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# Masculine norms, disclosure, and childhood adversities predict long-term mental distress among men with histories of child sexual abuse☆

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ABSTRACT

Child sexual abuse (CSA) can have a profound effect on the long-term mental health of boys/men. However, not all men with histories of CSA experience psychopathology. To improve prevention and intervention services, more research is needed to understand why some male survivors experience mental health problems and others do not. The purpose of this study was to examine factors related to mental distress among a large, non-clinical sample of men with histories of CSA ($N = 487$). Using a cross-sectional design with purposive sampling from three national survivor organizations, data were collected through an anonymous Internet-based survey. Multivariate analyses found that only one of the four CSA severity variables—use of physical force by the abuser—was related to mental distress. Additional factors that were related to mental distress included the number of other childhood adversities, years until disclosure, overall response to disclosure, and conformity to masculine norms. Overall, the final model predicted 36% of the variance in the number of mental health symptoms. Mental health practitioners should include masculine norms, disclosure history, and childhood adversities in assessments and intervention planning with male survivors. To more fully explicate risk factors for psychopathology in this population, future studies with probability samples of men that focus on mediational processes and use longitudinal designs are needed.



## Introduction

Not long ago, the sexual abuse of boys was considered a rare or even nonexistent public health problem (De Francis, 1969). Over the past few decades, however, media coverage of institutional scandals (e.g., Boys Scouts of America, Catholic Church, Penn State University) has brought dramatic accounts of sexual victimization of boys to the American public (Boyle, 1994). Although prevalence rates vary due to methodological considerations, Finkelhor, Turner, Ormrod, and Hamby (2009) found that 7.5% of boys experienced sexual victimization in a nationally representative sample of youth in the United States. This finding is consistent with international studies which have found that between 5% and 10% of men report having been sexually abused in childhood (World Health Organization, 2006).

Sexual abuse can have a profound effect on boys' development and negatively impact their long-term physical, psychological, social, and spiritual health in adulthood (for reviews, see Andrews, Corry, Slade, Issakidis, & Swanston, 2004;

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Hunter, 2006; Putnam, 2003; Spataro, Moss & Wells, 2001). In terms of mental health, CSA is related to an increased risk of experiencing a range of psychiatric disorders (Cutajar, Mullen, Ogloff, Wells, & Spataro, 2010; Molnar, Buka, & Kessler, 2001; Spataro, Mullen, Burgess, Wells, & Moss, 2004) and mental health problems such as suicidality (O'Leary & Gould, 2009). Recent studies have found that the deleterious effects of CSA and other child adversities can last across the lifespan and into old age (Draper et al., 2008; Talbott et al., 2009).

Despite advances in our knowledge of the prevalence and effects of CSA for boys/men, male survivors remain an under-researched and stigmatized population; most research on long-term outcomes of CSA has been conducted with female samples (Spataro et al., 2001). Also, not all adult survivors of CSA develop severe psychopathology or interpersonal dysfunction (Hunter, 2006; Putnam, 2003). In addition to sexual abuse characteristics (e.g., age at onset, relationship to abuser, physical injury), researchers have started to examine other factors that may explain the potentially harmful effects of CSA on long-term mental health such as parental response to disclosure, coping style, social support, blame/shame, and family environment (Elliott & Carnes, 2001; Whiffen & MacIntosh, 2005). More research is needed to understand the processes involved in psychopathology for survivors (Spataro et al., 2004; Steel, Sanna, Hammond, Whipple, & Cross, 2004) and to thereby improve our ability to strengthen and target prevention and intervention services. Thus, the purpose of this study was to identify risk and protection factors related to long-term mental distress for male survivors using a large, non-clinical sample of men with self-reported histories of CSA.

