

12-2021

## Childhood Sexual Abuse Disclosure and Mental Health Outcomes: The Relationship Between Gender, Parental Style, and Masculinity Norms

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### Recommended Citation

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A Thesis Presented to the  
Faculty of the Department of Psychology  
University of South Carolina Aiken

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In Partial Fulfillment of the  
Requirements for the  
Degree Master of Science

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Kayla E. Hall  
December 2021

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Kayla E. Hall


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## Abstract

**Objective:** The current study aims to investigate social reactions to childhood sexual abuse disclosure (CSA) in adult men and women. Additionally, the study explores the relationship between conformity to masculinity norms and perception of parental style on timing of disclosure and resulting internalizing and externalizing symptoms and substance abuse.

**Method:** Using Amazon's Mechanical Turk, 299 adult men and women residing in the U.S. ( $M_{age} = 35.9$ ,  $SD_{age} = 10.5$ ; 53% female; 78% European American) completed an anonymous online series of survey items pertaining to childhood sexual abuse, internalizing and externalizing mental health symptoms, substance abuse, social reactions to their CSA disclosure, perception of parental style, conformity to masculinity norms, and CSA disclosure characteristics.

**Results:** An independent samples *t* test revealed there was not a significant difference between time to disclosure for men and women. Hierarchical linear regression revealed that relationship to perpetrator, gender, and parental dysfunction did not account for a significant amount of variance in time until disclosure. A MANOVA revealed a trend in overall social reactions to CSA disclosure between men and women. Separate univariate tests revealed that women reported receiving significantly more positive and emotionally supportive responses than men. There were no differences between men and women on the other Social Reactions Questionnaire scales (e.g., Turning Against, Unsupportive Acknowledgement).

Negative reactions to disclosure, and the heterosexual self-preservation and self-reliance masculinity norms were significant predictors of internalizing issues. Negative reactions to disclosure and the masculinity norm heterosexual self-preservation were also significant

predictors of externalizing issues. Lastly, negative reactions to disclosure and perceived parental dysfunction were significant predictors of substance abuse.

The main effect of negative reactions to disclosure on internalizing mental health outcomes was significant, but this relationship was not moderated by gender. The main effect of negative reactions to disclosure on externalizing mental health outcomes was significant, but this relationship was not moderated by gender. The main effects of a) negative reactions to disclosure on substance abuse and b) gender on substance abuse were significant. However, the relationship between negative reactions to disclosure and substance abuse was not moderated by gender.

**Conclusion:** The findings have implications for better supporting CSA survivors; men and women may be similar in when they disclose but may receive different reactions to such disclosure. Negative reactions to disclosure, regardless of survivor gender, may increase risk for internalizing, externalizing, and substance abuse in CSA survivors. There remains much to be understood about the disclosure process and how changes in the way society views sexual abuse and assault impacts disclosure and its associated outcomes.

*Keywords:* Childhood sexual abuse, disclosure, social reactions, masculinity norms

### Childhood Sexual Abuse Disclosure and Mental Health Outcomes: The Relationship Between Gender, Parental Style, and Masculinity Norms

Compared to men without histories of CSA, suicide attempts were 4-11 times higher for men with CSA histories (Molnar et al., 2001a). In a study by Easton et al. (2013), men who were more frequently sexually abused in childhood had a higher risk of a past year suicide attempt. Although some data suggest about one in seven girls and one in 25 boys are sexually abused before they turn 18 (Townsend & Rheingold, 2013), more recent data suggest that one in four girls and one in 13 boys experience CSA (CDC, 2020). Schraufnagel et al. (2010) indicate that the rates of CSA among men are likely underestimated because the rates of disclosure are particularly low. The National Intimate Partner and Sexual Violence Survey (Smith et al., 2018) indicated that 24.8% of men in the United States experience some form of contact sexual violence (rape, forced to penetrate someone else, sexual coercion, and/or unwanted sexual contact) in their lifetime, while 17.9% of men in the U.S. report unwanted sexual contact (sexual touch but not sexual penetration) in their lifetime. In addition, among male victims of completed or attempted rape, 51.3% first experienced such victimization prior to age 18, 25.3% between ages 11 and 17, and 26.0% at age 10 or younger.

Recent increased awareness of sexual abuse in girls has been facilitated through the Me Too Movement and the sentencing of Dr. Larry Nassar to prison for at least seven counts of criminal sexual conduct of girls, thus further encouraging disclosure by girls (Alaggia & Wang, 2020). Highly publicized cases such as the Penn State University scandal have also shed light on the problem of sexual abuse in boys. Studies indicate that childhood victimization is associated with increased substance use, depression, posttraumatic stress symptoms and disorder, self-harm, and poor self-esteem in men (Easton, 2014). However, there is much left to be understood about disclosure experiences of men and subsequent mental health effects of disclosure.

### **Nature of Disclosure**

To date, there are several theories that attempt to explain why many people wait to disclose childhood sexual abuse (CSA) years after occurrence. Goodman-Brown and colleagues (2003) propose that, rather than constituting a single event, disclosure is a process that takes place over time. Throughout their lifetime, survivors' willingness and desire to disclose their abuse may change with new relationships and contexts. Disclosure cannot be thought of as a singular event, since victims often make the decision to disclose to several people at various points in their lives (Ahrens et al., 2010; Alaggia, 2010). According to Omarzu (2000), whether or not a person decides to disclose CSA is influenced by anticipated consequences that guide the individual's behavior (Omarzu, 2000). The approach versus avoidance behavior of the survivor is determined by a number of factors, including past experiences with disclosure. The survivor considers how they should disclose, whom they should disclose to, and when they should disclose based on the potential benefits and risks of doing so. Omarzu (2000) asserts that if the victim deems the risks associated with disclosing to be greater than the rewards, he or she will not disclose. The process of disclosure will be circumvented or interrupted if perceived risks include losing control or setting off a chain of negative consequences such as being blamed or accused of lying or anticipating withdrawal of support (Alaggia, 2005).

Some research supports the idea that men wait longer than women to initially disclose CSA, and survivors often feel silenced due to shame or fear. In a study that explored CSA disclosure experiences of men, Easton (2013) concluded that men, on average, delayed disclosing the abuse for an average of over 21 years. First disclosure of CSA is challenging enough, but subsequent disclosures of CSA may be even more difficult, particularly if the desired outcome is not achieved (Hanson et al., 1999). A phenomenon that describes the process of disclosure for survivors is "self-silencing," which is the reluctance or fear to disclose. Self-

silencing often results due to a lack of acknowledgement of victimization by the survivor (Paine & Hansen, 2002). The survivor may feel shame, guilt, or confusion surrounding the abuse, which leads him/her to refrain from telling someone about the experience (Tyler, 2002). O’Leary and Barber (2008) point out that while silencing is found among male and female victims, it is more common among male victims of sexual abuse; however, many studies exploring these relationships are based on small samples. In an Australian sample of 145 males and 151 females who were sexually abused before the age of 18, O’Leary and Barber (2008) found that men took significantly longer to discuss CSA than females—such that 44.9% of males waited more than 20 years to disclose compared to 25.4% of females. Males were especially less likely than females to disclose around the time the abuse occurred, such that 26.2% of men disclosed at the time of abuse compared to 63.6% of women.

Further support for the idea that males wait longer than females to disclose comes from a study by Hanson et al. (2003), in which they surveyed a probability sample of 4,023 adolescents (51.3% boys) ages 12 to 17 residing in the US. Within this sample, 326 (8.1%) reported having experienced an event that met criteria for CSA. Of the 326, 21.9% were boys and 78.1% were girls. Through telephone interviews, adolescents were asked about their victimization history and whether they had ever told anyone about the sexual abuse. Approximately two thirds (68.1%) of CSA victims reported that they had told another person about the abuse. Of those 222 children, girls were more likely to have told someone than boys (74.0% vs. 46.5%). There is much left to be explored about what factors impact the timing of CSA disclosure and the differences in disclosure experiences between men and women.

In a qualitative study that assessed the lived experiences of disclosure for men, Sorsoli et al. (2008) interviewed 16 men ranging in age from 24 to 61 years. To be eligible for the study,



the men had to have a history of childhood sexual abuse that was perpetrated by a caretaker, which could include a family member or teacher. Sorsoli and colleagues sought to understand to whom and in what contexts men disclosed sexual abuse and what they perceived as both incentives and barriers to disclosing. Their analyses revealed three main disclosure barrier domains—personal, relational, and sociocultural. In the personal domain, men reported urges to erase their abuse experiences from consciousness, a lack of cognitive awareness of the abuse, and feelings of shame as reasons they did not disclose. In the relational domain, men discussed the lack of a supportive opportunity to discuss the abuse, which included imagining negative repercussions such as what someone would say or do in reaction to disclosure. They also described societal demands for masculinity (strength, silence, stoicism) that often prevented them from feeling safe or comfortable enough to disclose. Many of the men in the study had co-occurring types of abuse (physical, emotional, neglect) that severely lessened the likelihood of having a confiding relationship, which is a major factor in alleviating the negative effects of abuse (Gilgun, 1990). Although these findings highlight unique sociocultural barriers to disclosure for men, it should be noted that men who chose to participate were those who agreed to disclose details of their abuse, resulting in selection bias for this study. It is likely that nonparticipants have valuable information regarding why they have not yet disclosed.

### **Barriers to Disclosure Models**

According to Alaggia et al. (2019), the complexity of barriers to disclosure can best be understood through the lens of a social-ecological perspective, such that individual, familial, contextual, and cultural factors interact to influence a survivor's decision to disclose. As a result of Alaggia's (2010) interview of 40 adult survivors of CSA, a proposed ecological mapping of individual, interpersonal, and environmental factors sparked a diverse understanding of barriers

to disclosure. Similarly, Collin-Vézina and colleagues (2015) categorized barriers to disclosure as originating from within, in relation to others, and in relation to the social world. In their sample of 67 (16 male) adults, qualitative analysis revealed themes such as internalization of victim-blaming, immature development at the time of abuse, family dysfunction, fragile social network, and taboo of sexuality that contributed to inhibiting CSA disclosure. Further, using an online qualitative study design with a sample of 460 men with CSA histories who ranged in age from 19 to 84 years, Easton et al. (2014) deducted three main barrier domains that discouraged men from disclosing CSA: sociopolitical (masculinity), interpersonal (mistrust, fear of being labeled “gay,” abuser characteristics), and personal (naming the experience, internal emotions). Thus, barriers to disclosure cannot be understood through a unidimensional lens, as many factors contribute to why CSA disclosure is delayed. The present study will enhance previous research by exploring how specific aspects of these barrier domains—such as parental dysfunction, social reactions to disclosure, and conformity to masculinity norms—influence timing of disclosure.

### **Familial Factors**

One theorized domain barrier to CSA disclosure involves family dysfunction, parental style, and family gender roles. Families characterized by rigidly fixed gender roles, patriarchal attitudes, power imbalances, dysfunctional communication and chaos, and social isolation contribute to the suppression of disclosure (Alaggia & Kirshenbaum, 2005; Collin-Vézina et al., 2015; Fontes & Plummer, 2010). In a study by Priebe and Svedin (2008), a sample of 1,505 (20% boys) high school seniors with sexual abuse histories answered questions related to disclosure of sexual abuse. The disclosure rate was 81% for girls and 69% for boys. Nine of 25 items from the Parental Bonding Instrument (Parker 1990; Parker, Tupling, & Brown, 1979) were included to assess two fundamental parenting dimensions: care and overprotection.

Regression analyses showed that boys were less likely to disclose if they lived with both parents or perceived their parents as either caring and overprotective or non-caring and not overprotective. Some cultures encourage family environments that silence children from speaking about things like sexual abuse. According to Fontes and Plummer (2010), taboos about sexuality, patriarchal attitudes, and devaluation of women are some of the culturally-influenced constructs that inhibit the process of disclosure. Fontes (2005) described shame from family members as one culturally-influenced factor that can inhibit CSA disclosure; specifically, the involvement of authorities, the possible negative perceptions from social support figures, and the taboo surrounding the use of body terms and instead being encouraged to use phrases such as “down there” can inhibit disclosure in children. Thus, parents who express too much protection, do not show enough care, or discourage healthy communication foster an environment that is not conducive to disclosure.

In addition to parental style and communication impacting disclosure, there is also evidence that physically and emotionally abusive environments inhibit disclosure. In a two-wave longitudinal study across 13 years, Tashjian et al. (2016) interviewed 79 alleged CSA victims (75% female) who had perpetrators that were not a parental figure. Victims ranged in age from 16 to 30 years old at the time of the Wave 2 interview and reported whether the CSA perpetrator was someone in their family other than a parent (34.2%) or someone outside their family (65.7%). Participants were also asked whether they had ever experienced emotional or physical abuse by their mother, father, or another caretaker. Regression analyses revealed that emotional and physical abuse by a parental figure significantly predicted longer delays in CSA disclosure perpetrated by someone other than a parental figure. Only participants who reported both types of abuse by a parental figure significantly differed in delay of disclosure from those who did not

experience abuse by a parental figure. Thus, these findings lend support to the idea that parent-child relationships are crucial to timely disclosure of CSA.

CSA survivors may also inhibit disclosure for fear of harm to their family members or because of the perception they are to blame for the abuse. Goodman-Brown et al. (2003) tested a model of factors (gender, type of abuse, age at report of abuse, child's perception of responsibility, and fear of negative consequences to others) that influence when children disclose sexual abuse. In a sample of 218 children whose cases were referred for prosecution for alleged child abuse, Goodman-Brown et al. (2003) found that children who believed that their disclosure would bring harm to others (versus harm to themselves or the offender) took longer to disclose than children who did not report those fears. Children who perceived more responsibility for the abuse also took longer to disclose. Interestingly, gender of the child was not significantly correlated with time to disclosure, despite predictions that girls would disclose more quickly than boys. These findings support the idea that wanting to protect family members who are not perpetrators of the abuse may play a role in why children wait longer to disclose. However, waiting to disclose can have further harmful effects; according to Easton (2013), early disclosure may lead to intervention by a trusted adult or authority figure like law enforcement, access to treatment, and increased social support.

