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**THE EFFECTS OF ABUSE ON MENTAL HEALTH OUTCOMES OF MALES**

by

Helana M. Russo

A Thesis

Submitted to the  
Department of Psychology  
College of Science and Mathematics  
In partial fulfillment of the requirement  
For the degree of  
Master of Arts in Clinical Mental Health Counseling  
at  
Rowan University  
September 9, 2015

Thesis Chair: Sandra Hargesheimer, MA



## **Dedications**

*I would like to dedicate this and my whole academic career to my grandmother who is my angel on earth, saving my life literally and figuratively more times than I count. She had been there for every moment of this journey and kept me grounded with faith, love, and most importantly loyalty! She never stopped believing in me and it's my honor to make her proud and call her my Mom!*

## **Acknowledgments**

I would like to express my gratitude to my advisor, Sandra Hargesheimer, my second reader, Eve Sledjeski, and program director, Ginean Crawford. Thank each of you for your patience, guidance, and support. This experience was quite the journey and it would not have been possible without each of you understanding and believing in me. I would also like to recognize some very significant people in my life that made this experience possible. To my Dad for being a part of my life and instilling in me qualities that only we would understand, without them I wouldn't be half the woman or person I am today and I know it! To my Aunt Nancy for inspiring me to follow my dreams. She is the perfect example of a hardworking woman, loving mother, and faithful wife. To my dear friend, Stacy, for her continuous support, understanding, and assistance in keeping me focused throughout this time of my life! To my better half, I don't think I would have made it without his hugs, continuous reassurance, and life lessons, teaching me more about myself and life than any book or class ever could! Thank you all so very much! I love you more than words could express.

## **Abstract**

Helana M. Russo

### **THE EFFECTS OF ABUSE ON MENTAL HEALTH OUTCOMES OF MALES**

2014-2015

Sandra Hargesheimer, MA

Master of Arts in Clinical Mental Health Counseling

Childhood sexual and physical abuse has been found to have lasting effects on one's physical and mental health in adulthood. Studies have found that childhood abuse is linked to a variety of mental health conditions that tend to present later in life. This paper investigates specifically how childhood abuse experiences may affect the mental health of male victims, explicitly examining whether the type of abuse has an effect on the way mental health problems express, whether internalized or externalized disorders are more prominent depending on the abuse type. The study also aims to compare mental health outcomes of abused males to the population of non-abused males. Hypothesis 1: Males that have experienced sexual abuse will display more internalized mental health symptoms as compared to those that have been physically abuse and those with no abuse history. Hypothesis 2: Males that have experienced physical abuse will display more externalized mental health symptoms as compared to those that have been sexually abused and those with no abuse. Analysis included two one way ANOVAs to compare the mean scores of both internalized and externalized disorders based on the type of abuse, with those categories being sexually abused, physically abused, non- abused, and both physically and sexually abused.

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## **Chapter 1**

### **Introduction**

The effects of childhood maltreatment on one's mental wellbeing in adulthood have been an area of interest in psychological research for over fifty years. Early research in this area dates back to the beginning of the 1960's. In 1962, Kempe and his colleagues were the first to describe the symptoms of "the battered child syndrome" (Kempe, Silverman, Steele, Drogemueller, & Silver, 1962). This study and earlier research focused on physical abuse, and the abuser's behavioral characteristics rather than those of the victim. Over the next thirty years, this research evolved and expanded to focus more on the victim's characteristics and the short term or immediate effects of physical abuse (Ammerman, Cassisi, Hersen, & Van Hasselt, 1986; Conaway & Hansen, 1989; Fantuzzo, 1990; Lamphear, 1985). Simultaneously, research was also being conducted focusing specifically on childhood sexual abuse and the long term consequences associated with this form of maltreatment (Browne & Finkelhor, 1986). Investigations documenting the relationship between childhood maltreatment and adult mental health outcomes continued well into the 1990's (Kendall- Tackett, Williams, and Finkelhor, 1993; Polusny & Follette, 1995; Kessler, Davis, & Kendler, 1997). In the early 2000's, researchers also began to dispute the negative effects of childhood abuse and argued that some victims may conversely show resiliency (Bonanno, 2004; Bonanno, Papa, & O'Neil, 2002; Masten, 2001). Despite these efforts, it remains difficult to specifically designate a causal relationship between experiences of childhood abuse and mental health disorders or resiliency. Previous research has supported both, as stated above and because childhood maltreatment and the possible effects that are linked to this area is so broad, additional research continues up to present day.

Throughout the last 15 years, studies in the area of childhood maltreatment and effects on adult mental health have isolated a number of different factors. Studies have aimed to isolate different contexts of childhood maltreatment and outcomes such as: specific maltreatment categories (physical, sexual, and emotional abuse), gender, disorders, and behaviors (Chandy, Blum, & Resnick, 1996; Fergusson, McLeod, & Horwood, 2013; MacMillan et al., 2009; Maniglio, 2009; Putnam, 2003; Kaplan, Pelcovitz, & Labruna, 1999; Malinosky- Rummell & Hansen, 1993; Mersky, Topitzes, & Reynolds, 2013). Despite the magnitude of collaborations and examinations in this area, there appears to be a lack of research that specifically examines the mental health of males that have been physically or sexually abused during childhood; much of the gender specific research in this area has included females. Furthermore, there is a lack of research that has focused explicitly on how these childhood abuse experiences have influenced any manifestation of disorders or behaviors in the male population, more precisely the classification of disorders and behaviors as it relates to the type of abuse (physical, sexual). In other words, are the types of maladaptive behaviors exhibited by the abuse victims different depending on the type of abuse exposure?

