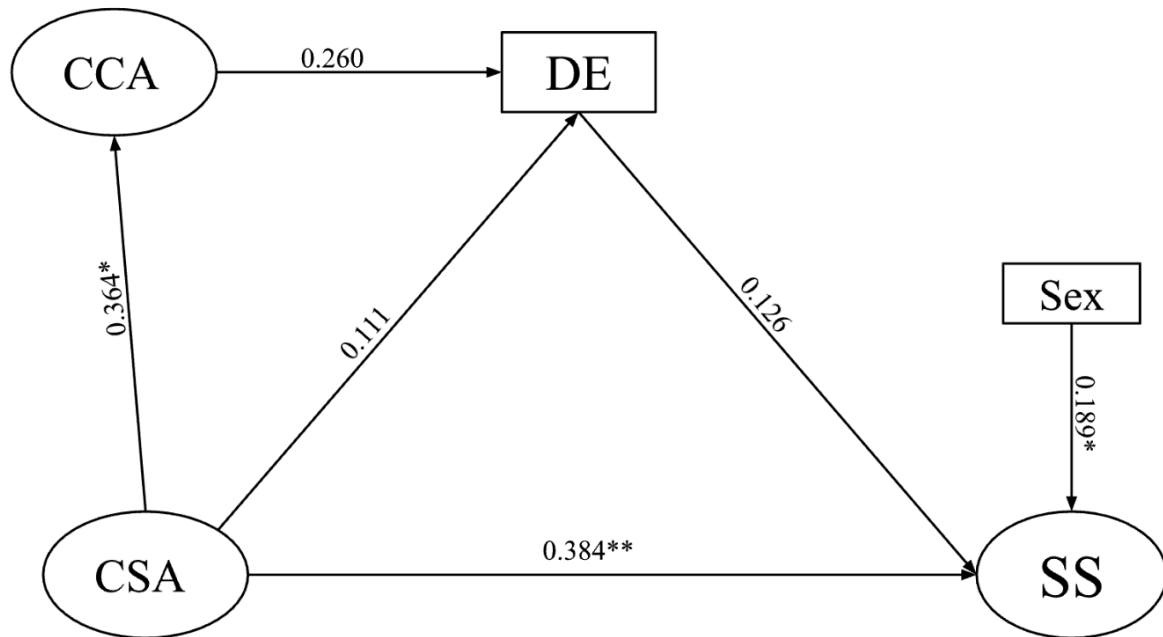
variable was omitted from the analysis. See Table 3.11 below. In the measurement component of this model, all items for CSA, CCA factors, and SS factors loaded significantly ($p < .001$) onto their latent variables (Figure 3.11). In addition, Factor 1 of CCA and both factors of SS loaded significantly ($p < .001$) onto their latent variables. Factor 2 of the second-order CCA was also statistically significant ($p = .035$).

Table 3.11. *Explained variance by the variables (childhood sexual abuse, self-directed sexual shame, interpersonal sexual shame, disclosure experiences, contextual childhood adversity) included in the CSA Model 1*

Variable	R ²
CSA 4	0.689
CSA 1	0.807
CSA 2	0.46
CSA 3	0.684
CSA 5	0.648
SD 3	0.953
SD 2	0.739
SD 4	0.56
IP 3	0.834
IP 2	0.326
IP 4	0.564
CPN 3	0.647
CPN 4	0.459
CPN 5	0.252
HSUD 1	0.316
HMI	0.226
EIPV	0.203
PI	0.322
CEN 3	0.665
CEN 1	0.453
CEN 2	0.542
CEN 4	0.492
CEN 5	0.58
DE	0.101
Factor 1	0.633
Factor 2	
SS	0.219

CCA Factor 1	0.55
CCA Factor 2	0.475
CCA	0.133

Figure 3.11: Illustration of CSA Model 1. All coefficients are standardised, with statistically significant path coefficients indicated, ** $p < .001$, * $p < .05$.



Notes. CSA = childhood sexual abuse; CCA = contextual childhood adversity; DE = presence of disclosure experience(s) in childhood; SS = sexual shame; Sex = sex/gender

CPA Model 1

The hypothesised CPA Model 1 included 24 measured variables (indicators), 3 continuous latent variables, and 83 free parameters. The model yielded the following fit statistics: $\chi^2(289) = 411.987$, $p < .001$; RMSEA = 0.065, 90% CI [0.053, 0.074]; CFI = 0.889; TLI = 0.876. These indices demonstrated moderately acceptable fit.

The indicator variable, CPA Q4 of the CTQ was omitted from the analyses, as its factor loading was < 0.4 , corresponding R^2 was low, and the overall fit indices were reduced. In the

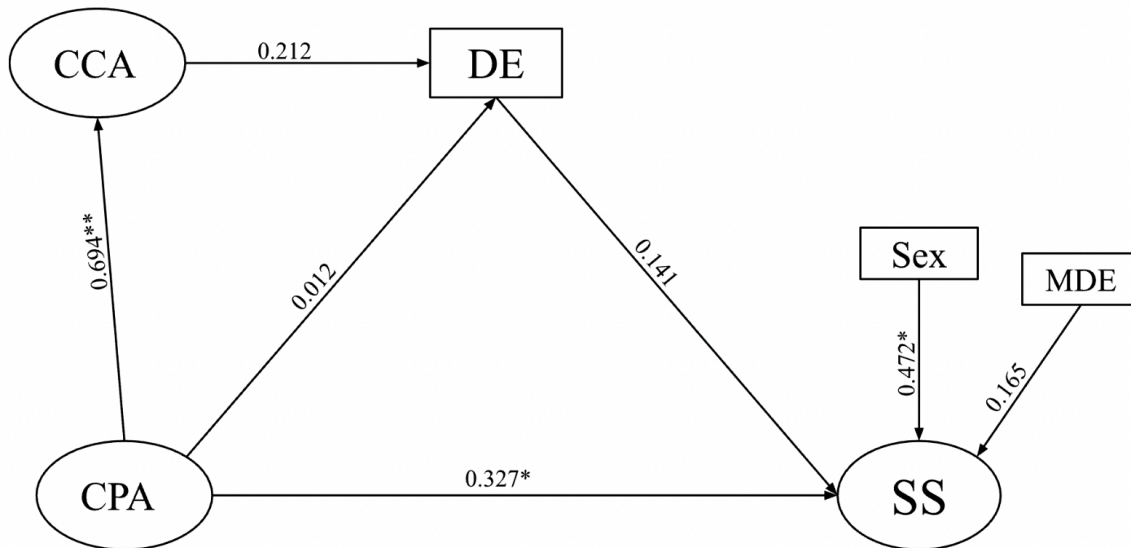
measurement component of this model, all items for CPA, CCA factors, and SS factors loaded significantly ($p < .001$) onto their latent variables (Table 3.12). Factor 1 of CCA and both factors of SS loaded significantly ($p < .001$) onto their latent factors; Factor 2 of the second-order CCA had a significance level of $p = .002$ (Figure 3.12).¹

Table 3.12. *Explained variance by the variables (childhood physical abuse, self-directed sexual shame, interpersonal sexual shame, disclosure experiences, contextual childhood adversity) included in the CPA Model 1*

Variable	R ²
CPA 2	0.747
CPA 5	0.441
CPA 1	0.45
CPA 3	0.388
CPA (ACE)	0.421
SD 3	0.952
SD 2	0.735
SD 4	0.585
IP 3	0.885
IP 2	0.328
IP 4	0.575
CPN 3	0.639
CPN 4	0.467
CPN 5	0.242
HSUD 1	0.383
HMI	0.236
EIPV	0.227
PI	0.331
CEN 3	0.62
CEN 1	0.439
CEN 2	0.578
CEN 4	0.511
CEN 5	0.582
DE	0.049
Factor 1	0.791
Factor 2	0.813
SS	0.233
CCA Factor 1	0.762

CCA Factor 2	0.349
CCA	0.482

Figure 3.12: Illustration of CPA Model 1. All coefficients are standardised. All coefficients are standardised, with statistically significant path coefficients indicated, ** $p < .001$, * $p < .05$.



Notes. CPA = childhood physical abuse; CCA = contextual childhood adversity; DE = presence of disclosure experience(s) in childhood; SS = sexual shame; Sex = sex/gender; MDE = major depressive episode

CEA Model 1

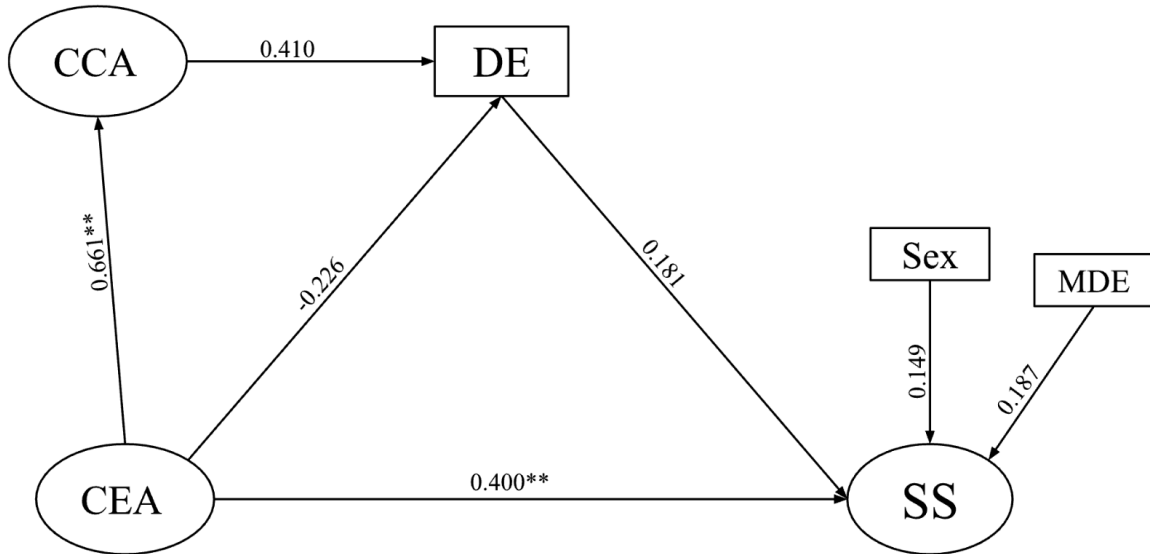
The hypothesised CEA Model 1 included 24 measured variables (indicators), 3 continuous latent variables, and 83 free parameters. The model yielded the following fit statistics: $\chi^2(289) = 403.007$, $p < .001$; RMSEA = 0.062, 90% CI [0.053, 0.074]; CFI = 0.902; TLI = 0.891. These indices demonstrated moderately acceptable fit.

The ACE CEA indicator variable was omitted from the analyses due to its low factor loading (< 0.4), low R^2 , and reduction in the overall fit indices. In the measurement component of this model, all items for CEA, CCA factors, and SS factors loaded significantly ($p < .001$) onto their latent variables (Table 3.13). All factors of the CCA and SS loaded significantly ($p < .001$) onto their latent factors (Figure 3.13).

Table 3.13. *Explained variance by the variables (childhood emotional abuse, self-directed sexual shame, interpersonal sexual shame, disclosure experiences, contextual childhood adversity) included in the CEA Model 1*

Variable	R ²
CEA 3	0.712
CEA 1	0.487
CEA 2	0.414
CEA 4	0.674
CEA 5	0.606
SD 3	0.949
SD 2	0.735
SD 4	0.585
IP 3	0.892
IP 2	0.326
IP 4	0.566
CPN 3	0.677
CPN 4	0.439
CPN 5	0.224
HSUD 1	0.397
HMI	0.249
EIPV	0.203
PI	0.33
CEN 3	0.643
CEN 1	0.426
CEN 2	0.563
CEN 4	0.499
CEN 5	0.592
DE	0.097
Factor 1	0.75
Factor 2	0.849
SS	0.269
CCA Factor 1	0.428
CCA Factor 2	0.349
CCA	0.482

Figure 3.13: Illustration of CEA Model 1. All coefficients are standardised, with statistically significant path coefficients indicated, **p < .001, *p < .05.



Notes. CEA = childhood emotional abuse; CCA = contextual childhood adversity; DE = presence of disclosure experience(s) in childhood; SS = sexual shame; Sex = sex/gender; MDE = major depressive episode

3.3.3.2 Models 2 & Models 3

Models 2 and 3 drew on existing childhood CSA disclosure experiences (DE), encapsulating this phenomenon as latent composite variables between CA types and SS. These ensuing analyses had low sample sizes due to the relatively few instances of DE within the sample. Because of the complexity of each SEM model, model parameters were reduced and more parsimonious SEM's were created; the number of paths had to be reduced by calculating the factors as single variables in order to avoid underpowered models relative to their complexity. Weighted composite or factor scores were used in order to account for the relative importance or contribution of each item to the overall construct of the measurement models. Different weights for each item were assigned before combining them into a single score for each measurement model. These weights were derived from parameter estimates—specifically factor loadings—in the CFA's, which indicated the strength of each item's relationship to the underlying construct. The weighted score for the latent constructs were calculated according to the following formula:

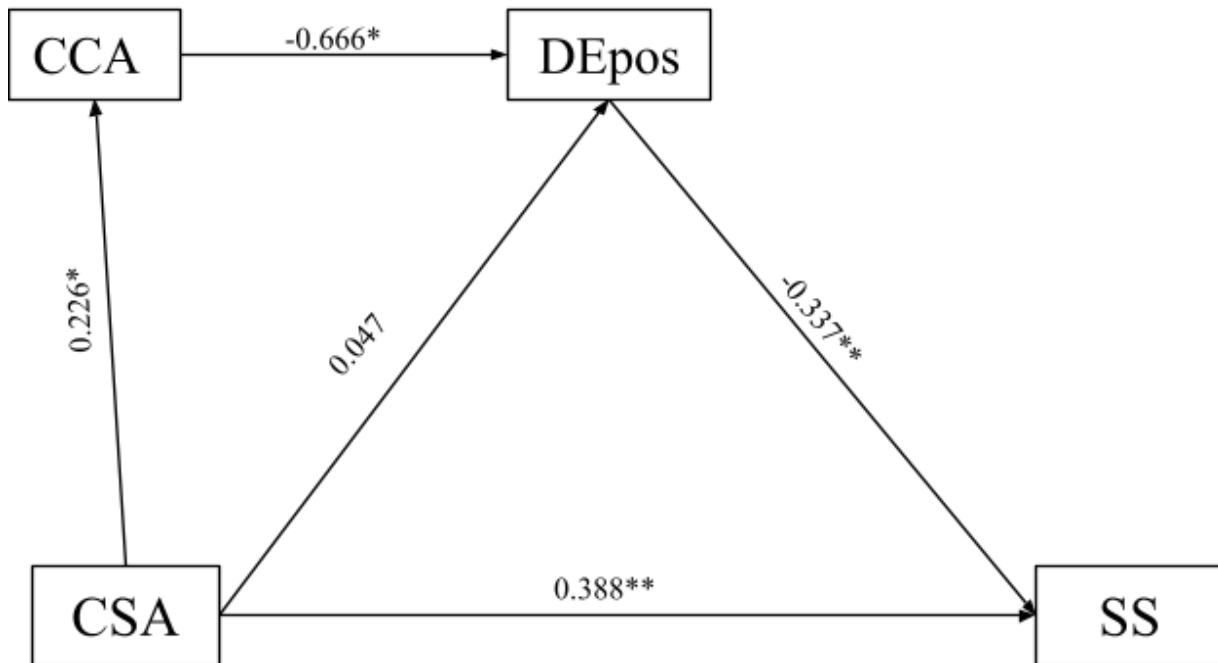
$$\text{Weighted Score} = \sum(w_i \times x_i)$$

Where w_i represents the factor loading (weight) of item i , and x_i represents the observed score for item i .

Because DE varied in their nature (i.e., positive DE as opposed to negative DE), combining the total score for DE did not adequately capture the meaning of this experience. DE was, therefore, separated into two different weighted scores, each acting as a composite meditating variable in the CA types and SS relationships. Models were, subsequently, created around each of these two mediating composite variables: Models 2—positive DE (“DE positive”), and Models 3—negative DE (“DE negative”). Models 2 and 3 were each created with each CA type—specifically, CSA, CPA, and CEA—as latent predictor variables in the model, resulting in a total of 6 SEM analyses/models. These analyses are referred to as CSA Model 2 and CSA Model 3; CPA Model 2 and CPA Model 3; and CEA Model 2 and CEA Model 3.

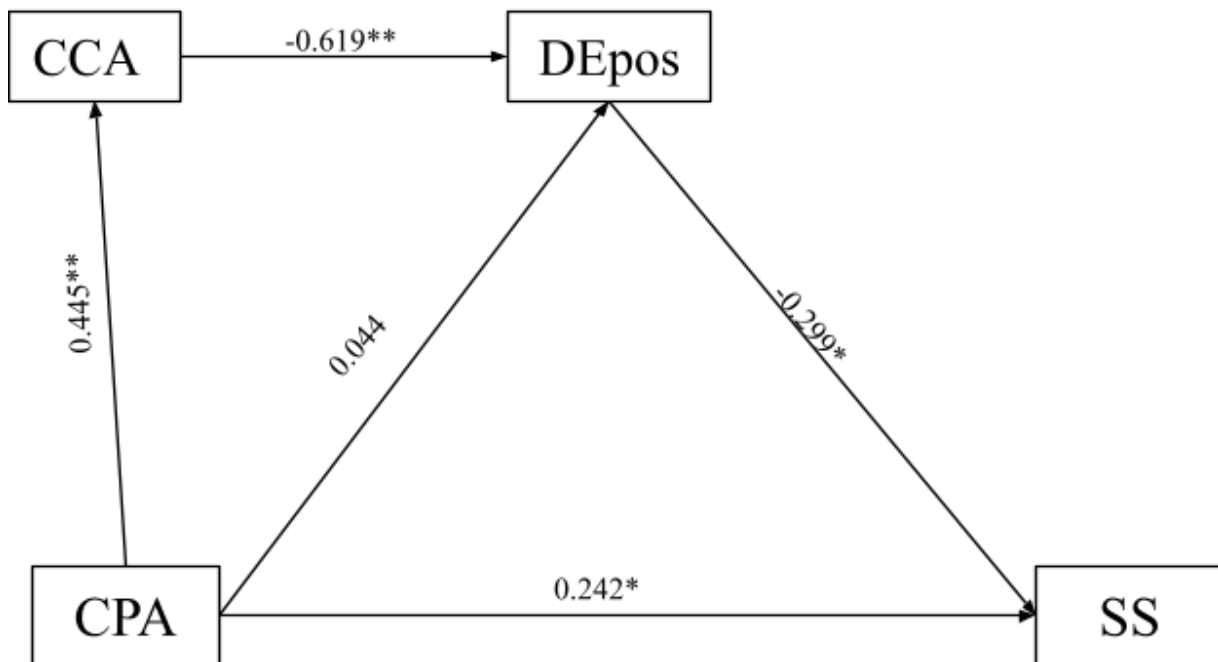
The addition of the sex and MDE variables resulted in very poor fit indices for all Models 2 and 3. For all Models 3, the addition of the mediator, CCA, resulted in unacceptable fit indices. Consequently, these variables were removed from their respective analyses, and the final Models 2 included four composite variables each: CA types, CCA, DE positive, and SS (see Figures 3.14 to 3.16).

Figure 3.14: Illustration of CSA Model 2. All coefficients are standardised, with statistically significant path coefficients indicated, **p < .001, *p < .05.



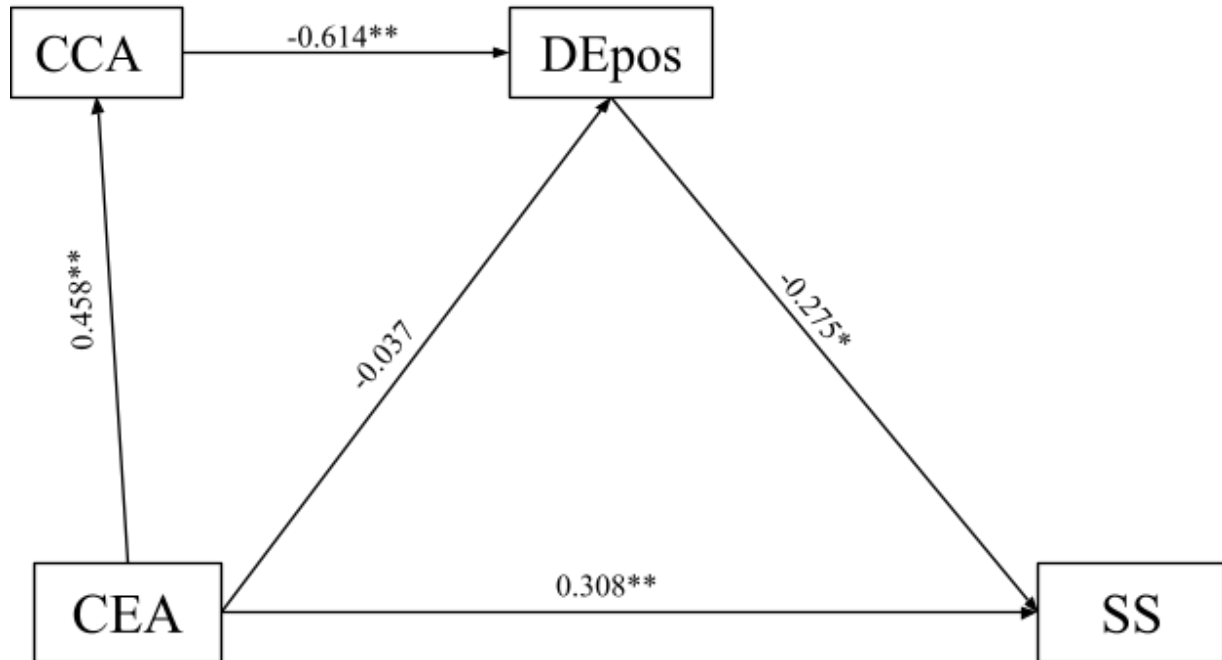
Notes. CSA = childhood sexual abuse; CCA = contextual childhood adversity; DEpos = positive disclosure experience(s) in childhood; SS = sexual shame

Figure 3.15: Illustration of CPA Model 2. All coefficients are standardised, with statistically significant path coefficients indicated, **p < .001, *p < .05.



Notes. CPA = childhood physical abuse; CCA = contextual childhood adversity; DEpos = positive disclosure experience(s) in childhood; SS = sexual shame

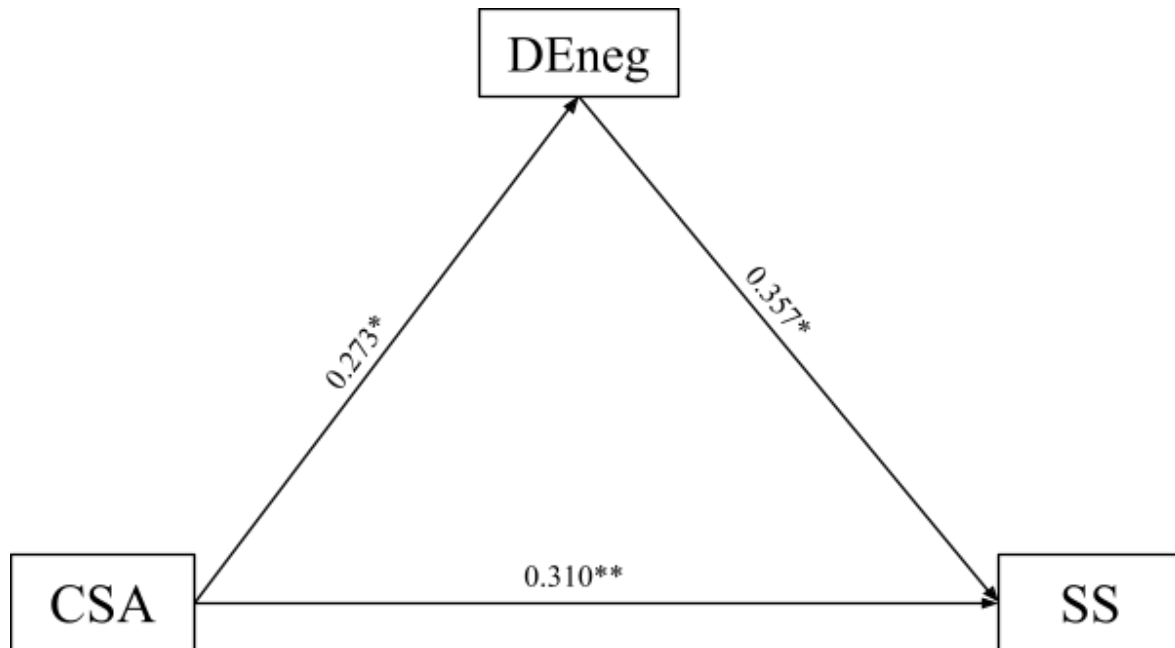
Figure 3.16: Illustration of CEA Model 2. All coefficients are standardised, with statistically significant path coefficients indicated, **p < .001, *p < .05.



Notes. CEA = childhood emotional abuse; CCA = contextual childhood adversity; DEpos = positive disclosure experience(s) in childhood; SS = sexual shame

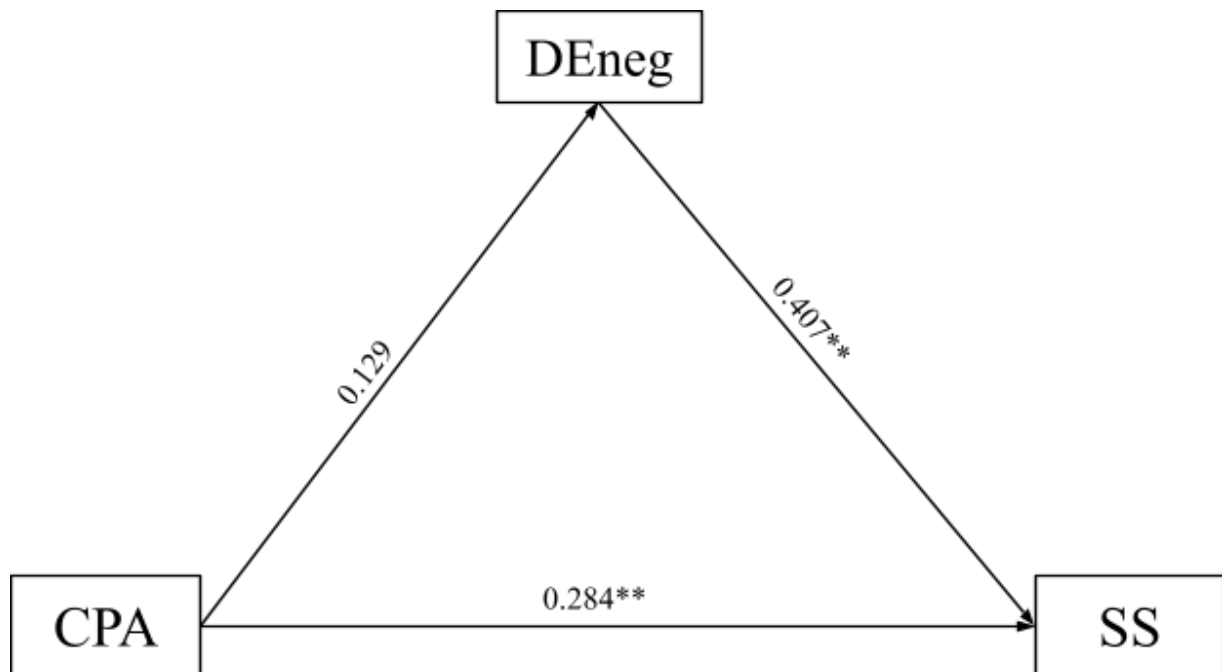
Models 3 included only three composite variables each: CA types, DE negative, and SS (see Figures 3.17 to 3.19).

Figure 3.17: Illustration of CSA Model 3. All coefficients are standardised, with statistically significant path coefficients indicated, ** $p < .001$, * $p < .05$.



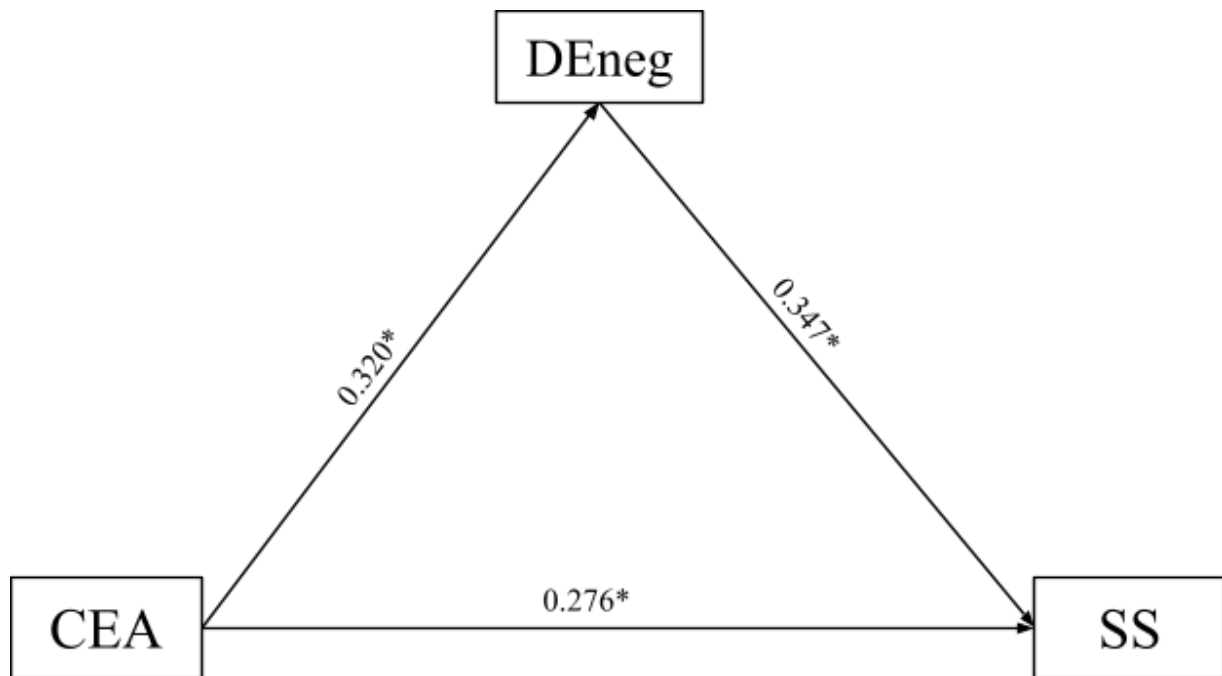
Notes. *CSA* = childhood sexual abuse; *DEneg* = negative disclosure experience(s) in childhood; *SS* = sexual shame

Figure 3.18: Illustration of CPA Model 3. All coefficients are standardised, with statistically significant path coefficients indicated, ** $p < .001$, * $p < .05$.



Notes. *CPA* = childhood physical abuse; *DEneg* = negative disclosure experience(s) in childhood; *SS* = sexual

Figure 3.19: Illustration of CEA Model 3. All coefficients are standardised, with statistically significant path coefficients indicated, ** $p < .001$, * $p < .05$.



Notes. *CEA* = childhood emotional abuse; *DEneg* = negative disclosure experience(s) in childhood; *SS* = sexual shame

Models 2 included DE positive as the mediator. All models demonstrated acceptable fit indices, had a sample size of $N = 135$, and 11 free parameters. For CSA Model 2, the model fit was excellent, $\chi^2(1) = 0.717$, $p = .397$, with $CFI = 1.0$, $TLI = 1.0$, $RMSEA = 0.0$, and $SRMR = 0.022$. CPA Models 2 had a Chi-square $\chi^2(1) = 0.699$, $p = .403$, with $CFI = 1.000$, $TLI = 1.000$, $RMSEA = 0.000$, and $SRMR = 0.022$, indicating an excellent measurement model. CEA Models 2 had a Chi-square $\chi^2(1) = 0.310$, $p = .578$, with $CFI = 1.000$, $TLI = 1.000$, $RMSEA = 0.000$, and $SRMR = 0.014$, indicating an excellent measurement model.

For Models 3, which included DE negative as the mediator, the fit indices were similarly strong across all analyses. All Models 3 demonstrated acceptable fit indices, had a sample size of $N = 135$, and 7 free parameters. In addition, all Models 3 had a Chi-square $\chi^2(0) = 0.000$, $p = 1.000$, with $CFI = 1.000$, $TLI = 1.000$, and $RMSEA = 0.000$, indicating excellent measurement models.

3.3.3.3 Hypotheses testing

Hypothesis 1: The severity of CA types will be differentially associated with levels of SS in individuals with SUD, with higher CSA severity predicting significantly higher SS compared to high CPA and/or CEA severity.

Partial support was found for hypothesis 1. Standardised coefficients of all direct pathways are reported in Tables 3.14 to 3.19. Both CSA and CEA each had a significant direct effect on SS ($p < .001$) in all three of their models. Similarly, CPA had a significant direct effect on SS in Model 1 ($p = .006$) and Models 2 and 3 ($p < .001$). The CSA models explained 21.9 to 29.1% ($R^2 = .219- .291$), the CPA models explained 19.4 to 23.3% ($R^2 = .194- .233$), and the CEA models explained 22.4 to 26.9% ($R^2 = .224- .269$) of variance in the SS score.

Table 3.14. Results from testing the direct pathways of CSA Model 1

Independent variable	Dependent variable	β	SE	Bootstrap 95% CI	
				Lower	Upper
Childhood sexual abuse Disclosure experience (presence) Sex	Sexual shame	0.384	0.084	0.114	0.496
		0.126	0.195	-0.139	0.683
		0.189	0.198	0.009	0.823
Childhood sexual abuse Contextual childhood adversity	Disclosure experience (presence)	0.111	0.036	-0.037	0.112
		0.26	0.076	-0.016	0.344
Childhood sexual abuse	Contextual childhood adversity	0.364	0.081	0.033	0.454

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Table 3.15. Results from testing the direct pathways of CPA Model 1

Independent variable	Dependent variable	β	SE	Bootstrap 95% CI	
				Lower	Upper
Childhood physical abuse Disclosure experience (presence) Sex Major depressive episode	Sexual shame	0.327	0.129	-0.036	0.774
		0.141	0.248	-0.21	0.864
		0.218	0.269	0.022	1.095
		0.165	0.254	-0.092	0.891

Childhood physical abuse	Disclosure experience (presence)	0.012	0.089	-0.32	0.196
Contextual childhood adversity		0.212	0.097	-0.101	0.53
Childhood physical abuse	Contextual childhood adversity	0.694	0.139	0.308	1.061

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Table 3.16. Results from testing the direct pathways of CEA Model 1

Independent variable	Dependent variable	β	SE	Bootstrap 95% CI	
				Lower	Upper
Childhood emotional abuse	Sexual shame	0.4	0.109	0.125	0.707
Disclosure experience (presence)		0.181	0.235	-0.05	0.929
Sex		0.149	0.254	-0.17	0.908
Major depressive episode		0.187	0.244	-0.086	0.974
Childhood emotional abuse	Disclosure experience (presence)	-0.226	0.078	-0.352	0.055
Contextual childhood adversity		0.41	0.13	-0.004	0.719
Childhood emotional abuse	Contextual childhood adversity	0.661	0.12	0.193	0.813

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Table 3.17. Results from testing the direct pathways of CSA Models 2 and 3

Independent variable	Dependent variable	β	SE	Bootstrap 95% CI	
				Lower	Upper
Childhood sexual abuse	Sexual shame	0.388	0.071	0.183	0.492
Disclosure experience (positive)		-0.337	0.174	-0.973	-0.199
Disclosure experience (negative)		0.357	0.247	0.208	1.188
Childhood sexual abuse	Disclosure experience (positive)	0.047	0.053	-0.094	0.132
Contextual childhood adversity		-0.666	0.085	-0.752	-0.337
Childhood sexual abuse	Disclosure experience (negative)	0.273	0.055	0.002	0.225
Childhood sexual abuse	Contextual childhood adversity	0.226	0.051	0.033	0.247

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Table 3.18. Results from testing the direct pathways of CPA Models 2 and 3

Independent variable	Dependent variable	β	SE	Bootstrap 95% CI	
				Lower	Upper
Childhood physical abuse Disclosure experience (positive) Disclosure experience (negative)	Sexual shame	0.242	0.136	0.009	0.681
		-0.299	0.203	-0.947	0.004
		0.407	0.239	0.201	1.278
Childhood physical abuse Contextual childhood adversity	Disclosure experience (positive)	-0.044	0.098	-0.224	0.125
		-0.619	0.094	-0.693	-0.29
Childhood physical abuse	Disclosure experience (negative)	0.129	0.094	-0.082	0.256
Childhood physical abuse	Contextual childhood adversity	0.445	0.08	0.282	0.622

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Table 3.19. Results from testing the direct pathways of CEA Models 2 and 3

Independent variable	Dependent variable	β	SE	Bootstrap 95% CI	
				Lower	Upper
Childhood emotional abuse Disclosure experience (positive) Disclosure experience (negative)	Sexual shame	0.308	0.105	0.106	0.592
		-0.275	0.201	-0.942	0.045
		0.347	0.26	0.05	1.222
Childhood emotional abuse Contextual childhood adversity	Disclosure experience (positive)	-0.037	0.078	-0.208	0.125
		-0.614	0.095	-0.684	-0.24
Childhood emotional abuse	Disclosure experience (negative)	0.32	0.072	0.051	0.315
Childhood emotional abuse	Contextual childhood adversity	0.458	0.063	0.244	0.499

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Hypothesis 2: Childhood disclosure of CSA will significantly mediate the relationship between childhood abuse types (i.e., CSA, CPA, and CEA) and SS in individuals with SUD.