In addition to the importance of familial support to disclosure, maternal support to children following CSA disclosure has been highlighted as a substantial contributor to the trajectory of CSA survivors. However, there is limited research on the effects of maternal support specifically for male survivors. In a study by Alaggia (2002), ten mothers (9 daughters and 1 son) completed qualitative interviews to provide clarity in determining what constitutes a supportive maternal response. As a result of grounded theory analyses, Alaggia (2002) defined

supportive responses as: belief of child's account, effective actions taken to protect child, and offering positive emotional support. Less supportive responses were defined as: disbelieving the child, displaying anger toward the child for disclosing, or not taking adequate action to protect the child. In a study by Bernard-Bonnin et al. (2008) involving 67 girls between 7 and 12 years of age with sexual abuse histories, participants answered questionnaires related to PTSD and perceived social (peer and parental) support. For the CSA group, mothers completed questionnaires about their perceived support given to the child. In the CSA group, they found that the child's perception of high parental support and the mother's perception of support both functioned as protective factors against PTSD symptoms in the CSA group.

Other studies also highlight the role of the maternal relationship in disclosing CSA. Broman-Fulks and colleagues (2007) conducted structured interviews that inquired about the sexual abuse and disclosure histories of 321 adolescents (22% boys) with a history of sexual assault, defined as the adolescent experiencing forcible sexual contact perpetrated by another person. Twenty-four percent of adolescents indicated that their first (or only) disclosure was to their mother, whereas 45% first disclosed to someone else, and 32% never disclosed to anyone. Compared to non-disclosers and those who disclosed to someone other than their mother, participants who first or ever disclosed to their mother had lower prevalence rates of: PTSD during the previous 6 months, past-year substance abuse/dependence, and past year delinquency. Broman-Fulks and colleagues mentioned that their findings are consistent with other population-based studies in which it has been found that in the majority of cases, disclosure to mothers was met with a protective and supportive responses (Ruggiero et al., 2004). These findings emphasize the importance of children a) being in an home environment in which they feel safe to disclose to

a caregiver and b) receiving a supportive maternal response to protect against the development of mental health and substance abuse.

However, maternal support following CSA disclosure in adulthood may be qualitatively supportive but may not be as helpful in protecting against development of mental health concerns. In an adult sample of 288 women who endorsed at least one instance of forcible sexual penetration prior to age 18, Ruggiero et al. (2004) found that 33.7% of the women reported having disclosed the rape to their mother at some point before the study. Among those who disclosed to their mother, a majority indicated that the maternal response included belief (79.9%) and/or support (70.4%). They found that women who endorsed both maternal belief and maternal support did not significantly differ from those who denied maternal belief and support with respect to PTSD prevalence, MDE, and substance use problems. Thus, disclosure to mothers was unrelated to current PTSD symptoms in the sample. However, results revealed a significantly higher past-year prevalence of PTSD and MDE among women who waited longer than 1 month to disclose their rape relative to non-disclosers and women who disclosed within 1 month of the rape. Since Broman-Fulks and colleagues (2007) found lower PTSD rates during the previous 6 months in adolescent participants (21.8% male) who first disclosed to their mother, the findings from Ruggiero et al. bring attention to the trajectory of symptoms related to disclosure over time.

While maternal support to disclosure may function differently when received in childhood versus adulthood, it should also be noted that much of the research assessing the influence of maternal support in response to CSA disclosure has been conducted with majority-female samples; there is some evidence to suggest that men are less likely to have experienced a supportive response to CSA disclosure from mothers. In a sample of 487 men with CSA histories ranging in age from 19 to 84 years, Easton (2013) asked participants whether they had ever told

someone about the abuse, whom they first disclosed to, and whether the response they received to their initial disclosure was helpful. Purposive sampling from three national organizations (Survivors Network of those Abused by Priests, MaleSurvivor, and 1in6.org) was used to recruit participants. Easton found that the majority of participants (97%) told someone about the sexual abuse at some point, but on average it took participants more than two decades ( $M = 21$  years) to tell someone and the mean age at the time of first disclosure was 32 years. Among those who told their mother about the sexual abuse during childhood ( $n = 63$ ), 57% reported that their mother believed them, 29% reported that their mother supported them, and 36% reported that their mother protected them. Less maternal support following disclosure in childhood was related to more mental distress in adulthood. In sum, men in Easton's (2013) study reported less frequently that their mothers believed and supported them compared to women in Ruggiero and colleagues' (2004) study. Further, among the 18.9% of the 487 men in Easton's (2013) study who told another person other than their mother about their CSA, 79% felt believed, 34% felt supported, and 31% felt protected. Response to first disclosure, maternal support, overall response to disclosure in lifetime, and response of most supportive recipient of disclosure were negatively related to mental distress. Thus, while maternal support may function as one piece of facilitation to disclosure, there are many other factors that contribute to why survivors inhibit disclosure.

### **Contextual Factors: CSA Characteristics**

One specific interpersonal factor that influences the decision to disclose is the survivor's relationship to the perpetrator. Disclosure is more difficult when the perpetrator is a family member or close to the family (Easton, 2013; Goodman-Brown et al., 2013; Priebe & Svedin, 2008; Schönbucher et al., 2012). As defined by Freyd (1994), betrayal trauma occurs when

people that are depended on for survival violate the person depending on them. On a related note, attachment theory (Bowlby, 1969) provides the foundation for understanding why trauma occurring in the context of an attachment relationship is uniquely detrimental to long-term adaptive functioning. The overlap between attachment theory and betrayal trauma explains that it is adaptive to either defensively exclude or selectively process experiences of maltreatment by a caregiver since complete processing involves acceptance of information that is incompatible to establishing secure attachment relations (Berstein & Freyd, 2014). Although this denial is adaptive in the short term for survival (emotional and physical needs met), these responses have problematic implications for relationship and psychological well-being later in life. Thus, relationship to the perpetrator serves as a unique threat to disclosure and attachment.

Research supports the idea that being related to the perpetrator serves as a barrier to disclosure due to the feared consequences. In a study by Marriott et al. (2016), traumatic events were coded as either low, medium, or high betrayal—with low betrayal traumas being ones that were not interpersonal in nature, medium betrayal traumas being perpetrated by an extrafamilial perpetrator, and high betrayal traumas being those in which the perpetrator-victim relationship is intrafamilial. In the sample of 124 participants who were attendees of a Mental Health Awareness event who had experienced a traumatic event and half of whom were male, Marriott et al. (2016) found that 28.2%, 36.3%, and 35.5% of participants experienced a low betrayal, medium betrayal, and high betrayal trauma, respectively. Those who had experienced high betrayal trauma were significantly more likely to delay disclosure (more than one month) of the traumatic event. In addition to delayed disclosure, betrayal trauma has been associated with PTSD symptom clusters and severity more so than injury or perceived life threat (Kelley et al., 2012). Factors contributing to hesitation to disclose interfamilial abuse may include conflicting



emotions toward the perpetrator, fear of disrupting the family unit, being punished for their disclosure, or feeling responsible for the abuse (Sauzier, 1989). Rather than finding gender being related to timing of disclosure, Goodman-Brown et al. (2003) found that age and type of abuse predicted time of disclosure. Specifically, children who experienced incestuous sexual abuse took longer to disclose, providing additional support for the idea that betrayal trauma is associated with delayed disclosure.

To illustrate the effects of betrayal trauma on disclosure in a sample of men ( $N = 487$ ), Easton (2013) found that incest survivors took longer to first tell someone about the sexual abuse ( $M = 24.86$  years until disclosure,  $SD = 12.02$ ) compared to survivors who were sexually abused by someone other than a family member ( $M = 20.90$ ,  $SD = 15.09$ ). Compared to male survivors who were not abused by a biological family member, a lower percentage of incest survivors reported the abuse to the authorities, told anyone about the abuse in childhood, told their spouse about the abuse, or discussed the sexual abuse in-depth with a spouse or partner. Other variables investigated by Easton (2013) include age at the time of abuse. Older survivors were also less likely to have reported the CSA to authorities during childhood, took longer to disclose, and reported less support following disclosure in adulthood than younger survivors. Easton proposed that generational norms pertaining to discussing abuse or current increased awareness of sexual abuse in boys through media coverage as possible explanations for these results.

Another characteristic related to disclosing CSA is age of the victim. Some studies have found that younger age at the time of the abuse has been related to a reduced likelihood of the child telling someone about the assault (Smith et al., 2000). According to Hanson et al. (2003), it is possible that developmental factors may explain this relationship, as younger children may not be cognitively mature to engage in disclosing the abuse or may not understand that the abuse

done to them is wrong and may struggle to verbally communicate what has happened. Goodman-Brown et al. (2003) found that the age of the child was significantly related to perceptions of responsibility for the abuse, with older children more likely to feel responsibility for the abuse or that they could have stopped it.

Thus, a critical consideration that is influential in CSA disclosure is the life stage of the survivor. According to a research review by Alaggia et al. (2019), one pattern across many studies is that rates of disclosure increase with age, supported by high rates of delayed disclosure reported later in the life course by adult survivors (Collin-Vézina et al., 2015; Easton, 2013; LeClerc & Wortley, 2015; Sorsoli et al., 2008). However, it is not yet clear what changes across the life course to facilitate disclosure. Perhaps individuals have more opportunities to disclose as they grow older, due to the formation of new, close relationships. Alaggia (2004) found that being in a committed relationship or the birth of a child served as facilitators for some survivors to disclose, particularly to their spouses. Life course development may lend support to the idea of a changing self-perception, particularly with the recent trend in social media that encourages strength via identification of being a survivor of sexual abuse. Survivors may also not identify as victims of abuse until many years after the abuse occurred. Studies suggest disclosures are more likely to occur within a dialogical context, meaning they occur after discussions of abuse or prevention forums providing information about sexual abuse (Hershkowitz et al., 2005; Jensen et al., 2005). Contextual, interpersonal, and social factors surrounding disclosure of sexual abuse for males warrant further exploration.

Although age of the victim at the time of sexual abuse impacting timing of disclosure has significant research support, the relationship between abuse duration (single event versus chronic abuse) and CSA disclosure has been investigated with mixed findings (Townsend, 2016). Lamb

and Edgar-Smith (1994) found that the length of time to the first disclosure was unrelated to the duration of the abuse the child experienced. In a probability sample of adult women, Hanson et al. (1999) found no significant difference between reported and non-reported cases (to police or other authorities) in regard to whether the rape involved a single incident versus a series of incidents. Smith et al. (2000), however, found that children who were younger at the time of rape and who experienced a series of rapes (compared to a single event of rape) took longer to disclose (longer than one month). In a predominantly female sample, Tashjian and colleagues (2016) found that sexual abuse duration significantly predicted CSA disclosure delay. Duration of abuse impacting disclosure may be influenced by other variables previously discussed such as age of the survivor and relationship to perpetrator, as there is not a decisive finding about the relationship between abuse duration and disclosure.

### **Social Reactions to Disclosure**

Beyond characteristics of the abuse and the survivor impacting timing of disclosure, social reactions to initial disclosure may serve as additional factors that impede psychological recovery. Negative consequences associated with early disclosure include nonbelieving or non-supportive responses (Malloy et al., 2007). Feiring et al. (2002) emphasize that hostile or non-supportive responses to disclosure can negatively contribute to the shame associated with the abuse and can lead to negative mental health outcomes. In a sample of college women (N = 374), Orchowski et al. (2013) assessed assault-specific reactions to disclosure of sexual victimization and sexual victimization, which was defined as unwanted sexual experiences from the age of 14 to the time of the survey. The majority of participants (98.1%) were 18- or 19-year old freshmen college women. Unwanted sexual experiences were reported by 35.8% of participants, with 74.6% of those women having disclosed the abuse to someone else. Regression analyses

revealed that one negative social reaction in particular—reactions that attempted to control the survivor’s decisions—was associated with less reassurance of worth from others, posttraumatic stress, depression, and anxiety. Reassurance of worth was measured by a subscale from the Social Provisions Scale (Cutrona & Russell, 1987) which included items like “there are people who value my skills and abilities.” Orchowski et al. (2013) found that when others attempted to influence survivors’ decisions, they had poorer outcomes; thus, it appears that it is important for survivors to feel autonomous over their recovery process or over their decision to choose what to do about the abuse.

In the same study, blaming social reactions were associated with lower self-esteem and less engagement in problem-solving coping strategies. Social reactions that treated the survivor differently—defined by a subscale on the Social Reactions Questionnaire (Ullman, 2000) and included items like “pulled away from you” and “treated you differently in some way than before you told him/her that made you uncomfortable”—were associated with higher self-esteem. Although treating the survivor differently is categorized as a negative social reaction in scoring (Ullman, 2000), Orchowski et al. (2013) explained that women in their college sample may not have identified being treated differently as hurtful, as the study did not ask participants to classify whether social reactions were perceived by them as helpful or harmful. Social reactions that provided emotional support to the survivor were associated with increased engagement in seeking emotional support as a means of coping—suggesting that one positive social reaction can initiate further help-seeking behavior. Although this study highlights what types of social reactions are particularly unhelpful versus helpful for female survivors, it is unknown if the same reactions are helpful for male survivors.

Survivors' beliefs about what they think their peers believe about sexual abuse may be particularly important in terms of how comfortable survivors feel disclosing the abuse. One construct related to the cognitive experiences of survivors is rape myth acceptance (RMA), which is an individual's level of agreement with beliefs about the causes and consequences of sexual assault. Rape myths are stereotypes and false beliefs related to rape victims and rapists (Burt, 1980). According to Payne et al. (1999), rape myths blame the victim and distort the role of the perpetrator. Those who have high levels of RMA are likely to harbor negative attitudes toward sexual assault survivors. Paul and colleagues (2009) found that in a group of 64 sexually assaulted college women who rated their perceived peers' level of RMA (and a group of non-assaulted peers who rated their agreement with RMA items), survivors significantly overestimated their peers' RMA, which in turn predicted posttraumatic symptoms. As estimated peer RMA increased, survivors reported disclosing fewer assault details. If survivors overestimate stigmatized beliefs of their peers, they may hesitate to disclose for fear of being blamed or further stigmatized. Even the perception of being judged or blamed can inhibit disclosure.