Maladaptive behaviors can be classified into two separate categories, internalized behaviors and externalized behaviors and based on whether they are internalized or externalized, these behaviors are linked to specific mental health diagnoses. The terms internalized and externalized are generally used in the adolescent population, but can be applied to the adult population as well. Internalized behaviors can be described as, “an over control of emotion, including social withdrawal, feelings of worthlessness or inferiority, and dependency” (Silva, Grana, & Gonzalez-Cieza, 2013). In contrast,

externalized behavior problems can be described as, “behaviors that are characterized by an under control of emotions, including difficulties with interpersonal relationship and rule breaking” (Silva et al., 2013). Internalization can additionally be described as the propensity to express distress inward. Some common internalizing disorders include: mood disorders such as major depressive disorder or dysthymia, and anxiety disorders such as generalized anxiety disorder, separation anxiety disorder, phobias and obsessive compulsive disorder. Externalization can be further described as the propensity to express distress outwards. Some commonly recognized externalizing disorders include attention deficit disorder, oppositional defiant disorder, conduct disorder, and antisocial personality disorder, and substance use disorders (Cosgrove et al., 2011). This area of isolating and identifying specific presentation of behaviors in the adult male populations as it relates to the effects of childhood abuse can be useful to the field of mental health services, as based on previous research and findings, there is a significant amount of males who have been victims of childhood physical abuse (CPA) and childhood sexual abuse (CSA) in the general population.

Data has generally been collected from three populations of participants to examine the prevalence rate of CSA in males. These populations include: college students, community based samples and clinical samples. Studies of college students have found prevalence rates of CSA in males from 4.8%- 28% (Lisak & Luster, 1994; Lisak, Hopper, & Song, 1996; Fritz, Stoll, & Wagner, 1981). Community based samples have yielded prevalence rates ranging from 2.8-16% (Kercher & McShane, 1984; Urquiza & Keating, 1990; Finkelhor, 1990). Finally, clinical samples have yielded prevalence rates from 3-23% (Belkin, Greene, Rodrique, & Boggs, 1994; Metcalfe,

Oppenheimer, Dignon, & Palmer, 1990). Additionally, the rates of CPA may actually be higher than that of CSA according to some reports.

In 2008, the U.S. Department of Health and Human Services reported that 16% of the population experienced CPA as compared to 9% who reported experiencing CSA. Another study conducted in the United States, The Adverse Childhood Experiences (ACE) Study, was one of the largest studies ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study was collaboration between the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Health Appraisal Clinic in San Diego (CDC, 1997). The ACE study found that of its 7370 male participant, 29.9% reported experiencing CPA (Brown et al., 2009). The above indicates that there is likely a significant amount of men in the general population that have experienced CSA or CPA. Because of this, it is important for the mental health field to examine the effects that these experiences have had on the mental health of these men.

### **Childhood Sexual Abuse and Mental Health Outcomes**

There are a variety of mental health outcomes that have been associated with CSA in males. Previous research has shown that overall, males that have experienced CSA experience worst mental health outcomes than those who have not been abused (Horwitz, Widom, McLaughlin, & White, 2001). Specifically, adults who report experiences of abuse and neglect as children, compared to those who do not, also report considerably higher rates of virtually every type of psychopathology including depression, anxiety, drug and alcohol disorders, personality disorders, and generalized distress. Additional research has found that a significant amount of these mental health disorders can be

considered to be internalized disorders. This theory has been supported by research that has included measures in symptom severity using standardized measures and examining case studies. In relation to standardized measures, it has been demonstrated that abused men tend to score significantly higher on measures including depression, anxiety, obsessive compulsiveness, dissociation, low self-esteem, sleep disturbances, impaired relationships, and suicide attempts (Briere, Evans, Runtz, & Wall, 1988; Fromuth & Burkhart, 1989; Hunter, 1991).

Additionally, in another form of investigation, a study was completed using personal interviews of 26 males that experienced CSA. The men were interviewed while being audio taped and the interviews were then transcribed and analyzed for content themes. There were 15 themes that were analyzed in this study. These interviews revealed that of the men that were included in the study, over fifty percent of them endorsed the following themes: anger, fear, helplessness, isolation and alienation, masculinity issues, negative schemas about self and people, self-blame and guilt, and shame/ humiliation (Lisak, 1994). Supporting these findings in earlier research as well, Lew (1988) also conducted a similar study using the same methodology and also found themes of problems with intimacy, shame, self-blame and guilt, low self-esteem, and negative self-images. The ACE Study also showed that there were elevated levels of depression and suicide attempts in male CSA victims. Of the 4015 participants that had a current diagnosis of depression, 11.8 % experienced CSA as compared to 7.9% that had no sexual abuse history and of the 7970 that endorsed lifetime suicide attempts 4.1% had been sexually abused, as compared to 1.5% that had not been (Dube et al., 2005).