In order to determine Hypothesis 2, Model 1 for CSA, CPA, and CEA were examined, as this model examined DE as a dichotomous variable. No evidence was found to support Hypothesis 2. All three CA models did not find a significant mediating effect of DE (i.e., the indirect effect), nor were any significant direct effects found in the Models 1 (i.e., with CA types, DE, and SS). Nevertheless, the overall model fit indices for each model were acceptable, along with model significance. See Tables 3.20 to 3.23.

Table 3.20. *Results from testing the mediation pathways of CSA Model 1*

Independent variable	Mediator variable	Outcome variable	β	SE	Bootstrap 95% CI	
					Lower	Upper
Childhood sexual abuse	Disclosure experience presence (DE)	Sexual shame	0.014	0.012	-0.005	0.073
Childhood sexual abuse	Contextual childhood adversity	Sexual shame (through DE)	0.012	0.008	-0.003	0.053
		DE	0.095	0.019	0.003	0.105

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Table 3.21. *Results from testing the mediation pathways of CSA Models 2 and 3*

Independent variable	Mediator variable	Outcome variable	β	SE	Bootstrap 95% CI	
					Lower	Upper
Childhood sexual abuse	Disclosure experience positive (DEpos)	Sexual shame	-0.016	0.031	-0.089	0.066
	Disclosure experience negative (DENeg)		0.098	0.05	0.004	0.249
Childhood sexual abuse	Contextual childhood adversity	Sexual shame (through DEpos)	0.051	0.021	0.013	0.104
		DEpos	-0.151	0.03	-0.143	-0.021

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Table 3.22. Results from testing the mediation pathways of CPA Models 2 and 3

Independent variable	Mediator variable	Outcome variable	β	SE	Bootstrap 95% CI	
					Lower	Upper
Childhood physical abuse	Disclosure experience positive (DEpos)	Sexual shame	0.013	0.054	-0.063	0.217
	Disclosure experience negative (DEneg)		0.111	0.07	0.02	0.344
Childhood physical abuse	Contextual childhood adversity	Sexual shame (through DEpos)	0.082	0.052	0.013	0.263
		DEpos	-0.276	0.058	-0.373	-0.106

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Table 3.23. Results from testing the mediation pathways of CEA Models 2 and 3

Independent variable	Mediator variable	Outcome variable	β	SE	Bootstrap 95% CI	
					Lower	Upper
Childhood emotional abuse	Disclosure experience positive (DEpos)	Sexual shame	0.01	0.039	-0.061	0.168
	Disclosure experience negative (DEneg)		0.111	0.07	0.02	0.344
Childhood emotional abuse	Contextual childhood adversity	Sexual shame (through DEpos)	0.077	0.04	0.003	0.201
		DEpos	-0.281	0.046	-0.292	-0.09

Note: β = Standardised (beta) coefficients. SE= Standard error. CI= Confidence intervals.

Hypothesis 3: Positive CSA disclosure experiences (DE positive) in childhood will significantly mediate the relationship between childhood abuse types (i.e., CSA, CPA, and CEA) and SS, with positive disclosure experiences associated with lower SS.

Hypothesis 4: Negative CSA disclosure experiences (DE negative) in childhood will mediate the relationship between childhood abuse types (i.e., CSA, CPA, and CEA) and SS, with negative disclosure experiences associated with higher SS.

In order to assess Hypotheses 3 and 4, Models 2 and 3 for CSA, CPA, and CEA were examined, as these models examine DE positive (Models 2) and DE negative (Models 3) mediating effects.

Results did not support the tested hypotheses. No significant mediating effects for DE (both positive and negative) were found in any of the CA models. DE positive and DE negative,

however, were found to have negative and positive (respectively) significant direct effects on SS in the CSA models ($p < .001$), and CPA and CEA models ($p < .05$). See tables 3.14 to 3.23.

Hypothesis 5: CCA will mediate the relationship between childhood abuse types (i.e., CSA, CPA, and CEA) and DE in individuals with SUD, with higher instances of CCA associated with lower rates of disclosure or more negative DE's.

Results partially supported the tested hypothesis. In Models 2, CCA was found to have a negative, mediating effect on the relationship between CA types and DE positive: CSA ($\beta = -0.151$, $SE = 0.03$, 95% CI [-0.143, -0.021]), CPA ($\beta = -0.276$, $SE = 0.058$, 95% CI [-0.373, -0.106]), and CEA ($\beta = -0.281$, $SE = 0.046$, 95% CI [-0.292, -0.090]). Thus, higher severity of CA types predicted higher instances of CCA, which in turn predicted lower levels of DE positive. In addition, significant direct effects were found between all CA types and CCA; CCA had a negative, significant relationship with DE positive in all Models 2. See tables 3.14 to 3.23.

In Models 1, a significant mediating effect of CCA was not found between CA types and DE. Nevertheless, in Models 1, a significant direct effect of CSA ($p = .005$), as well as CPA and CEA ($p < .001$) were found on CCA.

Models 3 for CSA, CPA, and CEA did not include CCA as a mediator, as the addition of this variable to each model resulted in unacceptable fit indices

Hypothesis 6: Sex will not significantly moderate the relationship between childhood abuse types and SS in individuals with SUD.

In contrast to the hypothesis, sex demonstrated a significant positive moderating effect in both the CSA and CPA Models 1, with $p = 0.033$. This finding indicates that female participants were significantly more likely to experience higher levels of SS compared to male participants, suggesting that the relationship between these CA types and SS varies by gender, with female survivors exhibiting a stronger association. No significant moderating effect of sex was observed in the CEA Model 1. Furthermore, Models 2 and 3 for each CA type did not include sex as a moderator, as incorporating this variable resulted in unacceptable model fit indices.

3.4 Discussion: Study II

This study explored the complex relationships between childhood abuse types (i.e., CSA, CPA, and CEA), CSA disclosure experiences, contextual childhood adversities, and sexual shame in individuals with substance use disorders. Using confirmatory factor analyses and structural equation modeling, the findings highlighted both direct and indirect effects of these constructs while addressing significant gender differences. The results contribute to understanding the nuanced pathways linking CSA and related adversities to psychosexual outcomes, specifically SS.

3.4.1 Childhood abuse and sexual shame

The findings confirmed that all three forms of childhood abuse—CSA, CPA, and CEA—were significantly associated with SS. This aligns with prior research identifying CA as a consistent predictor of negative self-perceptions and psychological distress in adulthood, including SS (Dorahy & Clearwater, 2012; Drewitt-Smith & Marczak, 2023; Ellenbogen et al., 2018; Healy et al., 2021). Survivors of childhood trauma often internalise feelings of shame, moral deficiency, and self-blame, which diminish self-esteem and shape negative self-perceptions, further compounding psychological distress and hindering recovery (Finkelhor & Browne, 1985; Litam & Speciale, 2021; Schramm & Tapia, 2024).

For CSA survivors, these internalised feelings are often exacerbated by perceptions of personal responsibility for the abuse, including beliefs that they failed to prevent it or allowed it to continue; some survivors may attribute the abuse to aspects of their identity or behaviour, such as their sexuality or sexual orientation, or to perceived signals that attracted the perpetrator, particularly if any form of sexual gratification occurred during the abuse (Drewitt-Smith & Marczak, 2023; Dorahy & Clearwater, 2012; Ellenbogen et al., 2018). These perceptions are often reinforced by societal attitudes that frame abuse as shameful, humiliating, or dirty, leading survivors to internalise these views and further entrench their feelings of SS (Finkelhor & Browne, 1985; Litam & Speciale, 2021). These pervasive feelings of shame, deeply rooted in the abusive experience and its aftermath, frequently underpin the development of SS (Dorahy & Clearwater, 2012; Drewitt-Smith & Marczak, 2023; Ellenbogen et al., 2018; Gewirtz-Meydan & Godbout, 2023; Kilimnik & Meston, 2021).

Nevertheless, CSA did not have the strongest direct effect, as all CA types were comparable in explaining the variance in SS. This finding contrasts with the initial hypothesis that CSA, as a sexual form of trauma, would exert a greater influence on SS. It also diverges from some prior research identifying CSA as a critical predictor of SS (Giordano et al., 2024; McKenzie & Botts, 2018; Racine et al., 2022). These results challenge earlier conclusions that CSA has a uniquely stronger impact on SS (Drewitt-Smith & Marczak, 2023; Giordano et al., 2024; Ellenbogen et al., 2018; Kilimnik & Meston, 2021; McKenzie & Botts, 2018; Racine et al., 2022). These studies, however, often focussed solely on the presence of each form of CA rather than incorporating both the presence and severity of each abuse type, as in the current study.

While this study supports the direct effects of all CA types on SS, it also underscores the importance of abuse severity as a critical determinant, a factor that remains underexplored in the literature. Ellenbogen and colleagues (2018) observed that the general correlation between shame and CSA or CPA was similar when accounting for the shared variance with abuse severity. The present findings suggest that the high correlations between CA types in this sample—where higher CSA severity was correlated with higher CPA and CEA severity—might highlight the compounding effects of polyvictimisation. Co-occurring forms of CA may amplify the psychological burden on survivors, intensifying the development of SS (Ellenbogen et al., 2018; Giordano et al., 2024).

In a related study involving 721 patients in residential SUD treatment, Basting and colleagues (2024) observed a plateau effect, indicating that beyond a certain threshold of ACE's, the dose-response relationship between ACE's and CSB levels off. This finding suggests that the cumulative quantity of ACE's may be a more significant predictor of adverse outcomes than the specific types of ACE's. Similarly, the present results may point to the compounding impact of multiple abuse types, where the interaction between CSA, CPA, and CEA, alongside their respective severities, creates a cumulative psychological burden that is crucial for understanding SS.

3.4.2 Disclosure experiences

Contrary to the hypothesis, neither the presence of CSA disclosure nor type of CSA disclosure experiences in childhood mediated the relationship between CA and SS. This finding challenges

prior studies that suggest disclosure—particularly helpful and supportive disclosure—facilitates emotional processing and reduces shame in CSA survivors (Bi et al., 2018; Drewitt-Smith & Marczak, 2023; Hemanth et al., 2024; Relyea & Ullman, 2015; Weare et al., 2024). The results indicate that disclosing CSA in childhood, regardless of whether the disclosure experience was positive or negative, does not significantly alter the pathway between CA types and SS in this population.

Shame has been identified as a critical barrier to disclosure, often preventing survivors from disclosing their experiences; Furthermore, when disclosure occurs, the reactions of others can sometimes elicit or reinforce shame rather than alleviate it (for a review, see MacGinley et al., 2019). This dynamic may partially explain the absence of a demonstrated mediating relationship between CA types, DE, and SS in the present study. The findings suggest that the relationship between these variables may be more intricate than the current measures can fully capture.

Participants in the current study were asked about their general disclosure experiences in childhood, including both positive and negative experiences. Notably, the majority of participants did not disclose CSA during childhood, and among those who did, most reported experiencing both positive and negative reactions to their disclosures. The study, however, did not assess the timing or recipients of these disclosures, as the number of questions was restricted. The relationship of the disclosure recipient to the CSA survivor—particularly when the recipient is a caregiver who can provide support or stop the abuse—has been shown to significantly influence the survivor’s experience and the effectiveness of any assistance provided (Brennan & McElvaney, 2020; Gemara & Katz, 2023; Manay & Collin-Vézina, 2021). Earlier disclosures to supportive recipients are more likely to result in protective interventions and better outcomes for survivors (Easton, 2020; Gemara & Katz, 2023).

Disclosure is a nuanced, multi-dimensional process that unfolds over time, shaped by dynamic and reciprocal influences that can affect subsequent disclosures and their outcomes (Easton, 2020; Gemara & Katz, 2023; Gemara, Mishna, & Katz, 2023). The current study’s inability to assess critical factors, such as the timing of disclosure and the recipient’s relationship to the survivor, likely influenced the findings.

Nevertheless, the current findings revealed a significant direct effect of negative disclosure experiences on SS, underscoring both the positive influence of supportive disclosures and the detrimental impact of unsupportive responses during childhood. Negative disclosure experiences have been identified in prior research as significant contributors to overall shame (Bi et al., 2018; Feiring et al., 2002; Relyea & Ullman, 2015). These unsupportive responses may reinforce feelings of self-blame, rejection, or inadequacy, exacerbating survivors' psychological distress. Consequently, some survivors may choose not to disclose their experiences at all, aiming to avoid the potential repercussions of negative reactions (Gemara et al., 2023). This dynamic could partially account for the mixed findings observed in this study, highlighting the complex relationship between disclosure experiences and SS.

3.4.3 Contextual childhood adversities

CCA, comprising instances of neglect and household dysfunction, were examined as mediators in the relationship between CA types and both the existence of CSA disclosures and type of disclosure experiences in childhood. The findings partially supported this hypothesis. CCA was found to mediate the relationship between all CA types and positive CSA disclosure experiences, specifically demonstrating a negative relationship. This suggests that higher instances of contextual adversities—particularly childhood neglect and household dysfunction—may exacerbate the effects of CSA, CPA, and CEA on positive disclosure experiences during childhood. These findings highlight how tangible aid and emotional support received by CSA survivors are diminished in adverse contexts.

Disclosure to primary caregivers typically results in better quality support and a clearer understanding of the abuse for CSA survivors (Brennan & McElvaney, 2020; Broman-Fulks et al., 2007; Gemara & Katz, 2023; Maleki et al., 2023; Manay & Collin-Vézina, 2021; Reitsema & Grietens, 2015). Conversely, in households with higher rates of CSA, CPA, and CEA, compounded by neglect and dysfunction, children who disclose CSA to non-offending caregivers may receive less support from these recipients (Elliott & Briere, 1994; Latiff et al., 2024). Furthermore, although this study did not inquire about the specific recipients of disclosures, it is possible that participants with higher instances of CCA disclosed to individuals outside their family, such as friends, rather than to caregivers or close family members. Such disclosures may

not yield the same supportive and positive outcomes typically associated with disclosing CSA to primary caregivers (Gemara & Katz, 2023; Maleki et al., 2023).

Contrary to the initial hypothesis, CCA did not have a direct or mediating role in whether CSA survivors disclosed the abuse during childhood, nor did it influence the likelihood of experiencing a negative disclosure reaction, such as stigmatising, infantilising, or blaming responses. This finding diverges from existing literature, which has linked emotional or physical neglect and household dysfunction to delays in disclosing abuse (Gemara & Katz, 2023; Hemanth et al., 2024; Lahtinen et al., 2018; Latiff et al., 2024; Priebe & Svedin, 2008; Tashjian et al., 2016). Disclosure within a hostile familial environment is often met with accusatory reactions or enforced secrecy, further complicating the survivor's experience (Gemara & Katz, 2023; Rees, Simpson, McCormack, Moussa, & Amanatidis, 2019; Tener, 2018).

Nevertheless, due to poor fit indices in the CFA, the current study did not assess negative disclosure reactions such as indifference, controlling behaviours, distraction, overreaction, or egocentric responses. These reactions are commonly associated with familial responses to disclosure (Relyea & Ullman, 2015). This limitation may be particularly relevant to this study's participants, who are currently receiving treatment for SUD and may have encountered familial environments marked by dysfunction and lack of support.

This study, moreover, found that all types of CA had a direct effect on CCA across all models. This finding suggests that higher levels of CSA, CPA, and CEA, within the context of CSA, are associated with increased instances of CCA, including physical neglect, emotional neglect, household mental illness, household substance use disorder, parental incarceration, and exposure to intimate partner violence. These results align with prior research indicating that higher severity or frequencies of childhood trauma are often accompanied by other ACE's within the home (Cassioli et al., 2024; Davis et al., 2019; Finkelhor & Browne, 1985). This co-occurrence underscores the compounding nature of adversities in childhood and their potential to exacerbate the psychological and developmental challenges faced by survivors.

3.4.4 Sex differences

Unexpectedly, sex demonstrated a significant positive moderating effect in the CSA and CPA models, with female participants exhibiting stronger associations between these abuse types and SS. This finding is particularly surprising given that male sex in this sample was significantly correlated with higher severity across all CA types. These results contradict prior literature suggesting that greater abuse severity is associated with worse outcomes related to sexual health and behaviour for survivors (Basting et al., 2024; Cassioli et al., 2024; Guiney et al., 2024; Vrolijk-Bosschaart et al., 2018). Additionally, while previous studies have highlighted the role of shame tied to sexuality among CSA survivors (Gewirtz-Meydan & Godbout, 2023; Petersson & Plantin, 2023; Pulverman & Meston, 2020; Rendina et al., 2019), only Gewirtz-Meydan and Godbout (2023) included both male and female samples. In addition, no known existing studies have simultaneously examined CA severity levels alongside disclosure experiences and contextual childhood adversities, making direct comparisons with the current findings challenging.

The sample's focus on individuals with SUD may partially explain these results. Women with SUD often face heightened stigma and worse outcomes compared to men, potentially exacerbating their vulnerability and hindering recovery efforts (Russell, Gajwani, Turner, & Minnis, 2022). Additionally, the observed higher levels of SS among women may reflect traditional societal gender norms that impose stricter expectations on female sexuality and suppress expressions of female sexual autonomy (Miano & Urone, 2024; Urone, Passiglia, Graceffa, & Miano, 2024).

Furthermore, no significant correlation between sex and disclosure experiences was observed in this study, suggesting that other factors, such as the timing of CSA or its disclosure, may account for some discrepancies. The timing of abuse and disclosure has been shown to influence the severity of long-term outcomes (Charest, Hébert, & Bernier, 2018; Ensink, Borelli, Normandin, Target, & Fonagy, 2020). These dimensions could not be fully assessed in the present study due to methodological limitations, highlighting an area for further exploration.

3.4.5 Conclusion and future research

This study explored the relationships between childhood abuse types (CSA, CPA, and CEA), CSA disclosure experiences in childhood, CCA, and SS among individuals with SUD's. Using SEM, the findings provided valuable insights into how these factors interact to influence psychosexual outcomes. Despite its contributions, the study has several limitations that warrant consideration.

One limitation is the reliance on retrospective self-reports, which may introduce recall bias or inaccuracies in participants' recollections of childhood events. Additionally, the study included a restricted number of questions due to its integration within a larger longitudinal study, limiting the scope of the variables assessed. The cross-sectional design further prevents causal inferences about the relationships between variables. While the SEM approach, particularly the use of bootstrapping, was rigorous and yielded important insights into potential pathways, longitudinal designs are recommended to capture the temporal dynamics of abuse, disclosure, and their effects on SS. The relatively small sample size, coupled with the use of weighted composite scores, may have reduced the precision of the analyses. Future research should aim to replicate these findings in larger samples.

Despite these limitations, the study also has notable strengths. By examining multiple types of abuse and assessing their severity levels, rather than merely their presence, the research offers a more granular understanding of how childhood adversities impact SS. The inclusion of individuals with SUD's—a population often overlooked in studies on CSA and SS—broadens the applicability of the findings to a high-risk group. Additionally, the study's emphasis on contextual adversities, such as neglect and household dysfunction, contributes to a more comprehensive framework for understanding how co-occurring adversities compound the effects of abuse, highlighting the interconnected nature of these experiences.

The findings have important implications for future research. To deepen the understanding of CSA disclosure dynamics, future studies should examine the timing of disclosures, the role of disclosure recipients, and the quality of support survivors receive. Longitudinal studies exploring the developmental trajectories of SS in relation to abuse and disclosure experiences are particularly needed to elucidate causality and change over time. Investigating gender differences

in SS within diverse populations may shed light on how gendered norms and stereotypes shape the outcomes of childhood abuse. Incorporating survivors' narratives through mixed-methods approaches could also enrich the understanding of how abuse and disclosure experiences influence psychosexual development, gendered experiences, and recovery trajectories.

This study underscores the enduring impact of CSA and other forms of childhood abuse, disclosure experiences, and contextual adversities on SS, particularly among individuals with SUD's. The findings challenge certain assumptions in the existing literature and highlight the complexity of these relationships, underscoring the importance of examining multiple intersecting factors. Building on these insights, future research can contribute to a deeper understanding of the pathways through which trauma, disclosure, and broader contextual factors influence survivors' psychosexual development and healing processes, particularly through in-depth explorations that capture the nuanced and lived experiences of survivors.

Chapter 4: Exploring Disclosure, Psychosexual Development, and Recovery in Male and Female Childhood Sexual Abuse Survivors: A Constructivist Grounded Theory Study – Study III

4.1 Introduction: Study III

4.1.1 Background

Childhood sexual abuse (CSA) constitutes a profound violation of personal boundaries and trust, often perpetrated within contexts that survivors are expected to rely on for safety and protection (Guiney et al., 2024; Hemanth et al., 2024). Research has consistently demonstrated that CSA is associated with a wide range of adverse outcomes, including physical health complications, psychological distress, and disruptions in social and relational functioning (Drewitt-Smith & Marczak, 2023; Easton et al., 2022). Among these, the disclosure of CSA and its subsequent impact on psychosexual development and recovery are critical dimensions warranting further exploration.

The process of disclosing CSA is typically prolonged, unfolding over time as fragments of the experience are gradually revealed. Disclosure is shaped by dynamic, reciprocal interactions that influence subsequent disclosures and a range of outcomes (Easton, 2020; Gemara & Katz, 2023; Gemara, Mishna, & Katz, 2023). It is further influenced by individual, familial, and societal factors (Depraetere et al., 2020; McElvaney et al., 2022; Vollman, 2021). Survivors may disclose their experiences to various recipients, including caregivers, peers, or professionals, with the timing, context, and responses to these disclosures playing a pivotal role in shaping the survivor's recovery trajectory (Gemara & Katz, 2023; Lassri & Gewirtz-Meydan, 2024; Manay & Collin-Vézina, 2021). Supportive and positive responses to disclosure can mitigate some of the adverse effects of CSA, enabling survivors to process their experiences and access appropriate interventions (Davis et al., 2018; Engel, 2022; Romano et al., 2019). Conversely, dismissive or accusatory reactions exacerbate feelings of guilt, shame, and isolation, further

compounding the trauma (Brennan & McElvaney, 2020; Hemanth et al., 2024; Weare et al., 2024).

Gender differences in CSA experiences and disclosure are particularly salient. Male survivors often face unique challenges in recognising and disclosing their abuse due to societal norms that equate masculinity with strength, invulnerability, and stoicism (Attrash-Najjar et al., 2023; Depraetere et al., 2020; Easton, 2020; Vollman, 2021). These constructs obscure male victimhood, leading many male survivors to reinterpret their abuse through the lens of traditional masculine ideals, thereby delaying or entirely inhibiting disclosure (Ragonese et al., 2019; Widanaralalage et al., 2022). In contrast, female survivors often contend with societal victim-blaming attitudes, where their credibility and innocence are scrutinised, which influences their willingness and ability to disclose (Flynn et al., 2023; Sugiura & Smith, 2020). These divergent experiences underscore the necessity for research that accounts for how gender intersects with CSA and its disclosure.

Psychosexual development—encompassing sexual identity, behaviour, and attitudes—can be profoundly influenced by CSA and the contexts in which it occurs, given the inherently sexual nature of the abuse (Alley & Diamond, 2021; Browne & Finkelhor, 1986; Ménard & MacIntosh, 2021; Vaillancourt-Morel et al., 2016). Survivors often report disruptions in forming healthy intimate relationships, with experiences of compulsive sexual behaviour, sexual avoidance, or confusion regarding sexual orientation emerging as recurrent themes (Borg et al., 2020; Gewirtz-Meydan & Godbout, 2023; Lewis et al., 2022). These disruptions frequently interact with the survivor’s disclosure experiences, as the reactions of recipients can either validate the survivor’s narrative or amplify feelings of shame and self-blame, further complicating their psychosexual development (Morrison et al., 2018; Li et al., 2023; Vollman, 2021).

Recovery from CSA is a multifaceted process that extends beyond the cessation of abuse to include the survivor’s ability to make sense of their experiences, rebuild trust, and develop adaptive coping mechanisms (Easton & Parchment, 2021; Mason, Taggart, & Broadhurst, 2020; Mills et al., 2019). Disclosure often serves as a catalyst for recovery by facilitating access to social support, therapeutic interventions, and community resources (Reitsema & Grietens, 2016; Stea et al., 2023). The recovery process, however, is not uniform and is influenced by individual

characteristics, the nature of the abuse, and the sociocultural context in which survivors seek to heal (Engel, 2022; Gemara et al., 2023). Integrating these factors into a theoretical framework is essential for advancing both research and practical applications in supporting CSA survivors.

The current study employs a constructivist grounded theory (CGT) approach to explore men's and women's experiences of CSA and its disclosure, as well as the influence of these experiences on their psychosexual development and recovery processes. By focussing on the relationship between individual experiences and broader socio-cultural constructs, this study aims to generate a thorough understanding of how gender shapes CSA disclosure and recovery.

4.1.2 Research aims

The aims of this study are to (a) explore men and women's experiences of CSA and its disclosure, and (b) to investigate how CSA and its disclosure influence the psychosexual development and recovery processes of male and female survivors.

4.2 Methodology: Study III

4.2.1 Introduction

The following section aims to provide an overview of the methodology of this qualitative study. The section commences with an exposition of the background and research aims, before presenting a cogent rationale for the selection of constructivist grounded theory (CGT) as the most suitable methodology for this study, as compared to other qualitative research approaches.

A detailed examination of the evolution and processes of grounded theory will then be presented, along with a discussion of its criticisms. Subsequently, the constructivist grounded theory approach will be outlined, with a specific emphasis on the role of the researcher in the research process, as well as the important concept of reflexivity. The section will, moreover, explore the researcher's interests in CSA, and how the researcher's positionality and intersectionality can influence the research outcomes.

This section will provide a foundation for the specific data gathering techniques, as well as the results of the study, which will be discussed in the subsequent section.

4.2.2 Qualitative inquiry and methodological considerations

There are several reasons to choose a qualitative methodology in relation to the current research questions. Some of these reasons are outlined by Creswell (1998), including responding to ‘how’ or ‘what’ questions; when the topic requires an exploration due to under-developed or non-existing theories or variables; the research area benefits from detail rather than breadth; the identified population is receptive; and to stress the role of the researcher as an active learner. The current study meets these criteria and involves understanding the subjective, rich and unique experiences of participants’ CSA and disclosure experiences, along with particular outcomes. A qualitative approach allows for the flexibility to generate rich, detailed, diverse, and subjective data that can help researchers to gain an in-depth understanding of complex phenomena that quantitative research may miss. Furthermore, qualitative methods match well with the chosen critical realist paradigm, where knowledge of phenomena are considered to be limited by subjective interpretations, and recognizing and addressing these interpretations and biases is essential (Bhaskar, 1975; Charmaz, 2014).

Qualitative research is a diverse field encompassing a wide range of philosophical positions, practices, contexts, and materials (Aspers & Corte, 2019; Plakoyiannaki & Budhwar, 2021). It involves an interpretive, naturalistic approach to understanding the world, with a focus on uncovering and interpreting the meaning that individuals and groups ascribe to their experiences (Moen & Middelthon, 2015). Researchers in this field utilise a variety of materials to gather data, such as field notes, interviews, conversations, photographs, recordings, and memos to the self, which represent the world in which meaning is made through an interpretative process (Aspers & Corte, 2019; Plakoyiannaki & Budhwar, 2021). Qualitative research is an essential tool for understanding the complexity and diversity of subjective human experiences, and to gain insights into the social and cultural context in which they live and work (Moen & Middelthon, 2015).

Childhood sexual abuse and other childhood trauma are sensitive and complex topics that require a deep understanding of the experiences of survivors. The subjective and often emotional nature of these experiences makes it challenging to capture the depth and complexity of the phenomenon through quantitative research alone (Padgett, 2016). Qualitative research, on the other hand, allows researchers to capture the voices and experiences of survivors in their own

words (Mihas, 2019), providing rich and detailed data that can reveal the nuances and complexities of their experiences.

Creswell (2013) highlights the benefit of qualitative research when investigating complex social phenomena that are difficult to quantify, such as childhood sexual abuse and other childhood trauma. By using qualitative methods, researchers can delve deeply into the experiences of survivors and gain a more profound understanding of the factors that contribute to their trauma. If conducted with sensitivity and following guidelines, researchers using qualitative methods can gain a deep understanding of the nuanced and complex experiences of survivors through establishing rapport with participants, and creating a comfortable setting for them to share their experiences (Carter, Shih, Williams, Degeling, & Mooney-Somers, 2021; Dempsey, Dowling, Larkin, & Murphy, 2016; Dickson-Swift, James, Kippen, & Liamputtong, 2008).

Qualitative research offers a range of methodological options that researchers can use to explore phenomena in depth. According to Creswell and Poth (2016), the five approaches to qualitative research are: narrative research, phenomenology, grounded theory (GT), ethnography, and case study research. Each of these approaches has unique features, but they share a common goal of prioritising the importance of context and meaning, seeking to understand how individuals make sense of their experiences. They all, moreover, emphasise the importance of interpretation and acknowledge the subjective nature of knowledge creation.

Narrative research and phenomenology both focus on the subjective experiences of individuals. Narrative research involves collecting and analysing stories or personal accounts of individuals' experiences (Clandinin & Connelly, 2004). In contrast, phenomenology focuses on understanding the meaning of an experience from the perspective of the individual who has experienced it (Moustakas, 1994). Both approaches rely on participants' own accounts to construct a narrative, but narrative research emphasises the actual narrative structure, whereas phenomenology highlights the underlying meanings and essences. Through the collection and analysis of data, GT likewise seeks to reflect the voices and experiences of individuals, but sets out to do so through developing a theory about a phenomenon (Bryant & Charmaz, 2007; Glaser & Strauss, 1967; Strauss & Corbin, 1990). GT is particularly suited to exploring experiences and meanings in relation to social phenomena (Padgett, 2017).

Ethnography and case study research are methodologies used to investigate particular social phenomena in depth. Ethnography involves the study of a culture or community, and is often used to explore topics such as social norms, values, and beliefs (Atkinson, Coffey, & Delamont, 2003; Wolcott, 1999). Conversely, case study research involves an in-depth exploration of a single case or a small number of cases (Stake, 1995; Yin, 2009). Ethnography typically involves a more extended period of observation, immersion, and fieldwork, while case study research emphasises detailed analysis of a particular instance.

Padgett (2017) further outlines a broad range of qualitative research designs and techniques that researchers can use, including content analysis, discourse analysis, and participatory action research. Content analysis is used to analyse the meaning behind textual data (Drisko & Maschi, 2016; Stemler, 2000), while discourse analysis is used to understand how people use language to create social reality (Brown, Brown, Yule, Brown, & Gillian, 1983). Participatory action research is a collaborative approach that involves the participants as co-researchers in the research process (McIntyre, 2007). Another popular methodology is thematic analysis, which is a widely used method that involves identifying patterns of meaning across a dataset; It is particularly useful when the research question involves understanding the attitudes, beliefs, and experiences of participants (Braun & Clarke, 2012). Thematic analysis can be used with a variety of qualitative data, including interviews, focus groups, and observation data.

Each of these approaches is beneficial to understanding the complexity and diversity of human experiences through focusing on exploring the personal experiences and meanings of participants, such as in narrative research and phenomenology, or focussing on describing the culture or community being studied, such as in ethnography and case study research.

Nevertheless, in the case where the researcher aims to explore questions that have not been previously addressed, GT is the most appropriate methodology, as it allows for a systematic yet exploratory and open approach to data collection and analysis (Bryant & Charmaz, 2007; Glaser & Strauss, 1967; Strauss & Corbin, 1990).

4.2.3 Grounded theory

4.2.3.1 Evolution and definition of grounded theory

Grounded theory (GT) is a popular qualitative research method that was first introduced by Glaser and Strauss (1967) in their seminal book, *The Discovery of Grounded Theory: Strategies for Qualitative Research*. The method has undergone significant evolution and variation since its inception, resulting in different versions of GT proposed by Glaser, Strauss and Corbin, and Charmaz, among others. Despite these differences, the core aim of GT remains consistent, which is to generate a theory that is grounded in the data and reflects the experiences of the participants (Charmaz, 2014; Creswell & Poth, 2016).

The key feature of GT that distinguishes it from other qualitative methods is its focus on understanding the process of a phenomenon and generating a theory to explain that process (Charmaz, 2014). This process involves a rigorous and systematic approach to data analysis, starting with open coding, which involves breaking down the data into discrete units (Teppo, 2015). Depending on the research question and specific type of GT chosen, researchers may employ various other forms of coding, such as axial coding, selective coding, or theoretical coding, to further refine and develop the emerging theory (Charmaz, 2014; Corbin & Strauss, 2008; Glaser, 2002). This process allows the researcher to develop a theory that is based on the data, thereby reflecting the experiences of the participants (Charmaz, 2017; El Hussein, Hirst, Salyers, & Osuji, 2014).

GT is a flexible and iterative approach that allows for unexpected findings and revisions to the emerging theory as more data are collected and analysed (Charmaz, 2017; El Hussein et al., 2014). As such, it is well-suited for exploring complex and dynamic phenomena and generating new insights and understandings. Nevertheless, unlike other methodologies, such as thematic analysis, GT has been criticised for requiring a significant investment of time and resources to collect and analyse data, which may be prohibitive for many researchers (Braun, Clarke, & Weate, 2016; Sandberg & Alvesson, 2011). Despite these criticisms, GT has the advantage of being a valuable and powerful methodology that results in a deep and nuanced understanding of the phenomenon of interest, which is particularly applicable to obtaining expertise in the researcher's PhD.

4.2.3.2 Constructivist grounded theory

One criticism of methodologies such as classical GT are their overreliance on the researcher's subjectivity, ignoring researcher biases and lack of objectivity (Maggs-Rapport, 2001; Sandberg & Alvesson, 2011). Constructivist grounded theory (CGT) is a methodology that has been gaining popularity in recent years due to its ability to generate theory from the data while acknowledging the influence of the researcher on the process (Charmaz, 2020; Mohajan, & Mohajan, 2022).

Unlike Glaser and Strauss' (1967) seminal conceptualization of grounded theory, CGT adopts a more flexible method that acknowledges research as a process of construction, where the participants and the researcher together co-construct—and not 'discover'—a theory (Charmaz, 2014; Mills, Bonner, & Francis, 2006). In CGT, data collection and analysis occur simultaneously, with the researcher coding and categorising the data into themes and concepts (Charmaz, 2014). The generated concepts and theories are not predetermined but rather developed from the collected data. CGT does not purport developed theories are generalisable and widely applicable (Bryant & Charmaz, 2007). Instead, this type of GT asserts that the researcher is inherently subjective, multiple meanings are possible from the data, and that reality is an interactive process influenced by cultural, temporal, and structural contexts (Charmaz, 2014). This methodology attempts to balance the advantages and disadvantages of participant expertise against researcher objectivity, as well as structured technique against flexible and responsive methodology. CGT, outlined by Kathy Charmaz (2000, 2014) was, therefore, employed.

An important feature and distinction of CGT is that it allows for a literature review prior to the study, to outline the rationale and assumptions for the study, and understand the depth of the data from the interviews (Charmaz, 2014). This is in contrast to classical GT and the views of Glaser (2013), where, through the positivist epistemology, it is argued that it is possible to conduct research without any preconceptions, and that reading the literature prior to conducting the research will influence how the researcher interprets the data. Hence, CGT is criticised for taking advantage of the literature through oscillating between abductive and inductive reasoning (Glaser, 2002; Kenny & Fourie, 2015). Nevertheless, it seems unlikely that researchers do not

either consciously or subconsciously make assumptions that affect their reasons for choosing a research topic, methods, and interpretation of the data, and that, “there is a difference between an open mind and empty head” (Dey, 1999, p. 251). Thus, it is essential that the researcher attempt to reflect on the degree to which his/her assumptions play a role in their findings (Charmaz, 2017). Following the CGT guidelines, the researcher is advised to recognise his or her own perception of self and area of research based on the existing literature. CGT underlines the importance of being beside the literature in the simultaneous process of collecting data and immersion in the literature to develop a more thorough review that assists in focusing on the theory (Charmaz, 2014; Glaser, 1998).