Although studies have highlighted the harmful effects of negative reactions to disclosure, there are also positive reactions to disclosure that have adaptive outcomes for survivors. Chaudoir and Quinn (2010) suggest that receiving a positive response to initial disclosure may influence overall well-being years after the abuse occurs by increasing trust and comfort with others regarding the often-stigmatized identity of being a sexual abuse survivor. In addition to the reaction to the initial disclosure being a pivotal occurrence in the process of recovery, Romano and colleagues (2019) found in a sample of 253 men with sexual abuse histories that older age at first disclosure was significantly associated with a more supportive disclosure

reaction. Although waiting to disclose may have harmful mental health outcomes, the benefit of waiting may be a more supportive reaction. This finding could be explained by considering to whom men first disclose if they disclose earlier versus later in life. Most of the men in Romano's (2019) sample first shared their sexual abuse experience with their friend (44.7%), mother (22.5%), or father (16.2%).

Foster parents in a caregiving role may have a unique position to foster a safe and supportive space for disclosure. In a cross-sectional study with 21 sexually abused children—19 of whom were female—ranging in age from 6 to 18, Gries et al. (2000) found that children who received full support from foster parents following disclosure showed significantly lower depression scores than did children who received only partial support. Foster family members are sometimes the first to learn of the child's past sexual abuse that occurred during their fostering experience (Wubs et al., 2018). Consistent with previous research, children often wait longer to disclose when the perpetrator is a family member. If foster children are able to tell a foster parent about sexual abuse, it may be because they are not a biological family member like the perpetrator may be or because they are no longer in the care of the person who abused them, thus making it safer to disclose. The opportunity to disclose to a trusted adult in a caregiving position outside of the abusive situation may be met with more supportive responses.

The type of social reaction received by survivors impacts mental health outcomes. Campbell and colleagues (2009) utilized a multilevel ecological model to assess factors that influence the psychological outcomes of female survivors of sexual assault. Bronfenbrenner's (1979) ecological theory of development concluded that positive social reactions and support from family and friends predicted less mental distress post assault, whereas negative social reactions predicted depression, anxiety, and posttraumatic stress. They also emphasized that

while receiving social support from family, friends, and peers is helpful, these positive reactions may not be as powerful as unexpected negative reactions which predict depression and PTSD severity. Supportive responses to disclosure have the potential to lessen the harmful mental health effects of CSA.

### **Cultural Factors: Masculinity Norms and Victim Identification**

Masculinity norms can be described as socially-prescribed guidelines that determine behavior that is appropriately masculine in any given culture (Ragonese et al., 2019). More specifically, Mahalik and colleagues (2003) conducted factor analyses that identified distinct masculinity norms: winning, emotional control, risk-taking, violence, power over women, dominance, playboy, self-reliance, primacy of work, heterosexual self-preservation, and pursuit of status. In Western societies, men tend to be praised for adhering to values that reflect dominant, powerful, and aggressive behavior and ideas. The social pressure to conform to these norms, such as emotional control, have made it unappealing for male CSA survivors to acknowledge and discuss the sexual abuse with others (Kia-Keating et al., 2005). Thus, the extent to which masculinity norms impede timely CSA disclosure will be explored in the current study.

In previous research, Alaggia (2010) identified traditional gender norms and the environments that uphold them as factors that could play a role in gender differences related to disclosure. Men identifying as victims challenges society to accept non-traditional ideas of masculinity. Meaning, while society tends to reject the idea that men can be victims (tend to think only girls can be victims of CSA) because this shows them in a weak light, they must accept it in cases of male CSA (Alaggia, 2010; Sorsoli et al., 2008). The concept of masculinity is incompatible with identification as a victim, which may leave men with a limited range of

outlets in which to make sense of their experiences (Javaid, 2015). This internal conflict may lead victimized men to compensate for their “broken” masculinity by engaging in exaggerated acts of “manliness” such as anger, aggression, and risky behavior like substance abuse (Javaid, 2015; Weiss, 2010). In a study examining male revictimization (victimization in both childhood and adulthood), Charak and colleagues (2019) predicted that men who were revictimized would report greater conformity to masculine norms, anger, and substance abuse. Using a sample of 294 men ( $M_{\text{age}} = 32.71$ ,  $SD = 9.73$ ) recruited online through Amazon Mechanical Turk, latent class analyses revealed that domains of conformity to masculine norms, anger, and substance use were greater among men exposed to revictimization (multiple types of maltreatment—not just sexual) relative to men in the low victimization class. Men in the revictimized class reported higher levels of emotional control, power over women, being a playboy, and self-reliance facets of masculinity as measured by the Conformity to Masculine Norms Inventory (CMNI; Mahalik et al., 2003) compared to men in the low victimization class (low rates of child maltreatment and no adult sexual victimization). Men who face abuse in both childhood and adulthood likely adopt rigid beliefs about masculine behavior as a tactic to combat “unmasculine” perceptions (identifying as a victim).

The CMNI (Mahalik et al., 2003) has also revealed some interesting relationships between conformity to masculinity norms and outcomes such as resilience in men. In a sample of 250 North American men ranging in age from 18 to 79 years, regression analyses revealed that conformity to the norms of winning, emotional control, self-reliance, and pursuit of status were associated with lower levels of personal courage, grit, personal control, autonomy, and resilience (Hammer & Good, 2010). Thus, men who highly valued emotional control were less likely to have personal control over their emotions and behaviors while solving problems. Greater



endorsement of self-reliance was associated with less resilience. These findings have potential implications for the relationship between masculinity norms and CSA disclosure. For example, if men who wait longer to disclose sexual abuse endorse greater adherence to self-reliance, it is possible that their ability to build resiliency may be impaired due to the lack of disclosure experiences.

Easton and Kong (2017) investigated the effect of CSA on depressive symptoms, somatic symptoms, and hostility in late life for men with CSA histories and also explored the moderating effect of masculine norms in the relationship between CSA and those three outcomes. Using the Wisconsin Longitudinal Study (WLS) population-based study, Easton and Kong (2017) conducted a secondary data analysis from the 2004-2005 WLS interviews which resulted in a sample of 129 men ( $M_{age} = 64.2$  years) with a history of sexual abuse and a matched comparison group of those who reported no such history. Regression analyses revealed that CSA was positively related to all three mental health outcomes (depressive symptoms, somatic symptoms, and hostility) for men. Although they found a direct relationship between masculine norms and psychological outcomes, they did not find a heightened effect of masculine norms among the group that had CSA history; the authors note this may be due to using a seven-item measure of masculine norms. Thus, these results reflect somewhat different findings from previous studies; Easton (2014) found that conformity to the masculinity norms emotional control, heterosexual self-preservation, and self-reliance were positively related to mental distress in a male sample of CSA survivors and Easton et al. (2013) that found that men with CSA histories who endorsed high conformity to masculinity norms were 230% more likely to endorse a past-year suicide attempt than men low in conformity. Easton and Kong (2017) emphasize the need to reliably measure conformity to masculinity norms due to the evidence of such conformity impacting

mental health outcomes in men. This study provides support for the use of a well-validated measure for masculinity norms for the present study.

In addition to conformity to masculinity norms, attitudes related to homosexuality have also been shown to influence disclosure. That is, many men with CSA histories fear being labeled as homosexual for revealing sexual abuse, which stems from homophobic discrimination in some societies (Goodman-Brown et al., 2003). In a sample of 19 female and 11 male Canadian survivors of CSA, Alaggia (2005) conducted interviews with survivors about their disclosure experiences, which revealed nine of the male victims (81.8 %) were abused by a same-sex perpetrator. Being abused by a male shaped the men's beliefs surrounding their sexual orientation and factored into their reasons for not disclosing the abuse. To illustrate, participants provided reasons for not disclosing such as “[people] will think I’m a fa\*\*ot and I’m not.” The authors posited that at the time of the study, homosexuality tended to be socially unacceptable, which lends support to their idea that men in this sample feared being viewed as homosexual because the CSA was perpetrated by another man. Easton (2013) has suggested that attitudes related to homosexuality encourage male victims of CSA to blame themselves and to feel shame related to the abuse that happened.

On the other hand, there has been some research that has found greater stigma when males are abused by females, since females are viewed as the “weaker” sex (Denov, 2004). In a study by Gagnier and Collin-Vézina (2016), 17 males ranging in age from 19 to 67 years with histories of sexual abuse were asked about their disclosure experiences with open-ended interview questions. Four of the men were abused by women, whereas 13 were abused by men. Only four of the men reported that they disclosed their abuse in childhood, while 11 concealed their abuse until adulthood, and the other two participants made indirect attempts to disclose in

childhood but were not taken seriously (parent ignored the explicit comment or sided with the abuser). They found that disclosing was more difficult for participants who spoke about stereotypes and taboo surrounding male CSA. Specifically, 55% of the men who waited until adulthood to disclose expressed difficulty being recognized as a victim by others and 36% of the men who waited until adulthood to disclose expressed concern about being labeled as “less manly” or as homosexual if they disclosed. Two men who were abused by a woman discussed feeling increased taboo of CSA because of the gender of their perpetrator, such that some male survivors who were perpetrated by a woman held the idea that the image of a woman being an abuser does not exist to an outsider looking in.

The idea that men cannot be abused by women is associated with the belief of some men themselves, who do not always identify themselves as victims of sexual abuse. In a sample of 5,226 females and 5,969 males, Stander and colleagues (2002) asked female and male Navy recruits whether they believed they had been sexually abused prior to age 18. Participants were categorized into two groups: Group 1 ( $n = 2,010$ ; 23% men) included those who reported childhood sexual experiences (CSE) with any individual at least five years older who was either a family or nonfamily member, while Group 2 ( $n = 663$ ; 3% men) included those who reported CSE with an immediate or extended family member who was at least 5 years older. They utilized hierarchical regression to determine that women (49%) identified themselves as sexual abuse victims more often than did men (15%),  $\chi^2 = 214.07, p < .01$ . Further, men were more likely to define themselves as victims if the perpetrator was male, which may relate to sexual behavior norms that suggest males can't be sexually assaulted by females. Characteristics related to self-defined abuse included reports of threats or force, incest, younger age at the time of abuse onset, and multiple CSEs involving penetration. Thus, the concept of even identifying as a victim is a

conflictual decision for male survivors, who must consider many factors in how they will be perceived if they identify as victims.

### **Mental Health Outcomes**

It is no surprise that individuals with CSA histories struggle with mental health symptoms, and factors such as abuse characteristics and timing of abuse disclosure can impact such symptoms. There is also evidence that these mental health symptoms differ for men versus women with CSA histories. Easton (2014) found that the use of force was related to an increase in the number of mental health symptoms among men with CSA histories. This finding is consistent with previous research on the relationship between coercion or force during the abuse and long-term mental health issues (Boudewyn & Liem, 1995; Molnar et al., 2001b). The use of force during the abuse may exacerbate the survivor's feelings of powerlessness over the abuse, which may bleed into feelings of general helplessness in adulthood. Additionally, Easton (2014) found that the length of time until first disclosure was positively related to symptoms of mental distress. Using data from the Canadian Community Health Survey 2012: Mental Health, Meng and D-Arcy (2016) explored the effects of different types of childhood abuse on a range of mental disorders in a sample of 23,395 men and women with childhood abuse histories. They found that the lifetime prevalence of internalizing disorders (major depression, bipolar disorder, generalized anxiety disorder, hypomania, mania, or mood disorder) was 12.75% in men and 20.47% in women. In contrast, the lifetime prevalence of externalizing disorders (alcohol or drug abuse) was 30.36% in men and only 12.24% in women.

Mental health outcomes associated with sexual abuse in general may begin earlier than adulthood. Garnefski and Diekstra (1997) measured emotional and behavioral concerns, aggressive behavior, addiction-risk behavior, and overall mental health in adolescents. In their

sample of 745 (20.3% male) students aged 12 to 19 years with self-reported histories of sexual abuse compared to 745 matched students without such histories, results indicated that the effects of sexual abuse for boys may have worse emotional and behavioral outcomes. Suicidality was reported 4.8 times more often by sexually abused girls than by non-abused girls, but it was reported 10.8 times more often by sexually abused boys than non-abused boys. Emotional problems, like anxiety and loneliness, were similar between sexually abused boys and girls in this study. Even when controlling for physical abuse (frequently concurrent with sexual abuse for males), the significant gender differences remained. It is not clear whether the inclusion of assessing whether the sexually-abused boys and girls had disclosed the abuse would have yielded significant differences or if this could explain the higher rates of emotional and behavioral problems in the boys compared to the girls.

Despite considerable research evaluating the barriers and facilitators of disclosure, evidence is mixed with regard to the mental health benefits of disclosure, as there are many contributing factors yet to be understood about effects of the disclosure process. Some studies indicate that delaying disclosure can negatively impact attachment style, sense of self, and sense of self-efficacy (Romano et al., 2019). However, if a child discloses sexual abuse and the abuse continues, outcomes may be worse. In a clinical sample of 301 (85.4% female) adult survivors of childhood sexual trauma, those who had disclosed their abuse and the abuse continued reported higher levels of depression and PTSD intrusion symptoms as adults compared to survivors who did not tell anyone about the abuse while it was occurring (Swingle et al., 2016). This suggests that disclosure may not always be a protective factor in the development of mental health symptoms.