*Sexual abuse severity*

Clinicians and researchers have speculated that characteristics of the sexual abuse experience may explain differential mental health outcomes for survivors (Andrews et al., 2004; Lew, 2004). More severe forms of sexual abuse may inflict a deeper wound by reinforcing helplessness, powerlessness, and self-blame for survivors. Many of the existing studies on long-term outcomes have focused on indicators of abuse severity. For example, some research has established that compared to other forms of CSA (e.g., pornography, voyeurism, exposure of body), sexual abuse involving physical contact is associated with higher levels of depression and other psychological problems in adulthood (Andrews et al., 2004; Nelson et al., 2002). Other studies have found that penetration (Briere & Elliott, 2003; Cutajar et al., 2010; Dube et al., 2005; O'Leary & Gould, 2009), duration or frequency (Briere & Elliott, 2003; Molnar et al., 2001; Steel et al., 2004), coercion or force (Boudewyn & Liem, 1995; Molnar et al., 2001), and relation to the abuser (Molnar et al., 2001; O'Leary, Coohey, & Easton, 2010) are related to more long-term mental health and trauma symptoms. However, not all studies have found that these abuse variables predict long-term psychopathology (e.g., Cutajar et al., 2010). Furthermore, because most of the existing research has been based on samples of female survivors, it is unclear whether indicators of CSA severity exert a similar effect for men. To examine these possibilities, we hypothesized that duration, penetration, use of force, and incest would be positively related to mental distress among men with histories of CSA.

*Other childhood stressors*

Recognizing that "sexual abuse does not occur in a vacuum" (Finkelhor, 1998, p. 1865), researchers have started to examine how childhood environment and other co-occurring stressors can compound the long-term effects of CSA on survivors' mental health. *Polyvictimization*, for example, has been proposed as a model to study childhood adversities (Finkelhor, Omrod, Turner, & Holt, 2009) and encompasses multiple forms of child maltreatment (e.g., neglect, physical abuse) and victimization (e.g., witnessing community or domestic violence). In a study with a large nationally representative sample of youth ($N = 2{,}030$), polyvictimization, defined as exposure to four or more types of adversities in the past year, was highly predictive of trauma symptoms (Finkelhor, Omrod, & Turner, 2007). Another pioneering study examined a range of childhood stressors or adversities (e.g., physical or sexual abuse, parental mental illness, domestic violence) in a large sample of adult patients in a California primary care setting ($N = 9{,}508$; Felitti et al., 1998). The Adverse Childhood Experiences (ACE) study found a graded relationship between the number of ACE categories and numerous health risk behaviors and diseases (e.g., smoking, obesity, heart disease) in adulthood (Felitti et al., 1998). Several subsequent studies have found that ACE categories are related to long-term mental health problems as well as the leading causes of death (e.g., Dube et al., 2001). Based on the ACE empirical studies and the polyvictimization perspective, we hypothesized that there would be a positive relationship between the number of childhood adversities and mental distress.

*Disclosure*

The interpersonal process of telling another person about the sexual abuse (i.e., disclosure) has been identified as a critical component of recovery for survivors in several theoretical frameworks. For example, account-making is a stage-based, sociopsychological trauma processing model (Harvey, Orbuch, & Weber, 1990). According to this theory, survivors attempt to gain understanding of traumatic experiences, in part, through discussions with other people. Other theories that focus more specifically on recovery (Chouliara, Karatzias, & Gullone, 2013) or healing (Draucker et al., 2011) from CSA also highlight the importance of disclosure. If met with a helpful response, disclosure of sexual abuse can promote health and recovery for survivors by reducing problems associated with shame, self-blame, isolation, and the burden of maintaining a secret.

The empirical research on the relation between aspects of disclosure (e.g., timing) and long-term mental health is underdeveloped and based largely on samples of female survivors of CSA. Some studies have found, for example, that delayed disclosure of CSA is related to more symptoms of posttraumatic stress disorder (PTSD) in adulthood (Ruggiero et al., 2004; Ullman, 2007) and that early disclosure is related to fewer symptoms of mental distress (Easton, 2012). However, O'Leary, Coohey, and Easton (2010) found that disclosure shortly after the sexual abuse was related to *more* mental health problems. Ullman and Filipas (2005) found no relationship between the length of time from onset of the sexual abuse to disclosure and PTSD symptom severity. Nonetheless, guided by account-making and CSA-specific theories of disclosure, we hypothesized that the elapsed time from sexual abuse onset to disclosure would be positively related to mental distress.