## **Childhood Physical Abuse and Mental Health Outcomes**

Childhood physical abuse has also been associated with a variety of mental health outcomes in adults, beginning in adolescence. Many studies have found an association between CPA and subsequent violent and criminal behavior in adolescence (Silva et al, 2013). Also among incarcerated adolescents, physical abuse was a better predictor of externalized problems (Bayer et al., 2011). These externalized behaviors in the youth, place the adult at risk for delinquency, juvenile and adult arrest, and early antisocial personality (McMahon, Witkiewitz, & Kotler, 2010). In adolescence, some traits associated with externalized behaviors are referred to as CU traits, or callous unemotional traits. In adulthood, these traits are referred to as psychopathological or antisocial traits. Some of these traits include callous and manipulative use of others, shallow and short-lived affect, irresponsible or impulsive behaviors, egocentricity, and pathological lying (Brinkley, Schmitt, Smith, & Newman, 2001).

These externalized behaviors in adulthood are linked to both specific mental health disorders. Some of these disorders include: attention deficit disorder, antisocial personality disorder, and substance use disorders (Cosgrove et al., 2011). These behaviors are also linked to oppositional defiant disorder and conduct disorder, but these are both disorders that are unique to the child or adolescent population (APA, 2013). Once an adult, the criteria of these disorders would equal that of antisocial personality disorder, a disorder new to the DSM-V. Previously, this would have been classified as psychopathy. Antisocial personality disorder and psychopathy are terms that are often used synonymously. Psychopathy itself refers to a disorder that begins in early life and is



characterized by a variety of antisocial behaviors and exploitative interpersonal relationships (Brinkley et al., 2001).

Males that have experienced CPA have been shown to display these externalized behaviors and some of the mental health disorders associated with these behaviors. In the juvenile male population, there have been findings that support the strong link between physical abuse and adolescent aggression. Adolescents who exhibit aggressive and violent behaviors demonstrate higher rates of maltreatment than the general population (Alfaro, 1981). Among incarcerated adolescents, physical abuse was a better predictor of externalizing problems than internalizing problems and according to reports 50.9 % of incarcerated youth were found to be victims of physical abuse in 1998 and 42.5% in 2010 (Silva et al, 2013; Mason, Zimmerman, & Evans, 1998; Coleman & Stewart, 2010). Additionally, a study involving children who were receiving mental health treatment those who had been physically abused exhibited more aggressive behaviors than their non-abuse peers (Cavaiola & Schiff, 1988). This pattern has been found to continue with adult males. Males that have experienced physical abuse have demonstrated increased likelihood to engage in violent behaviors. Sack and Mason (1980) found that convicted male felons, particularly those who committed sexual offenses, reported much higher rates of physical abuse than non-institutionalized males.

Multiple previous researchers have cited that there is not only gender differences in the expression of mental health issues of men that have experienced childhood abuse, but that there is also limited research in the area (Springer, Sheridan, Kuo, & Carnes, 2011). There is a large majority of research that focuses specifically on females that have had experiences of abuse (Chu & Dill, 1990; Bryer, Nelson, Miller, & Krol, 1987; Briere &

Runtz, 1988; Bifulco, Brown, & Adler, 1991; Mullen & Fergusson, 1999). In Malinosky-Rummell and Hansen's review of long term consequences of CPA in 1992, prior research was highlighted and the amount of female only studies outnumbered the number of male only studies by a 1 to 3 ratio.

There is a need in the field of counseling to gain more insight into the specific effects that experiences of childhood abuse may have on males in particular (Chandy et al., 1996; Beitchman et al., 1991; Croysdale, Drerup, Bewsey, & Hoffmann, 2008). Specifically discussing CSA, gender differences were found in current adjustment, retrospectively recalled immediate reactions, current reflections, and self-reported effects in college aged men and women (Rind, Tromovitch, & Bauserman, 1998). One paper cited that there are different aspects of mental health that should be examined while focusing on the male population because males in general tend to externalize their emotions more than women do with the focus of their mental health or emotional issues being behavioral (Chandy et al., 1996). Another study suggested that the future research should include measures that not only include disorders such as depression, anxiety, and PTSD, but also to include issues such as aggression and criminal behavior again because of the proposed differences in expression of maladaptive behaviors between males and females (Schilling, Aseltine, & Gore, 2007).

## **Purpose**

The purpose of this study is to expand on the research existing that examines the effects that childhood abuse experiences have the adult male population. Limitations of the previous research include not specifically isolating the male population that has experienced abuse. There is a significantly greater amount of research that focuses on the

female population only. Other research combined different types of abuse to be an overall generalization of maltreatment rather than isolating physical or sexual abuse. Previous research in this area has examined specific mental health disorders but not specific behaviors that are more prevalent in the male population such as aggression, antisocial behaviors, and psychopathologic traits.

The study will attempt to isolate instances of physical and sexual abuse in an adult male population. It will also use measures that examine overall mental wellbeing, symptoms associated with specific mental health disorders, and measures that examine thoughts and behaviors associated with specific problematic behaviors common with men, such as criminality and aggression. The symptomology and behaviors will then be separated into two categories being externalized and internalized behaviors. This categorical association can help to tailor the treatment of men that have these experiences and assist counselors to be able to better conceptualize the client if they present with specific mental health disorders or behaviors seen in the childhood abuse population.

The aims of this study are to explore the mental health outcomes of males that have experienced childhood physical and or sexual abuse as compared to those who have not, as well as to explore the differences of outcomes between physically and sexually abused males. The study also aims to expand on the symptomology that is examined when discussing the male childhood abuse victims. Based on previous research, it is hypothesized males that have experienced physical abuse will display more externalized mental health symptoms as compared to those that have been sexually abused and those with no abuse. It is also hypothesized that males who have experienced sexual abuse will

display more internalized mental health symptoms as compared to those that have been physically abuse and those with no abuse history.