Some evidence suggests increased externalizing issues but more supportive responses associated with longer time until disclosure in men. In a study by Romano et al. (2019) using a sample of all men, they found that on average, the time between age of sexual abuse onset and age of first disclosure was 15.4 years. Participants ( $N = 253$ ) reported a variety of reactions from others to their first disclosure, with 68.0% of men indicating that they received a response that was supportive, 13.8% being not believed, 10.7% being ignored, and 7.5% being blamed. Bivariate correlations revealed that greater time lapse between age of sexual abuse onset and age of first disclosure was associated with greater externalizing behaviors ( $r = .15, p < .05$ ) and greater substance abuse ( $r = .14, p < .05$ ), while a greater time lapse was also associated with a more supportive disclosure reaction ( $r = .16, p < .05$ ). Regression analyses indicated that disclosing to a greater number of people was related to fewer somatic symptoms, fewer aggressive behaviors, and lower number of intrusive behaviors (e.g., showing off, talking too much); however, analyses were correlational so causality of somatic symptoms and other experiences or behaviors related to disclosure must be interpreted with caution.

Other studies have replicated similar outcomes with convenience samples and samples of women. Ruggiero et al. (2004) found significantly higher past-year prevalence of PTSD and Major Depressive Episodes among women ( $M_{age} = 44.6$  years) who waited longer than one month to disclose their rape relative to non-disclosers and women who disclosed within one month of their rape. When victims are perpetrated by a family member, Ullman (2007) found in a convenience sample of college students that they had more PTSD symptoms if they delayed disclosure, received more negative reactions in childhood, and engaged in self-blame at the time of abuse. In a sample of 804 adults (393 men) from Quebec, CSA prevalence was 22.1% for women and 9.7% for men, and 34.2% of men never disclosed the abuse compared to 15.7% of

women who never disclosed (Hébert et al., 2009). CSA survivors who never disclosed the abuse or delayed disclosure (defined as waiting more than 5 years after the first episode) were more likely to obtain scores of psychological distress and posttraumatic stress compared to adults without CSA histories and compared to adults who promptly disclosed (within a month of the first abusive event) the CSA. Using a regression model with prompt disclosure (within one month of abuse) as the dependent variable and relationship to perpetrator, age of abuse onset, and sex of the victim as independent variables, female victims were 3.76 times more likely than male victims to disclose promptly. The perpetrator being someone outside the immediate family or the survivor being female were each associated with prompt disclosure (within one month of abuse).

Broman-Fulks et al. (2007) investigated mental health outcomes as they relate to victims' decision to disclose their sexual assault in a sample of 321 adolescents (21.8% male). Youth who disclosed the assault to someone within one month were at reduced risk for current major depressive episode (MDE) and delinquency, such that non-disclosers were more than twice as likely as short-delay disclosers to have committed a delinquent offense in the past year. Disclosure to the mothers of victims was also associated with reduced risk for PTSD and delinquency. Interestingly, they did not find a relationship between disclosure latency and risk for PTSD or substance use problems, but it is plausible more longitudinal research is necessary to better understand the course of PTSD risk throughout the lifespan as participants in this study had a mean age of 15.2 years.

Victim-blaming responses often encountered by survivors of sexual abuse contribute to rape-related stigma, shame, and depressive symptoms (Finkelhor & Browne, 1985). In a community sample of 103 women who had disclosed their rape experience to at least one person,

Bhuptani et al. (2019) found that 26.2% of participants received a blaming response to disclosure—characterized as being blamed for what happened or being told they weren't careful enough. The authors used a serial mediation model to examine whether current shame and experiential avoidance mediated the relationship between victim-blaming responses to rape disclosure and depressive symptoms. Results revealed that receiving a victim-blaming response to disclosure related to higher levels of shame about the rape, which related to greater experiential avoidance and subsequently greater depressive symptoms. Neither indirect effect of receiving a blaming response through shame only, nor experiential avoidance only on depressive symptoms was significant. Hayes et al. (2004) defines experiential avoidance as efforts to avoid unwanted internal experiences or the unwillingness to remain in contact with internal experiences. For example, avoidance of uncomfortable emotions like shame is negatively reinforced in the short-term through efforts such as distraction or substance use. Bhuptani et al. (2019) found that experiential avoidance related to the shame—and not the shame itself—lead to depressive symptoms in this sample of women. Not only could negative responses to initial disclosure lead to feelings of shame, they also have been found to decrease the likelihood of subsequent disclosures (Ahrens, 2006). A cyclical relationship explains the shame felt from initial disclosure, which leads to more shame, less disclosure, and mental health symptoms.

Some research on the relationship between disclosure and mental health outcomes has been conducted in samples of adult men. Among the same sample of 487 men with CSA histories, Easton (2014) found that overall response to disclosure of CSA was negatively related to mental distress. Mental distress was measured using the General Mental Health Distress Scale, which assesses symptoms related to internal sources of distress that were experienced in the past 12 months. For this study, 25 items were included to assess for internalizing disorders such as



anxiety and for suicidality. Participants were also asked if they had ever told someone about the abuse and, if so, how old they were when they first told, and how helpful the responses that they received were on a 5-point Likert scale. Easton concluded that how others reacted to the account of the abuse impacted the survivors' long-term adjustment, particularly in relation to ability to cope with stressors.

### **Present Study**

Amazon's Mechanical Turk was utilized in the present study to recruit a large, diverse sample to better capture disclosure experiences across the lifespan. In a group of 1707 (774 males) U.S. citizens aged 18-77 years, Burnham et al. (2018) found that demographic characteristics of MTurkers closely resembled the general U.S. population on gender and race but revealed a higher percentage of Atheists and Agnostics than the U.S. population. Further, van Stolk-Cooke et al. (2018) compared rates of PTSD in samples of MTurkers, undergraduates, and veterans. Results showed that the rate of PTSD in the MTurk sample (19.8%) was statistically higher than that found in a recent systematic review of studies that used traditional recruitment methods. PTSD severity in the MTurk sample was significantly greater than that reported in a college sample but significantly less than the veteran sample. The authors suggested that MTurk may provide greater access to individuals with exposure to traumatic events compared to undergraduate samples.

Although we know abuse characteristics such as relationship to perpetrator and age of the victim impact timing of CSA disclosure, more research is needed to explain the differences in barriers to disclosure for male survivors of CSA compared to women. In general, previous research has found that men tend to wait longer to disclose compared to women and that men do not disclose for a variety of reasons: do not identify as victims of CSA, feelings of shame, fear of

homosexual perceptions, and societal demands for upholding masculinity norms such as strength and stoicism. Barriers to CSA disclosure have the potential to be better understood through a social-ecological lens that considers multiple domains related to self, context, and culture. Dysfunctional family relationships, lack of maternal support following disclosure, unsupportive and victim-blaming social reactions to disclosure, and conformity to masculinity norms have contributed to delays in disclosure and mental health symptoms in a variety of samples. More specifically, some research has shown higher rates of internalizing symptoms in women and more externalizing and substance abuse in men with CSA histories. However, Easton (2013) and Gagnier and Collin-Vézina (2016) note that research typically has focused solely on female victims, and when studies do include men in their samples, the numbers are often so small that their experiences become either downplayed or grouped in with those of female survivors.

Thus, the present study was one of few to compare social reactions to disclosure and internalizing and externalizing mental health symptoms between adult men and women with CSA histories. The aim of incorporating perception of parental style and masculinity norms was to shed light on familial and sociocultural factors that may relate to differences in disclosure patterns between men and women with CSA histories. The exploration of factors impacting timing of disclosure provided better understanding of what makes disclosure different for men and women and has implications for the development of appropriate and supportive interventions aimed at reducing the negative impact of CSA.

### **Study Aims & Hypotheses**

**Aim 1:** Examine the influences of relationship to the sexual abuse perpetrator, gender, and perception of parental style on length of time to initial childhood sexual abuse disclosure.

**Hypothesis 1.1:** Time to initial CSA disclosure will be longer among participants who were abused by a family member compared to those abused by a nonfamily member.

**Hypothesis 1.2:** Time to initial CSA disclosure will be longer among males compared to females.

**Hypothesis 1.3:** Time to initial CSA disclosure will be longer among participants who report higher parental dysfunction.

**Aim 2:** Explore the differences in social reactions to disclosure (contextual factor) between men and women.

**Hypothesis 2.1:** Women will report significantly higher scores than men on the following social reaction scales—Negative Reactions (Turning Against and Unsupportive Acknowledgement), Positive Reactions, Victim Blame, Taking Control of Survivor’s Decision, Egocentric Reactions, Tangible Aid, Emotional Support. Men will report significantly higher scores than women on the following social reactions scales—Treat Differently/Stigma, Distraction.

**Aim 3:** Understand the influence of theorized variables (time until disclosure, negative social reactions, perceived parental dysfunction, conformity to masculinity norms) on mental health and substance abuse.

**Hypothesis 3.1:** Greater time to disclosure, higher indication of negative social reactions to disclosure, higher perceived parental dysfunction, and higher endorsement of masculinity norms, will positively relate to internalizing mental health symptoms.

**Hypothesis 3.2:** Greater time to disclosure, higher indication of negative social reactions to disclosure, higher perceived parental dysfunction, and higher endorsement of masculinity norms, will positively relate to externalizing mental health symptoms.

**Hypothesis 3.3:** Greater time to disclosure, higher indication of negative social reactions to disclosure, higher perceived parental dysfunction, and higher endorsement of masculinity norms, will positively relate to substance abuse.

**Aim 4:** Determine whether negative reactions to disclosure are associated with differences in mental health symptoms and substance abuse between men and women.

**Hypothesis 4.1:** Gender will moderate the relationship between negative reactions to disclosure and internalizing mental health symptoms. Specifically, negative reactions to disclosure will result in more internalizing mental health symptoms in women than in men.

**Hypothesis 4.2:** Gender will moderate the relationship between negative reactions to disclosure and externalizing mental health symptoms. Specifically, negative reactions to disclosure will result in more externalizing mental health symptoms in men than in women.

**Hypothesis 4.3:** Gender will moderate the relationship between negative reactions to disclosure and substance abuse. Specifically, negative reactions to disclosure will result in more substance abuse in men than in women.

## Method

### Participants

Participants were adults in the United States with CSA histories. Inclusion criteria included: having told at least one other person about the abuse, current residence in the United States, being at least 18 years of age, and answering “yes” to the CSA screener item. See **Appendix A**. A G\*Power analysis (Faul et al., 2009) was utilized to determine that the minimum sample size required to detect a medium effect was 402 participants. Participants were recruited

from Amazon's Mechanical Turk (MTurk). MTurk is a crowdsourcing marketplace that researchers can utilize to gather information from a large and diverse online population of participants. People who are 18 years of age or older can participate in online studies that interest them through MTurk once they are approved as "workers." Participants on MTurk are also compensated monetarily for their voluntary participation in various studies they can complete.

The original sample consisted of 450 participants. However, a total of 151 participants were removed from analyses for the following reasons: proxy address location somewhere other than the United States ( $n = 14$ ), age item unanswered ( $n = 1$ ), age inconsistent with birth year accompanied by inconsistent reporting on other CSA items ( $n = 23$ ), partial responders that answered less than half of survey items ( $n = 25$ ), nonsensical responses on open-ended CSA items such as "MOBILE PHONE, Safety, or he is product me" ( $n = 15$ ), responded with "no" to disclosure and had other nonsensical responses to CSA items ( $n = 41$ ), or had a negative value for the time until disclosure variable ( $n = 32$ ). Time until disclosure was calculated in SPSS by subtracting (in years) age of first sexual abuse incident from age of first disclosure (both of which were asked). See *Table 1*. Final analyses included 299 participants.

The final sample of participants ( $M_{age} = 35.9$ ;  $SD_{age} = 10.52$ ) was majority female (52.8%) and White/European American (77.9%), while others indicated they were Black/African American (8.4%), Hispanic/Latino (7.7%), Asian (3.3%), or another race/ethnicity. Participants indicated their highest level of education: Bachelor's degree (54.8%), Advanced degree such as a Master's or Ph. D. (19.7%), Associate's degree (8.7%), some college (8.4%), high school diploma (6.7%), trade/technical school (1.3%), and less than a high school diploma (.3%). The majority of participants indicated that they identified as a woman (52.2%) or a man (46.5%), while others identified as non-binary (1.0%) or transgender woman (.3%). Participants indicated

that they were either heterosexual or straight (79.9%), bisexual (16.1%), gay (1.7%), lesbian (1.0%), pansexual (.7%), queer (.3%), or asexual (.3%). Most participants indicated they were married or had a domestic partner (70.2%), while others indicated they were single/never married (24.4%), or divorced/separated (5.4%). See *Table 2* for sample demographics.

Other recent studies utilizing MTurk to recruit participants report similar demographic characteristics. Charak and colleagues (2019) recruited a sample of 294 sexually abused men from the U.S. with a mean age of 32.71 years ( $SD = 9.73$ ) and a relatively ethnically diverse spread (78.8% Caucasian, 8.2% African American, 8.5% Hispanic/Latino); the majority of the sample reported having a college degree (43.2%), with 12.6% having a graduate degree, 19.7% reporting some college, 15.6% completing high school, and 0.3% not graduating high school. In a sample of 266 trauma-exposed participants, Engle and colleagues (2020) found a similar mean age (34.04 years) but a somewhat different race breakdown (79.7% Caucasian, 12.0% Asian, 3.8% African American/Black) to both the present sample and the Charak and colleagues (2019) sample. Further, in a reexamination of data from an MTurk study on parental personality and child development, Chmielewski et al. (2020) reported sample demographics that were similar to the present study: mean age of 31.7 years, primarily White (79.0%) followed by Black (13.8%), and a median education of a four-year college degree.

## Measures

**Screener.** Items asked participants their country of residence, age, whether they have CSA history, and whether they disclosed their first occurrence of CSA. See **Appendix A** for screener items.

**Demographic Questions.** Items asked participants to indicate their age, highest level of education obtained, race/ethnicity, marital status, gender identity, and sexual orientation. See **Appendix B** for demographic items.

**Measure of Parental Style (MOPS; Parker et al., 1997).** The MOPS is a 30-item self-report measure of perceived parenting style that includes three subscales: Indifference, Abuse, and Overcontrol. Participants were asked to rate how true a list of 15 statements are as they pertain to the participant's mother and father during his/her first 16 years. Responses were scored on a four-point scale from 0 (not true at all) to 3 (extremely true). Cronbach's alpha for the 30 MOPS items in the present sample was excellent (.96). As done by Penjor et al. (2019), the 30 MOPS items were averaged into a single score to represent dysfunctional parenting for analyses.