Although a substantial body of research has demonstrated a positive relationship between parental support following disclosure and short-term mental health (for a review, see Elliott & Carnes, 2001), there is very little research on the effect of responses to disclosure—both during childhood and adulthood—on the *long-term* mental health of survivors (Easton, 2012). Ullman and Filipas (2005) found that negative social reactions to disclosure of CSA were related to more PTSD symptoms for adult survivors. Another study found that maternal support during childhood was negatively related to mental health symptoms in adulthood (Easton, 2012). Based on these preliminary studies and theories of recovery from CSA, it is reasonable that receiving supportive responses to disclosure (e.g., emotional, instrumental, informational) would be helpful to a survivor's mental health. In the current study, we hypothesized that the overall helpfulness of responses to disclosure would be negatively related to mental distress.

### *Masculinity*

In a model of masculine gender socialization, Mahalik (2000) proposed that gender standards and expectations are shaped by dominant, powerful groups in society and transmitted through descriptive, cohesive norms. Traditional masculinity consists of norms such as the importance of winning, an ethos of self-reliance, emotional control, a dislike of homosexuality, and pursuit of status (Mahalik, Locke, et al., 2003). A variety of individual (e.g., racial identity, socioeconomic status, personal history) and group (e.g., cultural values) factors filter gender expectations and affect the extent to which an individual conforms to the dominant gender role norms. Depending on the situation, conformity to these norms conveys both benefits and costs to men (Mahalik, Locke, et al., 2003).

Many men with histories of CSA struggle with issues surrounding masculinity and face gender role conflicts (Lew, 2004). For example, survivors often feel that it is un-masculine to be characterized as a victim, especially in cases of sexual violence (Spataro et al., 2001). Because many of the abusers were also men, male survivors often struggle with heightened issues of homophobia, shame, and stigma (Lew, 2004; Spataro et al., 2001). Stoicism and emotional control often make it difficult for men to acknowledge and discuss the sexual abuse with others (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005). To cope with feelings of inadequacy, some male survivors adopt a hypermasculine persona in which they display exaggerated masculine attitudes and norms such as aggression (Dorais, 2002; Kia-Keating et al., 2005).

A growing body of research has found that many masculine scripts are associated with poorer psychological and physical health outcomes for men generally (Mahalik, Good, & Carlson, 2003; Mahalik, Locke, et al., 2003) and in subpopulations such as Asian men (Liu & Iwamoto, 2007) or men who identify as gay (Kimmel & Mahalik, 2005). However, our review did not identify any studies on conformity to masculine norms and health with national probability samples of men in the general population. Furthermore, few researchers have examined gender rigidity among male survivors of CSA (e.g., Lisak, Hopper, & Song, 1996) or the possible effects of gender conformity on their long-term mental health. Based on Mahalik's (2000) model of masculine norms and previous research, we hypothesized that conformity to masculine norms would be positively related to mental distress in the current study.

## Methods

### *Data source*

This study used a cross-sectional survey design with purposive sampling from three national organizations that serve men with histories of CSA: the Survivors Network of Those Abused by Priests (SNAP), MaleSurvivor, and 1in6.org. Founded in 1989, SNAP is the nation's oldest and largest support and advocacy organization for adults who were sexually abused by religious authority figures (e.g., priests, ministers, rabbis, nuns). The organization has approximately 9,000 members (of which approximately two-thirds are CSA survivors) who are organized into local chapters. MaleSurvivor was incorporated in 1995 by a group of mental health professionals with the purpose of helping men recover from sexual victimization through education, research, treatment, and advocacy. Due to privacy concerns, membership information was not provided to the researchers. The third organization (1in6.org) was founded in 2007 and is dedicated to helping men recover from unwanted or abusive sexual experiences from childhood. This organization offers online recovery resources (e.g., educational materials, therapist locator) and does not have a formal membership.

Each organization posted the study announcement online. It could be viewed by both formal members and general visitors to the web site. SNAP also sent recruitment emails to its members. Potential participants were directed to a survey website with a welcome message, consent letter, and eligibility screening questions. Participants were eligible for the study if they self-reported that they were male, 18 years of age or older, and sexually abused in childhood (i.e., prior to age 18). Interested,

eligible participants then completed an anonymous, Internet-based survey during an 8-week period in the summer of 2010. Of the 546 respondents to the study announcements, 487 men met the selection criteria. There was no compensation for participation in the study. The original study received human subjects approval from the Institutional Review Board (IRB) at a Midwestern university. During the analysis phase, an IRB at a university in the Northeast provided human subjects approval. Several safeguards were included to protect the safety and privacy of participants (e.g., crisis hotline, therapist locator, list of community mental health centers).