4.2.3.3 Suitability of CGT for this study

For the purpose of this study, grounded theory has been employed, as it is beneficial for research in complex situations in which theory is sparse or under-developed (Glaser & Strauss, 1967). This methodology is, moreover, particularly useful for exploring complex and sensitive issues such as childhood sexual abuse (Schreiber & Stern, 2001). CGT is specifically chosen, as it emphasises retaining the voice of the participants, which is suitable for this area of research, given the relative invisibility of the voices of these survivors within the literature. CGT is influenced by social constructivism, which aligns with a component of the researcher’s critical realist approach to the research.

The purpose of this study is to understand the ways that the sexual identity, healing process, and life experiences of survivors of childhood sexual abuse is affected by the abuse and its disclosure experiences. CGT as a methodology is well suited to this topic for several reasons, particularly because it is directed towards theory generation (Charmaz, 2014; Jones, Torres, & Arminio, 2014). Given that the intersection of CSA and disclosure experiences is underexplored, a specific goal of the current study is to generate theory that can be used to inform future research and practice concerning this area of research.

Charmaz (2014) explains that “*the constructivist approach treats research as a construction but acknowledges that it occurs under specific conditions*” (p.13). Given the complexity of this potentially traumatic experience, the lens of CGT is appropriate in underscoring that findings will inform the topic in a particular, contextual format as a co-product of both the participant and

researcher. CGT permits an interpretative understanding of CSA disclosure experiences and sexual identity without presupposing a simplified and definitive answer to the question of how CSA disclosure impacts CSA survivors.

4.2.3.4 Reflexivity

4.2.3.4.1 Reflexivity and the role of the researcher

In order to more adequately observe and dissect researchers' worldviews and subjectivity in engaging in their research, CGT calls for reflexivity. The process of the researcher sensitising him-/herself to possible biases s/he may have towards the data and the worldview of the participants can be accomplished through going deep into both his/her own and the participants' experiences (Harding, 1991). Charmaz (2020) argues that, "*Constructivist grounded theory not only prompts us to dissect our research decisions but moreover to scrutinise our moral commitments.*" (p. 68).

In an effort to maintain reflexivity and observe assumptions and interactions with the data, the researcher has written memos in a reflexive diary throughout the entirety of the study.

4.2.3.4.2 Researcher positionality and intersectionality in the research process

Because a constructivist epistemology is assumed, the researcher's subjectivity and role will be outlined. Factors that influence the researcher include her education and work experience, culture and background (Western ideology), and personal experience and view of childhood sexual abuse, and gender.

The researcher acknowledges that her upbringing in Canada, being Canadian and American (Norwegian and Iranian background), working in mental health, holding research positions, and completing her education in both Canada and Britain has inevitably influenced her perspective in terms of possessing a Western individualistic view (Vandenberg & Hall, 2011), although the researcher's half Iranian (predominantly collectivist) background may have also influenced her. Nevertheless, the researcher's primarily individualistic views may enable her to view participants as having more agency in their outcome than is possible.

Furthermore, the researcher has personal experience in this field, specifically with CSA experiences of the nature that aligns with the majority of participant experiences in this sample. This allowed her to empathise with participants, but may have also resulted in her interjecting her ideas and experience into her coding and interpretation of the data. Two participants were aware of the researcher's experiences because of the nature of their relationships, although each was aware that the interviews were solely focussed on their experiences. The researcher's experience was not disclosed to other participants, as she wanted participants to impart as much knowledge of their interpretation of the disclosure and abusive experiences, outcome, and societal norms as possible without the interview appearing to be a setting for sharing experiences.

The female gender of the researcher may result in particular reactions from participants, particularly when addressing masculinity and issues with sexuality in men (Lefkowich, 2019).

4.2.4 Ethical considerations

Ethical considerations informed the research design and methods of this study, which adhered to the University of Edinburgh's School of Health in Social Science Research Ethics Committee and the University of British Columbia's Behavioural Research Ethics Board (UBC BREB). Because the research was conducted in Vancouver, Canada, the UBC BREB required an official proof of approval from the University of Edinburgh, as well as a "local" UBC supervisor, Professor Christian Schütz. Approval from both institutions was obtained and is provided in Appendices K and L.

In keeping with these ethics principles, the researcher provided willing participants who contacted her via email with a participant information sheet (see Appendix N). This document outlined the study's anticipated risks, confidentiality measures, the participants' rights, freedom to withdraw, and information on available mental health and counselling resources. Participants were given ample time to review the information before scheduling an interview and providing written consent either on paper or, following the COVID-19 pandemic, via an online link. The consent form included a request for the participants' general practitioner or mental health professional's contact details in the unlikely event that they express willingness to harm

themselves or others. Informed consent forms are available in Appendix O. Participants' anonymity and confidentiality were maintained by numerically labelling them in this study.

As required by the UBC BREB, the researcher created and followed a supervision and risk mitigation plan prior to and during all interviews. This plan involved informing her supervisors of each interview and requesting that they be available for debriefing and emotional support if needed (see Appendix N).

To ensure ethical standards were maintained throughout the study, annual renewals were required by both ethics committees, along with a final report detailing the conclusion of the study.

4.2.4.1 Confidentiality of data management

The research generated data in the form of consent forms, audio-recordings, anonymised transcripts, and emails. Prior to the COVID-19 pandemic, two participants had completed hard copies of the consent forms, which were kept in locked cabinets at the researcher's university. Audio-recordings were initially stored on an encrypted device but were subsequently transferred to the university's encrypted network drive, OneDrive, as soon as possible after each interview and then deleted from the audio recorder. Participant names and email information were password-protected. For Zoom/Skype meetings, participants used the code given by the researcher to log in. They were not required to have their video on, and no videos were recorded. Once each interview was transcribed, the recordings were transferred to a password-encrypted file on the researcher's computer and kept separate from any information that could be used to identify the participant.

All audio-recordings will permanently be deleted five years after the degree is successfully completed and approved by the dissertation committee. The consent forms, which were the only documents with the names of each participant, were kept separately from the data and stored as a password-protected Word document on the researcher's encrypted folder and computer. Only the PhD researcher had access to identifiable data. These consent forms had the codes to identify participants, which were used on any other documents or records. No names or identifiable information were in the documents uploaded into the NVivo computer software program. Data stored on the encrypted Microsoft's OneDrive and the University of Edinburgh's own DataSync were provided by the UoE. The audio-recordings and transcriptions were kept separately from

the consent forms, which were all held securely within the principal investigator's (Dr. Christian Schütz) locked office filing cabinet and will be destroyed five years after the degree is successfully completed and approved by the dissertation committee.

4.2.5 The research process

4.2.5.1 Recruitment

The present study aimed to recruit 20-30 participants, with approximately equal representation of men and women. Similar sample sizes have been obtained in other studies utilising grounded theory on CSA survivors, including 16 participants from Sorsoli, Kia-Keating, and Grossman (2008), 10 participants from Stensvehagen, Bronken, Lien, and Larsson (2019), and 27 participants from Anderson and Hiersteiner (2007).

The study recruited men and women aged 18 or above who had experienced CSA prior to the age of 16. Recruitment efforts were conducted through flyers, counselling/group therapy services, and relevant websites. Recruitment flyers were posted in waiting rooms, notice boards, and authorised websites of various counselling and mental health services. Some therapists or group therapy facilitators directly informed eligible CSA survivors about the study. In addition, flyers were posted on several websites that potentially reached CSA survivors.

Sampling differences were a crucial consideration in this study, as the representativeness of the sample affects the generalizability of the results. Theoretical sampling, a central component of grounded theory methodology, involves the continued recruitment and data collection to refine categories and their properties as the analysis progresses (Charmaz, 2014; Conlon, Timonen, Elliott-O'Dare, O'Keeffe, & Foley, 2020). Accordingly, the sampling strategy was re-evaluated during the later phases of theoretical sampling and analysis. The researcher discontinued recruitment from websites that were only vaguely relevant to CSA survivors, and aimed to recruit more participants from counselling services. This decision was made to ensure that the sample comprised individuals who had accessed mental health support services, as this group may have distinct experiences and coping mechanisms compared to those who have not sought professional help (Dworkin, Hessel, Gliske, & Rudi, 2016). In addition, the researcher wished to ensure that participants had necessary support following the interview, as a number of

participants from websites mentioned not being able to discuss the CSA and its impact with others.

Upon receiving expressive interest from potential participants, the researcher provided them with the participant information sheet, answered any questions they had, and emphasised the voluntary nature of participation. Participants were informed that they could withdraw from the study at any point during the interview or prior to the integration of analyses without it affecting their care or treatment. Those who met the study criteria and consented to participate were scheduled for a 1-2 hour semi-structured interview at the University of British Columbia (UBC). During and after the COVID-19 pandemic, interviews were conducted via Skype or Zoom, and participants were sent consent form links via email.

4.2.5.2 Interview procedure

The interview procedure for this study involved a one-to-two-hour meeting between the researcher and each participant. Given that this study was conducted in collaboration with the University of Edinburgh and the University of British Columbia (UBC), participants were reassured about the confidentiality, anonymity, data management, potential risks, and risk minimization strategies associated with their participation. At the beginning of each session, the researcher introduced herself to the participant, unless they had previously met, and reviewed the study's topic, purpose, procedure, and consent/withdrawal options. The researcher then inquired if the participant had any questions about the study, assessed their understanding and informed consent through follow-up questions, where necessary (Legerski & Bunnell, 2010). This conversation also served as an entry point into the interview.

Once the interview began, the audio-recorders were activated, and the researcher guided the participant through a semi-structured interview. At the conclusion of each interview, participants were provided with the opportunity to ask additional questions or provide any insights they felt they had not previously shared. The audio-recorders were then turned off, and the researcher conducted a debriefing session with the participant to ascertain their feedback on the interview experience. Additionally, participants were asked if they desired a copy of the interview transcript and/or any published works resulting from the interviews. Finally, the researcher

expressed appreciation to the participant, and the interview concluded. Participants desiring a transcription of their interview were contacted solely for this purpose at a later date.

4.2.5.3 Interview questions and structure

Interview quality is paramount to the effectiveness of data collection (Charmaz, 2014). As such, the data collection process adhered closely to the guidance on interviewing provided by Charmaz (2014) and Johnson and Rowlands (2012). To ensure focus on essential aspects of inquiry while enabling free and open participant responses, semi-structured interviews were conducted and became increasingly probing. Semi-structured interviews provide an advantage over structured and unstructured interviews, as they allow for essential aspects of inquiry to be maintained while permitting free, open responses from the participant, thereby enabling the interviewer to delve deeper into relevant points (Kallio, Pietilä, Johnson, & Kangasniemi, 2016). This approach provided a general focus in the interview, enabling the exploration of themes and patterns throughout the interview process. Given the study topic, this approach of combining flexibility, following up on relevant points, and remaining loyal to the research topic can yield a rich and robust narrative and eventual theory of adults' experiences around trauma (Johnson & Rowlands, 2012; Charmaz, 2014).

The initial question used in the interviews, '*Could you tell me about your first disclosure experience?*', was selected to elicit descriptive and broad narratives from participants, while also curtailing potential researcher biases and assumptions (Leavy, 2022). In the middle section of each interview, more focussed questions were used to explore participants' incentives for disclosure, coping strategies, healing or recovery behaviour, and psychosexual development or sexual experiences related to their CSA and disclosure experiences. These questions were intended to be open-ended and probed for detail, utilising intensive interviewing skills that are commonly employed in CGT research (Charmaz, 2014).

Intensive interviewing techniques are a crucial component of qualitative research and are appropriate for this study, as they allow for an exploration of the process and context of participants' narratives, rather than being constrained by a pre-set list of questions. This type of interviewing involves asking questions, such as "*How did you feel about that?*" or "*What led to this happening?*" in order to encourage participants to provide rich and detailed responses

(Charmaz, 2006). Furthermore, intensive interviewing skills are useful for identifying what is not mentioned, inquiring into participants' thoughts and meaning-making, and allowing participants to explain, expand on, and clarify their responses. This approach is congruent with an ethos of co-construction between the participant and researcher throughout the study (Charmaz, 2006). Through creating an interactional space where participants could relate their experiences, the researcher could collaborate with the participant to construct a narrative that reflects their unique experiences and perspectives (Charmaz, 2014).

In the final phase of the interview, participants were asked to explain their motivation for participating in the study, as exploring participant motives can enrich data interpretation (Dwyer & Buckle, 2009). Closing questions were then posed, such as, '*Do you have any insight that could help survivors of CSA?*' and, '*Is there anything else you'd like to share that you think I might have missed?*', in order to elicit any additional information that may have been overlooked. These closing questions were based on previous research that emphasises the importance of providing participants with the opportunity to contribute to the research process and to ensure that their perspectives are taken into account (Charmaz, 2014; Fusch & Ness, 2015).

During the interview, in cases where the participant narrative tended towards details of the actual abuse or loosely relevant personal or familial daily struggles, the researcher employed techniques to redirect the conversation back to the study topic and research aims. Charmaz (2014) outlines the importance of maintaining focus and ensuring that interview data aligns with research aims. Follow-up questions were also utilised to encourage participants to provide more detail on their answers and to help the researcher clarify any areas of confusion or uncertainty. This technique is consistent with previous research that suggests that such questions are crucial for obtaining rich and detailed data (Charmaz, 2006).

4.2.5.4 Interviewing in rounds

Consistent with Charmaz (2014), interviews were conducted in rounds, with each subsequent round aimed at testing and refining data collected in previous rounds through more pointed questions. The use of multiple rounds of interviews could ultimately lead to a deeper understanding of the participants' experiences. The first round of interviews began with broad, open-ended questions, allowing participants to share their experiences relevant to the research

aims. As the interviews progressed, patterns emerged in participants' narratives. For instance, some participants expressed reluctance to disclose the abuse to caregivers who did not seem receptive or open to sensitive topics. Other participants discussed their attempts to understand the perpetrator, their background, and their possible motivation to abuse. Some male participants felt a need to almost defend their sexual orientation. In subsequent rounds, the researcher probed participants further into these topics only when they were already broached by the participant. This approach helped to refine and deepen the data collected, as well as identify common themes that emerged across participants' experiences.

In the second round of interviews, the researcher employed increasingly focussed and pointed questions to explore central topics that emerged from the prior round of data collection. This process of iterative data collection and analysis is consistent with grounded theory methodology (Charmaz, 2014; Glaser & Strauss, 1967). Through initial and focussed coding, the researcher identified recurring themes, and used pointed questions when participants discussed central topics that had emerged from prior interviews. For instance, recurrent references to self-blame around the abuse were followed by justifications around being able to cope with the abuse without disclosing it. Additionally, narratives in which the abuse did not negatively impact psychosexual development or sexual interactions and experiences often described trusting long-term relationships. Unlike in the first round of interviews, in which these patterns were not always readily apparent, the second round involved a deliberate search by the researcher, who either took note of the patterns mentioned spontaneously by the participant or posed probing questions linked to the participant's personal account.

In the final round of interviews, a more structured and targeted approach was adopted to address specific areas of inquiry and address any gaps identified through focussed and theoretical coding (Charmaz, 2014). This more restrictive approach to the interview allowed for the assessment and refinement of key concepts and categories developed throughout the analysis and was influenced by the principles of theoretical sampling. In contrast to Glaser and Strauss' (1967) recommendation of beginning with theoretical sampling at the outset of the study, the researcher followed Charmaz's (2014) suggestion to apply this method in later stages, as it allows for controlled data collection and analysis guided by the emerging theory, while avoiding premature closure (Charmaz, 2009, 2014). The dual sampling strategy enabled the researcher to refine the

emerging theory through subsequent data collection, as well as to assess gaps in the data that could benefit from additional sampling.

4.2.5.5 Data analysis

Analysis was conducted as an iterative and flexible process that involves the researcher moving to the theoretic text relatively immediately after obtaining the experiential text (Jones, Torres & Arminio, 2014; Strauss & Corbin, 1990). To ensure accuracy, audio-recordings were transcribed immediately or within a short timeframe. According to Charmaz's (2014) procedure for CGT, the analysis comprised transcribing interviews, initial line-by-line coding, focussed coding, theoretical sampling, theoretical sensitivity, and theory development. In an effort to better interpret the data in grounded theory, a familiarity with the data is required (Charmaz, 2014; Deterding & Waters, 2018). The process of open reading across all interview transcripts and analytic memos was undertaken to obtain this familiarity with the data.

Coding and categorising were conducted in parallel with data collection, and each transcript was compared with previous interviews to identify emerging and recurring themes. Memo-writing and coding were used iteratively in the process of constant comparison, involving questions in later interviews informed by categories discovered in prior interviews, which facilitated the development of concepts and theories (Charmaz, 2014; Corbin & Strauss, 2008; Creswell, 2013). Constant comparison is a fundamental aspect of grounded theory methodology that involves an iterative process of "comparing data with data, data with code, code with code, code with category, category with category, and category with concept" (Charmaz, 2014, p. 342). The application of the constant comparison method facilitates the refinement of categories and subcategories by deconstructing them into smaller components, which aids the researcher in identifying properties that underlie the data (Willig, 2013). This inductive process allows for the identification of similarities and differences within and between emerging categories and theoretical concepts (Charmaz, 2014; Willig, 2013). As one engages in constant comparison, observations and reflections are documented in memos to make explicit the thought process behind the analysis. The comparison process is dynamic and changes based on the stage of analysis, with comparisons conducted differently at each stage. These comparisons have been noted in each stage of the analysis.

The analysis was complemented by the inclusion of other types of data, such as field observations and academic literature. In order to establish the rigour and credibility of the study (Charmaz, 2014), relevant academic literature, moreover, was consulted and compared to the resulting theoretical categories. The use of these approaches facilitated a more nuanced understanding of the data and contributed to the refinement of the emerging concepts in support of a robust theoretical framework (Charmaz, 2014; Glaser, 1992; Willig, 2013).

The data was managed using the qualitative data analysis software, QSR Nvivo (version 12), which involved creating, organising, and commenting on codes and categories, sorting through them, and noting any observations throughout the process (Edhlund & McDougall, 2018). Further details on the theoretical and practical aspects of each step of the analysis are presented in subsequent sections.

4.2.6 The analytic journey

4.2.6.1 Memo-writing

Through a constructivist grounded theory lens, reality is assumed to be constructed by both the researcher and participant, which heightens the requirement to account for the researcher's position, privileges, perspective, and interactions as an inherent component of the research (Charmaz, 2014). Memo-writing was, therefore, an integral portion throughout data collection. This mechanism allowed the researcher to engage in ongoing analysis and constant comparative methods with the data. This included memoing thoughts, feelings, and observations around the data, as well as preconceived ideas, personal influences and other analysis processes that may have influenced the research.

Three forms of analytic memos were generated in this study. Firstly, in order to encapsulate the initial thoughts and feelings of the researcher following each interview, an analytic memo was written. This allowed for preliminary observations and connections to data throughout the study. The collection of data through interviews presents several limitations, including the potential neglect of the contextual environment in which the interview takes place, as well as the behaviour of the participants beyond the interview setting (McGrath, 2021). Interview data is

limited to what participants choose to disclose verbally or through their actions, thoughts, and memories (Bryman, 2016; Emerson, Fretz, & Shaw, 2011). To address these limitations, reflective notes and observations, in the form of memo-writing, have been incorporated into the data collection process. These memos provide additional contextual information, and a more in-depth understanding of the research context and participants' experiences, allowing for the collection of data beyond what is typically obtained through interviews (Bryman, 2016; Emerson et al., 2011).

In the following figure, the researcher notices how she takes on a role other than that of the interviewer. The participant continues to ask her insight about his situation, and for trends in CSA victims that might help him understand himself. The researcher continues to remind the participant that she's a researcher, and not a therapist (he has a therapist):

Following Interview with P9 — 11.1.2021

Researcher-participant dynamic:

I don't know if it's that he's looking for answers and also seems to not disclose to many people, but I notice that I'm almost taking on the role of a therapist of sorts, which isn't good, as I'm not trained in that, and that's not my role. I find it hard to let some people anxiously looking for answers just sit with that...it's just hard to watch people struggling, I guess.

The second form of memo-writing was during formal analysis, such as transcribing, open reading, and coding data. A memo was written concurrently with transcribing each interview to record researcher observations of the data, and ideas about potential categories emerging from the data. In addition, memos were written to provide an explanation for the codes identified during the process of open coding. Memo-writing during formal analysis assists in capturing the researcher's thoughts and reactions to topics of interest in the data (Clark, 2005).

The memos during the transcription and line-by-line coding not only allowed the researcher to learn from and refine her interviewing skills, but also remember to focus on topics broached that

were related to the research aims. The following provides an example of when the researcher may have benefitted from inquiring into P1's disclosure experience to her brother:

Transcribing Interview with P1 — 4.3.2020

Refining research skills:

I asked her about her sister's reporting the abuse to police and if she was prepared. When she answers, she briefly mentions the following: "...but I don't know if I was actually ready to disclose, like even though I had conversations with my brother and said, like, this is going on...", and continues to answer the question. I should have asked more about her disclosure to her adopted brother (maybe later too)!

She spoke about how people might not think she was sexually abused as a child because she "presents well". What does this mean? --missed opportunity

The final type of memo-writing comprised topics related to the research project, with the researcher reflecting on data as they occurred, including conversations with supervisors to explore and question perceptions of the data (Charmaz, 2014). Such memos allowed the researcher to reflect on their engagement with participants, the research area, and the data. An example of such a memo following a supervision meeting with Dr. Emily Newman is shown below:

Post-Interview with P6221 — 21.4.2021

Reflecting on supervisor meeting, literature, and participants' thoughts:

Emily had asked me many questions when I had told her last week that I've noticed that a few of the male participants have mentioned something around CSA being emasculating. I'm not sure I'd ever actually thought of why—was it from a homophobic upbringing? I thought to ask this participant (female) about possible gender differences in victims. Unprovoked, she said something along the lines (will transcribe later) of feeling sorry for male victims because

traditional masculinity doesn't allow for men taking on a 'passive' role, and that many men (she has male friends who have been CSA victims) believe they are put in that position when undergoing this abuse. That might make it emasculating for them. I now remember reading this somewhere in the literature a year + ago, so I need to look for this again.

Memo-writing serves as a crucial link between data collection and the development of results (Charmaz, 2014). The researcher used memo-writing to record her thoughts, questions, coding rationality, and methodological decisions in chronological order, facilitating tracking of the researcher's evolving understanding of the data. The iterative process of continually reviewing and refining themes and categories throughout the three-year study period enabled the tracking of changes and the identification of paths from initial ideas, thus aiding the analytical process.

Upon completion of all interviews, the codes and categories were further developed into a larger theory, leveraging the researcher memos and considering potential relationships between the codes. An informal register was used with memos, as advised by Charmaz (2014). Throughout the explanation of all steps in the data analysis, memos were integrated and reported.

4.2.6.2 Transcription of interviews

The initial step in the analysis involved transcribing the interviews, which were self-transcribed verbatim. Self-transcription is a valuable method that allows the researcher to be immersed in the data (McMullin, 2021). The process of listening to and transcribing the interviews was valuable to the researcher in that it allowed her to focus on the meaning of what each participant said, as well as their accompanying emotional reactions. As a result, the researcher was more connected to the data and better equipped to interpret the meaning of the interviewees' responses.

Some of the tone, gestures, and feelings of the interview are undoubtedly lost in the transcriptions (Markle et al., 2011). Nevertheless, in order to remain as accurate as possible, particular measures were taken. Interviews were attempted to be transcribed within the same week of meeting the participants. This way, tone and register, as well as any other subtle cues within the interview could be remembered and recorded. The transcription of audio-recordings is a pivotal step in the analysis process. Through transcription, the researcher can generate a verbatim account of participants' expressions, visualise both verbal and non-verbal cues, and organise interactions (Evers, 2011). Notably, thoughtful transcription can significantly enhance

the quality of the analysis, as well as the credibility and reliability of the resultant findings (Johnson, Adkins, & Chauvin, 2020). Nonetheless, it is essential to acknowledge that transcription is a complex and challenging task that demands the researcher to make informed choices about which information to transcribe and how to transcribe it (Johnson et al., 2020).

Deterding and Waters (2018) recommend timestamps if transcriptions are outsourced, but since the researcher transcribed all the interviews, timestamps were not necessary. The “find” function accomplished the goal of tracking words or phrases in the transcriptions. In addition, certain punctuation rules and paragraph structures were not followed, as the researcher decided to use punctuation and paragraphing to emphasise the tone, pace, and break in thought of the participants. Some noted gestures included when the participant laughed (*‘laughs’*); paused for a short period of time (...) or an ample amount of time (*‘long pause’*), generally due to being asked a sensitive question; and cried (*‘cries’*). In cases where identifiable information was shared by the participant, the researcher indicated this via such examples as *‘brother’s name’*, *‘name of hometown’*, *‘name of wife’*, etc. When the audio-recorder was muffled or the connection was lost for a short period of time, the researcher indicated this (e.g., *‘inaudible due to connection’*).

Memos before and after interviews, as well as when transcribing, can aid in the interpretation and data representation process (McGrath, 2021). This technique was used when attempting to capture and document the participants' reactions to questions, their tone of voice, and any possible fidgeting or change in physical movement. Memos were, moreover, recorded to practise reflexivity, to minimise the potential impact of researcher preconceptions and biases on her interpretation during the transcription process.

Transcriptions were in documents that were uploaded onto NVivo 12. This program assisted in organising and storing the transcribed texts, as well as in retrieving data throughout analysis. Although transcription can be a time-intensive process, it plays a critical role in facilitating the creation of preliminary line-by-line codes, enhancing researcher engagement with the data, and elevating the quality, rigour, and credibility of the investigation.

4.2.6.3 Coding

The process of building theory through grounded theory involves several practices and strategies. Bryant and Charmaz (2007) identified coding as one such strategy, where the aim is to define

what the data represents. Through the process of coding collected data, the researcher is able to develop a deeper familiarity with the data, form categories of codes, and subsequently meaningfully and chronologically describe and develop a theory (Charmaz, 2006). The nature of coding in grounded theory may vary depending on the specific methodology employed. Glaser and Strauss (1967) initially introduced coding as an analytical approach for constant comparative analyses in their work on *The Discovery of Grounded Theory*. Glaser and Strauss's coding process involves two stages: substantive coding and theoretical coding, which involve conceptualising the empirical substance and the relationships between substantive codes respectively (Glaser, 1978). They did not, however, provide procedural explanations on how to conduct coding in grounded theory (Glaser & Strauss, 1967).

Different variations of grounded theory have developed over the years, leading to various approaches to coding in grounded theory literature. Charmaz (2006, 2014) suggests two phases of coding: initial and focussed. Initial coding involves identifying and conceptualising the properties and dimensions of the data, while focussed coding involves refining and categorising codes to develop themes and patterns (Charmaz, 2006, 2014). Importantly, the construction of codes in constructivist grounded theory is contingent upon the researcher's interpretation of participants' actions and meanings that emerge from the data. According to Charmaz (2014), the codes' names selected by the researcher function as a description of their understanding and interpretation of the data.

Coding in grounded theory is not linear, but rather requires movement back and forth between the coding phases as categories and concepts begin to emerge (Charmaz, 2014; Strauss & Corbin, 1990). To engage with the data, Charmaz (2014) suggests that grounded theorists remain open, focus on actions, and perform coding quickly. *In vivo* codes, which are codes in the participants' own words, help preserve participants' meanings, while coding in gerunds facilitates thinking in actions and processes (Charmaz, 2014; Glaser & Strauss, 1967).

In the present study, the researcher adopted Charmaz's (2000, 2014) approaches to coding, as they were aligned with the constructivist position of the study. During the process of coding, the researcher integrated her own interpretation and employed it to decide which data should be further collected and analysed (Rädiker, 2020). The subsequent subsections outline the detailed procedure of initial and focussed coding employed.

4.2.6.3.1 Initial coding

During initial coding, the researcher closely analyses fragments of data such as words, lines, segments, and incidents to define actions and interpret and assign meanings to emerging themes (Charmaz, 2014). The researcher followed Charmaz's advice to code with gerunds to notice actual emerging information in the data rather than superimpose theories onto the data. Atkinson, Coffey, and Delamont (2003) recommend that researchers consider coding as a tool to interact with and think about the data flexibly. In an effort to capture the meanings of particular phenomena, *in vivo* codes of participants' exact wording were sometimes preserved.

For the initial sixteen transcribed interviews, a line-by-line analysis was developed. By implementing this approach, the researcher was able to ensure that the emerging codes remained grounded in the data, in line with Charmaz's (2014) emphasis on the importance of staying close to the data. This resulted in thousands of line-by-line codes, which, in some instances, seemed arbitrary. Line-by-line coding may result in an excessive amount of data being included, leading to the possibility of misidentifying important data segments (Chenail, 2012). Thus, line-by-line analysis was not always followed, particularly when the meaning was diminished or unclear through this fracturing of the data. In such cases, coding of complete thoughts or ideas of the participants was followed in order to better interpret the participants' ideas. During the initial coding stage, the researcher assigned a definition to each code, which was provisional and subject to refinement as the analysis progressed. Table 4.1 provides an example of line-by-line coding when one participant (P2, *male, 32-years-old*) responded to why he is more comfortable speaking to women.

Table 4.1: An example of line-by-line coding from interview with P2

Transcript	Line-by-line coding
<i>Because I was scared of talking to a male about it. A male had abused me. I didn't have enough male affirmations. There was, it was different with women because with the #Metoo</i>	Fearing talking to men about abuse Not having enough support from men Society acknowledging sexual assault on women Lack of societal awareness for male sexual assault victims leading

<i>movement and stuff like that, women empowerment has become such a big thing. I just felt overall there was more of an understanding maybe their patience.</i>	<p>him to be less willing to disclose (particularly to men)</p> <p>Women empowerment helping both genders</p> <p>Finding women more understanding and patient</p>
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The researcher often returned to previously coded transcripts to check and refine codes, resulting in changes to the definitions of some codes and re-coding of some segments of the transcript. Additionally, certain initial codes underwent a process of renaming, while codes that possessed similar meanings were merged. Memo-writing during the initial coding process aided in keeping track of thoughts and recording changes in code definitions (Atkinson, Coffey, & Delamont, 2003). In addition, both memo-writing and constant comparative methods were employed during this stage to develop ideas and processes, consider new ways of analysing observed data, and explore the meaning participants attributed to thoughts and actions. Questions such as, “What are the thought processes of my participants in this event?” and “What occurring here?” were considered in an effort to better understand the data and create relevant codes, as advised by Charmaz (2014). These questions, moreover, led to further questions and fostered the development of ideas, moving the researcher towards creating focussed codes.

4.2.6.3.2 Focussed coding

Focussed coding is a critical step in CGT that involves analysing data to identify the core concepts and themes that are essential to understanding the phenomenon under study (Charmaz, 2014). Through this process, initial line-by-line codes are grouped conceptually, and similar or duplicate codes are collapsed into concise codes that reflect the essence of the data and research aims, while consulting the original data to avoid losing important details. (Creswell, 2013). This stage facilitates the researcher's transition from the descriptive level of the initial coding to a progressively more analytical level. Focussed coding incorporates the findings into the analytic story, which forms the basis of theory. This theory provides a coherent and nuanced understanding of the phenomenon under study and is grounded in the data (Creswell, 2013).

Focussed coding in this study began after initial coding of transcripts one to sixteen. In this process, some initial codes were renamed to potentially less ambiguous or clearer codes. Charmaz (2014) recommends continuing coding rapidly and maintaining simplicity, while identifying codes that reveal significant information and generate insight. During the focussed coding phase, initial codes are examined, evaluated, and organised analytically. According to Charmaz (2000, 2014), codes that appear to hold greater analytical weight and significance are elevated into preliminary categories. Here, such early focussed codes, which were identified and organised into categories, were employed and used to assign initial codes. This is generally a straightforward process (Charmaz, 2014). These categories are referred to as early focussed codes.

Table 4.2 illustrates text where initial codes drawn by the four male participants who stated that they were either not gay or sexually interested in men are allocated to the category “questioning heterosexual orientation”.

Table 4.2: An example of transforming initial codes into focussed codes

Participant	Text	Initial codes	Focussed codes
P2 (male)	<p>“Going through that experience with someone of the opposite sex that young made me realise that I am attracted to the opposite sex.”</p> <p>“I was attracted to women... and attracted to men, but more attracted to women, um, but not trusting my intuition about my own sexuality...”</p> <p>“It's repulsive. But it, but I'm curious about it. But I would never go there.”</p> <p>“I didn't feel gay, I don't, I don't feel gay. I felt as though that was like put on</p>	Realising he's attracted to the opposite sex when getting sexual at 12	Questioning heterosexual orientation
P8 (male)		Not trusting own intuition about sexuality and getting into uncomfortable situations with men	
P9 (male)		Discussing confusion over sexual interest and repulsiveness towards men who dress like women [<i>e.g., 1980's rock stars</i>]	
P10 (male)		Feeling victim-shaming at school and perpetrator being male leading him to falsely think he's gay	

	<p>me based upon the person who was abusing me, it was a man and so they were putting their own gay, weird, like, it's just sick and as twisted in a psychological..."</p>		
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Where it was important to preserve the original data supporting each focussed code, initial codes were maintained as sub-categories under the focussed codes, as advised by Holton (2017).

There were instances in which initial codes were allocated to multiple categories due to their multifaceted nature. Additionally, a category called "likely not useful" was established to gather seemingly irrelevant codes without discarding them, allowing for their review later in the analysis.

Nevertheless, focussed coding oftentimes necessitated contemplation and reflection, where determining the appropriate category for allocation was not always straightforward. The researcher continued to engage in memo-writing to document the decision-making process and to ensure that the most meaningful line-by-line codes were concentrated on and tested against extensive data.

Additionally, the use of focussed coding in CGT underlines the importance of reflexive thinking, which allows for the exploration of the researcher's own perspectives and biases and the influence she may have on the theory-developing process (Belgrave & Seide, 2019).

During the focussed coding phase, constant comparison and reflection of distinct incidents and the identification of similarities and differences within initial codes was performed. This prompted the creation of new focussed codes, the relabeling of existing codes, and the development of subcategories within focussed codes. Initial codes exhibiting similarities were grouped together and labelled accordingly, which was aided by the use of "child node" and "parent node" features in Nvivo. The researcher, moreover, moved subcategories out of focussed codes to create new focussed codes, and transformed focussed codes into subcategories when appropriate. Initial codes were re-assigned to these subcategories and categories to ensure their fit with the evolving analytical structure, and that they were grounded in the data.

The progression from initial coding to focussed coding is not always sequential (Charmaz, 2014). Gaps in the data may be encountered during the development of emergent theoretical categories, necessitating further data collection and modification of earlier codes or categories. As such, the focussed coding stage guides the research, enabling data collection to continue until the categories derived from focussed coding become saturated and result in the emergence of relevant theory pertaining to the research aims (Charmaz, 2000, 2014).

The selective codes, which were transformed from the concrete to the abstract, develop into the theory. Key categories are refined and developed in this coding phase through iterative readings of memos, which lead to a core category or theme (Corbin & Strauss, 2008). The researcher focussed on themes related to disclosure experiences and reasoning, as well as healing processes, management of the CSA experience and sexuality, and possible gender differences.

4.2.6.3.3 Theoretical saturation and sufficiency

The use of theoretical sampling is a crucial aspect of the analysis process in qualitative research. Theoretical sampling refers to the process of gathering additional data for the purpose of expanding and refining existing categories and their properties (Charmaz, 2014; Willig, 2013). Theoretical concepts from the data must be developed and research gaps identified prior to theoretical sampling. This ensures that the sampling process is meaningful and informed by theoretical insights derived from the data. Saturation, which refers to the point when new data is no longer revealing new insights, is a critical component of theoretical sampling (Glaser and Strauss, 1967; Corbin and Strauss, 2008; Charmaz, 2014). This concept has been widely applied in qualitative research (Denzin and Lincoln, 1994; Bryant and Charmaz, 2007; Hennink, Kaiser and Marconi, 2017) and is considered a fundamental aspect of the analysis process (Corbin and Strauss, 2008; Charmaz, 2014).

Nevertheless, the concept of saturation can be difficult to apply in practice (Hennink, Kaiser and Marconi, 2017; Nelson, 2017). Reaching saturation is an ideal rather than an feasible objective. Some argue that its reporting throughout the research process can be inconsistent and vague (McCrae and Purssell, 2016; Nelson, 2017), potentially undermining its essential role in the analysis process. Ryan and Bernard (2003) and Willig (2013) suggest that collecting additional data may lead to further insights, modifications to codes and categories, or a shift in theoretical

perspectives. Consequently, Ryan and Bernard (2003) propose that sampling terminate when researchers are content with ignoring infrequent cases, and when a particular number of consecutive interviewees do not provide novel information. Theoretical sampling and saturation are iterative and flexible processes that aim to provide sufficient data and insights to theorise and explain the data through theory developed (Charmaz, 2009, 2014). The concept of theoretical sufficiency provides a more practical means of determining when to cease data gathering, as it ensures that data provide adequate sufficiency for conceptual density of the core category (Dey, 1999; Nelson, 2017). Theoretical sufficiency, which means no new modifications are necessary and that the understanding is deep enough to theorise, is an alternative approach to determining when to stop data collection (Nelson, 2017).