Participants who did not live with a biological parent for the majority of the time prior to age 16 were asked to answer the items as they pertain to their primary caregiver. The MOPS has excellent reliability and convergent validity with the Parental Bonding Instrument (Parker et al., 1997). See **Appendix C** for the MOPS.

**Determination of CSA and Disclosure of CSA.** One item (adapted from McGuire & London, 2020) was included in the pre-screen to determine whether participants experienced sexual abuse prior to age 18. The item asked: "Did you ever have any sexual experience **before the age of 18** that was unwanted OR with someone 2 or more years older than you OR with any person who forced this experience regardless of their age?" In the full study, the five sexual abuse items from the Childhood Trauma Questionnaire (CTQ; Bernstein et al., 2003) were utilized to gather more specific data on the type of sexual abuse experience by participants; answer options for the five CTQ items were Never True (1), Rarely True (2), Sometimes True (3), Often True (4), Very Often True (5). Using various items from previous studies exploring disclosure of CSA, other

items assessed variables related to disclosure of childhood sexual abuse. It should also be noted that in a systematic literature review, McTavish and colleagues (2019) noted across 20 studies assessing the relationship between CSA and PTSD, author-generated or unvalidated measures were utilized to assess for disclosure process variables; thus, the present author was unable to locate an existing CSA disclosure measure. Responses were coded into numerical values for analyses; for all analyses, relationship to perpetrator was coded as “1” for family member and “2” for non-family member. See **Appendix D** for disclosure items.

**Social Reactions Questionnaire (SRQ; Ullman, 2000).** The SRQ is a self-report questionnaire that measures both positive and negative social reactions to disclosing sexual assault. The SRQ consists of 48 items that are classified into three general scales (Turning Against, Unsupportive Acknowledgement, and Positive Reactions) and seven specific scales (victim blame, treat differently/stigma, taking control of the survivor’s decision, distraction, egocentric reactions, tangible aid, and emotional support). Cronbach’s alpha for the 48 SRQ items in the present sample was excellent (.96). Items from the Turning Against and Unsupportive Acknowledgment scales can be combined under one scale called Negative Reactions (Ullman, 2000), to create an eleventh subscale. Cronbach’s alpha for the 11 SRQ subscales in the present sample was excellent (.95). Positive subscales include emotional support and information/tangible aid. Responses were measured using a Likert scale ranging from 0 (*never*) to 4 (*always*). Scale scores were calculated using the average of the items in each scale, with higher scores indicating greater endorsement of each construct. In three samples (community volunteers, college students, and victims contacting mental health agencies) of sexually assaulted women, Ullman (2000) found good reliability and validity, such that alphas for the seven subscales were .93 (emotional support), .86 (treated differently), .80 (distraction), .83 (taking control), .84 (tangible aid), .80



(blame), and .77 (egocentric reactions). Test-retest reliabilities for the sample of college students who took the measure eight weeks apart were .74 for distraction/discourage talking, .75 for emotional support, .73 for tangible aid, .64 for victim blame, .81 for treated differently, .78 for taking control, and .80 for egocentric reactions. See **Appendix E** for the SRQ.

**Global Appraisal of Individual Needs Short Screener (GAIN-SS; Dennis et al., 2006).** The GAIN-SS is a 20-item measure designed for self or staff administration and is designed to quickly and accurately identify individuals whom the GAIN would identify as having one or more behavioral health disorders. The GAIN-SS includes four subscales that are scored separately: internalizing disorders, externalizing disorders, substance use disorders, and crime/violence. Participants responded by indicating whether they experienced each statement either in the past month (3), two to 12 months ago (2), one or more years ago (1), or never (0). The total number of two and three responses in each subscale were summed for analyses. A score of three to five on any of the subscales indicates a high probability of a diagnosis, while a score of one to two indicates a possible diagnosis. Cronbach's alpha for the internalizing scale, externalizing scale, and the substance use scale in the present sample was .71, .75, and .80 respectively. 11 SRQ subscales in the present sample was excellent (.96). Dennis, Chan, and Funk (2006) found that for adults the four 5-item subscales have good internal consistency (alpha of .96 on the total screener) and were highly correlated ( $r = .84$  to  $.94$ ) with the 123-item GAIN Individual Severity Scale. See **Appendix F** for the GAIN-SS.

**Conformity to Masculine Norms Inventory (CMNI-46; Parent & Moradi, 2009).** The CMNI-46 is a shorter version of the original 94-item CMNI (Mahalik et al., 2003). The CMNI-46 is a 46-item self-report measure that assesses conformity to Western society masculine gender role norms and includes 9 subscales: Emotional Control, Winning, Playboy, Violence,

Heterosexual Self-Preservation, Primacy of Work, Power Over Women, Self-Reliance, and Risk Taking. Participants responded to the items using a Likert scale ranging from 0 (Strongly Disagree) to 3 (Strongly Agree) with higher scores indicating stronger adherence to masculine norms. Cronbach's alpha for the 46 CMNI items in the present sample was excellent (.82). Research suggests that the CMNI-46 correlates highly with the 94-item CMNI and has good convergent and construct validity (Parent & Moradi, 2009, 2011; Parent, Moradi, Rummell, & Tokar, 2011). See **Appendix G** for the CMNI-46.

### **Procedure**

The study was visible on MTurk to users who had Human Intelligence Tasks approval ratings greater than or equal to 95% to reduce the risk of random or "bot" responses. Participants answered four screener items (country of residence, age, whether they have CSA history, and whether they have disclosed their first occurrence of CSA) prior to being able to participate in the full study. After completing the screener, participants were directed to a screen that included an IRB-approved letter of invitation to read prior to participating in the study. The letter described the nature of the data collection, the confidential nature of the study, how they would be compensated, and whom to contact should they have questions or concerns. Participants were also informed that they could stop the study at any time. Participants were then directed to the full study items. Upon completion participants were provided the phone number for the crisis text line and a website that allowed them to search for mental health resources in their locality. Participants were compensated \$1.75 for their participation.

### **Results**

SPSS was utilized to conduct all analyses; an alpha level of .05 was used to determine statistical significance. Although a screener was included before the full study items to exclude

participants who weren't eligible for the study, MTurkers were able to skip the screener questions to complete the full study. This was made evident after data collection ended and the study was no longer visible to MTurkers; the author noticed that the number of completed responses for the screener was less than half of the number of completed responses for the full survey. It is possible that although constraints were utilized on the screener so that participants had to select an answer for each item, requiring answers to screener items did not apply once the study was uploaded to MTurk. Data were cleaned prior to analyses; see Participants section above for details.

### **Nature of Participants**

Prior to analyses for hypotheses, a few characteristics of the present sample are discussed. First, 50.5% of participants indicated that they were abused by a perpetrator who was a family member, while 48.8% were abused by a non-family member, and 0.3% of participants did not know their relationship to the perpetrator. The majority of participants (60.5%) waited at least one year before disclosing their first sexual abuse incident, while 29.8% disclosed within the first year. The maximum length until disclosure was 39 years (0.3% of participants).

Gender differences for all study variables were also examined to better understand the characteristics of the participants before performing hypothesis analyses. An independent samples *t* test revealed that there was not a significant difference between men ( $M = 5.92$  years,  $SE = 8.21$ ) and women ( $M = 5.36$  years,  $SD = 6.91$ ) on time until disclosure,  $t(265) = -.607$ ,  $p = .262$ . However, the individual CTQ sexual abuse items revealed some significant differences in sexual abuse histories between women and men. Participants responded to the CTQ items using a Likert scale in which a response of 1 represented "never true," 3 represented "sometimes true," and 5 represented "very often true." An independent samples *t* test revealed that women ( $M =$

3.53,  $SD = .98$ ) reported sexual touch more frequently than men ( $M = 3.14$ ,  $SD = 1.00$ ),  $t(293) = 3.36$ ,  $p < .001$  when responding to the item “someone tried to touch me in a sexual way, or tried to make me touch them.” An independent samples  $t$  test revealed a significant difference,  $t(293) = 2.03$ ,  $p = .043$ ), in that women ( $M = 3.28$ ,  $SD = 1.32$ ) on average reported more frequent molestation than men ( $M = 2.99$ ,  $SD = 1.10$ ) when responding to the CTQ item “someone molested me.” Another independent samples  $t$  test revealed that on average, women ( $M = 3.69$ ,  $SD = 1.12$ ) also more highly endorsed that they believe they were sexually abused compared to men ( $M = 3.33$ ,  $SD = 1.17$ ), which was significant  $t(293) = 2.71$ ,  $p < .01$ ; this item was “I believe that I was sexually abused.” An independent samples  $t$  test revealed a significant difference,  $t(293) = 2.50$ ,  $p < .01$ , in that women ( $M = 16.61$ ,  $SD = 4.69$ ) had a higher sum on the CTQ items than men ( $M = 15.27$ ,  $SD = 4.45$ ). Lastly, an independent samples  $t$  test revealed that on average, men ( $M = 1.48$ ,  $SD = .58$ ) more highly endorsed the CMNI-46 masculinity norm heterosexual self-preservation than women ( $M = 1.32$ ,  $SD = .72$ ), which was significant,  $t(290) = -2.04$ ,  $p = .042$ . Results revealed a lack of significant differences between men and women on other variables involved in study hypotheses (MOPS Parental Dysfunction average, other CTQ items, SRQ Negative Reactions average, the GAIN-SS scales, and the emotional control and self-reliance CMNI-46 scales). Despite this, analyses were completed to determine the effect of the hypothesized independent variables on the dependent variables regardless of gender.

### **Hypothesis Testing**

Model assumption checks were conducted for variables relevant to each hypothesis. An initial correlation matrix including the three MOPS subscales relevant to hypothesis one revealed a significant correlation between: female caregiver total abuse and female caregiver total indifference ( $r = .835$ ,  $p < .01$ ); male caregiver total abuse and male caregiver total indifference

( $r = .819, p < .01$ ). According to Field (2018), multicollinearity exists when there is a strong correlation of .80 or above between two or more predictor variables, which makes it difficult to obtain independent estimates of regression coefficients. Thus, as done in Penjor et al. (2019), the MOPS subscale totals for both male and female giver were combined to capture an average parental dysfunction score for analyses. See *Table 3* for the correlation matrix of variables relevant to hypothesis one.

### ***Hypothesis One***

The aim of hypothesis one was to examine the influences of relationship to the sexual abuse perpetrator, gender, and perception of parental style on length of time to initial childhood sexual abuse disclosure. Specifically, it was hypothesized that: 1) time to initial CSA disclosure would be longer among participants who were abused by a family member compared to those abused by a nonfamily member, 2) time to initial CSA disclosure would be longer among males compared to females, and 3) time to initial CSA disclosure would be longer among participants who reported higher parental dysfunction.

To test hypothesis one, a hierarchical linear regression was conducted to evaluate the predictive nature of relationship to perpetrator (block 1), gender (block 2), and MOPS parental dysfunction (block 3) on time until disclosure. Relationship to perpetrator was coded into either family member or non-family member, while time until disclosure was calculated by subtracting age of first sexual abuse from age of first disclosure. Gender was coded “1” for woman/transgender woman and “2” for man. The 3 cases of non-binary individuals were excluded from analyses due to the small sample size. Inconsistent with hypotheses, results revealed that the model was not significant at the first block,  $F(1, 249) = .543, p = .462, \Delta r^2 = .002$ , meaning that relationship to perpetrator did not account for a significant amount of

variance in time until disclosure. Additionally, the  $r$  squared value of .002 associated with block one suggests that the relationship to perpetrator only accounted for .2% of the variation in time until disclosure. Also inconsistent with hypotheses, results revealed that the model was not significant at the second block ( $p = .848$ ,  $\Delta r^2 = .000$ ), or at the third block ( $p = .644$ ,  $\Delta r^2 = .001$ ).

See *Table 4*.

### ***Hypothesis Two***

Hypothesis two explored the differences in social reactions to disclosure between men and women. Specifically, it was predicted that women would report significantly higher scores than men on the following social reaction scales—Negative Reactions (Turning Against and Unsupportive Acknowledgement), Positive Reactions, Victim Blame, Taking Control of Survivor's Decision, Egocentric Reactions, Tangible Aid, Emotional Support. Further, it was predicted that men would report significantly higher scores than women on the following social reactions scales—Treat Differently/Stigma, Distraction.

A multivariate analysis (one-way MANOVA) was utilized to test for significant differences in social reactions to disclosure between men and women. Hypotheses were partially supported. Using Pillai's trace, results revealed a trend toward a difference in overall social reactions (all items on the SRQ) to CSA disclosure between men and women,  $V = .05$ ,  $F(8, 285) = 1.91$ ,  $p = .059$ , partial  $\eta^2 = .05$ . Separate univariate tests (for each scale on the SRQ) revealed significant differences between men and women in reactions classified as positive,  $F(1, 292) = 4.61$ ,  $p = .033$ , and emotionally supportive,  $F(1, 292) = 4.83$ ,  $p = .029$ . Meaning, as hypothesized, women ( $M = 2.38$ ,  $SD = .85$ ) reported receiving significantly more positive reactions than men ( $M = 2.19$ ,  $SD = .68$ ); women ( $M = 2.49$ ,  $SD = .86$ ) also reported receiving significantly more emotionally supportive responses than men ( $M = 2.29$ ,  $SD = .69$ ). Inconsistent

with hypotheses, there were no differences between men and women on the other SRQ scales (Turning Against, Unsupportive Acknowledgement, Tangible Aid, Blame, Stigma/Treated Differently, Control, Egocentric, Distract, Negative Reactions). See *Table 5* for details.