## **Chapter 2**

### **Methodology**

The current study utilized a convenience sampling method. Participants included undergraduate students from a mid-sized university in the northeastern part of the United States. Participants were recruited through an online study management system called SONA-systems. Participants were informed of research credit opportunities by their professors and referred to SONA-systems to register for the current study. Participation was voluntary and individuals who participated were able to obtain research credit towards their course requirements. The current study gathered a total of 114 participants. Data was collected over a six month period. In order to protect confidentiality, each participant was assigned a number to which only the Principal Investigator and the study's Coordinator had access to. All of the data collected during this study was evaluated using the Statistical Package for the Social Sciences (SPSS) version 21.

### **Instrumentation**

**Childhood trauma questionnaire (CTQ).** The CTQ (Bernstein & Fink, 1997) was developed as a screening tool for histories of abuse and neglect. The entire self-report includes a 28-item test that measures 5 types of maltreatment – emotional, physical, and sexual abuse, and emotional and physical neglect. For this study, only the physical and sexual abuse questions were used. Approximately 5 minutes is required to complete the test. A 5-point Likert scale is used for the responses which range from Never True to Very Often True. Reliability for the CTQ subscales used in this study demonstrated a fair reliability with a Cronbach's alpha of .68.

**Trauma symptom checklist (TSC-40).** The TSC-40 (Briere & Runtz, 1989) is a research measure that evaluates symptomology in adults associated with childhood or adult traumatic experiences. It measures aspects of posttraumatic stress and other symptom clusters found in some traumatized individuals. It does not measure all 17 criteria of PTSD, and should not be used as a complete measure of that. The TSC-40 is a 40-item self-report instrument consisting of six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems, and Sleep Disturbance, as well as a total score. Each symptom item is rated according to its frequency of occurrence over the prior two months, using a four point scale ranging from 0 ("never") to 3 ("often"). The TSC-40 requires approximately 10-15 minutes completing. Reliability for the TSC-40 used in this study demonstrated a good reliability with a Cronbach's alpha of .93.

**Buss-Perry aggression questionnaire (BPAQ).** The BPAQ (Buss & Perry, 1992) assesses physical and verbal aggression, anger, and hostility. The BPAQ represents a revision of the Buss-Durkee Hostility Inventory (BDHI), including revisions of the response format and item content to improve clarity. This scale is 29-items, 5-point scale from 1 (extremely uncharacteristic of me) to 5 (extremely characteristic of me). Internal consistency for the four subscales and total score range from .72 (Verbal Aggression) to .89 (Total BPAQ score). Retest reliability for the BPAQ over nine weeks is also satisfactory. Correlations ranged from .72 for Anger to .80 for Physical Aggression and the total score (Buss & Perry, 1992). In the current study demonstrated good reliability as well with a Cronbach's alpha of .89.

**Self-report psychopathy scale (SRPS).** The SRPS (Levenson, Kiehl, & Fitzpatrick, 1995) is a measure of psychopathy based on the PCL-R criteria and designed to use in college samples. The SRPS consists of 26 items divided into two separate scales- primary and secondary psychopathy. Primary psychopathy was designed to assess a selfish, uncaring and manipulative posture towards others, while the secondary psychopathy scale was created to assess impulsivity and a self-defeating lifestyle. This study showed this measure to be reliable with a Cronbach's alpha of .73.

**Brief symptom inventory (BSI).** The BSI (Derogatis & Melisaratos, 1983) is a self-report symptom scale that was designed to measure levels of psychopathology. It is a shortened form of the revised version of the Symptom Checklist (SCL-90). The BSI consists of 53 items describing a variety of complaints and problems that are rated on a 5 point scale reflecting degrees of distress ranging from not at all to extremely. The items measure nine dimensions that include: somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism (Boulet & Boss, 1991). This study showed this measure to be reliable with a Cronbach's alpha of .96.

## **Procedure**

This study used a self-report survey design to explore the mental health and behaviors of males that have experienced childhood sexual or physical abuse. Participants were able to access an online survey through a secure, data collection company, SONA-systems. Data was collected over a six month period. Participants were asked to review an informed consent form that confirmed their willingness to participate in the study, outlined all risks and benefits of the study, gave permission to the

researcher to use the information for the intended purpose of this study, and provided the phone number of the university's counseling center in case any distress occurs during or after the study relating to the recall of childhood traumatic experiences. After providing electronic consent, participants were directed to the survey comprised of the measures; CTQ, TSC-40, BPAQ, SRPS, and BSI. All efforts were made to secure the data, maintain confidential information, and ensure that the survey was authentic and legitimate. Survey required approximately 30 minutes completing. All of the data collected during this study was evaluated using the Statistical Package for the Social Sciences (SPSS) version 21.



### Chapter 3

#### Results

A total of 114 (n=114) participants were included in the analyses. All of the participants that participated in this study were males (100%). No other demographic information was collected during this study. Descriptive statistics were run on the five measures that were used in the study (CTQ, TSC-40, BPAQ, SRPS, and BSI), results are presented in Table 1.

Table 1.