Ultimately, the use of theoretical sampling and saturation processes should aim to create coherent understandings of the properties, dimensions, and relationships between categories to construct robust and comprehensive categories (Glaser and Strauss, 1967; Corbin and Strauss, 2008; Charmaz, 2009, 2014). Reporting on the application of these processes in research should be clear, consistent, and well-defined, using practical examples to ensure that the analysis process is not undermined (McCrae and Purssell, 2016; Nelson, 2017).

After tentative categories were developed, theoretical sampling ensued. Subsequent data collection was then directed towards the emerging conceptual categories identified during the analysis of the previously collected data, with the aim of further developing these categories. Theoretical sampling was employed iteratively throughout the research process until a core category was established. This iterative process was evident in the evolution of the interview guides, which were updated in response to the developing middle-range theory derived from the data analysis.

The present study employed theoretical sampling as a means of advancing the development of a middle-range theory, guided by the principle of abduction. Abduction is a key component of CGT as it emphasises the development of theory from data rather than the application of pre-existing theoretical frameworks; it involves making inferences based on patterns observed, and then testing these inferences through further analysis (Charmaz, 2014; Reichertz, 2019). Abductive reasoning was initiated once the coding and categorisation of data had reached a satisfactory level. It should be noted that this was a recursive process, wherein the potential

theoretical explanations were frequently checked against the empirical data. Additionally, engagement with relevant theoretical literature was initiated in tandem with the abductive reasoning.

4.2.6.4 Theory development

In the construction of theory, initially, memos written throughout the analysis were reviewed and organised. The central category was then identified and explained through these memos (Corbin & Strauss, 2008).

The resulting categories were integrated into a cohesive explanation of one theory that explained the impact of disclosure experiences on survivors of CSA. Diagrams that were made, memos, and the process of focussed coding was used to organise the developed categories.

4.3 Results and discussion: Study III

4.3.1 Participant information

Nineteen participants were interviewed. One participant was excluded because his experience did not fit the study criteria, resulting in a total of 18 participants. Nine participants were women, and nine were men. To maintain anonymity within this study, participants are numerically labelled according to the order in which they were interviewed with 'P' for 'participant', followed by 'F' if the participant was a woman or 'M' if the participant was a man.

Most participants were not explicitly asked about their sexual orientation, but either provided it of their own volition, or were asked which gender they were sexually interested in to allow for a less restrictive answer. Only one participant (PM4) identified as exclusively homosexual, while one participant (PM14) described himself as being predominantly interested in men (and having only same-sex sexual experiences), but having some interest in women. One participant (PM3) identified as being sexually/romantically interested in all genders, two participants (PF11 & PF12) stated that they were sexually interested in both men and women (including transwomen), and the remaining 11 participants stated that they were either exclusively or primarily sexually interested in the opposite sex. Participant ages ranged from 29 to 69 years of age. All but two perpetrators were male (of PF13 & PM14), although PM2 stated that he *might have* had a female

perpetrator. The perpetrator relationship varied from family members to strangers. Most participants had one perpetrator, although seven (possibly eight) had more than one perpetrator. All participants were under the age of 17 at the time of their abusive experience(s). Table 4.3 outlines the demographics.

Table 4.3: Demographics of participants

<i>Code</i>	<i>Gender</i>	<i>Age</i>	<i>Age(s) at the time of abuse</i>	<i>Age at first disclosure (to whom)</i>	<i>Number of perpetrators</i>	<i>Perpetrator gender</i>	<i>Relationship to perpetrator(s)</i>	<i>Gender of sexually desired</i>
PF1	F	41	3-9	Young child (police)	1	M	Adopted father	M
PM2	M	32	7-14 (possibly as a toddler too)	7 (mother)	1 (possibly 2)	M (possibly F too)	Cousin(s)	F
PM3	M	29	11/12	Young adult (close male friends)	1	M	Father's friend	All
PM4	M	37	14	Adult (husband, counsellor)	1	M	Husband of family member	M
PF5	F	40	4-6	Adolescent (mother)	1	M	Uncle/stepfather-like figure	M
PF6	F	69	4-6; 14; 16	Young adolescent (father)	4	M	Babysitter's husband; father's friend; older teenager	M
PF7	F	44	11-15	Young adolescent (father)	Multiple	M	Passersby in city	M
PM8	M	31	12	18 (close male friend)	1	M	School bully	Primarily F
PM9	M	65	3-5	Adult (male friend; possibly wife)	1	M	Uncle (adult)	F
PM1	M	40	4-14	Adult	Multiple	M	Stepfather, friends of	P self defines as

0				(female service worker)			parents, etc.	not gay
PF11	F	32	6-14	Young adolescent (mother)	2+	M	Stepfather; one or more of stepfather's brothers	M, F (including transwomen)
PF12	F	30	10, 12-18	15 (mother)	Multiple	M	Stranger, stepfather, adult son of stepfather	Primarily M, but also F
PF13	F	38	5-9	13 (close female friends)	1	F	Neighbour	M
PM1 4	M	48	14-17	Adult (male psychiatrist)	3	M&F	Mother, stepfather, doctor (GP/ family physician)	Primarily M, but also F
PM1 5	M	48	16	Adult (wife)	1	M	Stranger	F
PF16	F	61	8	8 (mother)	1	M	Babysitter	Primarily M
PM1 7	M	48	6 or 7	29 (wife)	1	M	Older brother	F
PF18	F	37	1-14	12 (mother)	2	M	Father; maternal grandfather	M

Although the interviews did not explicitly inquire into other ACE's, their prevalence was notable in this study, with most participants reporting experiences of additional forms of childhood abuse alongside intrafamilial CSA, including five cases where the perpetrator was a parent. Table 4.4 illustrates participants' experiences of intrafamilial CSA, whether the perpetrator was a caregiver, ACE's within the home, and ACE's occurring outside the home (e.g., bullying). In the current sample, all but three participants reported experiencing additional ACE's within their households. The types and severity of these ACE's appeared to contribute to increased exposure to CSA, more complex disclosure experiences, and a significant impact on psychosexual development and other adverse outcomes.

Table 4.4: Presence of intrafamilial childhood sexual abuse and other adverse childhood experiences

<i>Participant</i>	<i>Intrafamilial CSA</i>	<i>Caregiver Perpetrator</i>	<i>Other ACE's</i>	<i>ACE's at home</i>	<i>Type of ACE(s)</i>
PF1	Yes	Adopted father	Yes	Yes	HSUD, PI; grew up in the foster system
PM2	Yes	-	Yes	Yes	CPA, CPN, CEN, EIPV, PI, HSUD, PS
PM3	Yes	-	Yes	Yes	CEA, CEN
PM4	Yes	-	Yes	Yes	CEN, bullying
PF5	Yes	-	Yes	Yes	CEA, CEN
PF6	-	-	Yes	Yes	CEN
PF7	-	-	-	-	-
PM8	-	-	Yes	Yes	CEN, bullying
PM9	Yes	-	Yes	Yes	CEA, CPN, CEN
PM10	Yes	Stepfather	Yes	Yes	CPA, CEA, CPN, CEN, HSUD, PS
PF11	Yes	Stepfather	Yes	Yes	CEA, CPN, CEN
PF12	-	-	Yes	Yes	CEA, CPN, CEN
PF13	-	-	Yes	Yes	CPN, CEN
PM14	Yes	Mother, stepfather	Yes	Yes	CPA, CEA, CPN, CEA, EIPV, HSUD, PS
PM15	-	-	Yes	-	Bullying
PF16	-	-	-	-	-
PM17	Yes	-	Yes	Yes	CEA, CEN
PF18	Yes	Father	Yes	Yes	CEA, CEN

4.3.2 Findings and discussion

4.3.2.1 Developed Theory

The development of theoretical categories in this study followed Charmaz's (2014) constructivist grounded theory methodology, grounded in the iterative processes of initial and focussed coding,

and informed by extensive memos and field notes. This process facilitated the synthesis and integration of significant codes, culminating in a comprehensive framework to elucidate the complex experiences of CSA survivors. Theoretical codes were employed to consolidate and coordinate focussed codes, enabling a deeper understanding of the interconnections between survivors' experiences of CSA, disclosure, psychosexual development, and recovery.

From the analysis, three central categories were constructed: *Attachment and relational dynamics, societal constructs and identity negotiation, and disclosure and recovery trajectories*. These categories encapsulate the inextricable influences of familial attachment patterns, societal constructs, and individual recovery processes.

A recurring theme across the categories is the pivotal role of secure relational dynamics—whether through therapy, supportive peers, or intimate partners—in facilitating recovery. Participants' narratives illustrated how societal misconceptions about masculinity, femininity, and CSA shaped their self-perceptions and disclosure experiences. Furthermore, recovery trajectories were deeply influenced by early caregiving relationships and subsequent efforts to renegotiate these relational patterns in adulthood. This framework integrates participants' experiences of abuse, the societal and relational contexts in which they occurred, and the processes by which survivors sought healing and recovery.

4.3.2.1.1 Foundations of CSA: attachment dynamics and societal influences

The nature of the CSA experiences varied within the study, including duration, degree of physical intrusiveness (e.g., penetrative acts, coerced physical aggression), and the relational proximity of the perpetrator to the victim (e.g., parental figure versus non-familial individual). Nevertheless, nearly all participants reported experiencing various other forms of ACE's, predominantly within the home, and several participants reported this alongside intrafamilial CSA.

Participants elucidated familial dynamics that significantly increased their exposure to CSA. PF6, who recounted a situation involving her mother's employment constraints and lack of awareness regarding the abuse. PF6 described frequent attempts to escape from her babysitter's household, where the babysitter's spouse was the perpetrator of abuse. Her efforts were,

however, consistently dismissed, with her mother labeling her as a “*troublemaker*.” Unaware of the ongoing abuse, her mother insisted on maintaining the childcare arrangement, citing her full-time teaching position, as “*In those days, women didn’t work very often*”.

Similarly, PF13 described her father’s parenting style as creating an environment in which she believed it had been inevitable that she would be a target of CSA:

“My dad was extremely neglectful and left me home alone all the time even though I was very young, obviously ten is very young to be left home alone for weeks at a time” (PF12)

PF12 outlined the multiple instances of CSA she experienced throughout her childhood as a result of this, stating, “*Let’s not forget, childhood sexual trauma doesn’t happen unless there is a deficiency somewhere in that child’s care.*”

The reported ACE’s differed in type, duration, and severity. PM10 recounted growing up in a “*gross small town*” where “*intergenerational trauma*” had negatively impacted his mother’s parenting and contributed to the omnipresence of abuse. This environment had exposed PM10 to CSA from multiple perpetrators and other ACE’s throughout his childhood, but also contributed to the fact that he “*equated [the CSA and ACE’s] to love*”.

Several participants, when discussing the negative impacts of CSA, intertwine these effects with the ACE’s they experienced during childhood. PM3, for instance, reflected on the combined challenges of his father’s severe authoritarian and abusive behaviour alongside the CSA he endured, despite his father being unaware of the sexual abuse:

“My father was not really the person who will talk... is a person who had like a fucking whip ready to hit the most of the time, you know? So from like I never had a relationship with my parents. [...] It wasn’t only to me with the [CSA] that happened with my dad’s friend. It’s also dealing with my fucking father as well.” (PM3)

Some participants reported that ACE’s had a more significant negative impact on their development than the CSA. PF11, while acknowledging the negative effects of CSA, described her family’s emotionally abusive behaviour as more impactful than the sexual abuse perpetrated by her mother’s husband at the time:

“My family was a little abusive towards me. They were always calling me names and demeaning me. So the person who was abusing me, he was kind of nice to me in a way, like he was the only one who wouldn’t call me names. And so, I always felt like he had an issue and he was a sick person, but my family, who were supposed to protect me and care for me, just didn’t. So I feel like all my pain stems more from that than he actually doing that.” (PF11)

Participants who experienced intrafamilial CSA, especially by a parent, often faced prolonged, penetrative abuse spanning several years; such experiences coexisted with other familial and external (e.g., bullying) ACE’s. In these cases, participants tended to report other forms of trauma being at least as impactful as the CSA. PM14 described a home environment where CSA had been perpetrated by his mother, stepfather, and family physician. Additionally, his parents had been physically abusive, particularly towards his stepbrother. PM14 frequently recalled listening to his stepbrother’s screams during these violent episodes. Throughout the interview, he frequently referenced his parents’ physical and sexual violence toward his stepbrother, stating that he often *“couldn’t stand listening to the screams.”* He consistently referenced these instances in relation to his significant emotional internalisations and decisions, indicating that his focus extended beyond his personal experience of CSA to encompass the broader dynamics of familial abuse.

In cases where one primary caregiver is the CSA perpetrator, participants described their mothers as witnesses who did not stop the abuse. These participants tended to emphasise their mothers’ behaviour more heavily, not only regarding their knowledge of the CSA but also their general indifference. This maternal indifference appeared to be indicative of broader emotional neglect or abuse in these situations. PF18 described her emotionally neglectful relationship with her mother, who had been aware of the abuse, noting that this dynamic throughout her adolescence had left her feeling *“confused”* during this period:

“We used to get in such bad fights that she would say I’m not her daughter. Like she would disown me. That’s what she would say to me. And so it made me feel very betrayed, not protected at all, not in a safe environment at all, not in a healthy environment. It felt very up and down emotionally. [...] when she was mad at me, [...] she would just completely withhold all of her love for weeks.” (PF18)

The emotional and psychological orientation of a child may be disrupted not only by the CSA itself but also by the broader context in which it occurs. This context, particularly family dynamics, plays a significant role, as highlighted by this study's sample, where intrafamilial CSA and other ACE's were highly prevalent. Thus, attachment theory offers a comprehensive framework for understanding how CSA in conjunction with adverse familial environments disrupts a child's ability to form secure attachments. Attachment theory posits that the emotional bond an infant forms with a primary caregiver functions as a foundational template for the development of attachment styles or internal working models (Gillath, Giesbrecht & Shaver, 2009; Mikulincer & Shaver, 2019). This bond arises from an innate psychobiological system that motivates the infant to seek proximity to the caregiver for protection and distress relief (Crittenden, 2017). When the primary caregiver is consistently emotionally attuned and responsive during times of need and distress, the infant is likely to develop a secure attachment.

The establishment of secure attachment is facilitated through parent-infant reflective and mirroring interactions, where caregivers help infants shape their self-concept by reflecting their mental states, thus supporting healthy emotional development (Fonagy & Campbell, 2017). These effective emotional mirroring processes foster mentalization, which is the ability to interpret one's own and others' behaviours through the lens of mental states—such as emotions, desires, and intentions. Mentalizing theory posits that early interactions are foundational to a child's ability to understand their own and others' mental states (Ensink et al., 2016, 2021; Borelli et al., 2018; Fonagy & Allison, 2014) and are associated with resilience in the face of stress due to their role in regulating emotions and maintaining interpersonal functioning (Ensink et al., 2016, 2021; Borelli et al., 2018; Fonagy & Allison, 2014; Luyten, Campbell, Moser, & Fonagy, 2024).

Reflective mirroring techniques operate through mechanisms involving ostensive cues—such as eye contact, specialised vocal communication, and attentive responsiveness—which are linked to the social-cognitive process of epistemic trust. These cues indicate to the infant that the caregiver's information is relevant and reliable (Csibra & Gergely, 2009; Milesi et al., 2023). Epistemic trust is defined as the capacity to perceive social information as accurate, reliable, and pertinent, facilitating the integration of new knowledge into existing cognitive frameworks and promoting adaptive social behaviour (Fonagy & Allison, 2014; Fonagy et al., 2019; Li et al.,

2023; Luyten et al., 2024; Sperber et al., 2010). This trust is regulated by epistemic vigilance, a cognitive mechanism that allows individuals to assess the accuracy of information, thereby safeguarding against misinformation (Sperber et al., 2010). Sensitive caregiving and effective mirroring interactions enhance epistemic trust by offering the child a manageable representation of their emotional states, fostering a sense of self and enhancing learning (Fonagy & Campbell, 2017; Kampling et al., 2022).

Nevertheless, when a primary caregiver is perceived as abusive, neglectful, or emotionally unavailable, attachment trauma may arise (Isobel, Goodyear, & Foster, 2019; Tassie, 2015). Children who endure sexual or other forms of abuse by a trusted adult, whom they believed would offer care and protection, are particularly susceptible to attachment trauma (Gewirtz-Meydan & Ofir-Lavee, 2020). This trauma can also occur when a trusted adult or primary caregiver witnesses or is aware of the abuse but fails to respond appropriately. In such environments, insecure attachment styles—emerging as defensive secondary attachment strategies—are likely to develop (Coffman, Swank, & Bayne, 2024; Oshri et al., 2015; Snyder et al., 2023; Turgeon, Milot, St-Laurent, & Dubois-Comtois, 2023; Ye, Wei, Zhang, Li, & Cao, 2024).

Insecure attachment styles include anxious, avoidant, and disorganised forms. Anxious attachment is marked by excessive distress in response to physical or psychological separation from caregivers, often resulting from inconsistent caregiving (Reisz, Duschinsky, & Siegel, 2018). These children may display excessive anxiety and clinginess during times of stress, uncertain whether their caregivers will provide the needed support. Conversely, avoidant attachment often develops in children who have experienced unresponsive or dismissive caregiving, leading to behavioural and cognitive avoidance of caregivers and a tendency to refrain from seeking comfort. Disorganised attachment, which fluctuates between anxious and avoidant behaviours, often occurs in response to unpredictable caregiving (Mikulincer & Shaver, 2019; Pollard, Bucci, & Berry, 2023).

In a study by Höltge et al. (2023) that examined the pathways from various forms of child maltreatment to adult attachment-related anxiety and avoidance, it was found that emotional abuse and neglect were associated with anxious and avoidant attachment styles, respectively, while other forms of child abuse influenced adult attachment through emotional abuse, indicating

patterns of complex traumatisation. Insecure parent-child dynamics are generally indicative of repeated exposure to unmirrored emotional experiences, fundamentally undermining the parent's capacity to recognise and address the child's psychological distress (Ensink et al., 2020; Luyten et al., 2020). Consequently, compromised mentalization arises, as caregivers struggle to understand their child's needs and emotions. A study by Ensink et al. (2015) demonstrated that parental mentalizing predicted mentalizing abilities in child CSA survivors; both CSA survivors and their parents exhibited significantly lower mentalizing abilities compared to a non-abused control group, with this effect being more pronounced in cases of intrafamilial CSA compared to extrafamilial CSA. This suggests that mentalizing impairments are not solely the result of the abuse, but also reflect the broader dysfunctions within the caregiving environment (Ensink et al., 2015, 2020, 2024; Sloover et al., 2022; Wais et al., 2024).

Insecure attachment dynamics and corresponding compromised mentalization can result in heightened epistemic mistrust. This condition is characterised by a rigid scepticism toward new information (Bateman & Fonagy, 2019; Fonagy & Allison, 2014; Luyten et al., 2020). Without the consistent use of ostensive cues, effective mirroring, and other healthy caregiving practices, this may cause an overactivation of epistemic vigilance or excessive epistemic credulity, where information is either scrutinised excessively or accepted without sufficient evaluation, making the individual more susceptible to misinformation and exploitation (Campbell et al., 2021; Fonagy & Campbell, 2017; Li et al., 2023; Sperber et al., 2010). Kampling and colleagues (2022) found ACE's to be associated with increased epistemic mistrust and epistemic credulity—both of which are linked to worse long-term outcomes for ACE survivors—and reduced epistemic trust. Similarly, Benzi et al. (2023), in their study examining ACE's, epistemic stances (trust, mistrust, and credulity), and mentalization, identified a significant association between emotional abuse and neglect with heightened epistemic mistrust and credulity. These disruptions may impair survivors' mentalization abilities, leading to either heightened doubt or uncritical acceptance of information provided by others.

Particularly in cases where CSA is long-term and involves close perpetrators—characteristics of intrafamilial abuse—this form of abuse often inherently includes elements of physical abuse (e.g., penetrative abuse or physical enforcement of CSA), emotional abuse (e.g., manipulation or threats), physical neglect (e.g., increased risk of targeting due to lack of supervision), and

emotional neglect (e.g., caregivers' distraction leading to heightened exposure to abuse). Thus, as CSA is often inextricably linked to other ACE's, isolating specific cognitive and behavioural outcomes directly linked to CSA is complex, if not impossible. This complexity is especially evident in this sample, where participants reported a high prevalence of childhood maltreatment, particularly within family contexts involving intrafamilial CSA.

Family dynamics, as conceptualised through the lens of attachment theory, interact with a broader cultural context that further shapes the impact of CSA. Participants highlighted societal ignorance, stigma, and misconceptions surrounding CSA—often reinforced within their family environments—including the pervasive belief that only girls can be victims of such abuse. PM10 discussed the scarcity of research and resources for men, despite increasing societal awareness of sexual assault following the #MeToo Movement:

“There's not a lot of research for male stuff, you know, like, there was like a #Metoo movement and this and that, but even at one point when they went for mental health checks, and psychiatrists and all this other stuff, there's no studies on guys because guys don't [experience] them.” (PM10)

Similarly, the lack of recognition of boys as victims of CSA was echoed by PM3:

“Honestly, the way I think society views it is that it doesn't happen, and that it happens to mainly females than males. [...] I mean, there has been a lot of boys who are sexually abused and yet, there is nothing in [home country] to support the men who are sexually abused. And the numbers are vast, you know, and it ranges from like men in their seventies that are still haunted by this. And nothing's been done, you know, and that kind of shows. And they have a lot of cases, like a fucking insane amount of cases.” (PM3)

Male participants highlighted a lack of awareness regarding male CSA, which appeared to be rooted in societal norms framing boys and men as incapable of vulnerability or of being seen as 'victims' following CSA. These norms hindered male participants from recognising their experiences as abuse. PM4 acknowledged that he did not recognise his CSA as abuse until well into adulthood, attributing this to historical and societal ignorance surrounding both CSA and masculinity, which he believed was reinforced by his mother:

“Sexual abuse happened only to women, or like, women should be the only ones that should be more watched or taken care of. You know, there's so much about violence against women throughout history that has been embedded in history and in education. [...] When it happens to a man, it's almost like, was not the same, like that thing that people would be like, 'well, it's not the same cause it's a man, and they are strong enough to like deal with it' or something. I don't know, because as a child, my mom is a person that is really a lot about, 'oppress your feelings'. [...] I was brought up that way. It's like, you don't cry. You don't. You're a man, you don't show your feelings. So I think that also has to do with, you don't tell, or you don't believe that what happened to you is bad, because you're a man or you have to be strong.” (PM4)

Some male participants seemed to have internalised societal beliefs about masculinity, including the idea that boys cannot be CSA victims in the same way as girls, a perception likely partially reinforced by societal norms emphasising male self-sufficiency. This internalisation was reflected in PM15's recurring struggle to identify as a victim of a stranger—an older man—who had groped him at a public pool during his adolescence, a theme that surfaced consistently throughout his interview. He expressed self-criticism, stating that his *“only regret”* and *“annoyance”* with himself regarding the CSA he experienced was his inability to stop the perpetrator, despite the perpetrator having been a stronger, older man. PM15, without prompting, described feeling that he had failed to *“catch the hardball”* and thus *“didn't get a passing grade.”* In addition, PM15 repeatedly emphasised how minor he perceived his own experience to be compared to that of others:

“If there's a richter scale, and I'm like 0.2 on the richter scale out all these things, so you know, I'm happy to be a data point, but I think I'm probably a fairly, um, not quite normal data point, if there is such a thing as normal. So I'm happy to kind of give my thoughts, but I'm not sure they're critical information.” (PM15)

The perception that boys cannot be victims of CSA in the same way as girls may be rooted in assumptions about physical size disparities and societal expectations that male victims should possess the strength to defend themselves. PM15 believed that gender differences in the perception of CSA victims should be acknowledged, particularly due to the physical size

disparities between genders, which he felt also applied to younger victims in relation to their perpetrators:

“[There is] a power, strength gap between males and females generally. So I think it’s more from a daring presence between males and females that isn’t necessarily there between females, you know. [...] I was big enough, probably strong enough to really give him a good crack. [Female victims] would be intimidated, more intimidated. [...] age is, I guess, a layer of dominance and strength, and then gender is another layer of dominance and strength.” (PM15)

Male survivors’ difficulty in identifying with victimhood, shaped by broader masculine norms and reinforced by familial upbringing, often intersected with their struggles to connect with and articulate emotions. PM4 exemplified this challenge, describing how societal and familial norms limited his ability to understand and express his feelings. He likened his emotional awareness to identifying colors, emphasising the complexity of recognising and articulating nuanced emotions he had never been taught to navigate:

“Primary colours, like yellow, blue, red—that’s the extent I knew about emotions, but when you start to think about secondary colours or third colours, then it starts to get all mixed up, and then there’s other emotions below the primary emotions that you just get complicated.” (PM4)

This struggle to navigate and express emotions due to societal expectations of masculinity was similarly outlined by PM10:

“There’s just like, so much pressure, to have to be together and to not be in my emotions, and not to have been sexually abused by other men.” (PM10)

For male victims of CSA, societal beliefs that boys should not, or even cannot, be victims complicated their ability to fully interpret or categorise their experiences as abuse. This difficulty in framing their experiences as violations may have contributed to a unique tendency among male participants to perceive their CSA as a sexual experience rather than abuse.

The challenge of identifying as a CSA victim is influenced by societal perceptions and misconceptions, often shaped by traditional gendered narratives. Sexual abuse and victimisation have historically been framed within a heteronormative victim-offender dyad, with societal

expectations presuming women as victims and men as offenders. Christie's (1986) "ideal victim" framework, still prevalent in gender-based research on sexual victimisation, underscores how society readily grants victim status to those fitting specific criteria, reinforcing these stereotypes. While female victims may experience stigma—being viewed as weak, helpless, or even partially to blame (Depraetere et al., 2018; Farmer, Byrne, & Mussap, 2024)—assumptions about male heterosexuality and societal expectations of men's roles profoundly affect how male victims, and the implications of identifying as a victim, are understood (Depraetere et al., 2020; Easton, 2020; Vollman, 2021).

Several studies highlight that male survivors do not always immediately interpret CSA as inappropriate or as victimisation, even when it is legally defined as such (Attrash-Najjar, Cohen, Glucklich, & Katz, 2023; Depraetere et al., 2020; Draucker & Martsof, 2010; Vollman, 2021). Attrash-Najjar and colleagues (2023) argue that societal misconceptions surrounding male CSA survivors are rooted in traditional masculine norms and stereotypes, which emphasise strength, invulnerability, and stoicism. These norms create an atmosphere that negates or minimises the experiences of male CSA survivors. Similarly, Depraetere and colleagues' (2020) critical interpretive synthesis of research, policy documents, and grey literature highlights the underrepresentation of male sexual victims, driven by societal gender roles, accepted sexual scripts, and rape myths; these frameworks depict men as dominant and sexually assertive, denying the possibility of male sexual victimisation and positioning women as the prototypical victims. Nevertheless, within these frameworks, while female victims are generally recognised as victims of sexual abuse and assault, they are constrained by restrictive societal roles. For female survivors to avoid societal blame, their victimisation is often contingent on factors such as ignorance or anonymity surrounding the assault; without these conditions, they are frequently perceived as at least partially responsible for their victimisation (Burt, 1998; Christie, 1986; Flynn, Cama, Powell, & Scott, 2023; Sugiura & Smith, 2020).

While these restrictive societal roles complicate how female victims are viewed and treated, male survivors face an additional layer of invisibility and denial rooted in societal views of masculinity and male rape myths. These perceptions contribute to a trajectory wherein male survivors often do not immediately recognise their experiences as victimisation. Instead, they

undergo a process through which they gradually come to identify themselves as victims (Draucker & Martsolf, 2010; Vollman, 2021; Widanaralalage, Hine, Murphy, & Murji, 2022).

All male participants reported experiencing CSA perpetrated by men, with only one (potentially two) also reporting abuse by a female perpetrator. This relationship between perceiving CSA as a sexual experience and the involvement of male perpetrators led participants to allude to societal misconceptions surrounding homosexuality.

None of these participants appeared to hold any homophobic views, but found that terms such as “gay” or “homosexuality” were used, “*as like a stupid schoolyard abusive term*” (PM8 on being labelled gay).

In addition, societal misconceptions about homosexuality further increased the vulnerability of boys, whether gay or perceived as gay, to male perpetrators. PM4, the only exclusively gay male participant, attributed his difficulty in recognising the CSA as abusive to societal stigma and misconceptions surrounding homosexuality, which had both been compounded by the perpetrator and exploited as tactics to gain access to him:

“Because I knew I was gay from a very young age, um, I think that perpetrator saw that in me and that’s how he acted. [...] at that time it was like, well, this is what gay people do, or this is the way that you are supposed to be gay is all by, behind sort of like behind the curtains, don’t tell anybody and don’t talk about it. [...] So it felt wrong. But at the same time you felt like, OK, well this is, it is what it is.” (PM4)

This belief—that his experiences had been inevitable or somehow intrinsic to being gay—was further reinforced by an adult family member who had been influenced by the perpetrator. PM4 recounted how this family member had addressed the subject in a way that implied shared complicity in these acts:

“So when I was 14—so basically a year into the abuse—she knew about it. And then she told me that it was my fault, and she didn’t do anything about it. And I think she asked him if he was going to continue doing that. And she asked me if I was going to do that. We both said no. He continued for two more years.” (PM4)

Similar perpetrator tactics were used on PM8, who was frequently teased at school for being gay, including by his perpetrator. The perpetrator referred to the sexual assault, during which he forced PM8 to perform oral sex, as “*playing gays*.”

Building on these societal frameworks, dominant gendered stereotypes and male rape myths often contribute to victim-blaming attitudes toward male CSA survivors, frequently centered on judgments about their masculinity and sexuality (Widanaralalage et al., 2022). A prominent aspect of these myths involves misunderstandings about male victims’ physiological responses to sexual abuse, particularly the association of responses such as erection or ejaculation with pleasure (Hine, Murphy, & Churchyard, 2021). For some boys, experiencing these physiological reactions during assault may lead to a mistaken belief that they enjoyed the encounter or prompt others to doubt the validity of their claims (Swathisha & Deb, 2022; Thomas & Kopel, 2023).

The assumption that physiological responses signify enjoyment—compounded by the societal perception that men are dominant in sexual interactions—creates significant barriers for male survivors in recognising their experiences as abuse (Hine et al., 2021; Thomas & Kopel, 2023). These misconceptions are especially problematic in cases where the perpetrator is male, as survivors may experience confusion regarding their sexual identity, fear of being perceived as homosexual, or, in the case of gay victims, feelings of complicity in the abuse.

Vollman (2021) highlights how individuals interpret traumatic experiences through the lens of their pre-existing master status—an identity already in place prior to the event. This interpretive process gives rise to two distinct narratives: one formed by the individual’s existing self-concept and another imposed by the abuser. In cases where a boy is sexually victimised by an older boy or man, this process is further influenced by frameworks of gender, power dynamics, and sexuality, as well as the nature of the relationship with the perpetrator (Vollman, 2021). Societal constructs surrounding masculinity, male sexuality, and sexual violence often obscure these experiences, making it more challenging for male CSA survivors to identify as victims, with significant implications for their understanding of the abuse and its impact.

These challenges may be further exacerbated by grooming tactics surreptitiously employed by perpetrators (Schoon & Briken, 2021). This poses a particular challenge for gay survivors of male perpetrators, as they may be especially vulnerable due to prevailing homophobic societal

beliefs that frame gay victims as “willing” participants (Hine et al., 2021). Despite considerable progress in the acceptance of and legal rights afforded to LGBTQ individuals, both victims and perpetrators continue to exist within a cultural context that often remains homophobic (Depraetere et al., 2020; Solomon, 2018; Vollman, 2021). Homosexual male survivors of male perpetrators may face additional obstacles in identifying as CSA victims due to manipulative perpetrator tactics and societal misconceptions surrounding homosexuality.

When the perpetrator is a woman, societal perceptions often frame such encounters as a form of sexual success rather than abuse, leading victims to question whether their experiences constituted genuine victimisation (Gerke et al., 2023; Kramer & Bowman, 2021). Cultural narratives frequently glorify relationships between boys and older girls or women, reinforcing the misconception that these interactions are a milestone of sexual achievement (Fraser, Bradford, Pritchard, & Moulden, 2024; McLeod, 2015; Stemple, Flores, & Meyer, 2017; Thomas & Kopel, 2023; Tozdan, Briken, & Dekker, 2019). Male survivors of abuse by female perpetrators also face societal denial regarding female sexual offenders, which contributes to these acts being dismissed or minimised (Tozdan, Briken, & Dekker, 2019).

Participants echoed the pressure to feel as though their masculinity or gender identity was compromised due to abuse, reflecting the idea that male survivors face an additional struggle because traditional notions of masculinity do not accommodate sexual passivity. Unlike female participants, whose femininity was not questioned, male participants described the abuse as “*like that scary, vulnerable, de-masculating thing*” (PM10). This perceived emasculation may imply a potential loss of their gender identity, while there is no equivalent term for femininity that reflects such a loss. Consequently, this dynamic reinforces the perception that CSA is primarily a female issue, potentially hindering male victims from fully conceptualising their experiences as CSA.

Nevertheless, female participants also described societal stigma and misconceptions surrounding CSA targeting female victims, although their accounts revealed subtle differences from those of male participants. Female survivors described CSA as being acknowledged by society, yet often framed as an inevitable or somewhat accepted occurrence. For instance, PF7, whose CSA experiences had been particularly frequent—occurring almost daily—explained that the cultural

context of her Middle Eastern city normalised such behaviour, making it a widespread and socially accepted phenomenon for girls her age. This normalisation rendered the abuse less traumatic in the eyes of society. She described her experiences as follows:

“Pre-teen basically age, then a lot of times they start to touch you. [...] It’s just crowded and people like crossing each other like that, and then you feel someone touching your back, like your bum, [...] your genitalia are wherever that is. And also they touch your breasts. So this happens quite a lot, but it’s kind of like almost a normal situation.” (PF7)

PF12 similarly highlighted how societal norms objectify women and reinforce their subjugation, reducing their value to their sexual utility:

“This is a societal thing that we view women as holes to fuck, not for their intellect and for their physical prowess. It’s all about their sexual prowess and their sexual ability to please and, uh, bear children and all this kind of, and make a home for a man. You know, all of this stuff is really contingent on pleasing a man. So, and in the patriarchal church of Christianity, again, this is all reinforced that a woman is subservient to her husband or her man. So I feel like no matter if that incident hadn’t happened, something would have happened somewhere.” (PF12)

PF18 echoed this sentiment, describing the societal message communicated to her as a female victim of CSA: *“You’re nothing but a sex object.”* Female participants frequently noted how societal norms and stigma surrounding CSA normalised the abuse, often shifting blame onto young female victims. PF7 articulated this societal attitude as *“the idea of like, ‘boys will be boys,’”* where responsibility is placed on girls as *“the ones becoming the sexual object.”* She added that the prevailing message was that it is *“your fault”* as a girl. PF6 similarly recounted how female CSA victims were often perceived as *“being permissive,” “precocious,”* and *“really ask[ing] for it”* even in instances involving very young victims.

Victim-blaming has been identified as a widespread societal issue that often manifests within the home and is frequently directed towards female victims (Flynn et al., 2023). Survivors of sexual assault and abuse more broadly, however, are among the most commonly blamed (Bhuptani & Messman-Moore, 2019). The portrayal of sexual violence often trivialises its severity, reinforcing the normalisation of rape culture and fostering desensitisation to such behaviours,

which ultimately undermines the recognition of the harm experienced by victims (Powell & Henry, 2017; Sugiura & Smith, 2020).

Much like male participants, female participants also described struggles with vulnerability and the concept of victimhood. Female participants, however, often framed these struggles within the context of frustration with being targeted for CSA, the stigma surrounding being a CSA survivor, and coping with the aftermath. PF11, whose partner was supportive and sensitive to her abuse, expressed not wanting “*to play the victim*” during sex, even though she struggled with being triggered during the act. Similarly, PF7 recounted how being a woman—and, therefore, a CSA survivor in her society—was equated with “*being weak, being a burden,*” and that the way to overcome this was “*to become a bitch, like a ball-breaker kind of a thing.*” She also characterised societal views of female CSA survivors as perpetually helpless, stating that they are seen as “*sitting there helpless... so helpless.*”

This contrasts with male survivors, whose struggles with vulnerability and victimhood often hindered their ability to recognise CSA as abuse, to see themselves as victims, and—once the abuse was acknowledged—to reconcile their experiences with their gender identity, leaving them feeling “*totally ruined*” (PM10).