### ***Hypothesis Three***

The aim of hypothesis three was to understand the how time until disclosure, negative social reactions, perceived parental dysfunction, and conformity to masculinity norms relate to mental health and substance abuse. It was predicted that higher endorsement of masculinity norms, greater time to disclosure, higher indication of negative social reactions to disclosure, and higher perceived parental dysfunction would positively relate to internalizing and externalizing mental health symptoms and substance abuse concerns. See *Table 6* for correlation matrix for all hypothesis 3 variables.

To analyze hypothesis three, three hierarchical linear regressions were utilized (one for each of the outcome variables: internalizing symptoms, externalizing symptoms, and substance abuse). For all three regressions, the six independent variables were entered in the following order based on hypothesized predictive ability: time until disclosure (block one), SRQ negative reactions average (block two), MOPS parental dysfunction average (block three), CMNI-46 heterosexual self-preservation average (block four), CMNI-46 emotional control average (block five), CMNI-46 self-reliance average (block six). The dependent variables for the three separate regressions were GAIN-SS past-year internalizing issues sum, GAIN-SS past-year externalizing issues sum, and GAIN-SS past-year substance abuse sum—respectively. For all GAIN-SS scales, “sum” is considered the total number of 3 (past month) and 2 (2 to 12 months ago) responses in each corresponding scale.

The predictive nature of the six variables on internalizing mental health issues was evaluated in the first regression. Hypotheses were supported at blocks two (SRQ negative reactions), four (CMNI-46 heterosexual self-preservation), and six (CMNI-46 self-reliance). The results of the first block (time until disclosure) revealed that the model was not statistically significant ( $p = .533$ ;  $\Delta r^2 = .002$ ). Additionally, the  $R^2$  value of .002 associated with block one suggests that time until disclosure accounts for only .2% of the variation in internalizing mental health issues. For the second block (SRQ negative reactions) analysis, results revealed a statistically significant model ( $p = .009$ ;  $\Delta r^2 = .027$ ); the  $R^2$  change value of .027 indicates that negative reactions accounts for 2.7% of the variation in internalizing issues. Results of the third block (MOPS parental dysfunction) did not reveal a statistically significant model ( $p = .720$ ;  $\Delta r^2 = .001$ ). When the fourth predictor variable (CMNI-46 heterosexual self-preservation) was added to the analysis, results revealed a statistically significant model ( $p < .001$ ;  $\Delta r^2 = .047$ ). Additionally, the  $R^2$  change value of .047 associated with this model suggests that the addition of parental dysfunction accounts for 4.7% of the variation in internalizing issues. For the fifth block (CMNI-46 emotional control) analysis, results did not reveal a statistically significant model ( $p = .195$ ;  $\Delta r^2 = .006$ ). Lastly, the addition of CMNI-46 self-reliance masculinity norm to the model revealed a statistically significant model ( $p = .025$ ;  $\Delta r^2 = .019$ ) accounting for an additional 1.9% of the variation in internalizing issues. See *Table 7*.

As with the first regression, the predictive nature of the six variables on externalizing mental health issues were evaluated in the second regression. Hypotheses were supported at blocks two (SRQ negative reactions) and four (CMNI-46 heterosexual self-preservation). Results of the first block (time until disclosure) revealed that the model was not statistically significant ( $p = .564$ ;  $\Delta r^2 = .001$ ). Results of the second block (SRQ negative reactions) revealed a



statistically significant model ( $p < .001$ ;  $\Delta r^2 = .120$ ). The  $R^2$  change value suggests that the addition of SRQ negative reactions accounts for 12.0% of the variation in externalizing issues. Results of the third block (MOPS parental dysfunction) revealed that the model was not statistically significant, ( $p = .418$ ;  $\Delta r^2 = .002$ ). The  $R^2$  change value suggests that the addition of MOPS parental dysfunction accounts for only .2% of the variation in externalizing issues. Results of the fourth block (CMNI-46 heterosexual self-preservation) revealed a statistically significant model ( $p = .048$ ;  $\Delta r^2 = .014$ ). The  $R^2$  change value suggests that the addition of CMNI heterosexual self-preservation norm accounts for an additional 1.4% of the variation in externalizing issues. Results of the fifth block (CMNI-46 emotional control) did not reveal a statistically significant model ( $p = .764$ ;  $\Delta r^2 = .000$ ). Results of the sixth block (CMNI-46 self-reliance) also did not reveal a statistically significant model ( $p = .488$   $\Delta r^2 = .002$ ). See *Table 8*.

The predictive nature of the six variables on substance abuse was evaluated in the third regression. Hypotheses were supported at blocks two (SRQ negative reactions) and three (MOPS parental dysfunction). Results of the first block revealed that the model was not statistically significant ( $p = .441$ ;  $\Delta r^2 = .002$ ), indicating that time until disclosure accounted for only .2% of the variation in substance abuse. Results of the second block (SRQ negative reactions) revealed a statistically significant change ( $p < .001$ ;  $\Delta r^2 = .108$ ), indicating that the addition of SRQ negative reactions accounted for 10.8% of the variation in substance abuse. Results of the third block (MOPS parental dysfunction) revealed a statistically significant model ( $p = .020$ ;  $\Delta r^2 = .019$ ). The  $R^2$  change value suggests that the addition of MOPS parental dysfunction accounts for 1.9% of the variation in substance abuse. Results of the fourth block (CMNI-46 heterosexual self-preservation) did not reveal a statistically significant model ( $p = .132$ ;  $\Delta r^2 = .008$ ). Results of the fifth block (CMNI-46 emotional control) also did not reveal a statistically significant model

( $p = .124$ ;  $\Delta r^2 = .008$ ). Lastly, results of the sixth block (CMNI-46 self-reliance) did not reveal a statistically significant model ( $p = .649$ ;  $\Delta r^2 = .001$ ). See *Table 9*.

#### ***Hypothesis Four***

The aim of hypothesis four was to determine whether associations between negative reactions to disclosure and mental health symptoms and substance abuse differ between men and women. Hypothesis four predicted an interaction between gender and reaction to disclosure on mental health difficulties (internalizing, externalizing, substance abuse). Specifically, it was predicted that men would have stronger associations between negative reactions to disclosure and externalizing mental health symptoms and substance abuse concerns compared to women who would have stronger associations between negative reactions to disclosure and internalizing mental health symptoms. PROCESS v4.0 (Hayes, 2022) was utilized for all hypothesis 4 analyses.

The following variables were analyzed using PROCESS for the first moderation analysis: SRQ negative reactions average (predictor), GAIN internalizing issues sum (outcome), and gender (moderator). The main effect of negative reactions to disclosure on internalizing mental health outcomes was statistically significant  $b = .305$ ,  $t(290) = 3.192$ ,  $p = .002$ ; this means that for every unit increase in negative reactions to disclosure, there was a .305 unit increase in internalizing mental health outcomes. However, inconsistent with hypotheses, the relationship between negative reactions to disclosure and internalizing issues was not moderated by gender,  $b = .214$ , 95% CI [-.164, .592],  $t = 1.115$ ,  $p = .266$ . See *Table 10*.

The following variables were analyzed for the second moderation analysis: SRQ negative reactions average (predictor), GAIN externalizing issues sum (outcome), and gender (moderator). The main effect of negative reactions to disclosure on externalizing mental health

outcomes was statistically significant,  $b = .593$ ,  $t(290) = 6.284$ ,  $p < .001$ ; for every unit increase in negative reactions to disclosure, there was a .593 unit increase in externalizing mental health outcomes. However, inconsistent with hypotheses, results indicated that the relationship between negative reactions to disclosure and externalizing issues was not moderated by gender,  $b = .182$ , 95% CI [-.191,.556],  $t = .960$ ,  $p = .338$ . See *Table 11*.

The following variables were analyzed for the third moderation analysis: SRQ negative reactions average (predictor), GAIN substance abuse sum (outcome), and gender (moderator). The main effect of negative reactions to disclosure on substance abuse was statistically significant,  $b = .613$ ,  $t(290) = 6.226$ ,  $p < .001$ ; this means that for every unit increase in negative reactions to disclosure, there was a .613 unit increase in substance abuse. Additionally, the main effect of gender on substance abuse was statistically significant,  $b = .418$ ,  $t(290) = 2.010$ ,  $p = .037$ ; this indicates that for men (coded as 2 while women coded as 1) there was a .418 unit increase in substance abuse over women. However, inconsistent with hypotheses, results indicated that the relationship between negative reactions to disclosure and substance abuse was not moderated by gender,  $b = -.002$ , 95% CI [-.392,.388],  $t = -.009$ ,  $p = .993$ . See *Table 12*.

### **Discussion**

Easton (2013) and Gagnier and Collin-Vézina (2016) noted that when CSA disclosure studies have included men in their samples, the numbers were often so small that their experiences became either downplayed or grouped in with those of female survivors. The present study addressed this limitation in the literature by recruiting a large, online sample of men and women with CSA histories in an attempt to explore differences in factors associated with timing of CSA disclosure between men and women. According to Alaggia et al. (2019), the complexity of barriers to disclosure can best be understood through the lens of a social-ecological

perspective, such that individual, familial, contextual, and cultural factors interact to influence a survivor's decision to disclose. This social-ecological framework laid the foundation for the exploration of factors associated with timing of disclosure in the present study, such that familial factors (perception of parental style), contextual factors (social reactions and perpetrator characteristics), and cultural factors (conformity to masculinity norms) were hypothesized to be associated with timing of disclosure and subsequent mental health outcomes in men and women. In addition, the present study was one of few to compare the association between social reactions to disclosure and internalizing and externalizing mental health symptoms between adult men and women with CSA histories.

Hypothesis one predicted that individuals who were perpetrated against by a family member, who were men, and who reported more parental dysfunction would wait longer to disclose. However, relationship to perpetrator, gender, and parental dysfunction accounted for less than .5% of the variance in time until disclosure, even when these factors were added to the model in a way that would reveal their additive properties in predicting time until disclosure. This suggests that in the current sample, relationship to perpetrator, gender, and parental dysfunction did not have a significant impact on when survivors disclosed their first sexual abuse incident. These findings are inconsistent with previous research that suggests relationship to perpetrator contributes to delayed disclosure (regardless of survivor gender), specifically when the abuse is perpetrated by a family member in a caregiving role. Mariott et al. (2016) found that in a sample of women and men, those who were perpetrated against by a family member were significantly more likely to delay disclosure (longer than one month). In a sample of 487 men, Easton (2013) found that incest survivors took longer to first tell someone about the sexual abuse compared to survivors who were sexually abused by someone other than a family member.

Perhaps a more detailed assessment of when the abuse started and ended, whether force or threats were used, how close the survivor was to the perpetrator, etc. would reveal a clearer relationship between familial CSA and timing of disclosure.

Although some previous research has found that men wait longer to disclose compared to women, the present study did not find gender to be a significant predictor of timing until disclosure. O'Leary and Barber (2008) found that a higher percentage of men compared to women in their sample waited more than 20 years to disclose. Easton (2013) found that men delayed disclosure for an average of over 21 years, but men in the present study waited an average of 5.92 years to disclose. This inconsistency suggests that MTurkers who are CSA survivors report different disclosure experiences compared to CSA survivors recruited from male CSA victim websites. In the present MTurk sample, men waited an average of 5.92 years to disclose and also had a younger mean age (35 years) compared to Easton's sample who delayed disclosure for 21 years and had an average age of 50 years. Perhaps many of the men who join such survivor websites do so as a way to gain support from other survivors if they have not received support from family/friends. Additionally, the present study compared to previous literature may demonstrate a cohort effect in that the present study consisted of, on average, younger participants who did not wait as long to disclose compared to older samples (as in Easton, 2013).

Previous research has not shown a clear relationship between survivor gender, parental relationships, and timing of disclosure. Maternal support following disclosure and its impact on the development of PTSD symptoms is a different but related idea to perception of parental style and disclosure. Priebe and Svedin (2008) found that boys were less likely to disclose if they perceived their parents as overprotective or non-caring. Supportive maternal responses to CSA

disclosure have functioned as protective factors for girls in the development of symptoms related to PTSD and substance abuse. Although Easton (2013) found that less maternal support following disclosure in childhood for male CSA survivors was related to more mental distress in adulthood, other studies have relied largely on female samples to investigate the role of maternal support in disclosure. Participants in the present study reported relatively low averages for parental dysfunction ( $M = 1.19$ ) on a scale where 1 indicated slightly true and 2 indicated moderately true to statements measuring indifference, abuse, and control. It is possible that samples who report higher parental dysfunction than the present sample may wait longer to disclose.

Hypothesis two predicted that men and women would report different social reactions to their initial CSA disclosure. Specifically, it was hypothesized that women would more frequently report the following reactions—negative reactions, positive reactions, victim blaming, taking control of survivor’s decision, egocentric reactions, tangible aid, and emotional support—while men would more frequently report that they were treated differently/stigmatized and distracted. There was not a significant overall difference (all scales on the SRQ combined, not broken down into subscales) in social reactions to disclosure of their first CSA experience between men and women in the sample. However, there were significant differences between men and woman in positive reactions and emotional support, such that women reported higher positive reactions and more emotionally supportive reactions to disclosure. Positive reactions included items like “told you that you were not to blame” or “held you or told you that you are loved.” Emotionally supportive reactions included items such as “told you it was not your fault” or “showed understanding of your experience.” It should be noted that there is substantial overlap in the items on the SRQ that are classified in the positive reactions and emotional support scales such

that all items in the emotional support specific scale are part of the larger positive reactions general scale. Further, since the positive reactions general scale is comprised of the emotional support and tangible aid specific scales, and the tangible aid scale did not reveal a significant difference between men and women, emotional support appears to be the driving factor that accounted for the significant difference in social reactions between men and women. Although the SRQ has not been used in samples of men to this author's knowledge, Orchowski et al. (2013) utilized the SRQ in sample of women and found that reactions that attempted to control the survivor's decision and blaming reactions were associated with anxiety, depression, and maladaptive coping. More research is needed to understand the extent to which men and women receive different social reactions from different support sources and the impact of various types of reactions.