*Descriptive statistics on the BPAQ, BSI, CTQ, SRPS, and TSC-40*

	N	Mean	SD
BPAQ	114	62.34	15.72
BSI	114	38.32	29.74
CTQ	114	1.96	3.42
SRPS	114	69.65	6.61
TSC-40	114	28.48	17.06

Frequencies were also run on the participants regarding abuse experiences. Participants were classified as having abuse experiences if they answered 1 or above on any of the questions on the CTQ (Appendix A). They were then classified as having physical or sexual abuse depending on the questions that were scored over 1. Questions

1-5 were classified as physical abuse and 6-10 were classified as sexual abuse. If the participants answered over a 1 in both categories they were listed in the both category. There were over half the participants that were listed as having physical abuse only (44.7%, N=52). Far fewer participants endorsed sexual abuse only (.04%, N=4) and both physical and sexual abuse (.06%, N=7). When the questions were combined, CTQ-1-10, 45.6 % of participants were categorized as having no abuse and 54.4% were categorized as having experienced either physical, sexual abuse or both.

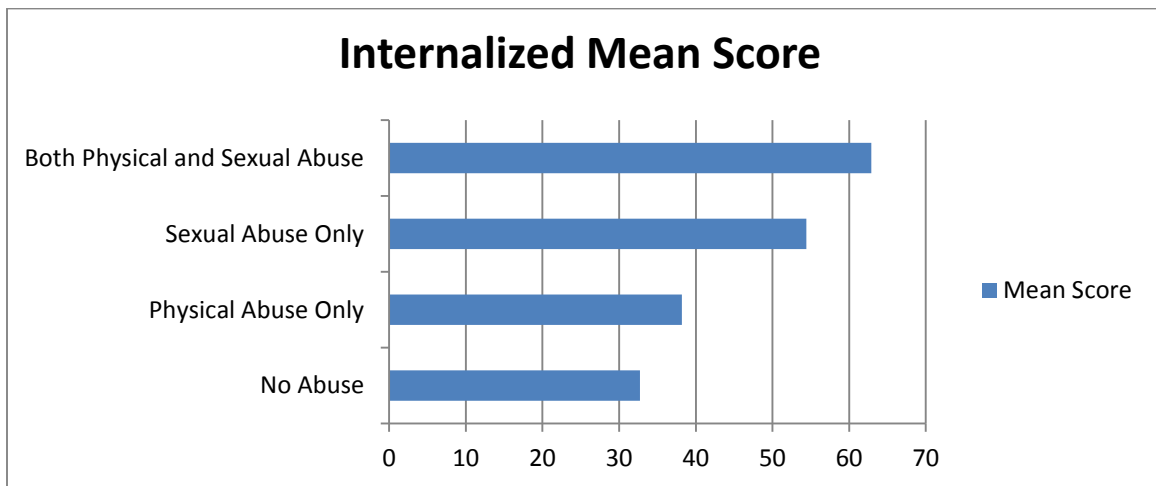
To examine the hypotheses, a series of one way between subjects ANOVAs were conducted in order to explore the relationship between internalized and type of abuse. Another series of ANOVAs were conducted in order to explore the relationship between externalized and type of abuse. The following were categorized as internalized: somatization, depression, anxiety, Sexual Abuse Trauma Index, sexual problems, sleep disturbance, obsessive compulsive behaviors, interpersonal sensitivity, phobic anxiety, paranoid ideation, and psychoticism. Externalized included: physical and verbal aggression, anger, hostility, and psychopathy.

Based on a series of one way between subject ANOVAs examining internalized disorders, there was a significant relationship between internalized and type of abuse  $F(3,110)=4.63, p=.004$ , see Table 2. A Tukey HSD test revealed that those that experienced both physical and sexual abuse ( $M=62.88, SD=29.46$ ) had a significantly higher scored in internalized compared to no abuse ( $M=32.72, SD=21.16$ ) and physically abused only ( $M=38.19, SD=21.75$ ), as well as sexually abused only ( $M=54.42, SD=29.34$ ). The mean scores of internalized are presented in Figure 1.

Table 2.

*Internalized ANOVA*

	SS	df	MS	F	p
Between	6858.49	10	2286.16	4.63	.004
Within	54263.00	103	493.30		
Total	61121.50	113			



*Figure 1.* Internalized Mean Scores

Based on a series of one way between subject ANOVAs examining externalized, there was a significant relationship between externalized and type of abuse  $F(3,110) = 4.25, p = .007$ , see Table 3. A Tukey HSD test revealed that those that experienced both physical and sexual abuse ( $M = 153.97, SD = 10.28$ ) had significantly higher scores in externalized as compared to those with no abuse ( $M = 127.65, SD = 18.28$ ), sexual abuse

only (M=134.70, SD=22.56), and physical abuse only (M=134.51, SD=20.55). The mean scores of externalized are presented in Figure 2.

Table 3.

*Externalized ANOVA*

	SS	df	MS	F	p
Between	4677.66	3	1559.22	4.25	.007
Within	40318.14	110	366.53		
Total	44995.81	113			