### *Sample*

The sample consisted of 487 men with histories of CSA ranging in age from 19 to 84 years ($M = 50.4$, $SD = 10.82$). The majority of participants self-identified as Caucasian (90.9%). The remaining participants indicated that they were biracial (2.9%), African-American (1.0%), Native-American (1.0%), Asian (0.4%), Pacific Islander (0.4%), or other (3.3%). In response to a question regarding Hispanic ethnicity, 5.6% of participants identified as Hispanic. The average household income for participants was between $60,000 and $69,999. The mean number of recent stressors endorsed by participants was 2.3. Most of the participants were members of a survivor organization (81%) and had told someone about being sexually abused sometime in their life (97%).

### *Measures*

The survey was developed and pretested in three phases over a 2-year period with input from national sexual abuse and trauma experts, clinicians, and graduate students in social work. The experts and practitioners assessed face and content validity of project-created measures, which has been described in more detail elsewhere (Easton, 2011). The final survey consisted of 137 items. The estimated length of time it took participants to complete the survey was approximately 30 min (Easton, 2011).

*Mental distress.* Mental health problems were measured using an adapted version of the General Mental Health Distress Scale (GMDS; Dennis, White, Titus, & Unsicker, 2008), a component of a larger, reliable and valid health screening instrument: the General Assessment of Individual Needs (Dennis et al., 2008). The GMDS is a symptom count of internal sources of distress that were experienced in the past 12 months. The GMDS has high internal consistency ($\alpha = .90$); generally increases with age; and has demonstrated an ability to detect differences in symptom patterns by gender, race, and age (Conrad, Conrad, Dennis, Riley, & Funk, 2009). For this study, the measure included 25 items related to internalizing disorders (i.e., depression, anxiety, somatization, and suicidality). Participants who responded *yes* received a score of 1 (*no* = 0) for each item. Endorsed items were added to create a total score (range = 0–25) with higher scores indicating more mental distress; the clinical divisions for distress severity were low (0–3), medium (4–6), and high (7–25). The Cronbach's alpha for the index was .90.

*Masculine norms.* The Conformity to Masculine Norms Inventory-22 (CMNI-22; Mahalik, Locke, et al., 2003) is the abbreviated version of the original 94-item Conformity to Masculine Norms Inventory (CMNI; Mahalik, 2000; Mahalik, Locke, et al., 2003). The CMNI measures overall conformity to 11 traditional masculine norms (e.g., winning, emotional control, risk-taking) and has strong convergent validity, good concurrent validity, high test–retest estimates, and good to excellent internal consistency (Mahalik, Locke, et al., 2003). The CMNI-22 uses the two highest loading items for each factor and correlates at .92 with the total score for the CMNI (Mahalik, Locke, et al., 2003). For each item, participants were asked their level of agreement with a statement using a 4-point Likert scale. Example statements include: "My work is the most important part of my life," "It is important to me that people think I am heterosexual," and "I tend to share my feelings." Nine items were reverse-coded so that higher agreement equated to higher conformity to masculine norms. Scores on the items were added and averaged (range = 0–4). The CMNI-22 has demonstrated good internal consistency (Rochlen, McKelly, Suizzo, & Scaringi, 2008). In the current study, the Cronbach's alpha coefficient was .71.

*Abuse severity. Penetration* was measured with the following item: "Did the sexual abuse involve penetration of you or the abuser? (oral, anal, or vaginal)". Participants were also asked if the abuser used *physical force* during the sexual abuse. For both items, participants who responded *yes* received a score of 1 (*no* = 0). To measure *duration* of the sexual abuse, participants were asked to estimate the length of time of the sexual abuse using a five-point Likert scale ranging from 1 (*less than one month*) to 5 (*more than three years*). Participants were asked about their relationship to the abuser and presented with 15 response options (e.g., biological parent, family friend, teacher/coach, clergy member). Participants who indicated that they were abused by a biological family member received a score of one for *incest* (*no* = 0).