Gender differences in societal stigma and misconceptions surrounding CSA, as well as their distinct effects on male and female survivors, highlight important nuances. Male and female participants described struggles with vulnerability and victimhood in ways that reflected these differing societal influences. While societal stigma often normalises CSA among girls and may partially shift blame onto female victims, CSA is still generally acknowledged as abuse in these cases. In contrast, CSA frequently goes unrecognised as abuse among boys. Male participants alluded to this lack of recognition throughout their interviews, emphasising how it hindered their ability to identify their experiences as abuse. Societal stigma and misconceptions did not, however, prevent female participants from recognising CSA as abuse or eventually disclosing it. These gendered cultural narratives, often reinforced within the family environment, shape disclosure experiences and psychosexual development in distinct ways for male and female survivors—topics explored further in the subsequent sections.

The intersection of CSA and other ACE's creates a complex tapestry of familial and societal dynamics that shape survivors' experiences. Within this context, gendered societal norms and family dysfunction often dictate how survivors perceive their abuse and the pathways available to them for disclosure. For male survivors, societal constructs of masculinity—emphasising self-reliance and emotional stoicism—frequently discourage recognising or labelling their experiences as abuse. Conversely, female survivors are often subjected to accusatory responses that reflect pervasive gender-based stereotypes. These intersecting factors highlight the challenges of disclosure, particularly during childhood, where attachment dynamics and caregiving failures play a critical role.

4.3.2.1.2 Navigating silence and voice: the complex pathways of CSA disclosure

Pathways to disclosure

Motivations and expectations for CSA disclosures varied depending on whether the survivor was a child or an adult at the time of disclosure. Childhood disclosures were primarily driven by a need for emotional support and intervention from caregivers, while disclosures in adulthood reflected participants' recovery stages and their proactive engagement with the healing process, a topic that will be discussed further in later sections. For childhood disclosures, attachment dynamics intersected with societal constructs surrounding masculinity and CSA in significant ways. In this sample, the prevalence of ACE's and intrafamilial CSA contributed to the predominance of insecure attachments. Participants referred to these dynamics when outlining their struggles with decisions and motivations around disclosing CSA to their caregivers. These struggles were further compounded by societal constructs regarding masculinity and widespread misconceptions about CSA, which revealed distinct gendered patterns.

During childhood, all but one male participant did not disclose their CSA experiences. Conversely, all female participants had a disclosure experience during childhood. PM10 highlighted that the lack of awareness regarding the possibility of men being victims contributes to male survivors' reluctance to disclose their abuse:

“It’s not so normal and comfortable for guys to talk about this stuff so eloquently or whatever, because I think, sadly, it has been sadly normalised with women that it has been this thing where it’s just like, ‘Oh, yeah, she got raped.’ But with guys, it’s like, they don’t talk about it.” (PM10)

Furthermore, most childhood disclosure experiences were initiated by the recipient, often a parent, and all such recipient-initiated disclosures involved female participants. This pattern likely reflects societal disregard and misconceptions surrounding male CSA survivors (Attrash-Najjar et al., 2023; Depraetere et al., 2020; Vollman, 2021).

In families where intrafamilial CSA and/or ACE’s are frequent, disclosures that result in emotional support, intervention, or cessation of the abuse may be critical (Ensink, Borelli, Normandin, Target, & Fonagy, 2020; Hébert, Langevin, & Charest, 2020). Such disclosures are, however, inherently more complex due to the familial context in which both the CSA and other ACE’s occur. PM14, who experienced abuse from both his mother and stepfather, described family dynamics that strongly discouraged discussing personal issues, including CSA and related problems, such as suicidality. He recounted how this “culture of silence” extended both within and outside the family:

“Prior to my own abuse, my stepbrother had been—younger stepbrother—was being physically abused, and in hindsight, I suspect, possibly even sexually abused for a number of years prior. And during those years, my maternal grandmother pulled me aside, and she said something about um, ‘we don’t air our dirty laundry in public.’ So you know essentially, whatever problems are in the family, we keep in the family, and that also became a factor in my suicide attempts, because, you know, if the family is a problem, then I have nobody to talk to, right? So it took a long time for me to figure out who might be trustworthy, and how to broach the subject.” (PM14)

Such environments characterised by childhood neglect and insecure attachments—particularly when intrafamilial CSA occurred, especially when the primary caregiver was the perpetrator—were reported by participants to significantly hinder their ability to develop the “language” or awareness needed to consider disclosure. In such settings, participants described having not even fully registered the abuse as abnormal, complicating their decisions to disclose. PM17, who experienced CSA perpetrated by his older brother, a figure he viewed as both a role model and a father-figure, described having “no recollection of [himself] as a child thinking, ‘I

need to go tell my parents about this, or I'm afraid what my parents would think.” He also noted that growing up with a narcissistic father contributed to an overall environment in which his home “*wasn't a good place to share what was really going on.*”

The formation of attachment styles plays a pivotal role in understanding why children may refrain from disclosing CSA, and not consider seeking help from primary caregivers or other adults. Secure attachment fosters a sense of safety and trust, enabling children to confidently request support when necessary. A securely attached child is likely to anticipate, and therefore receive, an empathetic and supportive response from a caregiver upon disclosure, potentially halting the abuse and mitigating its long-term negative impacts (Crittenden, 2017; Mikulincer & Shaver, 2019).

In family environments marked by intrafamilial CSA and other ACE's, insecure attachments to caregivers often prevail, accompanied by compromised mentalization (Ensink et al., 2015; Li, Campbell, Midgley, & Luyten, 2023; Wais et al., 2024). Research indicates that trauma, particularly in cases of intrafamilial abuse, impairs mentalization in children (Ensink et al., 2015; Li, Campbell, Midgley, & Luyten, 2023; Wais et al., 2024). When the perpetrator is an attachment figure, children may suppress their capacity to mentalize as a defence mechanism to alleviate anxiety and preserve the relationship with the caregiver, who remains crucial for their survival (Fonagy & Allison, 2014; Rosso, 2022).

Epistemic trust is particularly compromised in cases where the perpetrator is an attachment figure (Alyce et al., 2024; Crittenden, 2017; Fonagy et al., 2015). A lack of trust in others may stem from experiences of untrustworthy, negligent, or harmful behaviour by attachment figures, highlighting the importance of survivors engaging in transactional trust prior to disclosure (Alyce et al., 2024; Brennan & McElvaney, 2020; Mason et al., 2020). Survivors often seek to avoid unhelpful disclosure experiences that might discredit or invalidate their trauma. In addition, in environments characterised by intrafamilial CSA, disclosure might not even be considered due to confusion surrounding the morality of the abuse.

Participants frequently highlighted the importance of a basic level of trust required to disclose CSA to their parents. Many male survivors reported not even considering disclosure due to a

perceived lack of this foundational trust. PM8's reflection captured this sentiment, explaining why he chose not to disclose during childhood:

“My fear in telling my parents, it wasn't that they would dismiss it. It was just that there was an atmosphere where nothing could be spoken. So I think it wasn't even a consideration. Uh it's like, yeah. It's like, I couldn't talk about anything and there was no trust. So, it would be crazy to tell them about that.” (PM8)

The lack of consideration for disclosure due to adverse family environments, particularly in contexts marked by ACE's and/or intrafamilial CSA, is not unique to male participants. Nevertheless, unlike male participants, female participants who experienced similar environments were questioned about their CSA experiences during childhood. This disparity may reflect societal norms that fail to consider boys as potential victims, compounding their difficulty in defining and categorising CSA as abuse, and further inhibiting disclosure. For several male participants, these challenges were exacerbated by family taboos around discussing sex, contributing to an environment where disclosure was not even contemplated.

PM8, for instance, attributed his lack of consideration for disclosure to his family's discouragement of conversations about sex, describing an incident that underscored this dynamic:

“There was just something in that family where it was clear that they didn't want to know about things. Like I remember a screaming row between my mom and my sister when she was like 14 or 15 about condoms. And it was like, I think my mom had found a condom and like, a used one, like not one in a packet and just the screaming and it just showed how impossible it was to talk about anything, like most, a lot of 15-year-old girls become sexually active at that age.” (PM8)

Similarly, PM17 explained that his perception of his family's aversion to discussing sex-related topics influenced his decision not to disclose CSA in childhood:

“So the first one that jumps to my head is we didn't talk about sex in our family, and I wasn't educated on healthy sex, inappropriate sex, more like, you know, very like sex is for here, other than that, it's bad, that's kind of the mentality. So there was no education [...] So I never even would have thought of like sharing it”. (PM17)

Given that sex was framed as taboo or shameful within their families, and considering that male participants often likened CSA to a sexual experience, disclosure was likely perceived as unthinkable. This perception of sex as a taboo topic was not reported by any of the female participants when considering disclosing.

Due to the prevalence of abusive households represented in this sample, caregivers who were preoccupied, abusive, or lacked adequate techniques (e.g., ostensive cues, mirroring) likely contributed to impaired mentalizing abilities and diminished epistemic trust among male participants. These factors, coupled with the absence of secure attachments, may have left male survivors unable to freely explore and understand their abusive experiences—a process shown to benefit those with secure caregiver relationships (Ainsworth, 1979; Feldman, 2023; Gause et al., 2022). Consequently, these survivors were likely left to interpret their experiences through societal constructs.

These societal frameworks, predominantly heteronormative, often portray men as sexually dominant, invulnerable, and self-reliant, thereby obscuring male victimhood and introducing unique challenges to the recognition of CSA (Attrash-Najjar et al., 2023; Josenhans et al., 2020; Ragonese, Shand, & Barker, 2019). Using interpretative phenomenological analysis, Widanaralalage et al. (2022) found that gendered narratives—such as traditional masculine paradigms and the misconception that sexual abuse primarily affects female victims—further diminished the support male survivors received, complicating their understanding and processing of the abuse (Attrash-Najjar et al., 2023).

Societal beliefs about masculinity, combined with parenting styles associated with insecure attachment, create additional barriers for male survivors in disclosing CSA. This lack of trust, coupled with the significant stakes involved, further impedes disclosure and access to essential support.

For some male participants, these familial dynamics were compounded by broader societal norms surrounding masculinity and homophobia, creating additional barriers to disclosure. PM4 illustrated this intersection of family expectations and societal pressures, describing how the expectation to “*be strong by not crying*” and suppress his emotions, combined with stigma and

misconceptions about homosexuality, contributed to his inability to recognise his CSA as abuse until adulthood. This lack of recognition made the idea of disclosing in childhood inconceivable.

Female participants often framed their discussions of disclosure in childhood around grappling with whether or not to share their experiences with their parents. In contrast, male participants' accounts tended to focus on the factors that contributed to why disclosure was not even considered an option during childhood.

For PM2, the only male participant who disclosed during childhood, societal perceptions of masculinity—including the framing of CSA as a sexual experience—combined with insecure attachment dynamics were further reinforced by his mother's indifferent reaction to his disclosure. This lack of support influenced PM2's decision not to disclose his abuse again until his thirties. He described how societal stigma around sex, particularly within peer groups, played a role in silencing him. Referencing “*locker room talk*” among classmates, he noted that sexual experiences were framed as milestones, with “*everything [being] for the first time.*” Concurrently, PM2 recalled being introduced to societal stigma associated with younger girls in relationships with older boys, where the girls were often subjected to derogatory labels. He compared this judgment to how his own abuse—non-consensual sexual relations with his older male cousin—might have been perceived:

“So if people are looking at a situation where a girl who dates an older person [and is referred to in derogatory terms]... that's like an off-limits type thing. You don't do that. I can only imagine how my situation could be looked at if it was out there and if people had known about it.” (PM2)

The societal conflation of CSA with a sexual experience, compounded by pervasive stigma, added another layer of complexity to PM2's experiences of disclosure. Although he identified as heterosexual, PM2 described the additional barriers created by homophobia, which intensified his hesitation to disclose:

“[...] in that time and age, if you came out with anything of being gay or any sort of experience, you're instantly hung on the cross for it” (PM2)

This fear of being perceived as gay extended well into adulthood. When considering disclosing to his wife, PM2 expressed concern that she might “*question [his] sexuality*” due to the misconceptions surrounding his abusive experience.

PM2’s internalisation of his abuse, following an indifferent response to his childhood disclosure (the only indifferent response in childhood received by a participant), highlights how a lack of support from a primary caregiver can reinforce societal gender constructs for male survivors. The added influence of homophobic stigma and misconceptions further complicated the ability of male participants abused by male perpetrators to disclose their CSA, regardless of the victim’s sexual orientation.

Even as adults, many male participants expressed apprehension about disclosing their abuse, fearing homophobic reactions and their potential impact on personal relationships. For predominantly heterosexual victims, these fears often revolved around jeopardising romantic relationships. PM17, for instance, described his first disclosure to his then fiancée as an intensely emotional and physical experience, stating that his “*face was shaking*” and that he was “*afraid it would end their relationship.*”

By contrast, PF13, the only female participant sexually abused by a female perpetrator, did not perceive the gender of her abuser as a factor in her decision to disclose. This gender difference may stem from the perception among female survivors that CSA represents an act of abuse rather than a sexual experience. As PF18 described, the abuse was primarily about “*boundaries being breached.*”

For male participants who identified as exclusively or predominantly gay, these concerns were compounded by confusion and feelings of responsibility for the abuse based on their sexual orientation or perceived orientation. This challenge was often further shaped by the victim’s age at the time of the abuse. PM4, who was a young adolescent at the time of his abuse, initially struggled to understand his experience, questioning whether it was part of his “*gay experience.*” He expressed uncertainty about whether the abuse constituted a formative sexual encounter, a belief reinforced by the perpetrator, despite his discomfort:

“[...] because in my mind I was like, ok, well I’m gay, so I don’t have any issue having sex with this person, even though it’s gross [...], like if someone was straight, it would be impossible to do it. [...] I thought that because I was gay, it wasn’t, it was another layer or it was another reason why it wasn’t sexual abuse.” (PM4)

In contrast to male survivors, the majority of female participants—primarily or exclusively heterosexual and with male perpetrators—did not frame their CSA experiences as potential sexual initiations. Despite some female participants reporting physiological or psychological arousal during the abuse (e.g., PF5, PF11, PF13), none cited taboos or stigma surrounding sex as a reason for not disclosing their experiences. This distinction underscores the gendered differences in how CSA is perceived and internalised.

For male survivors, traditional masculine norms are often reinforced through parenting practices, particularly in environments marked by parental negligence or insecure attachments. Such dynamics may discourage individuals from viewing their parents as a safe avenue for discussing or processing the abuse. This may reinforce societal expectations of masculinity, self-sufficiency, and an aversion to vulnerability, further contributing to their reluctance to disclose CSA, even in adulthood. PM9, for example, disclosed his abuse in adulthood first to a long-time male friend who was “*borderline autistic*” with a “*clinical*” demeanour. He explained that this friend’s emotionally detached nature made disclosure easier, as he felt it would not “*open anything up.*” PM9, however, avoided disclosing to his wife, fearing her potential emotional reaction would overwhelm him and heighten his feelings of vulnerability:

“Because you don’t have an emotional attachment to them, right? So it’s fairly sterile and clinical. With a spouse, it’s different, you know. [...] Because of the reaction you get—you get empathy. And... It just brings down your guards. So it makes you feel, like more vulnerable somehow? As opposed to someone you don’t know. [...] they [a spouse] feel for me. And then that makes me emotional.” (PM9)

PM15, the only male participant who did not experience any ACE’s within the family home (he experienced bullying at school) and whose CSA was a single incident perpetrated by a stranger, chose not to disclose his abuse during childhood despite believing that his parents would have responded “*appropriately*” to a disclosure. PM15 expressed feeling no need to share his

experience, perceiving it as unnecessary and not worth “*making a big fuss about.*” He elaborated that disclosing both CSA and his frequent experiences of bullying offered no meaningful benefit:

“It doesn’t make any difference to me, but I think it makes a difference potentially to other people. So I think it, yeah, it’s kind of, you know, my hide is thick and impervious, and it doesn’t really bother me.” (PM15)

This reaction may reflect the internalisation of masculine norms emphasising self-sufficiency—an attitude not observed among female participants when considering disclosure. It may also be indicative of the specific nature of PM15’s CSA experience, which involved no intrafamilial CSA or accompanying ACE’s.

Environments characterised by childhood maltreatment, which are associated with insecure attachment and epistemic mistrust, have been shown to foster chronic distrust or susceptibility to exploitation (for a review, see Li et al., 2023). Victims of abuse may exhibit polarised epistemic responses. On one hand, they may become indiscriminately dependent on information from others, exhibiting heightened credulity and uncertainty about their own mental states; this lack of self-reliance can leave victims vulnerable to further abuse, as acknowledging the abuse may be too psychologically overwhelming (Benzi et al., 2023; Duschinsky & Foster, 2021; Ensink et al., 2023; Fonagy & Campbell, 2017).

Conversely, some victims may view information from others as entirely untrustworthy, leading to rigid certainty in their own mental states and excessive self-reliance; this behaviour may function as a self-protective mechanism in response to abuse (Ensink et al., 2023; Fonagy & Campbell, 2017; Li et al., 2023). A study found that individuals who experienced emotional abuse and neglect exhibited significantly higher levels of these polarised patterns compared to those without such experiences (Benzi et al., 2023).

For male participants, heightened self-reliance—potentially rooted in epistemic mistrust and reinforced by societal constructs of masculinity—may explain their reluctance to disclose abuse or even consider disclosure as an option. These constructs encourage self-reliance and invulnerability, further complicating the already challenging dynamics of recognising and sharing their experiences.

While epistemic mistrust and vigilance can lead to various maladaptive coping mechanisms (which will be explored in the subsequent subsection), a seemingly “deficient” trust may serve as an adaptive strategy for children when deciding whom to trust with the disclosure of CSA (Alyce et al., 2024; Mason, Taggart, & Broadhurst, 2020). This heightened epistemic vigilance may result in children not only refraining from confiding in their primary caregivers but also in other adults, thereby reducing the likelihood of CSA survivors disclosing to anyone outside their family (Ensink et al., 2023). The lack of trust may not only consciously or subconsciously prevent survivors from disclosing to their parents, but also contribute to their decisions to avoid disclosure to others.

Negative of suboptimal disclosure experiences

During childhood, all nine female participants disclosed their CSA experiences, compared to only one male participant. Most of these disclosures were prompted by external influences or direct inquiries from caregivers. Of the ten childhood disclosures, seven were initiated by someone asking the participant about CSA, all of which involved female participants. Only three participants self-initiated their disclosures during childhood, including PM2—the sole male participant to disclose CSA as a child. Participants’ decisions regarding disclosure were influenced by their perceptions of their parents’ likely responses, shaped by observed parenting styles and a perceived lack of care from caregivers.

PF6, for instance, acknowledged that her mother was unaware of the abuse but described feeling years of resentment towards her for the situation:

“For years I was resentful of her. But when I had an opportunity to speak with her as an adult, she said she had no idea. She was horrified. She was sick and she was angry. She was all those appropriate things. But [my mother said] that even if she had known in that moment, she wouldn’t have known what to do.” (PF6)

PF6 further noted that throughout her disclosure to her mother in adulthood, her mother did not “listen to or acknowledge” her experience, instead reacting in a more dismissive manner:

“Well, I heard you. I mean, I can’t do anything. What do you want me to do about it now?” (PF6)

This likely validated her prediction about the limited support her mother would have provided had she disclosed the abuse in childhood. Similarly, despite having chosen not to tell her parents about the abuse, PF13 narrated her negative feelings towards their lack of knowledge and hypothetical reactions:

“I feel angry at my parents, you know, even now, I feel angry at my parents sometimes. I go through things like, how could they have not known? How could they have not asked, like, you know, like the fact that I'm pretty sure if I told them, they wouldn't know how to react. My mom would probably make it about herself and start crying and play the martyr. [...] And I run these hypothetical scenarios through my head, and then I get angry about those reactions, but they haven't happened.” (PF13)

Even among those who self-initiated disclosure, participants frequently described reluctance or hesitance, citing factors such as parenting style, household stress, neglect, or abuse. Disclosures often occurred only after several abusive incidents and, in many cases, after years of enduring the abuse. These participants typically identified a turning point, such as a particularly severe or alarming incident, that prompted them to disclose their experiences to their parents.

For PF6, this turning point involved her second perpetrator, a close friend of her father, being “drunk” and “catching [her] up against a wall,” while her father was elsewhere in the house. Similarly, PM2 endured several years of CSA at the hands of his older male cousin, with other cousins making teasing remarks that suggested some awareness of the abuse. Ultimately, PM2 decided to disclose to his mother after witnessing physical evidence of the abuse that deeply unsettled him:

“I remember looking at my neck, that it was in the mirror. It was really bruised. And something told me that there's wrong, there's something wrong here. And then I went to my mom and I told my mother about what had happened.” (PM2)

PM2's decision to disclose was likely influenced by the severity of the physical violence he experienced, which may have helped him overcome fears of his mother's anticipated inadequate response. His disclosure occurred within a household marked by pervasive ACE's, including

emotional abuse, physical and emotional neglect, exposure to intimate partner violence, parental incarceration, and SUD's.

Participants' CSA disclosure experiences could be understood within the broader context of social support literature, which suggests that an individual's subjective evaluation of the expected and actual quality of support often serves as a protective factor against psychopathology (Dworkin, Brill, & Ullman, 2019; Hemanth et al., 2024). Expectancy violations theory (Burgoon, 1993) posits that individuals form expectations regarding responses based on the context, situation, and relational dynamics involved, with responses that deviate from these expectations—particularly within close relationships—being more noticeable. While some studies suggest that negative responses to victimisation tend to be more salient than positive ones (Burgoon, 1993; Dworkin et al., 2019), the complexity of this issue deepens when accounting for attachment styles, parenting strategies, and the specific environment in which CSA occurs.

Children with anxious attachment styles, often arising from unpredictable or inconsistent caregiving, may be uncertain about whether their caregivers will be available to provide necessary support. Spaccarelli's transactional model (1994) integrates trauma-specific cognitive appraisal and coping strategies while considering factors such as trauma severity, environmental influences, and individual differences. This model emphasises that CSA survivors' coping mechanisms are influenced not only by their perceptions of the abuse—such as the degree of self-blame—but also by external elements, including social support, reactions to their disclosures, and the broader societal context.

For instance, the transactional model posits that the process of disclosing CSA can serve as a significant stressor, necessitating effective coping strategies and taking into account how the social environment shapes this process and its subsequent outcomes. Spaccarelli's model asserts that the negative outcomes of CSA may be mediated by the extent to which the victim perceives the experience as threatening or harmful. This perspective may explain why certain circumstances can lead participants to reevaluate their experiences when they come to view the abuse as more severe than they had previously thought.

Thus, it is likely that these dynamics work hand-in-hand with the survivors' attachment styles, as these participants may require time and significant worsening of their circumstances to realise

the severity of their experiences and reassess whether they would receive the necessary support from their caregivers upon disclosing their CSA.

Notably, PM2 was the only participant in the sample to encounter a completely indifferent and unresponsive reaction from a primary caregiver following a childhood disclosure. This response may reflect the combined effects of his insecure attachment and societal misconceptions surrounding CSA and male gender norms.

For the remaining participants, disclosure experiences were initiated either by hearing another CSA survivor's story or, more commonly, through direct questioning—usually by a caregiver. These disclosures often occurred during the period when the abuse was still ongoing. PF1, whose adoptive father was her perpetrator, disclosed her abuse to authorities after her older sister reported the abuse to a professional, prompting the police to intervene. PF18, who was abused by her father and maternal grandfather, did not recall feeling a need to disclose her CSA and had not discussed it with her younger sister—who was also victimised by the same perpetrators—until they were directly questioned by their mother. Reflecting on the process, PF18 described how her sister's disclosure triggered memories of her own abuse by their grandfather:

“[My mother asked] if there's anything uncomfortable happening with me that I should tell her. And I didn't, I remember not knowing what that meant and being confused by that. And then all of a sudden while she kept repeating herself to share any uncomfortable things, it kind of sunk in a little bit during the conversation. And then I brought up feeling uncomfortable around my, I think it was my father, because that was at the time my father was doing something. And then I don't remember anything about my grandfather until my sister mentioned something about it. And then I realised I remember that very first memory of mine, when I was two or one or something.” (PF18)

PF12 did not disclose her CSA during childhood; however, following a second CSA experience with her perpetrator during adolescence—when her mother's boyfriend exhibited extreme violence alongside his CSA perpetration, and chased her with a loaded gun—her mother questioned her about the incident. For some participants, such as PF7 and PF16, their parents directly inquired about the abuse after witnessing evidence or observing their immediate reactions. After her first abusive incident, PF16 recalled seeing blood and described being “just

in shock and crying,” after which her mother entered the room, noticed the blood, and asked what had happened. Likewise, in one of several instances of sexual harassment and assault on the streets, PF7 recalled feeling frightened upon returning home, where her father opened the door and asked, *“What happened?”* as he noticed she was *“almost shaking.”*

Regardless of whether childhood disclosures were initiated independently or provoked by questioning, none of the participants’ disclosures during childhood were both emotionally supportive and effective in addressing the abuse—such as ending the abuse or confronting the perpetrator. Participants often conveyed an expectation, whether consciously or subconsciously, that disclosing to a caregiver or other adult during the time of the abuse would result in protection and emotional support, a hope that was consistently unmet.

Two female participants (PF6 and PF16) reported disclosing their abuse to their fathers in the 1960’s. While these disclosures had led to the removal of the perpetrators from their lives, the survivors did not recall having received any further discussion or emotional support from their fathers following the incidents. Instead, their fathers had responded in a “practical” manner, focussing on eliminating the immediate threat rather than addressing the emotional aftermath of the abuse.

Following her disclosure of her second perpetrator to her father, PF6, described her father’s response:

“My dad said, ‘Well, that’ll never happen again’. And he never spoke to that man again. We never went to their house.” (PF6)

Although her father never spoke about the incident during her childhood, he later revealed, in adulthood, how he had confronted the perpetrator. PF6 explained:

“He had accosted him [...] And I didn’t realise, I didn’t put the two together until my dad was considerably older and told me that he had done that.” (PF6)

She described feeling *“loved”* upon learning about how her father responded. Although this reaction brought her a sense of comfort in adulthood, she had been unaware of the full extent of his actions as a child and did not receive any emotional support during childhood. She later

experienced additional instances of sexual assault as an adolescent and young adult, which may have been mitigated by a more emotionally supportive response at the time, although this may also be attributed to her mother's perceived reactions around the circumstances of her first abuse and general lack of emotional availability.

PF16, who had disclosed the abuse to her mother, who had seen evidence of the abuse (her father was in the next room at the time), expressed that her mother's initial reaction—asking why she “*didn't say no*”—felt “*like a punch*”, “*jarring*”, and was “*almost more traumatic*” than the abuse itself, and years later, when she sought EMDR therapy, she shared that “*that's what came up*” and that she “*had to do a whole piece on that.*” Despite this reaction, she recalls possibly going “*into bed with [her parents] after, and crying or something,*” though she repeatedly mentioned throughout the interview that she could not fully remember if this had occurred. Towards the end of the interview, she reflected on her parents' role in her initial disclosure experience:

“Now I remember—they held me, and I cried. So it's not like... she said that, but it wasn't like she was a cold fish. She held me, and I was in bed, and I cried. Um, I remember that now, yeah, that was kind of the big part, I remember. So it wasn't like she did that and was like, 'just go!' She held me, and I cried. And then I knew that dad dealt with it.”

PF16's father later went to the perpetrator and his parents (the perpetrator was about 18 years of age), and addressed the abuse. She had not been aware of the details of it, but witnessed her father leaving and mentioned that this was “*positive*” and “*profound for [her]*”. Nevertheless, because her father was a perpetrator of several boys, including her own abuser (unbeknownst to her until adulthood), PF16 recalled being confused as to why her parents never discussed her abuse further, and seemed to put more emphasis on her mother's inability to appropriately deal with it:

“That's her way of dealing with things. I ended up asking later on, 'why did you never bring this up?' Right, and she said, 'I didn't know how to deal with it. I didn't know what to say. I never heard anything about it. I just was...' And she said, she would just leave it alone.” (PF16)

PF16's mixed disclosure experience left her with a mixture of feelings, with some self-blame, but not quite shame, as she describes below:

“There was that one little belief that maybe I asked for it, but I didn’t feel, people talk about the dirty and the shame. I guess, because my dad, knowing that my dad went up, and talked to them, that helped a lot. [...] It made me, you know, it was wrong, and he was going to protect me, or he was going to do something about it.” (PF16)

These practical and useful, albeit mixed, disclosure responses had some benefit on these survivors, although it left them with some lasting negative effects that seem to be mixed with other household contextual adversity (e.g., emotional neglect).

Other childhood disclosures to caregivers—including one made to both authorities and caregivers—were predominantly met with accusatory, dismissive, or overreactive responses. These negative reactions caused several participants to question the severity or even the reality of their experiences. For instance, PF1 described how such a response *“made me question, like, was the abuse wrong?”* and led her to believe, *“I just made it up.”* These reactions discouraged survivors from disclosing CSA to anyone else during childhood, delaying further disclosures until adulthood.

When PF5 disclosed the abuse to her mother, who had been romantically involved with the perpetrator in an extramarital affair, her mother responded with accusations, saying, *“You don’t know what you’re talking about! That never happened!”* This reaction led PF5 to doubt her own experience. She recalled feeling *“shame and embarrassment”* for possibly being *“wrong”* and *“accusing innocent people.”*

PF5’s experience of CSA, combined with her mother’s authoritarian and emotionally abusive parenting, had long-term repercussions on her self-esteem and sense of self:

“I’ve been working on my self-esteem and image of myself because I am happy to put everyone else ahead of myself, but I do not prioritise myself. And I think that [CSA is] a part of it. I’ve grown into that partially, too, to my relationship with my mother as well. But my self-worth is very historically, has been very low.” (PF5)

PF11 also reported an accusatory response from her mother, where the latter *“called [PF11] a whore, and she said that [PF11] was making it up”*. PF11 also described subsequent

internalisation of the abuse and disclosure to her mother with its lasting effects on her sense of self and trust of others:

“It just hurt me so deeply that it took me a lot of years to recover from that hate... pain. And I still carry that guilt feeling sometimes throughout my life. Like, I internalise things a lot in that they're my fault when they aren't. So I still carry that feeling that it's my fault, that I'm guilty about things that are not my fault. And it really damaged me. And I had a really hard teenage years. I was so full of hatred. And I was full of anger, and I was just scared of continually being let down by people who were supposed to protect me. So, I always felt really like I had to protect myself, like I always felt really wary of people. Till this day, I feel like I'm very distrusting and I'm always looking out to be not hurt.” (PF11)

Although PF12 did not disclose her abuse directly to her father, her mother informed her father about one of PF12's perpetrators. In response, he reacted in an accusatory manner, suggesting that PF12 had the “*intention*” of being a victim. This disclosure occurred after PF12's mother questioned her about the abuse following the violent behaviour of her mother's boyfriend—PF12's last perpetrator. PF12 felt that her mother's denial of the abuse compelled her to provide proof of what had occurred. She recounted her mother's demand for evidence of having seen her boyfriend (PF12's abuser) naked:

“The only reason my mom ended up believing me was because [mom's boyfriend's name] had this weird penis [...] So then my mom knew I was not lying, but that is what it took for my mom to come out of denial about that.” (PF12)

PF12's experiences highlight the significant impact of a caregiver's reaction to CSA and their overall parenting approach. Having been raised by her father and not meeting her mother until the age of 15, PF12 placed considerable emphasis on her father's negative response to the abuse and the broader implications of his parenting:

“I don't think he fully grasps the idea of how deep into the human cesspool I have been in my life as a result of this need for love. And this need for validation that I was only feeling able to, to be able to achieve through sexuality.” (PF12)

This sentiment reflects a common theme among participants: anger and frustration directed at their primary caregiver's inaction, regardless of whether or not the abuse had been disclosed. For many, this anger appeared more emotionally charged than discussions about their CSA perpetrators, suggesting that the perceived neglect or failure of caregivers left a profound emotional impact that shaped participants' views of their abuse and its aftermath.

Although he never disclosed CSA in childhood, PM14 also mentioned his grandparents were *"aware of what was happening, and they did nothing,"* and that the family's response had a negative effect on him:

"I wasn't part of a family, that I didn't have a family, that my life was completely worthless. And that, um, the relationships within the family were a complete fraud." (PM14)

PF18 likewise reported the long-term impacts on her sense of self and her beliefs on family that both her CSA experienced by her father and her mother's overall poor way of dealing with her disclosure had had:

"Family is supposed to protect you and take care of you. And so both of those [parents] had failed me, and I remember feeling very not confident. [...] If it were handled earlier, it would have prevented a lot of the confusion. And then part of that confusion is also a confusion about how to love yourself, and caring about yourself, and having self-respect, and yeah, I lost a lot of self-respect in my 20's." (PF18)

PF18 is the only participant who described her initial disclosure experience to a parent as *"extremely supportive."* She recounted her mother reassuring her, saying things such as, *"This is not your fault. Do not ever blame yourself,"* and assuring her that *"she was going to handle it."* Nevertheless, despite her mother's claim that she addressed the abuse with PF18's father, she *"didn't continue,"* leading PF18 to state that her *"relationship with [her] mom just progressively got worse for various reasons because of that."* Upon processing the abuse in adulthood, PF18 believed her mother's reaction was influenced by her own unresolved childhood trauma, as she was *"certain she had her own abuse"* and that her *"awareness wasn't complete."* Nevertheless, as a result of her mother's mixed response, PF18 felt *"very betrayed, not protected at all, not in a*

safe environment at all". She additionally mentioned that such experiences "*felt very up and down emotionally*."

Other participants reported that they "*never felt safe in the world*" (PF1) as a result of these disclosure experiences.

Insecure parent-child attachment dynamics, characterised by a lack of adequate support in processing CSA through positive and helpful disclosure experiences, compromise mentalization, which is essential for emotional processing and the prevention of psychopathology (Ensink et al., 2020; Fonagy & Campbell, 2017). Responses from insecure attachment figures often impair the development of emotion regulation—the ability to constructively manage and respond to emotional experiences (Hazan & Shaver, 1994). Emotion regulation encompasses awareness and acceptance of emotional states even in times of distress, management of impulsivity, and pursuit of goal-directed behaviour (Cheng & Langevin, 2023), the lack of which—found to be higher in CSA survivors—resulting in impaired sustained attention, particularly during periods of distress (Cheng & Langevin, 2023; Liu, 2019; Oshri et al., 2015). Insecure attachment styles, such as anxious and avoidant attachment, are strongly associated with emotional dysregulation (Cheng & Langevin, 2023; Gause et al., 2022).

Childhood maltreatment has been shown to impair the perception, interpretation, and management of emotional information, likely due to its link with insecure attachment (Falgares et al., 2024; Höltege et al., 2023; Oshri et al., 2015; Snyder et al., 2023; Turgeon et al., 2023; Ye et al., 2024). The perceived availability of caregiving plays a critical role in shaping emotion regulation strategies. Anxiously attached individuals often intensify emotional responses due to heightened sensitivity and preoccupation with caregiver availability, resulting in difficulties with self-soothing and exaggerated stress responses. Conversely, avoidantly attached individuals tend to suppress emotions such as anger and fear in response to inconsistent or unresponsive caregiving, which impedes healthy emotional processing and leads to unresolved emotional pain and maladaptive behaviours (Mikulincer & Shaver, 2019). These patterns are less adaptive in the long term compared to the strategies employed by securely attached individuals.

Research highlights the role of insecure attachment styles and emotion regulation in mediating the relationship between ACE's and psychological outcomes. Ye et al. (2024) found that emotion

dysregulation mediated the link between ACE's and depression, while Snyder et al. (2023) demonstrated that, after controlling for mental health treatment, the relationship between ACE's and anxious attachment was explained by difficulties in emotion regulation and dissociation. Emotion dysregulation has been consistently linked to maladaptive coping behaviours, heightened vulnerability to psychological difficulties, and post-traumatic symptoms in individuals with histories of childhood maltreatment (Cantón-Cortés et al., 2020; Crow et al., 2022; Hébert et al., 2020; Nielsen et al., 2017; Sizemore et al., 2022).

These findings suggest that emotion dysregulation may partially explain the psychological vulnerabilities observed in CSA survivors, particularly when disclosure elicits negative responses from caregivers in insecure attachment relationships.