On a related note to negative reactions, hypothesis four predicted that gender would moderate the relationship between negative reactions to disclosure and mental health outcomes, such that the association between negative reactions and mental health outcomes would vary across gender. Gender did not moderate the relationship between negative reactions to disclosure and internalizing symptoms, or externalizing symptoms, or substance abuse; however, negative reactions to disclosure predicted internalizing symptoms, externalizing symptom, and substance abuse. There was also a significant positive relationship between gender and substance abuse such that men reported more substance abuse than women. This may reflect data suggesting that men tend to report maladaptive substance use more frequently than women. In a report from the National Institute on Drug Abuse, they reported that men are more likely than women to use almost all types of illicit drugs (Center for Behavioral Health Statistics and Quality, 2017) and have higher rates of use or dependence on both illicit drugs and alcohol (SAMHSA, 2016).

The aim of hypothesis three was to understand the extent of the influence of time until disclosure, negative social reactions, perceived parental dysfunction, and conformity to masculinity norms on mental health and substance abuse. Negative reactions to disclosure were associated with internalizing, externalizing, and substance abuse. Specifically, negative reactions most strongly related to externalizing and substance abuse in the present study. These results relate to a study with an all-male sample by Romano et al. (2019), which found that 32% of men in the sample received negative reactions such as being ignored, not believed, and blamed; greater time until disclosure was associated with greater externalizing concerns and substance abuse. In samples of women, Ruggiero et al. (2004) found that college women with sexual abuse histories had more PTSD symptoms if they received more negative reactions to disclosure in childhood. Further, greater victim-blaming responses to disclosure has been shown to lead to greater depressive symptoms in samples of women (Bhuptani et al., 2019). Thus, it appears that negative reactions to disclosure differently impact internalizing, externalizing, and substance abuse in adults.

The present study also found that people who endorsed the heterosexual self-preservation masculinity norm were more likely to report internalizing and externalizing symptoms in the past year, while those who endorsed the self-reliance masculinity norm were more likely to report internalizing symptoms in the past year. These results relate to a study by McDermott and colleagues (2018) that found that the CMNI-46 masculinity norm self-reliance was associated with resistance in help-seeking for suicidal thoughts from both formal (psychologist) and informal (friend) sources in a sample of 2,504 college students (49% male). Taken together, self-reliance may be associated with less help-seeking due to internalized beliefs that seeking help represents personal failure or weakness; less discussion of and adaptive processing of internal



experiences with others may be associated with exacerbated internalizing symptoms.

Additionally, in a sample of male CSA survivors, Easton (2014) found that conformity to the masculinity norms emotional control (not found in present study), heterosexual self-preservation, and self-reliance were positively related to mental distress; men with CSA histories who endorsed high conformity to masculinity norms were also 230% more likely to endorse a past-year suicide attempt than men low in conformity (Easton et al., 2013). Easton and Kong (2017) also found a direct positive relationship between masculine norms and worse psychological outcomes. These findings—taken with the results of the present study—highlight the maladaptive role conformity to some masculinity norms may play in the maintenance of mental health symptoms.

Past research supports the fear of being labeled as homosexual for male survivors as a barrier to disclosure; this relates to the present study findings that reflected a desire for participants to engage in heterosexual self-preservation. Parental dysfunction was related to substance abuse, but no other mental health concerns. This could reflect a relationship between general parental dysfunction or parental substance abuse (often cooccurring with or defined as parental dysfunction) and substance abuse in their children. Due to the lack of research investigating the role of parental relationships and functioning as they relate to disclosure and subsequent mental health outcomes in samples including both men and women, more research is needed to further understand how negative reactions to disclosure can be differentially associated with externalizing, internalizing, and substance abuse.

The present study does have some limitations. First, it cannot be concluded that reactions to disclosure or timing of disclosure lead to (cause) negative mental health outcomes or substance abuse; we can only conclude that such variables are associated. Although MTurk

provides access to a broad range of participants in a timely manner, the present study raises some concerns about the quality of the data retrieved from MTurkers. In cleaning the data, 151 participants were deleted due to nonsensical responses to open-ended items (such as “MOBILE PHONE”), responding “no” to having ever disclosed but answering items such as whom they first disclosed to, or inconsistent age with birth year. It is possible that not all participants who fabricated responses were deleted due to not being able to always accurately identify bots or fake responders. Chmielewski and Kucker (2020) echoed similar data quality concerns as they found significant increases in MTurkers failing response validity indicators and failures to replicate well-established findings using MTurk samples. They did, however, recommend using response validity indicators and screening data when collecting data via MTurk. Although the present author added a validity check (asked for age and birth year to cross-check inconsistencies), narrowed access to the study to MTurkers with HIT ratings of at least 95%, and deleted nonsensical entries prior to analyses, MTurkers who were invalid responders were not rejected from being paid for the study, which was recommended by Chmielewski and Kucker (2020).

There are also some conflicting findings related to the ability of MTurk to capture PTSD prevalence rates and traumatic experiences in a similar fashion to other samples. On one hand, Engle et al. (2020) found that prevalence rates of PTSD and depression were not significantly different between MTurkers and comparison samples (undergraduates, community, treatment-seeking), but the MTurk sample had significantly lower mean scores of PTSD and depression than the comparison samples. However, van Stolk-Cooke et al. (2018) found that a sample of MTurkers exposed to traumatic events reported greater PTSD symptom severity compared to a review of studies with other types of samples (epidemiologic, alternative online methods, undergraduates, veterans). The authors suggested that MTurk is a reliable and effective way to

recruit participants who have experienced traumatic events, if validity checks and screenings are put in place to eliminate bad data.

Another limitation includes the retrospective nature of the perception of parental style measure; this measure asked participants to recall specific attitudes and behaviors related to abuse, indifference, and overcontrol domains of both a mother and a father figure prior to age 16. Previous research on the validity of the use of retrospective family environment (FE) measures has conflicting findings, with the content of what a person is asked to recall influencing the validity of such memory. In a longitudinal study, Bell and Bell (2018) assessed variables related to FE at an earlier time point (prospective) and 25 years later (retrospective). Among the areas of FE explored include cohesion (the degree of commitment and support from family members), organization (the degree of clear structure in family responsibilities), control (how rules and procedures dictate family life), and conflict (the amount of openly expressed anger and conflict among family members). They found that prospective and retrospective accounts involving the FE dimensions of cohesion and conflict matched. However, they found a positive bias where organization and control were over-recalled. Another study by Offer and colleagues (2000) looked at FE prospectively in a sample of males at ages 14 and 48; they found a lack of accuracy of recall in accounts of parental discipline. Thus, while there is evidence that these retrospective reports are generally valid, there could be some areas of the FE more prone to errors in recall.

Strengths of the present study include that the sample was nearly half male and half female. Many researchers have noted the need for studies that compare the disclosure experiences of men and women in the same study given that most studies have not done so. Additionally, the Social Reactions Questionnaire (Ullman, 2000) has not been used in samples of men to this author's knowledge. The present study yielded significant differences in two SRQ

subscales in particular (positive reactions, emotional support) between men and women. This has implications for future research that examines reactions to CSA disclosure, such that the measure may be capable of revealing differences in reactions that aid in our understanding of how to provide better support to male (and female) survivors when they do decide to disclose. On the other hand, the present study did not find an overall significant difference in social reactions to disclosure as measured by the SRQ; future research is needed to clarify the ability of the SRQ to capture the range of reactions received by both male and female survivors. Future research may also consider utilizing the SRQ separately for participants to describe their reactions from particular recipients. For example, useful implications may result from participants rating their mother, father, or spouse reactions to disclosure.

In sum, the present study sought to better understand variables that impact timing of CSA disclosure by comparing men and women and exploring how such variables influence mental health outcomes. The findings have implications for changing ideas and stigma related to better supporting CSA survivors; men and women may be similar in when they disclose but may receive different reactions to such disclosure. Negative reactions to disclosure, regardless of survivor gender, may increase risk for internalizing, externalizing, and substance abuse in CSA survivors. It is also important to consider and assess conformity to masculinity norms, particularly in treating men with CSA histories or men in a treatment setting. There remains much to be understood about the disclosure process.

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### Tables

Table 1. Deleted participants ( $N = 151$ ) and their reason for not being included in analyses.

<i>Exclusion Reason</i>	<i>N</i>
Non-United States Proxy Address	14
Age Left Blank	1
Age Inconsistent With Birth Year Accompanied by Inconsistent Reporting on CSA Variables	23
Partial Responders (Did not answer more than half of survey items)	25
Bots or Random Responders (Nonsensical responses on open-ended CSA question)	15
Said “no” to disclosure and had other nonsensical responses to CSA items	41
Negative value for time until disclosure	32
<b>Total</b>	<b>151</b>

Table 2. Participant demographic characteristics ( $N = 299$ ).

Characteristic	N	%
Gender		
Woman/Transgender Woman	157	52.5%
Man	139	46.5%
Non-binary	3	1.0%
Age		
18-27	65	21.7%
28-37	136	45.5%
38-47	51	17.1%
48-57	31	10.4%
58-67	14	4.7%
68+	2	0.7%
Race/Ethnicity		
White/European American	233	77.9%
Black/African American	25	8.4%
Hispanic/Latino	23	7.7%
Asian	10	3.3%
American Indian/Alaska Native	2	0.7%
Native Hawaiian or Other Pacific Islander	1	0.3%

Education		
Advanced Degree (Master's, Ph.D., M.D.)	59	19.7%
Bachelor's Degree	164	54.8%
Associate Degree	26	8.7%
Some college, no degree	25	8.4%
High School Graduate	20	6.7%
Trade/Technical Degree	4	1.3%
Less than High School	1	0.3%
Marital Status		
Married/Domestic Partner	210	70.2%
Single/Never Married	73	24.4%
Divorced	11	3.7%
Separated	5	1.7%
Sexual Orientation		
Heterosexual/Straight	239	79.9%
Bisexual	48	16.1%
Gay	5	1.7%
Lesbian	3	0.7%
Pansexual	2	0.7%
Asexual	1	0.3%
Queer	1	0.3%

*Table 3.* Correlation matrix for hypothesis one variables.

Variable	1	2	3	4
1. Time Until Disclosure	--			
2. Relationship to Perpetrator	-.046	--		
3. Gender	.037	.062	--	
4. Parental Dysfunction	-.029	.033	-.018	--

Table 4. Summary of regression analyses for predictors of time until disclosure (DV) for hypothesis one.

	<i>b</i>	<i>SE B</i>	$\beta$	<i>p</i>	$\Delta R^2$
Block 1					.002
Constant	5.441	.466		.001	
Relationship to Perpetrator	-.001	.001	-.047	.462	
Block 2					.000
Constant	5.180	1.436		.001	
Relationship to Perpetrator	-.001	.001	-.048	.456	
Gender	.181	.940	.012	.848	
Block 3					.001
Constant	5.536	1.631		.001	
Relationship to Perpetrator	-.001	.001	-.046	.467	
Gender	.179	.942	.012	.850	
Parental Dysfunction	-.302	.652	-.029	.644	

Note.  $R^2 = .002$  for step 1;  $\Delta R^2 = .000$  for step 2;  $\Delta R^2 = .001$  for step 3.

Table 5. Differences between men and women in reported social reactions to disclosure as measured by the SRQ for hypothesis two.

<i>SRQ Scale</i>	<i>Women (N = 156)</i>		<i>Men (N = 138)</i>		<i>F</i>	$\eta_p^2$
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Turning Against	1.70	1.17	1.67	1.05	.07	.00
Unsupportive Acknowledgement	1.88	.98	1.80	.95	.41	.00
Positive Reactions	2.39	.85	2.19	.68	4.61	.02*

Emotional Support	2.49	.86	2.29	.69	4.83	.02*
Tangible Aid	2.06	1.10	1.88	.94	2.12	.01
Blame	1.69	1.29	1.69	1.17	.00	.00
Stigma/Treated Differently	1.73	1.18	1.66	1.06	.22	.00
Control	1.69	1.12	1.72	1.05	.04	.00
Egocentric	1.87	1.11	1.80	1.01	.25	.00
Distract	1.96	1.06	1.89	1.05	1.60	.01
Negative Reactions	1.79	1.05	1.74	.98	.20	.00

Note. \* $p < .05$

Table 6. Correlation matrix for hypothesis three variables.

Variable	1	2	3	4	5	6	7	8	9
1. CMNI Self-Reliance	--								
2. CMNI Emotional Control	.339**	--							
3. CMNI Heterosexual Self-Preservation	-.022		--						
4. SRQ Negative Reactions	.217**			--					
5. MOPS Parental Dysfunction	-.020	-.055	.417**		--				
6. Time Until Disclosure	.130*	.008	.138*	.569**		--			
	.045	.030	-.165**	-.321**	-.029		--		

7. GAIN-SS	.159	.057	-.124*	.173	.092	.017	--	
Internal	**							
Distress								
8. GAIN-SS	.065	-.005	.016	.341**	.232**	.006	.612**	--
External								
Distress								
9. GAIN-SS	.042	.057	.054	.330**	.319**	-.041	.450**	.586**
Substance								
Distress								

Note. Correlation significant at the .01 level (2-tailed) = \*\*. Correlation significant at the .05 level (2-tailed) = \*.

Table 7. Summary of regression analyses for predictors of internalizing mental health outcomes for hypothesis three.