*Childhood adversity.* A standardized index was adapted to measure *childhood adversities*: the Child and Adult Stressors Index (Statistics Canada, 2002). Participants were asked, "Did any of the following things happen to you while you were a child or teenager (under the age of 18)?: physical abuse, parental substance abuse, parental mental illness, parental criminal activity, divorce, witnessing domestic violence, extended hospitalization, and parental unemployment" (*no* = 0; *yes* = 1). Participants

were able to check off all of the events that occurred in their childhood. A total score for childhood adversity was created by adding the number of endorsed events (range = 0–8) with higher scores indicating more adversities.

*Disclosure variables.* Participants were asked if they had ever told someone about the sexual abuse (not including the survey). Participants who had disclosed were asked to estimate their age at the time that they first told someone about the sexual abuse. An earlier item in the survey asked participants to estimate the age at which they were first sexually abused. A new variable, *years until told*, was then created by subtracting the age at the time of the sexual abuse from the age at the time of first disclosure. Another item asked participants to assess the *overall helpfulness of responses* that they received after telling others about the sexual abuse. The responses were based on a 5-point Likert scale (*very unhelpful* [1] to *very helpful* [5]).

*Control variables.* One item asked participants to provide their current *age*. Another item on race asked participants to choose from six response options. Because of small cell sizes, a new variable (*racial minority*) was created; participants who reported a race other than white/Caucasian received a 1 (*no* = 0). To measure *income*, participants were asked: "Including all sources of income from all household members, what was your total household income last year?" The responses choices ranged from 1 (<$*19,999*) to 12 (>$*120,000*). *Recent stressors* were measured with an adaptation of the List of Threatening Events Questionnaire (LTEQ; Brugha & Cragg, 1990). The instructions asked, "Have any of the following life events or problems happened to you during the past 12 months?" and presented participants with a list of 13 items (e.g., serious illness, death of parent, child or spouse, divorce, unemployment). The endorsed stressors (*no* = 0, *yes* = 1) were summed (range = 0–13) with higher scores indicating more current stressors. Participants were also asked about membership in a national survivor organization: *survivor group membership* (*no* = 0, *yes* = 1). To control for disclosure history, participants were asked if they had *ever told* someone about the sexual abuse (*no* = 0, *yes* = 1).

### *Data analysis*

Data were cleaned and imported into SPSS 19.0 for analysis. Diagnostic tests conducted prior to inferential testing found that assumptions were met for multivariate statistical analyses. After performing univariate and bivariate analyses, multivariate regression analyses (i.e., Ordinary Least Squares [OLS]) were conducted with two models. To examine the effects of demographic and background factors on mental distress, the control variables were entered into the first OLS model. To evaluate the research hypotheses of the study, the variables of interest were then added to create the second OLS model.

## Results

### *Descriptive findings*

Table 1 presents the descriptive findings for the variables of interest in the study. On average, men reported high levels of mental distress which were above the clinical cutpoint for high severity. More than half of the men reported that the sexual abuse involved penetration and lasted one year or more; slightly more than one-third of participants indicated that the abuser used physical force. The mean length of time until participants disclosed their abuse was more than two decades. Approximately one-third of participants indicated that the overall helpfulness of responses to disclosure were somewhat or very helpful. Men reported moderate levels of childhood adversities and masculine norms.

### *Multivariate results*

The results of both regression models are presented in Table 2. In the first model, which included control variables, three variables were significant. Both age and household income were positively related to mental distress; the number of recent stressors was negatively related to the dependent variable. Overall, the regression model was significant, $F(10, 458) = 16.811$, $p < .001$ and explained 25% of the total variance in mental distress. In the second regression model, the results supported five of the eight hypothesized relationships. Of the CSA severity variables, only the use of physical force was significant ($p < .01$). Additionally, childhood adversities ($p < .05$), years until told ($p < .01$), and masculine norms ($p < .001$) were positively related to mental distress. The overall response to disclosure was negatively related to the dependent variable ($p < .01$). Three control variables remained significant: age, household income, and recent stressors. Overall, the second regression model was significant, $F(18, 424) = 14.559$, $p < .001$, and explained 36% of the total variance in mental distress.