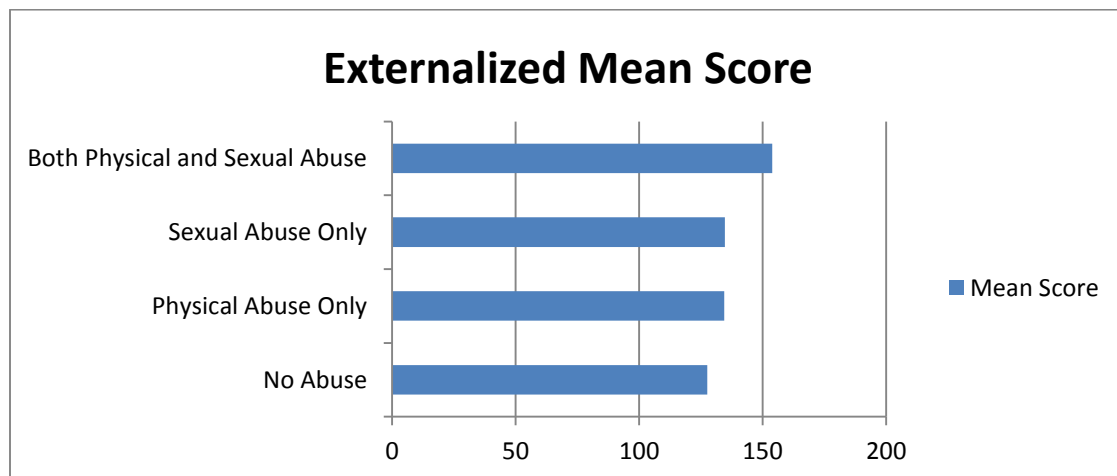


Figure 2. Externalized Mean Score

## **Chapter 4**

### **Discussion**

#### **Summary**

The aim of this study was to expand on the existing literature examining males that have experienced childhood sexual or physical abuse and their mental health in adulthood. To date, the majority of studies that exist have not isolated the male population or type of abuse when looking at outcomes in adulthood. This study was novel in that it categorized mental health disorders and behaviors into internalized or externalized and examined whether or not the type of abuse experienced is related to the type of mental health disorders or behaviors expressed. The participants in this study were limited to males and the type of abuse was also well defined as physical, sexual, or both. This study also helped to explore behaviors more prevalent to the male population, which can help give direction to therapists that may be treating a male exhibiting these behaviors or traits.

#### **Conclusions**

Based on the ANOVAs examined, there are significant relationships between the type of childhood abuse experienced and the presentation of mental health symptoms or behaviors. However, there was a variable that was not initially taken into consideration. There were a number of participants that endorsed both physical and sexual abuse. The researchers decided to make this a variable to be examined because otherwise the participants would be categorized falsely. When this variable was taken into consideration, this was the variable that showed a significant relationship between internalized and externalized. Physical abuse also showed significant relationship with

internalized. However, sexual abuse nor physical abuse showed a significant interaction with externalized and sexual abuse did not show a significant interaction with internalized. Based on this information, neither of the hypotheses were proven to be true.

Another finding that is important to discuss is the amount of participants that were categorized as physically abused. Some of the questions on the CTQ relating to physical abuse (CTQ1 and CTQ5) were broad and possibly overgeneralized. This classified the participants that endorsed it as physically abused and may have resulted in the high number of participants classified as physically abused.

### **Recommendations and Limitations**

In regards to the current study and its results, there are several recommendations for future research as well as limitations. First, the current study was exploratory in nature. Future researchers may benefit from creating an experimental design or a case study design to more concisely examine the variables of this study. This would aid in presenting a more concise description of the relationship between the type of childhood abuse males experiences and the type of pathology that presents. It may also be beneficial to attempt to exclude any participants that have experienced both physical and sexual abuse in another attempt to isolate the appropriate abuse populations.

The current study also categorized internalized and externalized behaviors and disorders. However, these categories were developed using some subscales of overall mental health measures. In future studies, it may be beneficial to isolate the disorders by using measures that examine only specific disorders and that are diagnostic measures. For example, that BSI has subscales that include anxiety and depression however the BDI or BAI are diagnostic measures of these specific disorders that would aid in specifically

linking the type of abuse to a particular disorder that can be classified as internalized or externalized. Diagnoses are not usually categorized as internalized or externalized by any formal association but rather by definition. Isolating the disorders by measures will help to mainstream symptomatology to assist in classifying the type of disorders and behaviors.

The current study also has numerous limitations that could be corrected in future studies. Demographic information for the participants was not collected in this study. This was an error on the part of the researcher. Although this information would be helpful to describe the sample in a more detail, the gender of the participants was the most important factor and this was limited to male participants. The sample was a convenience sample that was limited to a college population. Future studies could expand on this population to include a sample that is representative of the general population.

Expanding on the limitations of the current study, the word “abuse” was in the title of the study. This provides the participants with information about the study that may have influenced the way participants answered the questions. Previous research has shown that the use of the word “abuse” when assessing these experiences can lead to misrepresentation. The CTQ also uses direct questions about abuse experiences. The variables of the study were not well camouflaged, which could create a response bias. In relation to this, there were questions on the CTQ that were broad and endorsement of them may possibly not indicate abuse necessarily. Perhaps another measure of abuse could be used or definitions could be outlined more clearly.

In addition, no other factors or adverse life experiences were taken into account in the current study. It is possible that other factors may have influenced the mental health of the participants. Future studies would benefit from including a variety of life experiences and examining their relationship to internalized and externalized disorders in adult males.

Finally, it appears based on the findings of this study that the participants that endorsed both physical and sexual abuse had the worst outcomes in both internalized and externalized categories. Future research should probably then assess severity, duration, and specific type of maltreatment. This would help to inform and add to existing research about how severity of abuse is linked to mental health outcomes. For example this could examine if the outcomes would be the same based on type of abuse but vary depending on duration. Including these additional factors could provide helpful information when examining outcomes in mental health and prognoses.