Participants also reported experiencing overreactive disclosure experiences, where the recipient(s) “*push the pace of*” the processing of the abuse or “*make it about*” themselves (PF13). PF7, who had disclosed to her father upon his seeing her shaking in fear following an abusive instance from older boys in the street, believed her father's angry, overreaction was motivated by his “*defending his own honour*”, where he “*put [her] to shame*” by yelling in the streets, looking for the perpetrators. As this reaction attracted the attention of several neighbours, PF7 described feeling as though she were “*a sexual object*”, feeling “*a little bit sorry for those guys [perpetrators] too*” and that she “*didn't want to cause any conflict*”. PF7 also felt because of her father's “*crazy*” response, she “*got ashamed and [she] never told anything else to [her] dad.*”

PF1 perceived her disclosure to the authorities as extreme, as it resulted in her immediate removal from her adopted home. She described the subsequent lack of adequate explanation or support as “*devastating*”:

“It was very overwhelming in the sense that I didn't really understand what was going on. I thought I was just going to answer these questions, and life was going to go back to normal, and I didn't realise that my life was never going to be the same after that. Like, I essentially, lost everything, right?” (PF1)

Although these participants disclosed their CSA either in response to inquiries from their parents or other adults, or in anticipation of receiving helpful reactions, they encountered devastating responses that were uncharacteristic of a caring parent or adult. Consequently, none of these

participants disclosed their CSA experiences again until adulthood. As PM2 noted, his mother's reaction to his disclosure discouraged him from sharing further, as he "*[thought] others wouldn't believe [him].*" For several participants, the continuation of their CSA left them feeling even more confused and complicit in the abuse. They discussed how these negative reactions, set against a backdrop of adverse family environments, led to a range of detrimental effects, including impacts on their psychosexual development.

Negative CSA disclosure experiences, indicative of insecure attachment dynamics and impaired mentalization, contribute to heightened epistemic mistrust, which is incorporated into internal working models (Benzi et al., 2023). These internal working models, shaped by early traumatic experiences, often include self-schemas—cognitive and emotional structures developed through the infant-caregiver relationship—that are self-reinforcing and resistant to change (Baugh et al., 2019; Seeds & Dozois, 2010). Self-schemas, rooted in cognitive theory, encompass beliefs about one's attributes, abilities, and identity, and function as subconscious cognitive frameworks that shape the processing, encoding, and interpretation of information (Beck, 2011).

According to Finkelhor and Browne's (1985) traumagenic dynamics model, betrayal—a core dynamic—elicits feelings of anger, loss of trust, dependency, and grief, increasing vulnerability to further abuse. This dynamic reflects not only the realisation that a trusted individual has exploited the victim, but also that the caregiver has failed to protect them. Consequently, maladaptive self-schemas become entrenched, as supported by Hovellius et al. (2021), who found significant correlations between insecure attachment styles and maladaptive self-schemas in individuals undergoing methadone or buprenorphine maintenance treatment. These individuals exhibited higher rates of insecure attachment, maladaptive self-schemas, and relapse compared to employed individuals or those engaged in studies.

Emotional dysregulation, compromised mentalization, and negative self-schemas—common features of insecure attachment—are further exacerbated by negative caregiver responses to CSA disclosure. These negative reactions can be as damaging as the abuse itself, heightening post-disclosure stress and increasing the risk of self-blame and trauma symptoms (Alyce et al., 2024; Faller, 2020; Halvorsen et al., 2020; Jouriles et al., 2022; Spaccarelli, 1994). Such responses shape victims' self-perceptions, reinforce self-blame and trauma symptoms, and

influence their beliefs about coping strategies (Dworkin et al., 2019; Hébert et al., 2022; Manay & Collin-Vézina, 2021). Impaired mentalization and epistemic mistrust, resulting from insecure attachment dynamics, further diminish children's ability to engage with supportive information in their environment, which might otherwise buffer the impact of abuse and reduce its internalisation (Ensink et al., 2015; Kampling et al., 2022).

Insecure attachment styles, whether associated with CSA or anticipated negative disclosure reactions, often lead to the persistence of abuse, confusion about its morality, and reinforced feelings of shame and self-blame (Jouriles et al., 2022). Lower emotional regulation abilities, immature defence mechanisms, and maladaptive response patterns—all linked to psychopathology—are significantly associated with epistemic mistrust and/or credulity (Campbell et al., 2021; Kampling et al., 2022; Nimbi et al., 2023; Tanzilli et al., 2022). Consequently, survivors of childhood abuse may become trapped in cycles of victimisation, shaped by attachment patterns, emotion dysregulation, and caregiving dynamics (Hébert et al., 2020; Höltge et al., 2023). These patterns indicate that secure attachment mitigates the impact of child maltreatment by enhancing resilience through adaptive coping and emotional regulation, whereas insecure attachment exacerbates PTSD symptoms and impairs effective coping mechanisms (Crow et al., 2021; Mikulincer & Shaver, 2019).

Disclosure, whether absent, delayed, or negatively received, emerged as a key factor in shaping participants' recovery journeys. Male survivors, who often refrained from childhood disclosures, struggled with recognising their victimhood due to societal expectations of masculinity. Meanwhile, female survivors, despite a higher prevalence of childhood disclosures, faced dismissive or accusatory responses that compounded their trauma. For many participants, the absence of disclosure during childhood, or the negative reactions they encountered, shaped their understanding of intimacy, sexuality, and self-perception. These experiences often perpetuated maladaptive patterns, such as emotional avoidance, hypersexuality, or confusion regarding sexual identity. Psychosexual development thus emerged as a pivotal area where the long-term effects of CSA, compounded by disclosure experiences and societal constructs, became evident, requiring survivors to navigate complex interpersonal and intrapersonal challenges in adulthood.

4.3.2.1.3 Shaping intimacy: the impact of CSA on psychosexual experiences and identity

As CSA is a form of sexual trauma, coupled with the high prevalence of ACE's and intrafamilial CSA in this sample, as well as the absence of childhood disclosure experiences or positive and supportive disclosure responses, participants' narratives highlighted substantial impacts on their psychosexual development. Seventeen out of the 18 participants reported that CSA affected their sexual identity, sex life, and/or intimate relationships. These impacts included struggles with unwanted sexual thoughts and fantasies, engagement in undesirable sexual behaviours, psychological or physiological discomfort during sexual activity, difficulties maintaining healthy and stable relationships, and efforts to prove or determine their heterosexuality. Participants who experienced a higher frequency of ACE's within the family home—particularly those subjected to intrafamilial CSA, especially by a primary caregiver—reported more frequent and severe impacts on their psychosexual experiences and intimate relationships.

Several participants (e.g., PF5, PM9, PM10, PF11, PM14, PF18) reported struggling with unwanted sexual fantasies, which they attributed to their CSA experiences. These thoughts and fantasies varied in intensity, with some being relatively innocuous, yet perceived negatively by participants due to the association with CSA and potentially sexual shame. Others, however, were more concerning and potentially dangerous. Although PM9 acknowledged his sex addiction and was receiving treatment, he described many fantasies and sexual activities that would typically be considered common among people without a sex addiction. He framed these experiences with shame, frequently labelling them as problematic or “*bad*”. For instance, he referred to engaging in sex twice a week at the age of 66 as a “*dysfunction*.”

PF5 likewise described her pornography preferences, specifically involving multiple men engaging in sex with one woman, as “*embarrassing*”, and felt “*shame*” for being drawn to such scenarios. While such preferences might be considered aggressive, they are not necessarily unusual. Nevertheless, when reflecting on her internal conflict regarding these preferences, she connected them to her experiences of abuse:

“I think that there might be some form of connection. Obviously, the person that abused me was much older and I was much younger. And it wasn't something that I desired or wanted. [...] And they are not something that I would want to participate in physically, but watching them, are

something that excite me. And then there's also something in the same token in a very, um, polar opposite, also offend me, because often the women are being mis- mistreated, they're being, well, they are, they're being treated horribly. And so that's...causes a lot of conflict for me.” (PF5)

Physically aggressive sexual fantasies were also reported appealing to PF18. PF18 outlined the benefit of processing her abuse, whereby she distinguished between her current fantasies, which she chose to act out in relationships, and the actions imposed on her by men who had treated her aggressively in the past. She explained this difference in mentality as follows:

“I just liked being treated that way. And also, I felt I should have been treated that way, it was both of those things. Right now, it's no longer that I feel I need to be treated that way. It's that I like being treated that way. You know, there's a difference. It's more of a choice.” (PF18)

PM10, who displayed violent thoughts and behaviour towards himself and sexually aggressive thoughts and behaviour towards others during childhood—coinciding with the period of his sexual and physical abuse—was expelled due to these latter actions. He explained the reasons behind his aggressive fantasies and how gaining an understanding of his trauma ultimately led to a change in this behaviour:

“ [...] realising like what had happened to me and just putting everything together, but so yeah, so the fantasising started super young as well, on that note, because I was addicted, you know, and this sounds horrible, um, but I wasn't like... I was addicted to the rape fantasy then too because it happened, you know. [...] it's been an exhausting journey of healing.” (PM10)

Some participants' sexual fantasies—and the planning of such—became more concerning, prompting them to seek professional help. PF11 reflected on a period when she was intrigued by child pornography, although she noted she never actually watched it. She connected this interest to her own experiences of CSA:

“I'm not sure if this is related, but sometimes I feel like I have impulses to hurt children because I'm curious of how that person felt when they abused me. So sometimes I feel I have, like dark, really dark thoughts about abusing other children.” (PF11)

PM14 similarly described *“having a lot of difficulty trying to cope with the memories and self-esteem”* tied to his sexual fantasies around children. He recalls reaching a point where he

found himself “*planning how it might play out,*” which ultimately motivated him to seek professional help for addressing the impact of his CSA:

“It became more difficult to cope with, and I felt like I was in danger of becoming an offender myself. And so, rather than taking the risk of hurting somebody else, then I sought [professional] help.” (PM14)

All participants who reported such thoughts and fantasies had experienced intrafamilial CSA. In most cases, the abuse was prolonged, involved penetration, and was perpetrated by a parent or a caregiver in a parental role.

Participants who experienced sexual fantasies, whether innocuous or potentially dangerous, often expressed significant feelings of shame. This shame extended beyond fantasies to their sexual activities, where many reported engaging in behaviours they perceived as unwanted or unhealthy.

Undesirable sexual behaviours reported by several participants referred to “*promiscuous*” or “*hypersexual*” behaviour (henceforth referred to as “hypersexual behaviour”). Some level of dissociation was implied by these participants, who engaged in such behaviours due to a need or urge to escape stress, dissociate, or gain validation, among other reasons. This behaviour did not always align with the definition of compulsive sexual behaviour (CSB), as not all participants reported a loss of control over their sexual thoughts and behaviours (Karila et al., 2014; Pistre et al., 2023; Reed et al., 2022; Stavro et al., 2013). Rather, some used substances to engage in sex, or agreed to sex with anyone who sought it, without being overwhelmed by compulsive sexual urges.

It is worth noting that, with the exception of PM9—who reported that his hypersexual behaviour was so severe that he sought ongoing help in a sex addiction group—all other participants who exhibited this behaviour also either concurrently had or had previously experienced some form of SUD. Furthermore, all participants who reported engaging in hypersexual behaviour had experienced both intrafamilial CSA and additional ACE’s.

PM9 acknowledged that his sex addiction was a key factor that prompted him to initially confront his experience of CSA. Similarly, PM10 connects his traumatic childhood experiences to his sexual behaviour:

“So yeah, like I was just addicted to the sex, like, you know, I was putting my penis in things. I was obsessively masturbating until I was bleeding. [...] It’s such a traumatic big thing to happen to a little being, now I know this, that was, what’s going to match that? What is going to, what’s going to like, counteract it, what’s going to trump it, trump that exact same excitement and trauma and overload and adrenaline and all these different things? And so all I would do were things that were bigger and bigger.” (PM10)

Attachment styles, established during childhood, persist into adulthood and significantly influence romantic relationships, which often parallel the caregiver-child relationship in fulfilling a similar role in emotion regulation (Dykas & Cassidy, 2011; Hazan & Shaver, 1987; Johnson, 2019). Securely attached infants internalise the soothing, responsive caregiving relationship, enabling the formation of healthy relationships and effective distress regulation through mental representations of the infant-caregiver bond.

Conversely, individuals with insecure attachment frequently experience emotional dysregulation, which can manifest in impulsive behaviours, including sexual risk-taking and CSB, as maladaptive strategies to manage unresolved emotional difficulties (Cassioli et al., 2024; Petersson & Plantin, 2023; Pulverman & Meston, 2020). Gewirtz-Meydan and Lahav (2020) investigated adult CSA survivors’ sexual functioning through the lens of attachment theory, revealing that CSA history significantly moderated the relationship between attachment insecurities and sexual functioning. Specifically, among survivors, higher levels of attachment avoidance predicted lower sexual desire, while attachment anxiety was linked to increased physiological arousal during sexual activity—patterns not observed in nonabused individuals. Sexual problems, such as dysfunction or dissociation, may also function as defence mechanisms, potentially safeguarding survivors from engaging in sexual activities that could trigger traumatic flashbacks or emotions (Kratzer et al., 2022; O’Driscoll & Flanagan, 2016).

The Traumagenic Dynamics Model posits that exposure to sexuality within an abusive context adversely affects psychosexual development (Finkelhor & Browne, 1985). CSA, as a form of sexual trauma, exerts particularly detrimental effects when the perpetrator is an attachment figure. Traumatic sexualisation is associated with increased sexual problems and confusion regarding sexual norms or identity, contributing to behaviours such as sexual risk-taking,

compulsive sexual activity, and sexual aversion or dysfunction. This model also highlights how CSA fosters negative emotions linked to betrayal and traumatic sexualisation, distorting perceptions of sex and influencing survivors' choices and relationships with romantic partners (Finkelhor & Browne, 1985).

Some participants linked their hypersexual behaviour to their lack of self-worth. PF11 explained her reasons for engaging in hypersexual behaviour as follows:

“I was just something to fuck, or like I was a sperm vase or something like that. I just felt worthless” (PF11)

Similarly, PM14, who grew up in a severely abusive household where his mother, stepfather, and family physician were sexually abusive, explained that his hypersexual behaviour was driven by a need to derive self-worth from how others perceived him:

“Outside of relationships, I was extremely promiscuous, sometimes as much as three or four interactions in a day. [...] Those actions were where I found some sense of being attractive, of being valued by somebody placing importance or value on their time with me, right? And so that's how, that's how I derived self-worth.” (PM14)

Despite this behaviour, PM14 noted that he had been in a monogamous marriage for several years because he believed *“the ultimate arrangement would be a lifetime monogamous relationship,”* and his *“goal [was] to find a way to get out of the promiscuity.”* He later discovered, however, that his husband had been unfaithful throughout their marriage, which his husband attributed to his own history of CSA. Although PM14 struggled to trust him, he agreed to an *“open relationship,”* despite admitting it was *“not at all what [he] had wanted or expected.”* He explained that he valued romantic relationships over short-term sexual encounters because the former was superior in terms of *“the other person's sense of the value for [him].”* Ultimately, the marriage ended as their *“own personal history started clashing, and it just caused a whole lot of problems.”*

Several participants reported experiencing psychological or physiological discomfort or pain during sex or when contemplating sexual acts, attributing these experiences to both their abuse and other aspects of their upbringing. This discomfort was often linked to their frequent

dissociation, which they described as affecting various areas of their lives. PM10 referred to this as *“pain that I pushed down into my genital region”* from his CSA, and remarked, *“I didn’t realise that I actually was suffering from disassociation a lot, and I would leave my body.”*

Similarly, PF6 shared that she *“got through the original abuse by dissociating”* and described how her *“body didn’t really belong to [her].”* This dissociation extended into her adult sexual relationships, creating significant challenges in her sex life. When reflecting on the impact of CSA, PF7 highlighted experiencing difficulties with sex, particularly with penetration. She acknowledged that these problems, while physiological, were rooted in psychological difficulties and fears. PF7 further explained that this had complicated her attempts to conceive a child through IVF, as *“a lot of things need to go inside.”*

PM2 experienced flashbacks or triggers during the act of sex, although he attributed these directly to vicarious trauma resulting from his group therapy sessions:

“Whenever I would engage in sex, foreplay, whatever it is with the opposite sex, I would never ever have a triggering moment from my past. [...] it was after the first day of group therapy, however, when I sat in with men and they were talking about their experiences with their significant other and them having to relive experiences in their past because of touching their wife, that my wife and I, we engaged in foreplay, and I thought about my abuse. But the reason, and then as the sessions went on, I learned about vicarious trauma. I started to realise I’m, I’m living my trauma through somebody else’s eyes.” (PM2)

PF13 described sexual and intimacy difficulties she had, and not being sure if it was from the CSA or her religious upbringing:

“I have discomfort around being touched in particular ways or having certain things done to me that maybe I don’t know if it’s a sexual thing and I’d be the same any other way. But I don’t know whether it’s the abuse or the like some residual Catholic shame that I haven’t been able to shake off.” (PF13)

PM17 described sex in his *“almost asexual”* or *“sexless marriage”* as *“never super great to begin with,”* and attributed some of it to both his wife and himself, citing various serious life events within their marriage, but attributing much of it to his CSA, where he reflected that they *“both*

weren't really aware when she entered into the marriage that like this was something [he] was gonna be challenged with." PM17 was quite vague about these sexual difficulties, stating that he did not "*think [he] need[ed] to go into big details*". Nevertheless, he outlined a connection between his CSA, the ACE's within his family, and how these experiences negatively impacted his sexual relationship with his wife:

"...this played out to how I protected my family too is, you know, I became a people-pleaser, co-dependent if you want to call it that. And so that affects your sexuality too because you're not really focussed on like, 'What do I like? What am I into? What do I need?' And so in sexuality, it's not really give and take that, you know, could be there, should be in a healthy situation. It's more one-sided and that's... yeah, it just affects your communication in every realm of your life and then it plays on the sexuality in a large way too." (PM17)

Although the researcher reminded participants that they could share only details about their sex lives they felt comfortable disclosing, female participants appeared more open and forthcoming in discussing their sexual experiences and related challenges. They often provided specific details about the issues they faced. Conversely, most male participants were more vague about their psychological or physiological discomfort or pain. This reticence may have been influenced by the researcher's opposite sex and relatively younger age compared to the male participants displaying these behaviours.

Participants frequently reported psychological or physiological discomfort, often linked to dissociation, stemming from CSA and family dynamics. This discomfort significantly influenced their experiences when considering or engaging in sexual activity. Furthermore, as a result of their CSA experiences and subsequent maladaptive sexual behaviours or discomforts—both psychological and physiological—several participants reported a range of difficulties in forming and maintaining romantic or intimate relationships. These challenges were particularly prevalent and impactful among those who had experienced intrafamilial CSA and other ACE's.

PM17 felt that his sexual problems due to his CSA and ACE's were "*tainting*" his view of sex and adding "*a little bit of like a dirtiness to it*". This was impacting his relationship with his wife:

“It’s strange because like, I’ve always had a strong sexual desire, but then from my wife’s perspective, she’d probably feel like she’s not being desired. I think that’s one of the facts—like I can be kind of hot and cold sexually.” (PM17)

PM10 attributed his problems around intimacy as stemming from his confusion around the CSA from close perpetrators:

“Because it happened so young, I feel like somewhere in my small baby brain, I equated it to love. [...] And my mom’s first husband was involved, I know that like after doing a lot of work, like I equated it to love. You know, so, it’s just hard for me to, and I have to remember that it’s not love, you know? And so that’s the thing is I did equate, OK, well, this person is supposed to be taking care of me, you know, so my child still... So this is where I go into my child zone and my inner child right now. And yeah, like, I just thought that he loved me, like it was supposed to be my dad. And so, um, and yeah, so that’s where I got mixed up. And I’ve been sort of stuck back and forth there processing well, my whole life type of thing.” (PM10)

Consequently, PM10 acknowledged that he was *“in an emotional relationship with [his] trauma,”* making it difficult for him to engage in emotionally available relationships with others. Much like several participants, PM10 expressed fears of intimacy or struggle with the tendency to avoid healthy relationships. He described this internal conflict regarding the potential to ward off healthy romantic connections:

“So intimacy, like I can attract people. But I’m terrified. I usually end up pushing them away. I usually end up, like picking them apart. I know that I already have anxious attachment, I definitely, uh, revert to being the age that I was abused. Sometimes, I don’t like who I become. I always say, I’ve been saying actually—and I should really stop saying this—but when I meet someone, and they like me, I become my worst possible version.” (PM10)

Similarly, PM14 noted an understanding of his prior relationship dynamics having been a reflection of his abusive experiences:

“In hindsight, looking back through everything, I can see, um, elements of the abuse impacting every relationship along the way in different ways.” (PM14)

PF10 attributed her prior proclivities towards unhealthy sexual encounters—and avoidance of healthy relationships—to feelings of worthlessness:

“I felt dirty and I felt disgusting, and I felt gross with myself and with my body. Um, and I just didn't want to be touched, or I felt like I wasn't worth it.” (PF11)

Avoidant attachment is characterised by defensiveness, self-reliance, discomfort with closeness, and scepticism about relationship longevity, whereas anxious attachment involves a preoccupation with love, a strong desire for closeness, negative self-perceptions, and fear of rejection (Dykas & Cassidy, 2011; Hazan & Shaver, 1987; Johnson, 2019). A review by Zamir (2022) investigating the relationship between childhood maltreatment and relationship quality found that maltreatment, including neglect and various forms of abuse, is linked to poorer relationship outcomes in both men and women. Mediators included psychological distress, cognitive-behavioural issues, insecure attachment, and self-dysregulation, while protective factors comprised effective coping strategies, emotion regulation, parental support, and early secure attachment (Zamir, 2022). Emotional dysregulation and impulsivity, commonly linked to insecure attachment, present significant challenges in forming and maintaining healthy relationships, as individuals may struggle with intimacy, trust, and emotional stability.

In addition, CSA survivors have been found to be more prone to epistemic mistrust compared to non-survivors, which may affect their romantic relationships (Lassri & Gewirtz-Meydan, 2024; Luyten et al., 2024). Impaired mentalisation, epistemic trust, and emotional dysregulation—often associated with insecure attachment styles—may compromise emotional and physical intimacy within personal or romantic relationships (Petersson & Plantin, 2023; Stagaki et al., 2022; Turgeon et al., 2023; Zamir, 2022). These challenges, critical to young adulthood's developmental tasks (Erikson, 1959), not only hinder recovery from trauma but also heighten the risk of enduring psychological difficulties, including anxiety, depression, and persistent relationship problems (Ensink et al., 2020; Hébert et al., 2020; Stagaki et al., 2022; Zamir, 2022). Such mechanisms may explain why studies have consistently found that CSA survivors face significant difficulties in forming and maintaining intimate relationships in adulthood (Attrash-Najjar et al., 2023; Lewis et al., 2022).

Despite comparable negative impacts of CSA on later sexual experiences and intimate relationships for female and male survivors, gender differences were evident in the outcomes related to psychosexual development. These differences were shaped by varying perceptions of CSA, with male participants often interpreting the experience as a sexual encounter, while female participants predominantly viewed it as a violation. These perceptions were further influenced by societal constructs, including masculine ideals emphasising sexual prowess, self-sufficiency, and invulnerability, as well as feminine norms centring on agreeableness and objectification. Additionally, homophobia and societal gender norms compounded these gendered trends in psychosexual development. Family dynamics, coupled with the lack of or negative disclosure experiences in childhood, further exacerbated these outcomes.

Male participants' tendency to frame CSA as a sexual experience was closely linked to struggles in understanding, defining, or validating their sexual orientation. For gay male CSA survivors, this challenge was particularly pronounced. PM4 reflected on believing the CSA was “[*his*] *fault*” and described how this belief influenced his subsequent romantic and sexual relationships. He noted a pattern of engaging exclusively with men “*twice as old as*” himself, mirroring the dynamic he had with his perpetrator, which he acknowledged caused him significant turmoil. PM4 further critiqued what he perceived as an acceptance and encouragement of such dynamics within gay culture, arguing that these norms could be especially detrimental for CSA survivors.

“In gay culture, there is a lot about that idea of like daddy and son, like an older man with a younger boy. [...] almost like the need, the need of a child to wanting to be sexually abused”
(PM4)

The gender of the perpetrator also appeared to play a role in shaping participants' understanding of their sexual orientation. PM14, the only male participant who acknowledged that one of his perpetrators was a woman (his mother), described a “*kind of turning point*” when he decided he did not “*want anything to do with women*” after witnessing his mother engaging in abusive behaviour:

“I was attracted to women before the abuse started. Um, after the abuse, I had such a low view of women, I, yeah, had difficulty with just talking to them. So I, all of my primary relationships were with men.” (PM14)

PM14 attributed his exclusively same-sex sexual and romantic relationships to a desire to avoid close connections with women despite also having been sexually abused by two men (including his stepfather).

Several primarily or exclusively heterosexual men abused by male perpetrators seemed to seek validation for, or experience confusion around, their sexual orientation in the process of negotiating the meaning of their abuse within the context of their emerging sexual identity. PM2 described at length his viewing of heterosexual pornography and constant evidence that he is indeed exclusively sexually attracted to women. He additionally mentioned having a sexual relationship at 12 years of age with a girl of the same age:

“Going through that experience with someone of the opposite sex that young made me realise that I am attracted to the opposite sex.” (PM2)

PM9, who considers himself to have a sex addiction, highlighted that he had only engaged in sexual activity with cisgender women, although he mentioned being interested at times in transgender women when viewing pornography. He described the idea of engaging in sex with men as being *“repulsive”* to him, and that he had never *“acted out”* and engaged in sex with men. Nevertheless, PM9 reflected on having had a *“fascination”* with male band members from the 1980s who dressed as women, despite stating that he *“cannot imagine being with a man”* sexually. For these men, the abuse by a male perpetrator might be perceived as a challenge to their heterosexual identity, leading to efforts to affirm their heterosexuality post-abuse.

The confusion and need to confirm their sexual orientation may have been further influenced by the nature of the abuse and the perpetrator’s justification of it. This, in turn, affected these survivors’ choices in engaging in certain sexual relationships. PM8’s perpetrator often bullied him for being gay, and used this term to justify the abuse. PM8 reported on his struggle with understanding his sexuality:

“[My sexual interactions were] like searching, and not trusting that even though I was attracted to women... and attracted to men, but more attracted to women, um, but not trusting my intuition about my own sexuality and that a few quite uncomfortable situations where I like tried, try things out with men. Um, not like, not feeling OK or right to me, but one thing to test my sexuality, it seems like really strange... not having trusted that I am heterosexual.” (PM8)

PM8 additionally attributed what he thought as his “*unfortunately binary*” attraction to be as a result of a homophobic upbringing, and having been bullied for appearing gay. Similarly, PM10 attributed his understanding of his own sexuality to the abuse and exploitation of stigma around homosexuality by one of his perpetrators:

“So just being like, taunted and teased about being gay and different things when I didn’t feel gay, I don’t, I don’t feel gay. I felt as though that was like put on me based upon the person who was abusing me. It was a man and so they were putting their own gay, weird, like, it’s just sick and as twisted in a psychological, you know. But so forever, I thought that I was gay. And so I did all these like stupid things. I just like, look back, and I got with, it was just over the top like gay guys.” (PM10)

Confusion or seeking validation around one’s sexual orientation as a result of the abuse and gender of the perpetrator appeared to exist only among several male survivors. This was not the case for PF13 (a female victim of a female perpetrator), who did not allude to her perpetrator’s same gender in her subsequent sexual experiences and identity, despite identifying as primarily heterosexual.

Although several participants of both genders cited their hypersexual behaviours, in addition to the reasons behind this behaviour stated above, distinct gender differences also existed in their rationale. Only male participants reported feeling an impulse to engage in such behaviours, in order to deal with stress, or an unwillingness to be “*peeled back*” (PM2) by any one romantic partner. PM3 explained his reasons for choosing to engage in hypersexual activity:

“I’ve realised that I’ve been so up there in the hypersexual scale. That it’s also, when I’m stressed. I go, I get like to deal with it, I need to have sex. Like, I go really hypersexual.” (PM3)

Similarly, PM9 described feeling as though he was in a “*bubble*” where “*nothing bothers*” him when engaging in such behaviour. Using a social constructionist thematic analysis with male CSA survivors, Lewis, Kiemle, Lowe, and Balfour (2022) found that some survivors overcompensated for their trauma by engaging in hypersexual behaviours with multiple partners or displaying aggression as a means of affirming their masculinity. Furthermore, confusion around sexual identity stemming from CSA experiences often led to a crisis in gender roles and a

diminished sense of belonging within the male group, prompting survivors to assert their masculinity through hypersexual behaviours (Lewis, Kiemle, Lowe, & Balfour, 2022).

Conversely, several female participants were more likely to attribute their hypersexual behaviour around their lack of self-worth that was compounded by the societal stigma/notion of girls and women being sex objects. These participants described a societal message that being a woman implied their “*inherent value was [their] sexuality*” (PF12). PF18 linked her intrafamilial CSA experiences (from her father and maternal grandfather) and her identity as a woman to both her hypersexual and substance use behaviours, which she described as being driven by feelings of unworthiness:

“So the process is you’re abused by the people who are supposed to love you the most. Sexually, you’re made to feel that you’re like, as a woman, you mean nothing, or as a person, you mean nothing. You’re nothing but a sex object. And you have no self-respect or no love towards yourself. And so it’s like a runaway technique, because it’s really uncomfortable to sit with yourself when you have no love for yourself.” (PF18)

While some female participants (PF1, PF5, and PF6) did not report engaging in hypersexual behaviour, they referenced sexual interactions—some of which developed into relationships—where their partners initiated sex despite their own lack of interest or reluctance. PF1 reported having engaged in sexual and romantic relationships with partners she had not been genuinely interested in, stating that she had been “*trying to get love and approval.*” PF5 attributed her pattern of not refusing unwanted sexual advances or relationships to both her experience of CSA and the influence of her authoritarian mother:

“If the person that I’m being intimate with wants to engage in sexual activity, then that’s what I do because that’s what they want to happen. I grew up where you did what you were told, kind of situations—that whole, if an adult told you to do something, then you did it. [...] I don’t think that I have ever in my life said no...” (PF5).

PF6 disclosed that her first marriage began after her future husband raped her, despite her knowing that “*this guy was not a good fit for [her].*” She noted that this behaviour occurred before her “*healing*” from CSA and linked it to a broader social issue at the time:

“It was part of that inequality between men and women thing. And this is what women are here for. And so if they say no, it just means yes anyway.” (PF6)

This difficulty in refusing unwanted sex or romantic partners was not something that was referenced by male participants. The pervasive societal beliefs surrounding masculinity and misconceptions about CSA not only hinder survivors’ willingness to disclose but also profoundly shape their long-term recovery processes. These beliefs often create internal conflicts, as male survivors struggle to reconcile their experiences of victimisation with societal expectations of male identity, which emphasise strength, self-reliance, and invulnerability (Attrash-Najjar et al., 2023; Lewis, Kiemle, Lowe, & Balfour, 2022). Similarly, female survivors face societal constructs that frame women as sexually passive, a stereotype that perpetuates restrictive gender roles and undermines their agency in addressing the abuse (Torenz, 2021).

Ragonese et al. (2018) describe masculinity as a construct characterised by rigid norms, including a hierarchical distinction between overt masculinity and femininity. This hierarchy emphasises dominance and hypersexuality in men while positioning women as subordinate and sexually passive. These gendered expectations not only obscure male victimhood but also reinforce stereotypes that silence both male and female survivors of CSA. For men, hypersexuality as a societal ideal can lead to misinterpretations of CSA as a sexual experience rather than a violation, further complicating their ability to recognise and disclose the abuse. For women, the cultural framing of sexual passivity and victim-blaming attitudes contributes to feelings of shame and self-blame, which impede their recovery.

These rigid gender norms and misconceptions influence the ways survivors internalise their abuse, process their trauma, and navigate their healing journeys. For male survivors, the societal denial of vulnerability and emotional expression often results in delayed or suppressed disclosures, increasing their risk of psychological distress and maladaptive coping strategies (Widanaralalage et al., 2022). Female survivors, constrained by societal expectations of sexual purity and submissiveness, frequently encounter stigma and disbelief when they attempt to disclose, further perpetuating cycles of silence and trauma (Flynn et al., 2023; Sugiura & Smith, 2020). These societal constructs also contribute to significant disruptions in psychosexual

development, including confusion regarding sexual norms and identity, difficulties in forming healthy intimate relationships, and increased vulnerability to maladaptive sexual behaviours.

The challenges participants faced in their psychosexual development—ranging from difficulties with intimacy and sexual functioning to struggles with identity and self-worth—underscored the need for healing relational experiences. These challenges were intricately tied to their histories of CSA and their subsequent disclosure experiences, necessitating a recovery process centred on redefining attachment dynamics and renegotiating societal constructs. Recovery often involved addressing the psychosexual repercussions of CSA within the context of safe, supportive relationships, providing survivors with the tools to rebuild their sense of agency and connection.

4.3.2.1.4 Reconstructing self: pathways to healing after CSA

The recovery process, as described by participants, was neither linear nor uniform but rather an evolving journey characterised by critical turning points. Central to this process was the realisation of the gravity of CSA, often facilitated by supportive relationships or therapeutic interventions. This awareness marked the beginning of a shift from maladaptive coping mechanisms—rooted in attachment trauma and societal constructs—to healthier patterns of behaviour. Recovery involved reworking attachment dynamics, exploring psychosexual challenges, and renegotiating societal norms that had previously hindered participants' ability to heal. For many, the establishment of secure attachments in adulthood, whether through romantic relationships, friendships, or therapeutic alliances, was instrumental in promoting long-term well-being.

Reconstructing self through awareness and relational healing

For participants, the process of recovery and processing their CSA experiences often involved gradually breaking subconscious patterns that reinforced their insecure attachment styles and subsequently establishing relationships that supported healthier, more secure attachment styles. These relationships were formed with a range of individuals, including therapists, friends, romantic partners, or their own children. The motivations for engaging in these relationships varied and were influenced by both indirect factors (e.g., stemming from maladaptive coping

mechanisms) and direct efforts (e.g., a conscious decision to seek and maintain healthy, supportive relationships).

An initial step in this process often involved recognising that the CSA was an abusive experience inflicted upon them, rather than something they had willingly participated in. This shift in awareness appeared pivotal, as it allowed participants to reframe their experiences and view themselves as victims of abuse rather than as complicit in the events. For several participants, this realisation led to a range of positive changes, though the specific nature of these changes varied between individuals.

For many, this understanding was facilitated by exposure to others' stories, such as through group therapy or shared personal accounts, which provided a context for processing their own experiences. Additionally, changes in life circumstances—such as entering into a stable relationship or seeking professional support—further enabled participants to confront and make sense of their abuse. This gradual realisation of the gravity and meaning of their CSA experiences often served as a catalyst for their recovery journeys.

PM2's mother's indifferent reaction to his disclosure of the abuse prevented him from fully questioning or processing the experience at the time. It was only later, after changing schools and countries and forming friendships with older adolescents who openly shared their first sexual experiences, that he began to compare their stories with his own and reflect on his sexual abuse:

“So for me, it started telling me now. Ok, hold on here. All the things that you thought of as being a normal thing is not suddenly normal anymore.” (PM2)

For PM2, this change in environment and perspective did not lead to disclosure, but the newfound knowledge of this being abuse, along with the stigma attached to it, led to his increased awareness of the perpetrator's transgressions:

“Now, I was aware by this being abuse [...] It was at this point, I pushed him. I nudged him [...]. I pushed him and he got the hint.” (PM2)

Despite enduring years of CSA, his mother's dismissive reaction to his disclosure, and the broader dysfunction within his household, PM2 eventually came to recognise his experiences as

abuse. This understanding, although delayed and accompanied by maladaptive patterns that persisted into adulthood, enabled him to take action and put an end to the abuse himself.

Other participants described how changes in their environments or life circumstances exposed them to new people and perspectives, which in turn influenced their decision to disclose their CSA experiences. For example, PF13, who had been abused by an older female neighbour during childhood and had not disclosed the abuse to her parents, shared her story for the first time years later with her three closest friends. This disclosure occurred during her early adolescence, a few years after the abuse had taken place, and following her family's relocation to a different country. She reflected on her motivations for disclosing:

“I don't remember what prompted it. [...] I think it just kind of came out and I don't, like to this day, I don't know where it came out of. [...] I think I just needed to get it off my chest. And that's probably why it came out.” (PF13)

PF13 described her friends' reactions as “*validating*” and as though a “*weight that was lifted*”. She believed this disclosure experience was essential to her coping with her CSA, as she noted that “*without having had the support, it would be way more intense.*” Although PF13 expressed uncertainty as to why she made the decision to disclose, she described discussions with these friends as always having been a “*safe space*”.

The tendency for survivors to disclose their experiences to peers rather than caregivers as they age aligns with their developmental stages and shifting perceptions of parental figures. As children transition through adolescence, they gain greater autonomy and independence, reflecting Erikson's (1959) framework of psychosocial development. During this period, the role of parents evolves from being the primary attachment figure to one of several sources of support, as peer relationships gain importance.