## Discussion

The purpose of this study was to examine factors associated with long-term mental health problems among men with histories of CSA. After controlling for background factors, we found that the use of force was related to an increase in the number of mental health symptoms. This finding is consistent with previous studies on the impact of coercion or force and long-term mental health (Boudewyn & Liem, 1995; Molnar et al., 2001). The use of force by an abuser may exacerbate feelings of helplessness or powerlessness in the survivor that may persist in adulthood, thereby impairing long-term mental health. Mental health practitioners working with men with histories of CSA should assess whether force was used during

**Table 1**
Descriptive statistics for key variables ($N = 487$).

| Variable | % | Mean (*SD*) | Range |
|---|---|---|---|
| Age | | 50.37 (10.82) | 19–84 |
| Racial minority (% yes) | 9 | | |
| Income | | 6.26 (3.80) | 1–12 |
| Less than $19,999 | 13.8 | | |
| $20,000–$29,999 | 7.7 | | |
| $30,000–$39,999 | 8.2 | | |
| $40,000–$49,999 | 8.8 | | |
| $50,000–$59,999 | 6.0 | | |
| $60,000–$69,999 | 7.2 | | |
| $70,000–$79,999 | 8.8 | | |
| $80,000–$89,999 | 7.0 | | |
| $90,000–$99,999 | 4.5 | | |
| $100,000–$109,999 | 6.0 | | |
| $110,000–$119,999 | 3.7 | | |
| More than $120,000 | 15.6 | | |
| Recent stressors | | 2.27 (2.05) | 0–12 |
| Survivor group membership | 80.3 | | |
| Ever told | 97.1 | | |
| Penetration | 54.2 | | |
| Abuser used physical force | 36.1 | | |
| Incest | 11.7 | | |
| Duration of CSA | | 3.48 (1.51) | 1–5 |
| Less than one month | 17.2 | | |
| One month to less than 6 months | 11.9 | | |
| 6 months to less than one year | 9.9 | | |
| One year to less than three years | 23.0 | | |
| More than three years | 34.9 | | |
| Abuser used physical force | 36.1 | | |
| Childhood adversities | | 1.87 (1.77) | 0–8 |
| Years until told | | 21.39 (14.69) | 0–63 |
| Helpfulness of response to disclosure (lifetime) | | 2.57 (1.03) | 1–5 |
| Very unhelpful | 4.3 | | |
| Somewhat unhelpful | 6.6 | | |
| Both helpful and unhelpful | 51.3 | | |
| Somewhat helpful | 16.4 | | |
| Very helpful | 20.5 | | |
| Masculine norms | | 2.34 (.32) | 1.59–3.55 |
| Mental health symptoms | | 12.50 (6.27) | 0–25 |

the sexual abuse. Strength-based clinical interventions (Saleebey, 2002) that build on survivors' competencies, resources, and personal assets may be critical counterweights to sexual abuse that involved the use of force. Interestingly, the other indicators of CSA severity—penetration, duration, and incest—were significant at the bivariate level, but not significant in the final model of mental distress. These results were not consistent with some of the existing empirical studies (e.g., Dube et al., 2005; Molnar et al., 2001; O'Leary & Gould, 2009). It is, however, possible that the relationship between abuse severity