Despite the limitations of this study, the conclusions and findings suggest that this is possibly an area of research that is worth further exploration. The study addressed some shortcomings in this area of research. Much of the literature that was examined for this study was dated and it was because many more recent studies have not isolated the male population, nor have they examined specific childhood maltreatment experiences. Furthermore, this researcher did not find any studies that examined the relationship between specific categories of pathology and behaviors as the current study did. It is the hope that this area of research can be expanded upon and that the findings will aid in the treatment and improvement of men's mental health.



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## Appendix A

### Childhood Trauma Questionnaire (CTQ)

#### Physical and Sexual Abuse Subscales

Listed below are questions for this section of the survey. Please provide a response for every question. If you are given the option to decline to answer a question, then declining to answer is considered a response. The scale for this section of the survey is 0-Never True to 4-Very Often True

1. Got hit so hard that I had to see a doctor or go to the hospital 0 1 2 3 4
2. Family hit me so hard that it left me with bruises or marks 0 1 2 3 4
3. I was punished with a belt, board, cord, or other hard object. 0 1 2 3 4
4. I believe that I was physically abused 0 1 2 3 4
5. Beaten so badly that it was noticed by teachers/ neighbor/ doctor. 0 1 2 3 4
6. I believe that I was sexually abused. 0 1 2 3 4
7. Someone molested me. 0 1 2 3 4
8. Someone tried to make me do/watch sexual things. 0 1 2 3 4
9. Someone tried to touch me in a sexual way/ made me touch them. 0 1 2 3 4
10. Someone threatened me unless I did something sexual. 0 1 2 3 4



## Appendix B

### Trauma Symptom Checklist (TSC-40)

Listed below are questions for this section of the survey. Each question the prefaced by:  
"How often have you experienced the following in the last two months?" Please provide a  
response for every question. The rating is 0 (never)-3(often).

- |                                                          |         |
|----------------------------------------------------------|---------|
| 1. Headaches                                             | 0 1 2 3 |
| 2. Insomnia (trouble getting to sleep)                   | 0 1 2 3 |
| 3. Weight loss (without dieting)                         | 0 1 2 3 |
| 4. Stomach problems                                      | 0 1 2 3 |
| 5. Sexual problems                                       | 0 1 2 3 |
| 6. Feeling isolated from others                          | 0 1 2 3 |
| 7. "Flashbacks" (sudden, vivid, distracting<br>memories) | 0 1 2 3 |
| 8. Restless sleep                                        | 0 1 2 3 |
| 9. Low sex drive                                         | 0 1 2 3 |
| 10. Anxiety attacks                                      | 0 1 2 3 |
| 11. Sexual overactivity                                  | 0 1 2 3 |
| 12. Loneliness                                           | 0 1 2 3 |

- |                                                                   |         |
|-------------------------------------------------------------------|---------|
| 13. Nightmares                                                    | 0 1 2 3 |
| 14. "Spacing out" (going away in your mind)                       | 0 1 2 3 |
| 15. Sadness                                                       | 0 1 2 3 |
| 16. Dizziness                                                     | 0 1 2 3 |
| 17. Not feeling satisfied with your sex life                      | 0 1 2 3 |
| 18. Trouble controlling your temper                               | 0 1 2 3 |
| 19. Waking up early in the morning and can't get<br>back to sleep | 0 1 2 3 |
| 20. Uncontrollable crying                                         | 0 1 2 3 |
| 21. Fear of men                                                   | 0 1 2 3 |
| 22. Not feeling rested in the morning                             | 0 1 2 3 |
| 23. Having sex that you didn't enjoy                              | 0 1 2 3 |
| 24. Trouble getting along with others                             | 0 1 2 3 |
| 25. Memory problems                                               | 0 1 2 3 |
| 26. Desire to physically hurt yourself                            | 0 1 2 3 |
| 27. Fear of women                                                 | 0 1 2 3 |
| 28. Waking up in the middle of the night                          | 0 1 2 3 |

29. Bad thoughts or feelings during sex	0 1 2 3
30. Passing out	0 1 2 3
31. Feeling that things are "unreal"	0 1 2 3
32. Unnecessary or over-frequent washing	0 1 2 3
33. Feelings of inferiority	0 1 2 3
34. Feeling tense all the time	0 1 2 3
35. Being confused about your sexual feelings	0 1 2 3
36. Desire to physically hurt others	0 1 2 3
37. Feelings of guilt	0 1 2 3
38. Feelings that you are not always in your body	0 1 2 3
39. Having trouble breathing	0 1 2 3
40. Sexual feelings when you shouldn't have them	0 1 2 3

## Appendix C

### Buss Perry Aggression Questionnaire (BPAQ)

Rate each of the following items in terms of how characteristic they are of you.

Use the following scale, 1 2 3 4 5, 1 being extremely uncharacteristic of me to 5 being extremely characteristic of me.

\_\_\_\_\_ 1. Once in a while, I can't control the urge to strike another person.

\_\_\_\_\_ 2. If I have to resort to violence to protect my rights, I will.

\_\_\_\_\_ 3. I have trouble controlling my temper.

\_\_\_\_\_ 4. I often find myself disagreeing with people.

\_\_\_\_\_ 5. I have become so mad that I have broken things.

\_\_\_\_\_ 6. I am an even-tempered person.

\_\_\_\_\_ 7. When people are especially nice, I wonder what they want.

\_\_\_\_\_ 8. Given enough provocation, I may hit another person.

\_\_\_\_\_ 9. I tell my friends openly when I disagree with them.