In cases where the parent-child relationship is neglectful, abusive, or complicit in adversity, the ability of children to form secure attachments is often significantly compromised. CSA and other forms of maltreatment are known to impair mentalizing abilities—critical for understanding and navigating social relationships (Ensink et al., 2015; Li et al., 2023; Wais et al., 2024).

Nevertheless, adolescence is characterised by substantial brain maturation in social-cognitive

regions and increased exposure to broader social environments, both of which enhance mentalizing capacities and foster adult-like relational complexity (Poznyak et al., 2019; Taylor, Barker, Heavey, & McHale, 2013, 2015). As a result, while attachment to parents remains relevant, peer relationships increasingly serve as significant sources of emotional connection and support (Feldman, 2023).

For CSA survivors, especially those who perceive their caregivers as abusive or unavailable, improved mentalizing abilities during adolescence may facilitate the formation of trusting attachments to peers. These peer relationships can offer a vital context for positive disclosure experiences, particularly when characterised by openness and vulnerability. Research demonstrates that peer relationships can build trust and provide much-needed emotional support for CSA survivors, even in the presence of insecure parental attachments (Alyce, Taggart, & Turton, 2024; Love & Robinson Kurpius, 2022). Adolescents who experienced CSA are often more likely to confide in peers before disclosing to caregivers, reflecting the critical role peers play in providing validation and emotional security (Gemara, Mishna, & Katz, 2023; Jouriles et al., 2022; Manay & Collin-Vézina, 2021).

Love and Robinson Kurpius (2022) found that stronger attachment to friends predicted more positive problem-focused coping strategies among young adults who were CSA survivors, suggesting that peer relationships can have a protective and adaptive quality. While negative disclosure experiences with both caregivers and peers are linked to trauma symptoms (Jouriles et al., 2022), peer relationships that foster trust and understanding are more likely to facilitate recovery and coping in survivors.

Older children and adolescents are also more likely than younger children to disclose to adults outside their immediate caregiving circle, such as extended family members or professionals. This tendency may be attributed to improved mentalizing abilities with age, enabling a greater capacity to evaluate and seek out supportive figures (Jouriles et al., 2022; Manay & Collin-Vézina, 2021). These disclosures, depending on the reactions of the recipients, can play a pivotal role in shaping survivors' recovery trajectories.

For some participants, recognising the seriousness of their CSA experiences prompted them to seek support from professionals or to cultivate healthy relationships in which they felt safe

sharing their stories. PM4 reflected on how the #MeToo movement helped him realise that his CSA experience constituted abuse. This awareness motivated him to pursue individual and then group therapy. He also noted how this understanding could have been beneficial during his earlier attempts to seek therapy as a young adult struggling with depression:

“I remember when I realised that what had happened to me, it was like a big turning point in my life. Like it was a big turning point in my life because I, I was depressed. Therapy was hard, like I was crying, and I don't cry a lot. And so I was just like letting go of a lot of stuff. So, I think it would have helped me back in 2006, 2005. I think it would have helped me because maybe at the time, again, it would have been such a, sort of like a big deal, but I think the seed would have been planted in my mind. And then it would have grown sooner and maybe I would have realised the gravity of it sooner.” (PM4)

Several participants highlighted the role of the #MeToo movement in fostering a partial societal shift towards more open discussions about sexual assault, although some noted that this shift appeared to primarily benefit female survivors. Hearing others’ stories often served as a catalyst for disclosure and the initiation of help-seeking or processing their CSA experiences. In a study examining CSA survivors’ perceptions of trust and disclosure, Alyce, Taggart, and Turton (2024) found that mutuality—particularly when the other person demonstrates vulnerability—can mitigate inherent power imbalances between survivors and their trusted individuals, fostering a deeper sense of trust and creating opportunities for disclosure.

PF16, who had received a mixed response to her disclosure from her parents and did not revisit the topic during childhood, recalled reading an article about abuse around the age of 18, which heightened her awareness of its prevalence:

“So that's when I started thinking about it more, like wow, this is common. But it was the Reader's Digest article that did it.” (PF16)

PF16 also reported that reading a book with an abusive incident similar to that which she had experienced *“ripped [her] wide open”*, and further increased her awareness of the prevalence and repercussions of CSA, which led her to disclose her abuse to her first boyfriend. PF16 is one of the only participants who reported a negative disclosure experience in (young) adulthood, where

her first boyfriend's response was "icky." Nevertheless, she mentioned that reading the article on CSA helped her to view his response as such and to seek out new, more accepting friendships:

"He was an ass. He's still an ass. I mentioned it to him at 19. He was like, "every girl I've been with has been abused." I was like, "nice response!" But that got, opened my eyes. And I started to talk to the people, started asking people." (PF16)

Much like other participants, for PF16, this awareness around CSA led her to initiate her disclosure as a means to confront the abuse and take a step towards recovery.

For some participants (PM8 and PF12) forming new, healthy attachments along with substances contributed to their willingness to discuss their childhood trauma. PM8 reported his first disclosure was to his closest friend, and that MDMA made him feel less inhibited:

"I was like 18 at this festival and on MDMA and then telling my friend that was the first person I told, and he was very understanding.[...] I think some things that are repressed can dislodge and be more available, be thought about and spoken, so I do think it was a lot to do with the actual chemical." (PM8)

Although MDMA reduced his inhibitions, PM8 described the friend to whom he first disclosed as trustworthy, attributing this trust to the friend's upbringing by "accepting parents" and his belief that "nice people would understand." This positive disclosure experience, facilitated by MDMA, appeared to enable PM8 to grasp the gravity of both his CSA and the years of bullying perpetrated by those involved in the abuse. This realisation initiated a recovery process similar to that of other participants. PM8 described this process as lasting "a few months," driven by a need to "release the tension" and engage in the "process of grief," highlighting the multiple factors that contributed to his ability to process the abuse:

"I had to prove to myself that I can tell people and they would still like me. I'm talking about that event [CSA], which did hold a lot of power and why I didn't tell anyone for eight years. [...] to prove to myself that if they're still not mean, if they understand, then we can still be friends and it's like different. I don't know, some kind of moving on, but maybe in a more unhealthy way, it was like almost like actual need to like get rid of it and tell people." (PM8)

The awareness of CSA as abusive appeared to play a pivotal role in motivating participants to seek and establish new, healthy relationships and attachments, which often facilitated adulthood disclosures. PM17 reflected on his decision to confide in trusted friends after his initial disclosure as an adult:

“I remember sharing with, you know, people I trust or came to trust, I call friends. And it was out of this place of feeling very liberated. You know, like not, ‘oh, I need help and I need support in this,’” (PM17)

In adulthood disclosures to peers, participants appeared to have different needs and expectations compared to those they held during childhood disclosures. PF5 articulated this distinction, noting that she was *“in a position where I feel that I don't need anybody to protect me or to save me.”* Rather than seeking immediate protection or intervention, these adulthood disclosures often served as a step in the recovery process, reflecting survivors' proactive engagement with their healing journey.

For some participants, particularly those who had experienced multiple ACE's within their household and/or intrafamilial CSA, the recognition of the severity of their abuse emerged only after their maladaptive coping mechanisms—such as SUD, suicidality, or CSB—became unmanageable. These maladaptive behaviours often escalated to a point where professional intervention was necessary, ultimately leading to an understanding of the underlying trauma stemming from CSA. PF18 described turning to frequent alcohol and cocaine use to *“take away some of [her] thoughts, feelings and it took away reliving the abuse.”* The severity of her substance use, however, eventually reached a breaking point, as she recalled being unable to answer a basic question about her education, which prompted her to seek professional help:

“He asked me a very basic question, and I couldn't answer it. And I remember that being very distressing to me and I was like, ‘I can't do this’. I was doing so much cocaine that I destroyed my brain [...] I bring it up because of how extensive the self-destruction was and, it was after that that I decided to go into therapy.” (PF18)

Several participants reported entering therapy due to risk behaviours, such as substance use or other maladaptive coping mechanisms. While this initial therapy did not always lead directly to processing their CSA experiences, it often initiated a trajectory of self-awareness, helping

participants identify the roots of their negative behaviours and recognise the gravity of the abuse. For many, this process was described as distressing, marked by psychological struggles that had initially driven their maladaptive behaviours. Participants characterised this journey as “messy” and protracted, often requiring significant time before they sought direct intervention for their CSA. PF1 reflected on the process involved in her initial therapy for substance use:

“And then what happened when I got clean and sober, things got really messy for me. Like, that’s when a lot of mental health stuff started coming out, my inability to be in healthy relationships. [...] I don’t function at a capacity that I would have if I hadn’t had those experiences in my life. Trauma experiences definitely hindered and impacted my ability to function in healthy ways.”
(PF1)

PF1 eventually sought therapy specifically to address her CSA. PM14 described how his suicide attempt and drug overdose forced him to see a psychiatrist, to whom he disclosed his CSA, which was helpful short-term:

“Although I was feeling better at the time, you know, when I was having these daily conversations with the psychiatrist. Um, the difficulty in coping returned not long after I was released. So um it was beneficial, my stay in the psych ward was beneficial short-term, but not long-term.” (PM14)

PM14 described subsequently struggling with depression, anxiety, and distressing sexual fantasies. Encouraged by his positive experience with a previous psychiatrist, he sought therapy specifically focused on addressing his CSA. Similarly, PM2 recounted that ceasing substance use led to experiencing “frequent panic attacks,” prompting him to seek help from a physician to whom he disclosed his CSA. Following this disclosure and a period of grappling with depression and other mental health challenges, he reconnected with the same physician, who then referred him to a group therapy programme centred on CSA:

“I said that I have a problem, that there’s something wrong. And then I spoke to my doctor about it. And so my doctor, super supportive, told me where to go, told me about the counselling.”
(PM2)

Participants outlined how such therapy, established through trust, helped them process the abuse. PF1 described this process:

“I can’t even tell you the difference that’s made to me. Just, I’m just a little over halfway through, but now, to have that sense of safety, that once a week, I’m going and seeing the same person. We’ve established this trust.” (PF1)

The trajectory from engaging in risk behaviours to seeking help—often initially for those risk behaviours—followed by further mental health struggles and eventual focussed therapy addressing CSA, reflects a prevalent pattern among those with a history of multiple ACE’s and/or intrafamilial CSA. This process, which often involves establishing healthy, trusting relationships with therapists and subsequently with others, underscores the compounded challenges of recovery for CSA survivors with insecure attachments stemming from attachment trauma and dysfunctional parental figures.

Participants described the initial awareness of the gravity of their abuse—triggered by others’ stories, safe spaces for disclosure, or professional insights into their maladaptive behaviours—as both helpful and distressing. For several, this awareness eventually led to more focussed help-seeking after prolonged struggles. PM3 illustrated this progression, recounting how his awareness (following his first CSA disclosure to two close friends in adulthood) led to hypersexuality and unhealthy sexual and relational behaviours:

“It’s not that it gets; it got better. It’s more like what it did, it got better because it brought awareness of the whole abuse, but it was at its very primitive stage of awareness. And then most of my sexual partners I had, I told them about it. So my awareness kind of grew around that, but with the awareness growing, and we’re talking about it, and especially with a partner, you know, you leave yourself vulnerable and when you leave yourself vulnerable, you attack [yourself].” (PM3)

A shift to a positive environment or supportive setting fostered an initial awareness of the gravity of CSA, which, through self-reflection, therapy, and disclosure in safe spaces, facilitated the formation of secure and healthy attachments. Consequently, recovery encompassed several interconnected processes, including releasing shame and internalised perceptions of CSA, recognising and actively disengaging from unhealthy patterns (such as maladaptive behaviours

or unhealthy relationships), and renegotiating societal constructs. For most participants, therapy emerged as a crucial component in this phase, facilitating the establishment of trusting relationships and providing a framework for processing the abuse. PF5 reflected on how therapy became a transformative tool, describing it as “*one of the biggest eye-openers to give validity*” to her struggles with CSA. She elaborated on how therapy enabled her to process the abuse:

“Over the years since then, I’ve managed to piece together more and more things and work on [the CSA] with my counsellor, just in the last maybe two to three years to try and put myself in a more comfortable position regarding it.” (PF5)

For many participants, especially male participants, therapy helped them to understand their internal state or emotions, as stated by PM4:

“ [...] a big part of my therapy is just to even realise what an emotion is, and to acknowledge it, and to be aware of them when they happen.” (PM4)

Participants who engaged consistently in therapy noted that once they accessed therapy centred on their CSA, it became instrumental in processing the abuse and addressing maladaptive patterns in their psychosexual lives that had developed as a result of the CSA.

Participants’ recovery involved an initial understanding of the seriousness of their CSA, often prompted by increased awareness through their environment, supportive others, or helping professionals. This awareness established trust and laid the groundwork for developing secure attachment dynamics.

CSA awareness ←→ professional help/supportive others (compelled or sought) → establishment of secure attachment dynamics

Rebuilding attachment and relational foundations

Participants generally became increasingly aware of unhealthy sexual and relationship patterns, leading them to make efforts to change these behaviours. For several participants (as noted earlier), they became aware of their engagement in unhealthy sexual and romantic relationships.

For some participants, particularly those who had experienced multiple ACE's and intrafamilial CSA, and who had exhibited undesirable sexual behaviours, their recovery process often involved a period of time where they made a conscious decision to avoid romantic relationships or remain "*celibate*". This generally coincided with their ongoing professional help. Prior to the age of 25, PF11 described her transition from being "*really hypersexual and having risky partners*" to a state of being "*in celibacy*". Although some of the reasons for this had been religious in nature, and driven by guilt, PF11 reported some of the motivation had, in part, been protective, "*because the pain was so much*". Similarly, PM14 noted that his motivations for remaining single were influenced by religious beliefs as well as a desire for self-protection and an understanding of his previous relationship dynamics:

"I'm choosing not to pursue relationships partly for religious reasons. Also, I don't think I'm healthy enough for relationships. [...] I think, at least for the time being, it's probably best for me and for them just to focus on friendships for now." (PM14)

PF1 explained that her decision to remain single was stemming from a place of healing:

"I have a lot more peace in my life than I had before when I was in relationship after relationship.[...] like not having any sense of worth or value [...] I made the decision to kind of stop dating for awhile. You know, it was just a recognition of, like I was hurting myself and I was hurting other people because I wasn't able to show up in a healthy capacity." (PF1)

Similarly, PM10 described his choice to be "*celibate*" as a means to "*find the right person that can hold space for [him]*."

Through a trusting relationship, often with a helping professional, participants explored the impact of CSA and ACE's on their insecure attachment patterns, eventually seeking healthier, secure romantic relationships over time.

CSA awareness ←→ professional help/supportive other (compelled or sought) → establishment of secure attachment dynamics → exploration (over time) of unhealthy relationship dynamics and adult insecure attachment patterns stemming from CSA/ACE's → desire to engage in intimate relationships grounded in secure attachment styles.

Renegotiating societal constructs and attachment norms

Embedded within the recovery process was participants' frequent allusion to renegotiating societal constructs, including masculine norms and/or stigma and misconceptions surrounding CSA.

PM4 described how societal stigma and misconceptions around his homosexuality compounded his self-blame and lack of awareness regarding his CSA experiences. He highlighted how these dynamics, coupled with cultural narratives within the gay community, exacerbated his challenges in overcoming a conflicting desire to engage in romantic and sexual relationships with men twice his age—individuals resembling his perpetrator. He reflected on reevaluating and rejecting beliefs and dynamics he perceived as unhealthy in gay culture:

“In gay culture, there is a lot about that idea of like daddy and son, like an older man with a younger boy. [...] That now to me now just reminds me of like, almost the need of a child to wanting to be sexually abused. And that need stays with you and it's not resolved. And then you grow up with it and then relationships are always trying to find that fantasy. So, to me, that is a little bit uncomfortable. So before, even though I was looking for that, now, it sort of reminds me of my past. So I don't see it the same way or when people make fun of it or on TV or in gay culture, they make fun of that, and make jokes about it, I just don't find it funny anymore.” (PM4)

Similarly, several male participants reflected on how adherence to societal masculine norms had shaped their coping mechanisms and hindered their ability to process the trauma. PM17, for example, described how grieving the loss of his son also forced him to confront his CSA—a process he found exceptionally challenging due to societal expectations that men remain stoic and “*hold it together*.” He likened this struggle to navigating a labyrinth:

“We weren't allowed to enter into the labyrinth, but even as we entered in, we'd come across stumbling blocks and we'd sit down in the labyrinth. And there was all these women passing by us. And they'd get to the centre and they would receive what they needed to do there, and then they'd come back out and we're just sitting in the same spot. We're just stuck. [...] But then even as we enter into it, people, the pushback is like, ‘what are you doing?’ Like, ‘you need to carry

on, you need to, you know, man up, you need to get back to your family and do what you got to do.’’ (PM17)

PM17 described eventually challenging and renegotiating these masculine norms, enabling him to grieve and process his abuse in a meaningful way.

Adult attachment styles can be reestablished or strengthened by cultivating attachment security in adulthood, often facilitated through healthy relationships or therapeutic practices (Butler, Gossner, & Fife, 2022; Coffman et al., 2024; Johnson, 2019; Jouriles et al., 2022; Mikulincer & Shaver, 2016). Research by Dansby Olufowote, Fife, Schleiden, and Whiting (2020) highlights that transitioning from insecure to secure attachment in adulthood occurs when a surrogate attachment figure provides a supportive context, enabling the individual to engage in personal growth and redefine their needs and self-worth.

These findings align with Coffman et al. (2024), who explored the pathways to secure attachment for individuals with histories of childhood maltreatment. Their study emphasised the importance of community and spiritual healing, forming long-term secure relationships, and engaging in reparative work with safe, attuned individuals. The research underscores that achieving attachment security is not a solitary process but one that often involves external support and relational dynamics.

For men, this process is further complicated by societal and cultural expectations of masculinity, which often discourage vulnerability and emotional expression. Navigating these norms requires redefining male identity and adopting security-enhancing attitudes and behaviours that are not traditionally encouraged (Dansby Olufowote et al., 2020; Lewis et al., 2022; Sugiura & Smith, 2020). Overcoming these barriers necessitates deliberate efforts to challenge and renegotiate ingrained notions of masculinity, fostering personal growth and the development of secure attachment.

Rebuilding secure attachments through healthy relationships

Both PF11 and PF5 indicated that this phase of consciously choosing to remain celibate or single had preceded the establishment of healthy relationships. PF11 noted that she later developed “*supportive*” romantic relationships, including that with her current partner, along with her

connections to “*really good friends who were really supportive.*” She emphasised that her first partner after her period of “*celibacy*” was the first person to whom she disclosed her CSA since her accusatory disclosure to her mother in childhood, describing this partner as “*very supportive.*”

Similarly, PF5 believed that her phase of remaining single had been crucial for her in finding a suitable and healthy relationship dynamic, as it had allowed her to learn to rely on herself while also leaning on her husband, as she outlined:

“I have spent a lot of time by myself over the years. I have spent a lot of time taking care of myself, and I have put myself in a position where I feel that I don’t need anybody to protect me or to save me. But my husband is my rock and my support. So if I needed somebody to fall back on, that’s very much what he is.” (PF5)

Consequently, a shift in adult attachment styles became evident, with participants increasingly seeking relationships characterised by secure attachment dynamics. Nevertheless, engaging in healthy romantic relationships was a challenging process for many participants, requiring not only patience from their partners but also consistent awareness and effort from the survivors themselves to cultivate deserving relationships.

PF18 described her struggle with the impulse to “*shoo [healthy partners] away,*” framing the process as involving “*steps, small steps, small changes, and it gets easier,*” rather than a singular “*epiphany.*” She highlighted the need to remind herself that she was “*receiving love*” and that she “*deserves to receive love from somebody who’s healthy.*” This reminder was difficult for her due to the nature of her CSA.

Furthermore, PF18 noted that she often encountered men who “*were not good men for [her] and that weren’t good for [her] daughter,*” yet these individuals would “*spark more of the sexual desire in [her].*” She mentioned that motherhood helped her choose better partners, but emphasised that this process required continuous effort:

“I didn’t make that decision every day. It was a small decision once a week. It was a Friday night, I was feeling sexy, and I wanted to get with somebody. And it was like, ‘No. Today, I’m not

going to engage with this man.’ [...] My point in all of this is it's action. It's action. It's just one small action.” (PF18)

She eventually entered her current relationship, noting that while she had not initially been attracted to her partner, her *“whole body, soul, everything told [her] he was a good human being.”* Despite this positive development, she acknowledged the ongoing effort required to maintain healthy relationships and continue her healing journey, recognising that mistakes might still occur along the way:

“Each day that comes, when that situation arrives, I’m going to just say, ‘Don’t engage in that, or try not to.’ [...] I’ll try my best not to, and maybe someday, I will. I don’t know. But what I can say right now is that, like, I actually got to that point of being with a man who is a good man, and I’m receiving love that I deserve to receive.” (PF18)

Participants frequently noted an awareness of their tendencies toward unhealthy relationships rooted in insecure attachment dynamics. This awareness often served as a turning point, guiding them toward current romantic relationships characterised by secure attachment dynamics, which in turn reinforced their recovery process. Reflecting a similar trajectory as others, PF12 highlighted her patient and loving relationship with her husband as pivotal to her ability to cope with and process the abuse:

“Despite all the ways that I have wronged my husband, he has loved me through them. And I believe it is his unconditional love of me, which does not mean he’s down for me to abuse—we have had issues with that as well. He just, he has been able to unconditionally love me. And that’s been what has made me come back together as a human being. I think that is the piece that probably most people that have lived a life similar to mine don’t ever get. [...] How do you give them unconditional love, especially if they don’t get it from their parents and they don’t even know what it is? You know, I believe that without my husband in my life, I would be dead. I do not believe that my child would be in my care.” (PF12)

PM9 described his girlfriend as accepting and supportive, particularly in encouraging his pursuit of therapy and assistance. He expressed admiration for her nonjudgmental attitude and her ability to *“always give people the benefit of the doubt.”* Similarly, PM17 credited his wife as being

instrumental in his healing process, highlighting her empathetic and supportive nature: “*She’ll just listen, and people love her for that.*” The supportive and empathetic responses of partners, especially in reaction to CSA disclosures, appeared to play a crucial role in helping participants repair the insecure attachment styles formed in childhood. PM17 further elaborated on how disclosing his CSA to his wife positively influenced his ability to process and communicate his experiences:

“It’s kind of an important part of my story with my wife is, she was one of the first people I actually really took the time to, not only disclose that I was abused, but who abused me. And she’s a good reference point of how I think I’ve healed and been able to communicate and share things now. I used to be really like mute.” (PM17)

PM2 described a similarly “*amazing*” and “*profound*” disclosure experience with his wife, noting that it brought them “*way closer.*”

While PM2 acknowledged that this disclosure experience “*wasn’t enough for [him] to get better,*” it motivated him to seek further help, particularly to strengthen his relationship with his son.

Through the exploration of unhealthy relationship dynamics and adult insecure attachment patterns stemming from CSA and ACEs, participants became more inclined to seek romantic relationships characterised by secure attachment styles. This shift often resulted in the establishment of healthy partnerships, further reinforcing their recovery process.

CSA awareness ←→ professional help/supportive other (prompted or sought) → establishment of secure attachment dynamics → exploration of unhealthy relationship patterns stemming from CSA/ACE’s → desire to engage in intimate relationships based on secure attachment styles → establishment of such relationships

Navigating intimacy and resolving sexual challenges

Participants frequently identified the establishment of supportive romantic relationships—grounded in secure attachment dynamics—as pivotal to their healing process.

Within these relationships, they addressed psychosexual discomfort or pain stemming from their abusive experiences. Nevertheless, the approach to addressing these issues often differed by gender. Male participants tended to work through their challenges primarily with professional therapists, rarely involving their romantic partners directly, while female participants often sought support from both their therapists and intimate partners. This gendered difference may reflect societal masculine norms, which discourage vulnerability and emphasise self-sufficiency, leading men to reserve their emotional openness for therapeutic settings.

PM4 shared how his early romantic and sexual relationships mirrored the dynamics of his CSA, describing how he exclusively dated men “*twice as old as*” himself despite the relationships feeling “*wrong*.” With the guidance of his therapist, he eventually stopped pursuing such relationships, which allowed him to prevent the abuse from influencing his subsequent intimate experiences. Similarly, PM2 reported resolving intrusive “*flashbacks*” during sex, which he attributed to “*vicarious trauma*,” through therapy. He described how his therapist helped him “*separate it very quickly*” and “*diffuse it*,” noting that he did not feel the need to discuss or process these issues with his wife.

PM9, who reported engaging in sexually compulsive behaviour, initially claimed that his girlfriend “*totally knows everything*,” but later acknowledged withholding certain details out of fear that “*she’s gonna leave me if I tell her that*.” Instead, he focussed on addressing these issues with his counsellor as part of his treatment for sex addiction. Similarly, PM17 shared that he was actively working through sexual difficulties in therapy and group settings, describing these challenges as “*an ongoing issue*” in his marriage. He, however, admitted that these difficulties remained a “*stumbling block*” in his communication with his wife.

In contrast, female participants often turned to their intimate partners for support when facing intrusive thoughts or discomfort during sex. PF6, for instance, described how her dissociation during sex compromised intimacy with her husband. She sought therapy and involved her husband in the healing process, stating:

“[It involved] learning to be connected to my body. Learning that not every pleasurable sensory experience was bad, and it was somehow reprehensibly my fault. But that took a while. Took a lot of patience on [my husband’s] part to understand.” (PF6)

PF13 acknowledged persistent sexual discomfort but explained that open communication with her husband helped her navigate these challenges, saying:

“We’ve been married forever and a day, and we have our groove, and we have trust, and we have things. So we don’t really, like we’ve found the things that work for us.” (PF13)

Similarly, PF7, who experienced difficulties with penetration, highlighted the importance of trust and communication in her relationships. She shared that she needed *“a long time of foreplay”* and that intimacy was only possible with someone she *“trusts”* and could openly communicate with about her challenges.

These gendered differences in addressing sexual and intimacy difficulties may stem from societal norms that discourage male vulnerability while encouraging men to prioritise self-reliance. Nevertheless, both male and female participants worked on these issues, often with the assistance of professionals. For both genders, the process of addressing these challenges within a supportive framework appeared instrumental in fostering emotional and physical intimacy in their relationships.

Participants frequently highlighted how relationships characterised by secure attachment dynamics facilitated their ability to process their CSA experiences and address intimate challenges. For many, these relationships provided a foundation of trust, safety, and emotional support necessary for recovery. PF12, reflecting on her journey, encapsulated the critical role of unconditional love in overcoming the long-term effects of CSA:

“I really think this idea of unconditional love is the missing piece of how to help people with childhood sexual trauma overcome all of these difficult behaviours that come out of it. [...] It’s all about, not allowing it to affect you and rule your life, finding the way to, remember the experience without having to relive the pain every time, if you need to talk about it, which again, the whole unconditional love thing, it’s kind of like this blanket.” (PF12)

This perspective underscores how unconditional love—whether from a partner, friend, or therapist—can act as a catalyst for healing, enabling survivors to navigate the complexities of their trauma while fostering resilience and emotional growth.

The establishment of secure attachment dynamics in romantic relationships allowed participants to identify and address nuanced sexual difficulties, discomforts, or triggers stemming from their childhood abuse—issues that often remained undiscovered prior to such relationships. Women tended to work on these challenges with both professionals and their romantic partners, while men primarily addressed these issues with professionals, often without involving their partners directly. Nevertheless, for men, secure attachment dynamics in their relationships provided the foundation to recognise and seek help for these challenges.

CSA awareness ←→ professional help/supportive other (forced or sought) → establishment of secure attachment dynamics → exploration (with time) of unhealthy relationship dynamics/adult insecure attachment patterns stemming from CSA/ACE's → desire to engage in intimate relationships based on secure attachment styles → establishing an intimate relationship based on secure attachment styles → addressing sexual challenges related to abuse

The impact of CSA on adult romantic relationships is profound, with mentalizing or reflective functioning playing a crucial role. CSA survivors often experience epistemic mistrust, which can hinder their ability to establish and sustain intimate relationships (Lassri & Gewirtz-Meydan, 2024; Luyten et al., 2024). Lassri and Gewirtz-Meydan (2024) conducted a study exploring the influence of CSA on adult romantic relationships and found that mentalizing significantly mediated and moderated the impact of CSA on relationship satisfaction, with robust mentalizing serving as a protective factor that buffers the negative effects of CSA. This suggests that the ability to understand and interpret mental states—both one's own and those of others—is critical in mitigating the challenges CSA survivors encounter in their intimate relationships.

Couples facing relational distress, particularly those involving CSA survivors, frequently struggle with communication and interpersonal challenges, which can negatively affect their relationship satisfaction without appropriate therapeutic support (Lassri & Gewirtz-Meydan, 2024; MacIntosh, Fletcher, & Ainsworth, 2019). Addressing these difficulties requires targeted therapy, as survivors' epistemic mistrust may disrupt their engagement in therapeutic processes. For instance, in both individual and couples therapy, therapists are trained to consider both partners' viewpoints, which can unintentionally exacerbate a CSA survivor's trust issues

(Fonagy & Campbell, 2017; Luyten et al., 2024). This highlights the need for trauma-informed approaches that consider the survivor's unique needs (Lassri & Gewirtz-Meydan, 2024; Luyten et al., 2024).

Therapies rooted in mentalization-based approaches have shown effectiveness in addressing epistemic mistrust and impaired mentalizing abilities among CSA survivors. By validating survivors' perspectives, recognising their challenges with trust, and maintaining a nonjudgmental stance, therapists can aid survivors in reframing distressing experiences and developing a cohesive sense of self; These therapeutic practices not only strengthen the therapeutic alliance but also enhance mentalizing capabilities and improve relationship satisfaction (Fonagy & Campbell, 2017; Lassri & Gewirtz-Meydan, 2024; McElvaney, Monaghan, Treacy, & Delaney, 2023).

Thus, addressing epistemic mistrust and compromised mentalizing abilities among CSA survivors requires the development of secure and supportive relationships, which can aid survivors in recalibrating their understanding of distressing events and fostering a more integrated sense of self. These relationships, built on trust and mutual respect, complement therapeutic interventions by providing consistent and affirming interactions that enhance mentalization and relationship satisfaction.

The recovery journey of participants highlights the profound relationship between awareness, relational support, and societal constructs. While many participants initially grappled with maladaptive patterns stemming from their abuse, the establishment of secure attachment dynamics—whether through professional relationships or healthy intimate partnerships—served as a cornerstone for healing. These relationships provided survivors with the stability and trust needed to explore their trauma, address psychosexual challenges, and redefine their identities. Ultimately, recovery was not merely about mitigating the impacts of CSA but about cultivating a sense of agency, connection, and self-worth that allowed participants to thrive despite their abusive histories.

4.3.3 Conclusion and Implications

This constructivist grounded theory study explored the diverse experiences of CSA survivors, focussing on disclosure, psychosexual development, and recovery. The findings highlight the significant influence of attachment dynamics, societal constructs, and secure relationships in shaping survivors' trajectories. By examining the relationships between gender, CSA disclosure, and recovery, the study provides insights into the complex ways CSA impacts survivors' lives, particularly within the domains of psychosexual identity and interpersonal relationships.

The findings emphasise the foundational role of secure attachment in recovery. Participants frequently reported disrupted attachment dynamics stemming from intrafamilial abuse or neglect, which impacted their capacity to establish trust in relationships. This aligns with prior research, which underscores how attachment security influences mental health and relationship satisfaction among CSA survivors (Ensink et al., 2023; Lassri & Gewirtz-Meydan, 2024). Studies have shown that mentalization, a cognitive capacity affected by CSA, mediates these negative impacts and enhances relational outcomes when strengthened (Luyten et al., 2024). Furthermore, supportive relationships, whether with therapists, peers, or romantic partners, emerged as critical for rebuilding trust and fostering attachment security, echoing existing findings (Fonagy & Campbell, 2017; Lassri & Gewirtz-Meydan, 2024).

Disclosure was revealed as a complex and iterative process shaped by survivors' developmental stages and the responses of confidants. Male participants reported particular challenges in navigating societal stigma surrounding masculinity and vulnerability, leading to delays in disclosure and emotional suppression. These difficulties reflect broader societal constructs, which discourage vulnerability in men and are frequently linked to delayed emotional processing (Attrash-Najjar et al., 2023; Easton, 2020). Female participants, although more likely to disclose earlier, often encountered invalidating or accusatory responses, which exacerbated feelings of shame and isolation. These gendered disclosure patterns are consistent with literature on victim-blaming and its psychological repercussions on survivors (Flynn et al., 2023). Collectively, these findings underscore the need for interventions tailored to addressing societal stigma and promoting supportive disclosure environments.

Psychosexual development also emerged as a domain profoundly affected by CSA. Participants frequently described difficulties in forming healthy intimate relationships, reporting patterns such as hypersexuality, sexual avoidance, and confusion surrounding sexual identity. These findings are consistent with prior studies that link CSA to disruptions in sexual and relational development (Abrams et al., 2019; Thomas & Kopel, 2023; Lewis et al., 2022). The study further revealed that recovery in this domain often required addressing disrupted attachment dynamics and societal constructs surrounding gender roles. Such renegotiation of societal norms, particularly those related to masculinity and femininity, helped survivors reshape their self-perceptions and relational behaviours, supporting existing literature on the interconnections between CSA, mentalization, and relationship dynamics (Gewirtz-Meydan & Lahav, 2020; Li et al., 2023).

4.3.4 Limitations

While this study offers valuable insights, limitations must be acknowledged. Recruitment was particularly challenging due to the sensitive nature of the study and the time required for in-depth interviews. This limitation, compounded by PhD time constraints, meant that data saturation was not fully achieved. Additionally, the findings are based on the narratives of participants willing to discuss their CSA experiences, potentially excluding survivors with ongoing difficulties in disclosure.

4.3.5 Future Research Directions

Future studies should prioritise diversifying participant samples to include survivors from non-Western and marginalised communities, enabling a broader understanding of how CSA affects individuals across different sociocultural contexts. Intersectional analyses could illuminate the unique challenges faced by survivors at the intersection of multiple forms of marginalisation. Longitudinal research is needed to capture the dynamic and evolving processes of disclosure, recovery, and psychosexual development over time. Additionally, further exploration of therapeutic interventions, particularly those focussed on repairing attachment, enhancing mentalization, and rebuilding epistemic trust, could provide valuable insights for clinical practice.

4.3.6 Practical Implications

The findings highlight the importance of tailoring interventions to survivors' specific needs, with an emphasis on fostering secure attachment dynamics and promoting supportive disclosure environments. Professionals working with CSA survivors should be aware of the role of societal constructs, particularly gender norms, in shaping survivors' experiences and recovery trajectories. Training and education for caregivers, peers, and professionals are crucial to reducing stigma and fostering validating responses to disclosure. Furthermore, interventions aimed at strengthening survivors' mentalization capacities and rebuilding epistemic trust are essential for addressing relational and psychosexual challenges associated with CSA.

Incorporating survivors' voices into theoretical frameworks enriches the understanding of CSA's impact and recovery. This study's findings contribute to the literature by illuminating the relationship between attachment, disclosure, and recovery, offering a foundation for developing targeted interventions. These interventions should aim to create a more inclusive and supportive environment where survivors can heal.

Chapter 5: General discussion

5.1 Conclusion

This thesis examined the complex and multifaceted impacts of childhood sexual abuse (CSA) and associated adversities through an integrated exploration of behavioural, psychosocial, and psychosexual outcomes. The findings illuminate how CSA shapes survivors' trajectories, with disclosure experiences (DE), contextual adversities, and gendered dynamics emerging as critical factors. By combining quantitative and qualitative methodologies, this research offers a layered understanding of the long-term consequences of CSA and related adversities, revealing interconnected pathways that influence survivors' lives.

A central theme identified was the role of disclosure in shaping recovery and developmental outcomes. Supportive disclosure environments were consistently linked to better psychosocial and psychosexual outcomes, while dismissive or negative reactions exacerbated feelings of shame and hindered recovery processes. These findings align with prior literature that underscores the importance of fostering validating and empathetic responses to disclosures (Alaggia et al., 2017; Easton & Parchment, 2021; Gemara & Katz, 2023). Beyond disclosure, contextual factors such as broader childhood adversities significantly affected survivors' trajectories, highlighting the cumulative impact of abuse and adversity on long-term well-being (Attrash-Najjar et al., 2023; Grummitt et al., 2024).

Gender differences provided further insight into the varied experiences of CSA survivors. Male survivors faced distinct challenges, including societal stigma and misconceptions that limited disclosure and access to support (Attrash-Najjar et al., 2023; Sivagurunathan et al., 2019). Conversely, female survivors' disclosures, albeit more common, were often met with disbelief or victim-blaming attitudes, reflecting entrenched biases (Latiff et al., 2024). These findings emphasise the importance of interventions tailored to address these gender-specific barriers and to promote equity in recovery pathways.