**Table 2**
Ordinary least squares regression results for mental distress.

| Variable | Model 1 | | | Model 2 | | |
|---|---|---|---|---|---|---|
| | *b* (SE) | *B* | *p* | *b* (SE) | *B* | *p* |
| Age | −.09 (.02) | −.16 | <.001 | −.10 (.03) | −.17 | <.001 |
| Racial minority | −.66 (.91) | −.03 | .465 | −.56 (.89) | −.03 | .529 |
| Income | −.25 (.07) | −.15 | <.001 | −.22 (.07) | −.13 | .001 |
| Survivor group membership | .09 (.65) | .01 | .886 | 1.02 (.13) | .33 | <.001 |
| Recent stressors | 1.20 (.13) | .40 | <.001 | .06 (.64) | .00 | .921 |
| Ever told | 1.27 (1.61) | .03 | .433 | 1.69 (1.66) | .04 | .309 |
| Penetration | | | | .77 (.57) | .06 | .175 |
| Duration | | | | .20 (.18) | .05 | .252 |
| Abuser used physical force | | | | 1.47 (.54) | .11 | .007 |
| Incest | | | | .74 (.79) | .04 | .351 |
| Childhood adversities | | | | .35 (.14) | .10 | .013 |
| Years until told | | | | .06 (.02) | .13 | .002 |
| Helpfulness of disclosure response | | | | −.88 (.25) | −.14 | .001 |
| Masculine norms | | | | 3.19 (.82) | .16 | <.001 |
| Constant | 14.44 (2.04) | | <.001 | 6.71 (3.25) | | .039 |
| Adjusted $R^2$ | .25 | | | .36 | | |

and mental distress is more nuanced than a direct relationship (e.g., Steel et al., 2004). To clarify the relationship between indicators of CSA severity and mental health, future studies should explore the possibility of mediational processes.

Consistent with the ACE line of research in the general population (e.g., Dube et al., 2001; Felitti et al., 1998), the number of childhood adversities (other than CSA) was positively related to the number of mental distress symptoms in the current study. The result is also consistent with Finkelhor, Ormrod, et al.'s (2009) model of polyvictimization and research on the detrimental effects of problem-saturated childhood environments. Because other forms of child maltreatment (e.g., physical abuse) and deprivation (e.g., parental criminality) commonly co-occur with CSA for boys (Andrews et al., 2004), it is important for mental health practitioners to include ACE in clinical assessments and help male survivors untangle the residual effects of other environmental stressors that occurred early in the lifespan.

As hypothesized, the length of time until first disclosure was positively related to symptoms of mental distress. Given the mixed empirical research on the effect of disclosure timing on mental health, this finding is important. Similar to some of the previous studies (Ruggiero et al., 2004; Ullman, 2007), delaying disclosure of CSA contributed to more mental health symptoms in adulthood. Because of the high levels of shame, stigma and self-blame for male survivors (Lew, 2004; Spataro et al., 2001), many men maintain the secret of CSA long into adulthood, a phenomenon labeled as self-silencing (O'Leary & Barber, 2008). The burden of carrying the secret from childhood into adulthood appears to have a heavy cost in terms of mental health. Although delaying disclosure may temporarily protect young survivors who are in unsupportive or hostile environments, the results of this study suggest that maintaining secrecy appears to be harmful as a long-term strategy for dealing with CSA.

Aside from the timing of disclosure, how others react to the survivors' revelation or account of CSA also impacts the survivors' long-term mental health. This finding is consistent with previous studies on support following disclosure and long-term adjustment (e.g., Ullman & Filipas, 2005). It should be noted that the variable in the current study was an aggregate measure of the helpfulness of disclosure responses across the lifespan. Future studies should investigate survivors' perceptions of what constitutes a helpful response to disclosure and their history of disclosure. It is also possible that some survivors faced unhelpful initial responses to disclosure, but then later found individuals who provided support and encouragement. Indeed, the type of support (e.g., emotional, instrumental, informational) or source of support (e.g., family member, partner/spouse, friend) may also be important to recovery. Mental health practitioners can help survivors evaluate the impact of negative reactions to previous disclosures and identify individuals in their social networks who could provide support following future disclosures.

Conformity to masculine norms was positively related to symptoms of mental distress in this study. Some of the norms that were measured included emotional control, disdain for homosexuality, and self-reliance. It is possible that these norms inhibited help-seeking or processing of the sexual abuse. Other research has confirmed that men with histories of CSA routinely face discordance between sexual victimization and living up to cultural prescriptions for manhood, and that resilience depends, in part, on being able to contain, resist, and renegotiate masculine roles (Kia-Keating et al., 2005). Therapists working with men with histories of CSA should assess their adherence to masculine norms, and, if necessary, help them develop more flexible, adaptive gender scripts. These alternative scripts should include permission for the survivor to acknowledge and process the impact of being sexually abused during childhood.