- \_\_\_\_\_ 10. If someone hits me, I hit back.
- \_\_\_\_\_ 11. I get into fights a little more than the average person.
- \_\_\_\_\_ 12. I can think of no good reason for ever hitting a person.
- \_\_\_\_\_ 13. I am sometimes eaten up with jealousy.
- \_\_\_\_\_ 14. I know that “friends” talk about me behind my back.
- \_\_\_\_\_ 15. I have threatened people I know.
- \_\_\_\_\_ 16. When people annoy me, I may tell them what I think of them.
- \_\_\_\_\_ 17. I can’t help getting into arguments when people disagree with me.
- \_\_\_\_\_ 18. My friends say that I’m somewhat argumentative.
- \_\_\_\_\_ 19. Other people always seem to get the breaks.
- \_\_\_\_\_ 20. Sometimes I fly off the handle for no good reason.
- \_\_\_\_\_ 21. There are people who pushed me so far that we came to blows.

\_\_\_\_\_ 22. I wonder why sometimes I feel so bitter about things.

\_\_\_\_\_ 23. I sometimes feel that people are laughing at me behind my back.

\_\_\_\_\_ 24. When frustrated, I let my irritation show.

\_\_\_\_\_ 25. I sometimes feel like a powder keg ready to explode.

\_\_\_\_\_ 26. Some of my friends think I'm a hothead.

\_\_\_\_\_ 27. At times I feel I have gotten a raw deal out of life.

\_\_\_\_\_ 28. I am suspicious of overly friendly strangers.

\_\_\_\_\_ 29. I flare up quickly but get over it quickly.

## Appendix D

### Levenson Self-Report Psychopathy Scale (SRPS)

Rate each of the following as it applies to you.

Scale 1-5      1- Disagree                  3 -Neutral                  5 -Agree

1. Success is based on survival of the fittest; I am not concerned about the losers.
2. I find myself in the same kinds of trouble, time after time.
3. For me, what's right is whatever I can get away with.
4. I am often bored.
5. In today's world, I feel justified in doing anything I can get away with to succeed.
6. I find that I am able to pursue one goal for a long time.
7. My main purpose in life is getting as many goodies as I can.
8. I don't plan anything very far in advance.
9. Making a lot of money is my most important goal.
10. I quickly lose interest in tasks I start.
11. I let others worry about higher values; my main concern is with the bottom line.
12. Most of my problems are due to the fact that other people just don't understand me.
13. People who are stupid enough to get ripped off usually deserve it.
14. Before I do anything, I carefully consider the possible consequences.
15. Looking out for myself is my top priority.
16. I have been in a lot of shouting matches with other people.

17. I tell other people what they want to hear so that they will do what I want them to do
18. When I get frustrated, I often "let off steam" by blowing my top.
19. I would be upset if my success came at someone else's expense.
20. Love is overrated.
21. I often admire a really clever scam.
22. I make a point of trying not to hurt others in pursuit of my goals.
23. I enjoy manipulating other people's feelings.
24. I feel bad if my words or actions cause someone else to feel emotional pain.
25. Even if I were trying very hard to sell something, I wouldn't lie about it.
26. Cheating is not justified because it is unfair to others.



## **Appendix E**

### **Brief Symptom Inventory (BSI)**

Below is a list of problems that people sometimes have. Please read each one carefully. Then circle the number that best describes how much that problem has distressed or bothered you during the past 7 days including today. The numbers refer to the following descriptive phrases.

Not at all 1-a little bit 2-moderately 3-quite a bit 4-extremely-5

1. Nervousness or shakiness inside
2. Faintness or dizziness
3. The idea that someone else can control your thoughts
4. Feeling others are to blame for most of your troubles
5. Trouble remembering things
6. Feeling easily annoyed or irritated
7. Pains in the heart or chest
8. Feeling afraid in open spaces or in the streets
9. Thoughts of ending your life
10. Feeling that most people cannot be trusted
11. Poor appetite
12. Suddenly scared for no reason
13. Temper outbursts that you cannot control
14. Feeling lonely even when you are with people
15. Feeling blocked in getting things done
16. Feeling lonely

17. Feeling blue
18. Feeling no interest in things
19. Feeling fearful
20. Your feelings being easily hurt
21. Feeling that people are unfriendly or dislike you
22. Feeling inferior to others
23. Nausea or upset stomach
24. Feeling that you are watched or talked about by others
25. Trouble falling asleep
26. Having to check and double-check what you do
27. Difficulty making decisions
28. Feeling afraid to travel on buses, subways, or trains
29. Trouble getting your breath
30. Hot or cold spells
31. Having to avoid certain things, places or activities because they frighten you
32. Your mind going blank
33. Numbness or tingling in parts of your body
34. The idea that you should be punished for your sins
35. Feeling hopeless about your future
36. Trouble concentrating
37. Feeling weak in parts of your body
38. Feeling tense or keyed up
39. Thoughts of death or dying

40. Having urges to beat, injure, or harm someone
41. Having urges to break or smash things
42. Feeling very self-conscious with others
43. Feeling uneasy in crowds, such as shopping or at the movies
44. Never feeling close to another person
45. Spells of terror or panic
46. Getting into frequent arguments
47. Feeling nervous when you are left alone
48. Others not giving you proper credit for your achievements
49. Feeling so restless that you couldn't sit still
50. Feelings of worthlessness
51. Feeling that people will take advantage of you if you let them
52. Feelings of guilt
53. The idea that something is wrong with you