Behavioural and psychosexual outcomes were interconnected, revealing dual dimensions of CSA's impact. Externalising behaviours, such as substance use disorder (SUD) and self-directed violence (SDV), coexisted with internalising processes, such as sexual shame and disrupted psychosexual development. These findings underscore the necessity of trauma-informed care that addresses both the behavioural and emotional aspects of CSA's impact (Pulverman & Meston, 2020; Talwar et al., 2023). Addressing these dimensions simultaneously is critical to supporting comprehensive recovery for survivors.

Despite these contributions, some limitations must be acknowledged. The cross-sectional nature of the quantitative studies limits the ability to infer causal relationships between variables. Longitudinal designs would provide a more robust understanding of the temporal dynamics linking CSA, disclosure, and outcomes, enabling an exploration of developmental trajectories over time. While the qualitative study offers rich insights into survivors' lived experiences, its focus on a particular population, such as those with a high prevalence of other ACEs, cannot be generalised. Future research should continue to include diverse populations, encompassing a broader range of cultural, socioeconomic, and demographic backgrounds, to enhance the applicability of findings.

The reliance on self-reported measures in the quantitative studies, moreover, introduces potential bias, as participants' recall and perceptions may influence their responses. Incorporating objective measures, such as clinical assessments or longitudinal data, would triangulate findings and enhance reliability. Furthermore, the thesis' focus on specific psychosocial and psychosexual outcomes, while significant, may not capture the full spectrum of CSA's impact. Exploring additional domains, such as educational and occupational trajectories, could provide a more holistic perspective on CSA's effects.

Finally, the integration of quantitative and qualitative methodologies enriched the understanding of CSA's effects. Quantitative methods provided measurable insights into patterns and pathways, while qualitative approaches captured the lived experiences and contextual nuances of survivors' journeys. This alignment with critical realism principles—bridging empirical patterns with experiential narratives—strengthened the thesis' capacity to generate actionable insights. Overall, this thesis provides a foundation for both theoretical advancements and practical

applications in addressing the profound impacts of CSA while recognising areas for further exploration and methodological refinement.

5.2 Implications and Future Research

The findings of this thesis carry significant implications for improving practices, informing policies, and guiding future research efforts aimed at supporting survivors of CSA. First, the role of disclosure as a critical juncture in recovery emphasises the importance of creating systems that facilitate safe and supportive reporting mechanisms. Training programmes should focus on enhancing the capacity of caregivers, clinicians, and first responders to respond empathetically to disclosures, promoting environments where survivors feel validated and empowered. Such programmes must be tailored to recognise the distinct needs of diverse populations, particularly those from marginalised or underrepresented groups.

Intervention frameworks should move beyond addressing behavioural symptoms alone to integrate psychosocial and psychosexual dimensions of recovery. Effective therapeutic approaches must account for the complex relationship between experiences of disclosure, contextual adversities, and survivor outcomes. For instance, interventions targeting sexual shame may benefit from combining trauma-informed practices with relational and community-based supports, fostering environments where survivors can rebuild trust and resilience.

Gender-sensitive programmes are particularly crucial, addressing the societal stigma that often affects male survivors and the systemic barriers faced by female survivors.

At the policy level, there is a need to strengthen cross-sector collaboration among healthcare, education, and social services to ensure that CSA survivors receive comprehensive and coordinated support. Policies should prioritise equitable access to resources and services, recognising the long-term impacts of CSA across various domains, including mental health, relationships, and employment outcomes. Incorporating survivor voices into the development of these policies could further enhance their relevance and effectiveness.

Future research must address gaps in understanding the developmental trajectories of CSA survivors. Longitudinal studies are particularly important for uncovering how survivors' experiences evolve over time and identifying key moments for intervention. Additionally,

exploring the intersection of CSA with other ACE's will provide a more holistic view of the cumulative effects of childhood trauma.

Expanding research to include culturally diverse and underrepresented populations is essential. Survivors from collectivistic or traditional societies may encounter unique challenges influenced by cultural norms and societal structures. Investigating these dynamics can inform the development of culturally tailored interventions that better address the specific needs of these groups. Furthermore, intervention-focussed research should evaluate programmes that incorporate gender-specific considerations, addressing issues such as stigma, blame, and societal expectations that impact recovery pathways.

Methodologically, mixed-method approaches remain valuable for capturing the complexity of CSA's impacts. Future studies should continue to integrate quantitative measures, such as longitudinal data and objective clinical assessments, with qualitative insights that delve into the lived experiences of survivors. This approach both enhances the depth of understanding and bridges the gap between empirical findings and practical applications, contributing to more effective and inclusive support systems for CSA survivors.

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Appendices

Appendix A: Edinburgh Study I ethical approval

Re: 23-24CLPS090_Re: Ethics questions and Level 1 application

From HiSS Research Ethics <ethics.hiss@ed.ac.uk>
Date Thu 11/07/2024 04:42
To Asal Skrenes <A.Skrenes@sms.ed.ac.uk>
Cc HiSS Research Ethics <ethics.hiss@ed.ac.uk>

 1 attachment (122 KB)

23-24CLPS090_Response_CAPU Ethics Application UoE.docx;

Thank you for your revised application. Based on your responses the application meets the standards for favourable opinion from the Clinical Psychology, University of Edinburgh Ethics Committee. The signed ethical response sheet/application is attached – please note that this is fine to attach to your dissertation etc. If you require a formal letter of ethics approval (this is only required if you are approaching third parties, NGOs etc) then please contact the new ethics mailbox (ethics.hiss@ed.ac.uk) requesting this and a formal letter of approval will follow in due course. If you need to make any changes to the study, you should return your amendment to the new ethics email - ethics.hiss@ed.ac.uk, cc'd above with the changes clearly noted in the relevant section of the form.

This is the perfect time to pre-register your study on OSF (Open Science Foundation):
<https://osf.io/dashboard>

You put a lot of time in your application and provided us with many details of your study, which could make preparing a pre-registration quite quick! To help this process, we mapped the forms and made suggestions regarding which sections of the form of our committee might contain the relevant information to the different sections of the pre-registration forms. You can find these enriched templates for quantitative and qualitative studies on the HiSS Research Ethics website: [Ethics and Integrity | The University of Edinburgh](#)
Preregistration is the practice of registering the hypotheses, methods, and/or analyses of a scientific study before it is conducted and involves creating a time-stamped record of the study and analysis plan. So, when you preregister your research, you're simply specifying your research plan in advance of your study and submitting it to a registry. Pre-registration of studies is to be uploaded before you start any data analysis. That means that you can submit the pre-registration while you are collecting data. If anything should change, you can also update the pre-registration before starting the analyses. Why would I want to pre-register my study? See a list of benefits here: [Ethics and Integrity | The University of Edinburgh](#)

Good luck with your project.

Best wishes,
Zsofia

Dr Zsofia Garai-Takacs
Lecturer in Applied Psychology
Ethics & Integrity Lead

Appendix B: UBC Study I ethical approval



UBC Clinical Research Ethics Board

Certificate of Ethical Approval: Amendments for Harmonized Minimal Risk Clinical Study

The University of British Columbia
Clinical Research Ethics Board
Room 210, 828 West 10th Avenue
Vancouver, BC V5Z 1L8

Also reviewed and approved by:

- Simon Fraser University



Principal Investigator: Christian G. Schutz	Primary Appointment: UBC/Medicine, Faculty of Psychiatry	Board of Record REB Number:	REB Number: H14-01985 PAA #: H14-01985-A024
Study Title: Cross-sectional assessment of substance use disorder, mental health and quality of life in diverse clinical settings: A study for future practice-based assessment of substance use disorder intervention trials			
Approval Date: December 12, 2022		Expiry Date: December 1, 2023	
Research Team Members:	Siavash Jafari Elliot M. Goldner Vijayakumar Seethapathy Michael Krausz Mae E. Burrows Richard Leon Dubras Reza Rafizadeh Alasdair Barr		
Sponsoring Agencies:	- Canadian Centre on Substance Use and Addiction - "Cannabis and Polysubstance Use (CAPU)" - Canadian Institutes of Health Research (CIHR) - "Developing a CRISM node: the Canada Pacific node"		
Documents included in this approval:	Consent Forms: CAPU Survey Consent Form	Version: 6.5	Date: December 4, 2022
<p>This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.</p> <p>The Board of Record (as noted above) has reviewed and approved this study in accordance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2018).</p> <p>The "Board of Record" is the Research Ethics Board delegated by the participating REBs involved in a harmonized study to facilitate the ethics review and approval process.</p> <p>In respect of clinical trials:</p> <ol style="list-style-type: none"> 1. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Part C Division 5 of the Food and Drug Regulations; 2. This Research Ethics Board carries out its functions in a manner consistent with Good Clinical Practices. 			
<ol style="list-style-type: none"> 3. This Research Ethics Board has reviewed and approved the clinical trial protocol and informed consent form for the trial which is to be conducted by the qualified investigator named above at the specified clinical trial site. This approval and the views of this Research Ethics Board have been documented in writing. 			
This study has been approved either by the Board of Record's full REB or by an authorized delegated reviewer.			



SUBJECT CONSENT TO PARTICIPATE

Cross-sectional assessment of substance use disorder, mental health and quality of life in diverse clinical settings: A pilot for future practice based assessment of substance use disorder intervention trials

By signing this document you consent to participating in this study led by Dr. Christian Schütz at the Burnaby Centre for Mental Health and Addictions. This statement certifies the following:

- I have read and understood the subject information and consent form.
- I have had enough time to consider the information provided and to ask for guidance if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential and that the result will only be used for scientific objectives.
- I authorize access to my health record as described in this consent form.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without changing in any way the quality of care that I receive.
- I understand that I am not waiving any of my legal rights as a result of signing this consent form.
- I understand that there is no guarantee that this study will provide any benefits to me.
- I have read this form and I freely consent to participate in this study.
- I have been told that I will receive a dated and signed copy of this form.

You should know that you have the right to see the results prior to them being published. A copy of this consent form will be given to you. By signing this form you are stating that you are over 19 years of age, you understand the above information and you consent to participate in this study.

Printed name of subject

Signature

Date

Printed name of
Person obtaining consent
Study role: _____

Signature

Date

Appendix D: Study I correlation matrices

Table 2.1: Bootstrapped Pearson correlations between outcome variables and demographic variables

	Gender	Age	PD	SUF	PSU	YASU	SDV
	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)
Gender	1	.053 (-.064, .164)	-.173** (-.272, -.069)	-.012 (-.159, .125)	-.010 (-.213, .028)	.105 (-.023, .226)	.066 (-.051, .192)
Age		1	-.256** (-.379, -.130)	-.012 (-.159, .125)	-.278** (-.394, -.161)	.105 (-.023, .226)	.066 (-.051, .192)
PD			1	-.133* (-.258, -.020)	-.190** (-.063, -.313)	.105 (-.023, .226)	-.133* (-.258, -.020)
SUF				1	.415** (.309, .523)	.105 (-.023, .226)	-.073 (-.181, .044)
PSU					1	-.143* (-.245, -.031)	-.073 (-.181, .044)
YASU						1	-.133* (-.258, -.020)
SDV							1

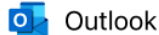
Notes. * $p < .05$; ** $p < .01$; *** $p < .001$. 95% BCa CI = 95% bias-corrected and accelerated bootstrap confidence intervals based on 1000 samples. PD = psychotic disorder; SUF = substance frequency; PSU = polysubstance use; YASU = youngest age of substance use; SDV = self-directed violence

Table 2.2: Bootstrapped Pearson correlations between predictor and outcome variables

	CA	CSA	CPA	CEA	SUF	PSU	YASU	SDV
	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)	r (95% BCa CI)
CA	1	.499*** (.434, .564)	.511*** (.444, .579)	.634*** (.568, .703)	-.045 (-.146, .068)	.063 (-.066, .287)	-.144 (-.167, .045)	.131* (.014, .240)
CSA		1	.519*** (.416, .622)	.495*** (.394, .588)	.020 (-.089, .129)	.108 (-.052, .198)	-.066 (-.167, .045)	.074 (-.052, .198)
CPA			1	.633*** (.541, .712)	.097 (-.025, .204)	.015 (-.144, .127)	-.066 (-.167, .045)	.159** (.043, .259)
CEA				1	.033 (-.082, .137)	.072 (-.052, .198)	-.066 (-.167, .045)	.273** (.170, .369)
SUF					1	.020 (-.116, .141)	-.066 (-.167, .045)	.020 (-.116, .141)
PSU						1	-.066 (-.167, .045)	-.010 (-.144, .127)
YASU							1	-.066 (-.167, .045)
SDV								1

Notes. * $p < .05$; ** $p < .01$; *** $p < .001$. 95% BCa CI = 95% bias-corrected and accelerated bootstrap confidence intervals based on 1000 samples. PD = psychotic disorder; SUF = substance use frequency; PSU = polysubstance use; YASU = youngest age of substance use; SDV = self-directed violence

Appendix E: Edinburgh Study II ethical approval



Re: 23-24CLPS100_Re: ROAR Substudy Ethics Application: Level 1

From HiSS Research Ethics <ethics.hiss@ed.ac.uk>
Date Thu 23/05/2024 07:21
To Asal Skrenes <A.Skrenes@sms.ed.ac.uk>
Cc HiSS Research Ethics <ethics.hiss@ed.ac.uk>

1 attachment (131 KB)
23-24CLPS100_Response_ROAR Substudy Ethics Application UoE.docx;

Dear Asal,

Thank you for your revised application. Based on your responses the application meets the standards for favourable opinion from the Clinical Psychology, University of Edinburgh Ethics Committee. The signed ethical response sheet/application is attached – please note that this is fine to attach to your dissertation etc. If you require a formal letter of ethics approval (this is only required if you are approaching third parties, NGOs etc) then please contact the new ethics mailbox (ethics.hiss@ed.ac.uk) requesting this and a formal letter of approval will follow in due course. If you need to make any changes to the study, you should return your amendment to the new ethics email - ethics.hiss@ed.ac.uk, cc'd above with the changes clearly noted in the relevant section of the form.

This is the perfect time to pre-register your study on OSF (Open Science Foundation):
<https://osf.io/dashboard>

You put a lot of time in your application and provided us with many details of your study, which could make preparing a pre-registration quite quick! To help this process, we mapped the forms and made suggestions regarding which sections of the form of our committee might contain the relevant information to the different sections of the pre-registration forms. You can find these enriched templates for quantitative and qualitative studies on the HiSS Research Ethics website: [Ethics and Integrity | The University of Edinburgh](#)
Preregistration is the practice of registering the hypotheses, methods, and/or analyses of a scientific study before it is conducted and involves creating a time-stamped record of the study and analysis plan. So, when you preregister your research, you're simply specifying your research plan in advance of your study and submitting it to a registry. Pre-registration of studies is to be uploaded before you start any data analysis. That means that you can submit the pre-registration while you are collecting data. If anything should change, you can also update the pre-registration before starting the analyses. Why would I want to pre-register my study? See a list of benefits here: [Ethics and Integrity | The University of Edinburgh](#)

Good luck with your project.

Best wishes,
Zsofia

Dr Zsofia Garai-Takacs
Lecturer in Applied Psychology
Ethics & Integrity Lead

Appendix F: UBC Study II ethical approval



UBC Clinical Research Ethics Board

Certificate of Ethical Approval: Renewal for Harmonized Minimal Risk Clinical Study

The University of British Columbia
 Clinical Research Ethics Board
 Room 210, 828 West 10th Avenue
 Vancouver, BC V5Z 1L8

Also reviewed and approved by:

- Simon Fraser University



Principal Investigator: Christian G. Schutz	Primary Appointment: UBC/Medicine, Faculty of Psychiatry	Board of Record REB Number:	REB Number: H19-00846 PAA #: H19-00846-A015
Study Title: Reducing Overdose and Relapse: Concurrent attention to neuropsychiatric ailments and drug addiction (ROAR CANADA)			
Approval Date: September 25, 2023		Expiry Date: September 25, 2024	
Research Team Members: Amanda L. Butler Karen Petersen Tonia L. Nicholls			
Sponsoring Agencies: - BC Mental Health & Substance Use Services Research Institute - "Expanding ROAR CANADA to forensic psychiatric patients" - Health Canada - "Reducing Overdose And Relapse: Concurrent Attention to Neuropsychiatric Ailments and Drug Addiction (ROAR CANADA)"			
Documents included in this approval: N/A			
This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.			
The Board of Record (as noted above) has reviewed and approved this study in accordance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2018).			
The "Board of Record" is the Research Ethics Board delegated by the participating REBs involved in a harmonized study to facilitate the ethics review and approval process.			
In respect of clinical trials:			
<ol style="list-style-type: none"> 1. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Part C Division 5 of the Food and Drug Regulations; 2. This Research Ethics Board carries out its functions in a manner consistent with Good Clinical Practices. 3. This Research Ethics Board has reviewed and approved the clinical trial protocol and informed consent form for the trial which is to be conducted by the qualified investigator named above at the specified clinical trial site. This approval and the views of this Research Ethics Board have been documented in writing. 			
This study has been approved either by the Board of Record's full REB or by an authorized			

delegated reviewer.



WANT TO CONTRIBUTE TO MENTAL HEALTH AND ADDICTIONS RESEARCH? JOIN THE ROAR STUDY!



YOUR ROLE:

- Complete **6 research sessions** over the next 7 to 14 months. In the sessions you will:
- Answer questions about your background, mental health, substance use and more



YOU'LL RECEIVE:

- **Walmart gift cards** for each of the 6 research sessions!



YOUR IMPACT:

- Help us better understand your experiences as a patient to inform future mental health and substance use treatments



Your participation is optional and will not impact your treatment

We work around your schedule!



WANT TO JOIN? TALK TO A RESEARCHER IN A UBC T-SHIRT →



Appendix H: CSA substudy portion of the ROAR consent form



OPTIONAL STUDY SESSIONS

initial In addition, I agree to continuously wear a wrist-accelerometer “wristwatch” (day and night) for my entire stay at the centre to track my sleep and fill out a 15-minute sleep questionnaire. I understand that I must return the “wristwatch” at time of discharge.

initial In addition, I agree to participate in the 5-10-minute CSA questionnaires.

initial In addition, I agree to participate in the 5-10-minute Mother Interview.

initial If I do participate in the Mother Interview, I agree to be audio recorded.

*Signature of Person
Obtaining Consent*

Printed Name

Study Role

Date

Appendix I: Study II demographic questions

Demographics

Age _____

How would you identify your gender identity?

- Male
- Female
- Transsexual
- Transgender
- Genderqueer
- Two-spirit
- FTM (female-to-male)
- MTF (male-to-female)
- Intersex
- Unsure
- Questioning
- Other
- Prefer not to answer

Please specify: _____

What sex were you assigned at birth? (on your birth certificate)

- Male
- Female

Which population group do you most identify with? Please check ONE answer.

- White/European ancestry
- Black/African ancestry
- East Asian (e.g., Chinese, Japanese, Korean, Mongolian)
- South Asian (e.g., Indian, Pakistani, Afghan, Bangladeshi)
- Southeast Asian (e.g., Vietnamese, Thai, Cambodian, Malaysian, Indonesian, Filipino)
- Middle Eastern/West Asian (e.g., Iraqi, Iranian, Syrian, Turkish, Egyptian, Kuwaiti, Lebanese, Qatari)
- First Nations/Inuit/Metis ancestry
- Pacific Islander (e.g., Hawaiian, Samoan, Fijian)
- More than one population group
- Other

Please specify: _____

Are you Hispanic or Latino?

- Yes
- No

Where were you living or staying most of the time in the past month?

- With family or other relatives
- With group of friend(s) or non-family members
- Alone in own dwelling
- Homeless
- Hospital, rehabilitation facility, or nursing home
- Jail, prison, or other correctional facility
- Other

If other, please specify:

What is your relationship status? Please mark ONE answer.

- Single, not currently in a romantic relationship with a significant other
- In a romantic relationship with a significant other, but not married or living together
- In a romantic relationship with a significant other and living together
- Engaged to be married; living together
- Engaged to be married; not living together
- Married
- Married, but separated

How would you describe your sexual orientation?

- Straight/heterosexual
- Lesbian
- Gay
- Bisexual
- Other
- Prefer not to answer

Please specify:

Do you have any children?

- Yes
- No

How many?

Are you the primary care giver for any of your children when they were growing up?

- Yes, up to 18 years of age
- Yes, for months or years
- No

Which of the following best describes your living situation growing up? (If multiple apply, choose the one that applies to the largest amount of your life up to age 18)

- Household with both biological parents
- Household with one biological parent and no step-parent
- Household with one biological parent and a step-mother or step-father
- Household with two adoptive parents
- Household with one adoptive parent
- Household with one foster parent
- Household with two foster parents
- Other

Please specify:

How many years of education have you completed?

(High school is 12 years (13 if you completed grade 13))

What is the best description of your educational level?

- Less than high school graduate
- High school graduate (or GED)
- Some college/university
- Associates degree completed
- Bachelors degree completed
- Masters degree completed
- Professional degree completed (e.g., MD, PhD, JD)

Are you currently a student?

- No
- Yes, part-time
- Yes, full-time

What is the highest level of schooling completed by either of your parents or guardians?

- Less than high school graduate
- High school graduate (or GED)
- Some college/university
- Associate's degree completed
- Bachelor's degree completed
- Master's degree completed
- Professional degree completed (e.g., MD, PhD, JD)

Without giving exact dollars, how would you describe your HOUSEHOLD's financial situation right now?

- Not enough to pay some bills no matter how hard you try
- Enough to pay bills, but have had to cut back
- Enough to pay bills without cutting back but no "extras"
- Enough money for "extras"

Which category best describes your total PRE-TAX HOUSEHOLD income last year?

Note: If you are a financial dependent of your parents (meaning that they state that you depend on them on their taxes), then household refers to your family including your parents. If you are not a dependent of your parents, household refers to you and your financial dependants (the people who depend on you for money, such as your legal spouse and children, but not roommates).

- Less than \$15,000
- At least \$15,000 but less than \$30,000
- At least \$30,000 but less than \$45,000
- At least \$45,000 but less than \$60,000
- At least \$60,000 but less than \$75,000
- At least \$75,000 but less than \$90,000
- At least \$90,000 but less than \$105,000
- At least \$105,000 but less than \$120,000
- Greater than \$120,000

How many people are in your household (in terms of your household income)? _____

What is the outcome of your current educational program?

- High school graduate
- Technical qualification
- Associates degree
- Bachelors degree
- Masters degree
- Professional degree (e.g., MD, PhD, JD)

Indicate your employment status, as of TODAY:

- Full Time
- Part Time
- Legally disabled
- Unemployed
- Retired

Do you currently have a primary care physician (GP)?

- Yes
- No

Are you currently receiving treatment from a mental health professional? (e.g., psychiatrist, psychologist, social worker or other mental health professional)

- Yes
- No

Which of the following conditions are you currently taking prescription medications for? (Non-recreationally; i.e., as prescribed by a medical professional)

- None
- Allergy
- Antibiotics
- Birth control
- Cancer
- Endocrine (e.g., diabetes medications; thyroid medications)
- Gastrointestinal (throat, stomach, and intestinal medications)
- Heart health (e.g., blood pressure, cholesterol, or blood clotting medication)
- Human immunodeficiency virus (HIV)
- Kidney
- Liver
- Mental health
- Neurological (e.g., medications for Parkinson's disease; seizure disorders)
- Pain management (e.g., opioid pain medications; anti-inflammatory medications)
- Respiratory (lung health), asthma, or emphysema medications
- Skin
- Vitamins (by prescription, not over-the-counter)
- Other prescription medications

Please specify:

Which types of mental health medications are you taking?

- Addiction (e.g., alcohol, tobacco, opioid medications)
- Attention deficit hyperactivity disorder (ADHD)
- Anxiety
- Bipolar disorder
- Depression
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Schizophrenia and related conditions
- Sleep disorders
- Other

Please specify:

Appendix J: Study II additional demographic data

Variable	N (%)	Variable	N (%)
Neighborhood Income		Employment Status	
Not enough to pay bills	50 (36.0%)	Employed (including self-employed)	10 (7.1%)
Enough to pay bills, but had to cut back	42 (30.2%)	Unemployed	76 (54.3%)
Enough to pay bills, no extras	20 (14.4%)	Unable to work (legally disabled)	51 (36.4%)
Enough money for extras	27 (19.4%)	Retired	3 (2.1%)
Total	139 (100%)	Total	140 (100%)
Highest Level of Education		Housing	
Less than high school graduate	35 (25.0%)	Living in own or rented house/apartment	24 (17.1%)
High school graduate (or GED)	39 (27.9%)	Living in an institution/supportive housing	61 (43.6%)
Some college/university	50 (35.7%)	On the street/shelter	17 (12.1%)
Associate's degree	9 (6.4%)	Living in family member's house/apartment	25 (17.9%)
Bachelor's degree	5 (3.6%)	Other	12 (8.6%)
Master's degree	2 (1.4%)	Jail/prison/correctional facility	1 (0.7%)
Total	140 (100%)	Total	140 (100%)
Legal Charges			
Past	1 (8.3%)		
Present	1 (8.3%)		
None listed	10 (83.3%)		
Total	12 (100%)		

Appendix K: Edinburgh Study III ethical approval

Your Online Ethics application - Disclosure Experiences of Survivors of Childhood Sexual Abuse (CSA) has been approved

1 message

REIG Review <REIGNoReply@ed.ac.uk>

23 December 2019 at 06:51

To: SKRENES Asaly <A.Skrenes@sms.ed.ac.uk>, NEWMAN Emily <Emily.Newman@ed.ac.uk>, HISS Research Ethics <ethics.hiss@ed.ac.uk>, CLINICAL PSYCHOLOGY Research Ethics <submitting.ethics@ed.ac.uk>

Dear SKRENES Asaly, Your Online Ethics application has been approved.



The University of British Columbia
 Office of Research Services
Behavioural Research Ethics Board
 Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T
 1Z3

CERTIFICATE OF APPROVAL- MINIMAL RISK RENEWAL

PRINCIPAL INVESTIGATOR: Christian G. Schutz	DEPARTMENT: UBC/Medicine, Faculty of/Psychiatry	UBC BREB NUMBER: H19-02889 PAA #: H19-02889-A008
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:		
<small>Institution</small>	<small>Site</small>	
UBC	Vancouver (excludes UBC Hospital)	
Other locations where the research will be conducted: David Strangway Building rm. 440 at UBC; Skype/Zoom; Other counselling services/centres where participants seek therapy and a therapist offers (unprovoked by researcher) a site for the interview (e.g., 204-1448 Commercial Drive, Vancouver BC V5L 3X9).		
CO-INVESTIGATOR(S): Asal Skrenes		
SPONSORING AGENCIES: N/A		
PROJECT TITLE: Disclosure Experiences of Survivors of Childhood Sexual Abuse (CSA)		
EXPIRY DATE OF THIS APPROVAL: March 18, 2025		
APPROVAL DATE: March 18, 2024		
The Annual Renewal for Study have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.		
<i>This study has been approved either by the full Behavioural REB or by an authorized delegated reviewer</i>		



Are you a man or woman who has experienced childhood sexual abuse?



If you have had this experience before the age of 16, and are now 18 or over, you are invited to potentially participate in a research study seeking to better understand how or why individuals discuss this with others and cope with such an experience.

There are some additional criteria, but if you are interested, you might be asked to participate in an online or face-to-face interview lasting one to two hours. This is a PhD research study conducted by Asaly Skrenes under the Principal Investigators, Dr. Christian Schuetz, Dr. Emily Newman, and Prof. Matthias Schwannauer to help better understand the nature of this experience, and to attempt to better serve those who are in need in the future.

For more information, please contact Asaly Skrenes at A.skrenes@sms.ed.ac.uk



Participant Information Sheet

Disclosure Experiences of Survivors of Childhood Sexual Abuse (CSA)

Introduction

My name is Asaly Skrenes, and I am researching childhood sexual abuse (CSA) as part of my PhD in Clinical Psychology at the University of Edinburgh under Dr. Emily Newman and Prof. Matthias Schwannauer, and under the guidance of the principal investigator, Dr. Christian Schütz, at the University of British Columbia. I have several years of experience working with people as a teacher and relief worker in addition to conducting psychology studies with children at UBC. Although I have attended training courses in conducting such interviews with adults, I do not have clinical experience in this area. Nevertheless, this study will be under the guidance and oversight of my very experienced supervisors, who have many years of experience in conducting such studies. I invite you to take part in the following study. Before you decide to do so, however, I need to be sure that you understand why I am doing it, and what it would involve if you agreed. I am, therefore, providing you with the following information. Please read it carefully, and be sure to ask any questions you might have. If you want, discuss it with others, including your friends and family. I will do my best to explain the project to you, and provide you with any further information you may ask.

Study purpose

You are invited to take part in a study about disclosure experiences in CSA. The aim of the study is to understand the disclosure experiences of some survivors of CSA, and how this disclosure experience may affect their well-being.

Your contribution to the study will help us to understand more about how people think and feel about the impact of CSA. It will also allow us to develop our work in this important area, which may later be used to help find ways to understand and protect children and adults in the aftermath of this abuse.

What does the study entail?

If you are a man who has experienced boyhood sexual abuse, or a woman who has experienced girlhood sexual abuse and have previously spoken about this with another person/ other people, and are interested in taking part, you will be asked to describe your disclosure and CSA experience as far as you feel comfortable. Some basic questions, such as your age, gender, age of when the abuse took place, and nature of the abuse (specifically, whether it was contact or no contact) will be on a demographic questionnaire. There will then be a 1-2-hour interview with the researcher (Asaly Skrenes) via Skype/Zoom, in which you will describe the disclosure experiences you had regarding the CSA, as well as your feelings about your gender and sexual orientation. Face-to-face interviews will be offered only to participants who cannot have the interview online due to health-related issues. The interview will be audio-recorded so that the researcher can analyse the precise details following this meeting. If the interview takes place over Skype/Zoom, only an audio-recording (not a video-recording) will be made. You will be given the opportunity to read through the transcribed audio-recording two weeks after the interview takes place.

Do I have to take part?

No. It is up to you to decide whether or not to take part. You can stop taking part in the study at any time before, during, or after the interview without giving a reason. The researcher will not use any of your information or interview material should you decide not to take part at any point before the analysis and integration of all data. If a service provider has informed you of the study, this will not affect any service care you might receive. Your information will not be shared with any service provider.

What are the possible disadvantages and risks of taking part?

Some questions may cause unpleasant thoughts or memories, and you may prefer not to answer some of them. Should you feel distressed during or after the interview process, please let the researcher, institution, or service providers in the information hand-out know. Depending on how distressed you are, and if we have any concerns about your safety or the safety of others, then the researcher may contact your family physician or other professionals on your behalf. For 24-hour accessible health in B.C., Canada, please contact the following:

Crisis Intervention and Suicide Prevention: 1-800-SUICIDE (1-800-784-2433) (24-hour help)

Crisis Centre Chat: 604-872-3311 or visit <https://crisiscentrechat.ca/> to chat online.

Seniors Distress Line: 604-872-1234

Affordable Counselling in Vancouver:

<https://willowtreecounselling.ca/wp-content/themes/willowtree/reduced-cost-counselling.pdf>

There are no predicted long-term harmful consequences to this study.

What are the possible benefits of taking part?

Some people enjoy taking part in research because they feel proud to be contributing to new knowledge in this field. We can't promise that the study will help you personally, although some participants may find discussing these topics to be helpful. The results, however, should help our understanding of the experience of CSA. This, in turn, is expected to be beneficial to both children and adults who experience this form of abuse.

What if there is a problem?

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, please contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598. You may additionally contact the University of Edinburgh with any concerns or complaints by visiting the following website: <https://www.ed.ac.uk/health/research/ethics/research-misconduct>

What will happen to the information that you give?

The handling and storing of the data will comply with Data Protection Law. All information collected about you will be kept strictly confidential. Your data will be referred to by a unique participant number rather than by name. All audio-recordings will be destroyed once they have been transcribed. If you agree to a Skype/Zoom interview, any emails with your consent form or demographic questionnaire will be deleted immediately after reception. When using Zoom, you will log in using the code the researcher gives you (not your name). If you feel uncomfortable with your camera on, you may turn it off; please note, however, that the researcher will not video record, and it might help her understand you and your level of comfort better with the video on. If you need to use the washroom or answer someone, you may also mute yourself. Only audio-recordings (not video-recordings) will be made via Skype/Zoom. Your data will only be viewed by the research team. All electronic data will be stored on a password-protected computer file and all paper records will be stored in a locked filing cabinet. Your consent information will be kept separately from your responses in order to minimise risk.

Instances when a breach of confidentiality is required:

If during our interview, the researcher has reason to believe that a child may be abused, neglected, or is for any other reason in need of protection, we must report it to the Ministry of Children and Family Development. This ministry will also be reported to if the researcher learns that a participant has perpetuated CSA. A similar ministry or association will be reported to in the participant's country should this participant not reside in Canada, and should the circumstances call for this.

Will this data be internationally transferred?

Your data will be stored and processed in Scotland, as this study is part of the researcher's PhD at the University of Edinburgh. All data protection laws for this study in Scotland are the same as those in Canada.

Who is reviewing this study?

The University of Edinburgh's School of Health in Social Science Research Ethics Committee, which has responsibility for scrutinising all proposals for behavioural research by researchers from the University of Edinburgh, has examined the proposal and has raised no objections from the point of view of behavioural ethics. It is a requirement that your records in this research, together with any relevant records, be made available for scrutiny by monitors from this ethics board. It is the role of this ethics board to protect your safety, rights, wellbeing, and dignity. Your name and contact information, however, will not be displayed on any documents.

What will happen to the results of the research study?

The data will be anonymised, analysed, combined with data from other interviews, and be made available to a range of people, including health professionals and researchers through written reports, established website reports, the media, presentations and journal publications. Some quotes that do not contain identifiable information may also be included in the study. It will not, however, be possible to identify any individual participant from these reports or publications.

Further information and contact details:

You can get more study information or discuss the project with the research team by contacting Asaly Skrenes at a.skrenes@sms.ed.ac.uk. Enquiring further does not mean that you have to agree to take part; it means that you can discuss the research and any questions you have. Further information about public involvement in the School of Health in Social Science at the University of Edinburgh can be found at the following web address:

<https://www.ed.ac.uk/health/research/ethics/committee>

If you decide you are interested in participating in the study after reading this information sheet, please either print off a copy of these forms or complete these forms when you meet for the interview. One copy of the completed consent form will be given (or sent) to you. If you would like to find out more about the research before participating, please do not hesitate to contact me.

Thank you for taking the time to read this study information sheet.

Asaly Skrenes:
Email: A.skrenes@sms.ed.ac.uk

Dr. Christian Schütz:
Tel.: 778-873-4785
Email: christian.schutz@ubc.ca

Dr. Emily Newman:
Tel.: +44 (0) 131 651 3945
Email: emily.newman@ed.ac.uk

Prof. Matthias Schwannauer:
Tel.: +44 (0)131 651 3954
Email: headofschool.health@ed.ac.uk



DISCLOSURE EXPERIENCES OF SURVIVORS
OF CHILDHOOD SEXUAL ABUSE (CSA)
ASAL SKRENES

CONSENT FORM

1. I confirm that I have read and understood the information sheet dated
..... for the above study. I have had the opportunity to consider the
information, ask questions, and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at
any time without giving any reason, and without any therapy, psychological care
or legal rights being affected.
3. I understand that the researcher may contact my family physician or other
professionals _____ at the following number _____
_____ on my behalf should I feel distressed enough to be at risk of harming myself
or others.
4. I understand that my participation will be audio recorded and analysed. If this is a
Skype interview, I understand that only an audio-recording and not video-recording
will be made. Anonymised quotes may be used in publications about the research;
however, it will not be possible to identify me from this information. I give my permission
for this.
5. I understand that my data and information will be securely kept at the University
of British Columbia and the University of Edinburgh for 5 years following the
completion and submission of the study results.
6. I understand that data from this study may potentially be accessed by the public
(journals, funding bodies, and other researchers), but that any names, information
means of identifying me will be removed first.
7. I understand that once this anonymised data is made available to the public, I will
no longer be able to withdraw my data.
8. I understand that at any point in the study, if the researcher becomes aware that there
has been abuse and/or neglect of a child (or that there is a risk of such occurring in the
future) she must, by law, report this information to the appropriate authorities.
9. I understand that if I have ever sexually abused a child or adolescent, I am not
permitted to take part in this study, and if the researcher is made known of this
information, she must report this information to the appropriate authorities.

10. I would like to receive a summary of the results upon completion of the study.

11. I agree to take part in the above study.

Name or initials of participant Date Signature or initials

Name of researcher taking consent Date Signature