Three control variables were significant in our final model. Household income was negatively related to mental distress and may reflect a disparity in access to recovery resources. At the policy level, communities need to ensure that all men with histories of CSA have access to mental health resources, regardless of income level. The number of recent stressors (e.g., divorce, death of a friend, unemployment) was also significant. This result suggests that mental health practitioners should include these stressors in assessments and treatment planning. A third control variable, age, was negatively related to mental distress. This finding is consistent with O'Leary et al.'s (2010) study in which older survivors reported fewer mental health symptoms than survivors in their 30s and 40s. One explanation is that older survivors may be further along in their life course trajectories than young adults (e.g., starting careers) or middle-aged adults (e.g., dealing with marital problems); higher levels of economic resources and social support may assist older adults in managing the effects of CSA. Another explanation is that there may be a developmental recovery process through which survivors progress that is assisted by the passage of time. Although plausible, these explanations are speculative. Currently there is a dearth of empirical research on the aging process and the mental health of men with histories of CSA. Research studies with longitudinal designs are needed to gain understanding of the effects of age and improve clinical services for male survivors across the lifespan.

### *Strengths and limitations*

In interpreting the results of the study, several strengths and limitations should be mentioned. Through assistance from several national survivor organizations, the researchers were able to reach a large sample of a hidden, stigmatized population. However, due to this recruitment approach, the sample may not be representative of men with histories of CSA in the general population. For example, national survivor organization may provide its members with recovery resources (e.g., online support groups, psychoeducational materials) not readily available to male survivors in the general population. Also, the vast majority of participants were Caucasian; survivors from minority backgrounds were under-represented. Although both survivor group membership and race were controlled in our models, the use of probability sampling could enhance the generalizability of results in future studies. Another sampling concern was that most participants (62%) were abused by a member of the clergy. Some research suggests that clergy abuse survivors face unique problems (e.g., spiritual distress;

Fater & Mullaney, 2000) that could undermine recovery from CSA. However, diagnostic testing found that clergy abuse survivors were similar to other study participants on most variables in our models. Furthermore, post hoc tests confirmed that abuse by a clergy member was not a significant predictor of mental distress in this study. Nonetheless, future studies can expand our knowledge by exploring possible differences in recovery needs for this culturally unique sub-population.

Another strength of the study was that the model of mental health included domains beyond CSA severity (e.g., other childhood adversities, disclosure history, masculine gender norms) that have seldom been explored with this population. The model also included an elaborate set of control variables which reduced the likelihood of spurious findings for the variables of interest. However, because of the cross-sectional design of the study, the results were based on correlational analyses and should not be used to infer causal relationships. Also, the psychometric properties of some of the measures in this study were not established. Future studies that use a prospective, longitudinal design and standardized measures would advance our knowledge of the determinants of mental health for men with histories of CSA.

Finally, the use of an anonymous, internet-based survey for data collection maximized privacy protections for men who were providing information on highly sensitive topics. Although this methodology was helpful in reaching a large sample of survivors, the single source, self-report technique may have reduced the accuracy of the data due to retrospective recall bias. Additionally, internet-savvy participants may have differed from survivors in the general population in important ways. To improve both the accuracy of the data and the generalizability of the results, future studies should consider collecting data from multiple sources (e.g., administrative records, spouses/partners, therapists) and through different modalities (e.g., paper-based surveys, in-person interviews).

Despite these limitations, the study made important contributions to our understanding of mental health among men with histories of CSA. To date, few researchers have examined differential mental health outcomes among male survivors of CSA. Based on a large, non-clinical sample of male survivors across a wide age range, the current study found that only one indicator of CSA severity was related to long-term mental health. Beyond abuse severity, we found that other environmental stressors in childhood negatively influenced survivors' mental health in adulthood. The use of an expanded, lifespan approach to disclosure allowed us to examine the influence of disclosure timing and responses to disclosure on mental health. Finally, the results highlighted the salience of gender norms as strict conformity to traditional masculine norms was associated with more mental health symptoms. Although more research is needed, this study represents an important step in expanding our knowledge base on this population. Ultimately, the knowledge that we gain can inform interventions designed to alleviate suffering and promote the health and well-being of men who endured sexual abuse in childhood.

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