	<i>b</i>	<i>SE B</i>	<i>β</i>	<i>p</i>	$\Delta r^2$
<b>Block 1</b>					.002
Constant	2.638	.135		.001	
Time Until Disclosure	.009	.015	.040	.533	
<b>Block 2</b>					.027
Constant	2.067	.254		.001	
Time Until Disclosure	.022	.015	.093	.160	
Negative Reactions	.291	.110	.174	.009	
<b>Block 3</b>					.001
Constant	2.091	.263		.001	
Time Until Disclosure	.022	.016	.097	.149	
Negative Reactions	.318	.133	.190	.018	

Parental Dysfunction	-.065	.181	-.027	.720
Block 4				.047
Constant	2.668	.304		.001
Time Until Disclosure	.020	.015	.088	.181
Negative Reactions	.533	.144	.319	.001
Parental Dysfunction	-.155	.178	-.065	.387
CMNI Heterosexual Self- Preservation	-.616	.174	-.247	.001
Block 5				.006
Constant	2.299	.416		.001
Time Until Disclosure	.020	.015	.086	.189
Negative Reactions	.546	.144	.326	.001
Parental Dysfunction	-.166	.178	-.070	.353
CMNI Heterosexual Self- Preservation	-.626	.174	-.251	.001
CMNI Emotional Control	.261	.201	.080	.195
Block 6				.019
Constant	1.757	.478		.001
Time Until Disclosure	.020	.015	.086	.185
Negative Reactions	.532	.143	.318	.001
Parental Dysfunction	-.213	.178	-.089	.234
CMNI Heterosexual Self- Preservation	-.525	.178	-.210	.004



CMNI Emotional Control	.102	.211	.031	.629
CMNI Self-Reliance	.452	.201	.151	.025

*Note.* CMNI = Conformity to Masculine Norms Inventory.  $R^2 = .002$  for step 1;  $\Delta R^2 = .027$  for step 2;  $\Delta R^2 = .001$  for step 3;  $\Delta R^2 = .047$  for step 4;  $\Delta R^2 = .006$  for step 5;  $\Delta R^2 = .019$  for step 6.

*Table 8.* Summary of regression analyses for predictors of externalizing mental health outcomes for hypothesis three.

	<i>b</i>	<i>SE B</i>	$\beta$	<i>p</i>	$\Delta r^2$
<b>Block 1</b>					.001
Constant	2.044	.138		.001	
Time Until Disclosure	.009	.015	.037	.564	
<b>Block 2</b>					.120
Constant	.818	.248		.001	
Time Until Disclosure	.035	.015	.148	.019	
Negative Reactions	.625	.107	.364	.001	
<b>Block 3</b>					.002
Constant	.765	.256		.003	
Time Until Disclosure	.033	.015	.139	.030	
Negative Reactions	.566	.130	.330	.001	
Parental Dysfunction	.143	.176	.058	.418	
<b>Block 4</b>					.014
Constant	1.086	.302		.001	
Time Until Disclosure	.032	.015	.134	.035	

Negative Reactions	.685	.142	.399	.001
Parental Dysfunction	.093	.177	.038	.600
CMNI Heterosexual Self-Preservation	-.342	.172	-.133	.048
<b>Block 5</b>				<b>.000</b>
Constant	1.001	.414		.016
Time Until Disclosure	.032	.015	.134	.036
Negative Reactions	.688	.143	.401	.001
Parental Dysfunction	.090	.177	.037	.611
CMNI Heterosexual Self-Preservation	-.344	.173	-.134	.047
CMNI Emotional Control	.060	.199	.018	.764
<b>Block 6</b>				<b>.002</b>
Constant	.833	.479		.084
Time Until Disclosure	.032	.015	.134	.036
Negative Reactions	.684	.143	.399	.001
Parental Dysfunction	.076	.179	.031	.671
CMNI Heterosexual Self-Preservation	-.313	.179	-.122	.081
CMNI Emotional Control	.011	.212	.003	.960
CMNI Self-Reliance	.140	.202	.046	.488

*Note.* CMNI = Conformity to Masculine Norms Inventory.  $R^2 = .001$  for step 1;  $\Delta R^2 = .120$  for step 2;  $\Delta R^2 = .002$  for step 3;  $\Delta R^2 = .014$  for step 4;  $\Delta R^2 = .000$  for step 5;  $\Delta R^2 = .002$  for step 6.

*Table 9.* Summary of regression analyses for predictors of substance abuse for hypothesis three.

	<i>b</i>	<i>SE B</i>	$\beta$	<i>P</i>	$\Delta r^2$
<b>Block 1</b>					<b>.002</b>
Constant	2.090	.144		.001	
Time Until Disclosure	-.012	.016	-.049	.441	
<b>Block 2</b>					<b>.108</b>
Constant	.885	.259		.001	
Time Until Disclosure	.014	.016	.056	.372	
Negative Reactions	.615	.112	.345	.001	
<b>Block 3</b>					<b>.019</b>
Constant	.727	.266		.007	
Time Until Disclosure	.008	.016	.031	.626	
Negative Reactions	.438	.134	.246	.001	
Parental Dysfunction	.426	.182	.168	.020	
<b>Block 4</b>					<b>.008</b>
Constant	.980	.313		.002	
Time Until Disclosure	.007	.016	.027	.668	
Negative Reactions	.533	.148	.299	.001	
Parental Dysfunction	.387	.184	.152	.036	

CMNI Heterosexual Self-Preservation	-.270	.179	-.102	.132
<b>Block 5</b>				<b>.008</b>
Constant	.529	.428		.218
Time Until Disclosure	.006	.016	.025	.689
Negative Reactions	.548	.148	.307	.001
Parental Dysfunction	.373	.183	.147	.043
CMNI Heterosexual Self-Preservation	-.283	.179	-.106	.115
CMNI Emotional Control	.318	.206	.092	.124
<b>Block 6</b>				<b>.001</b>
Constant	.415	.496		.404
Time Until Disclosure	.006	.016	.025	.689
Negative Reactions	.545	.148	.306	.001
Parental Dysfunction	.363	.185	.143	.051
CMNI Heterosexual Self-Preservation	-.261	.185	-.098	.159
CMNI Emotional Control	.285	.219	.082	.195
CMNI Self-Reliance	.095	.209	.030	.649

*Note.* CMNI = Conformity to Masculine Norms Inventory.  $R^2 = .049$  for step 1;  $\Delta R^2 = .108$  for step 2;  $\Delta R^2 = .019$  for step 3;  $\Delta R^2 = .008$  for step 4;  $\Delta R^2 = .008$  for step 5;  $\Delta R^2 = .001$  for step 6.

*Table 10.* Hypothesis four linear model of predictors of internalizing issues.

	<i>b</i>	<i>SE B</i>	<i>t</i>	<i>p</i>	<i>LLCI</i>	<i>ULCI</i>
Constant	2.687	.096	27.906	.001	2.497	2.876
Negative Reactions	.305	.095	3.194	.001	.117	.493
Gender	.039	.193	.204	.838	-.340	.419
Negative Reactions x Gender	.214	.192	1.115	.266	-.164	.592

Table 11. Hypothesis four linear model of predictors of externalizing issues.

	<i>b</i>	<i>SE B</i>	<i>t</i>	<i>p</i>	<i>LLCI</i>	<i>ULCI</i>
Constant	2.125	.095	22.330	.001	1.938	2.312
Negative Reactions	.593	.094	6.284	.001	.407	.778
Gender	-.144	.191	-.756	.450	-.520	.231
Negative Reactions x Gender	.182	.190	.960	.338	-.191	.556

Table 12. Hypothesis four linear model of predictors of substance abuse.

	<i>b</i>	<i>SE B</i>	<i>t</i>	<i>p</i>	<i>LLCI</i>	<i>ULCI</i>
Constant	2.023	.099	20.394	.001	1.831	2.223
Negative Reactions	.613	.099	6.226	.001	.420	.807
Gender	.418	.199	2.010	.037	.026	.810
Negative Reactions x Gender	-.002	.198	-.009	.993	-.392	.388

## Appendix

### *Appendix A. Screener.*

1. In what country do you currently reside?
2. Please indicate your age (in years).
3. Did you ever have any sexual experience **before the age of 18** that was unwanted OR with someone 2 or more years older than you OR with any person who forced this experience regardless of their age?

Some examples of unwanted or forced sexual experiences include—but are not limited to—watching sexual acts or explicit sexual material, looking at others' private areas, being photographed or videotaped for obscene or pornographic purposes, being touched/fondled in private areas, touching another person's body parts for the sexual gratification of the other person, intercourse involving oral sex or penetration, or sexual assault.

4. Have you ever disclosed that sexual experience that you indicated in the previous question to another person who was NOT authorities like police or child protective services?

*Appendix B. Demographic Items.*

1. Please indicate the year you were born.
2. What is the highest level of education you have obtained?  
Multiple Choice Options: Less than high school, graduated high school, trade/technical school, some college/no degree, associate degree, Bachelor's degree, Advanced degree (Master's, PhD, M.D.), Other – write in, Prefer Not to Answer
3. What is your race/ethnicity?  
Multiple Choice Options: Asian, Native Hawaiian or Other Pacific Islander, Black/African American, White, Hispanic/Latino, American Indian/Alaskan Native, Multiracial, Other – write in, Prefer Not to Answer
4. What is your current marital status?  
Multiple Choice Options: Married/Domestic Partner, Widowed, Divorced, Separated, Single/Never Married
5. What sex were you assigned at birth according to your original birth certificate?  
Multiple Choice Options: Male, Female
6. What is your gender?  
Multiple Choice Options: Woman, Man, Transgender Man, Transgender Woman, Gender Variant/Non-Conforming, Non-Binary, Other – write in, Prefer Not to Answer
7. What is your sexual orientation?  
Multiple Choice Options: Asexual, Bisexual, Gay, Straight (Heterosexual), Lesbian, Pansexual, Queer, Questioning or Unsure, Other – write in, Prefer Not to Answer

*Appendix C. Measure of Parental Style (MOPS).*

**Pre-Screen:** Please think about a female caregiver that was present during your first 16 years of life. This should be someone who took part in caring for you, such as a birth or adoptive mother, grandmother, aunt, or some other family member or friend. Indicate your relationship to this female caregiver:

**Multiple Choice:** Birth mother, adoptive mother, grandmother, aunt, cousin, other family member (fill in), other (fill in)

During your first 16 years how ‘true’ are the following statements about your Mother’s (or female caregiver’s) behaviors towards you? Rate each statement either as: not true at all (0), slightly true (1), moderately true (2), extremely true (3)

1. Overprotective of me
2. Verbally abusive of me
3. Over controlling of me
4. Sought to make me feel guilty
5. Ignored me
6. Critical of me
7. Unpredictable towards me
8. Uncaring of me
9. Physically violent or abusive of me
10. Rejecting of me
11. Left me on my own a lot
12. Would forget about me
13. Was uninterested in me
14. Made me feel in danger
15. Made me feel unsafe

**Pre-screen:** Please think about a male caregiver that was present during your first 16 years of life. This should be someone who took part in caring for you, such as a birth or adoptive father, grandfather, uncle, or some other family member or friend. Indicate your relationship to this male caregiver:

**Multiple Choice:** Birth father, adoptive father, grandfather, uncle, other family member (fill in), other (fill in)

During your first 16 years how ‘true’ are the following statements about your FATHER’s (or male caregiver’s) behavior towards you? Rate each statement either as: not true at all (0), slightly true (1), moderately true (2), extremely true (3)

16. Overprotective of me
17. Verbally abusive of me
18. Over controlling of me
19. Sought to make me feel guilty
20. Ignored me
21. Critical of me
22. Unpredictable towards me
23. Uncaring of me



24. Physically violent or abusive of me
25. Rejecting of me
26. Left me on my own a lot
27. Would forget about me
28. Was uninterested in me
29. Made me feel in danger
30. Made me feel unsafe

*Appendix D. Determination of CSA and Disclosure Characteristics.*

The following questions will ask you to provide information related to experiences you may have had PRIOR to age 18. Use the answer options to complete items 1 through 4: Never True, Rarely True, Sometimes True, Often True, Very Often True.

1. Someone tried to touch me in a sexual way, or tried to make me touch them.
2. Someone threatened to hurt me or tell lies about me unless I did something sexual with them.
3. Someone tried to make me do sexual things or watch sexual things.
4. Someone molested me.
5. I believe that I was sexually abused.

The following questions will ask you to provide information related to the FIRST sexual experience you had that occurred before the age of 18 (that was unwanted, forced, or with someone who was 2 or more years older than you).

6. What was your relationship to the perpetrator?  
**Multiple Choice Options:** Birth Mother, Birth Father, Other Primary Caregiver, Grandparent, Other Adult Family Member, Sibling Under 18 Years Old, Babysitter or Child Care Provider, Sibling 18 or More Years Old, Family Friend, Other (write in)
7. Approximately when did the FIRST sexual abuse incident occur? Please be as specific as possible (provide day, month, and year). If you can only think of the year, please enter it.
8. Approximately how old were you at the time of the FIRST sexual abuse incident? Please estimate to the nearest month.
9. Approximately how old were you at the time of the LAST sexual abuse incident? Please estimate to the nearest month.
10. Approximately how many times were you sexually abused by the same person before you were age 18?
11. Did you experience any other sexual abuse involving a different perpetrator before you were age 18?
12. Approximately how many separate incidents of sexual abuse with a different perpetrator did you experience before you were age 18?
13. Did you ever voluntarily tell anybody about the sexual abuse?
14. If so, approximately how old were you when you **first voluntarily** disclosed the sexual abuse? Please estimate to the nearest month.
15. If so, approximately when did you voluntarily disclose? Please be as specific as possible (provide day, month, and year). If you can only think of the year, please enter it.
16. When you voluntarily disclosed for the first time, was the abuse still occurring?
17. What was your relationship to the recipient of the first disclosure?  
**Multiple Choice Options:** Friend, Mother/Maternal Caregiver, Father/Paternal Caregiver, Sibling, Other Family Member – Fill In, Clergy Member, Spouse/Partner, Another Survivor or Survivor Organization, Mental Health Professional, Medical Professional, Etc., Other – fill in
18. How would you rate the level of helpfulness of the person you first disclosed the sexual abuse to?  
**Scale:** 1-5 with 1 being very unhelpful and 5 being very helpful

19. Was the sexual abuse reported to authorities (e.g., police, child protective services)?
20. Is there any person you wished you had told? If yes: what could have helped you to disclose to them?
21. Please estimate the number of people whom you have voluntarily told about the sexual abuse in your lifetime.
22. How would you rate the OVERALL level of helpfulness of all responses you have ever received to telling others about the sexual abuse?  
**Scale:** 1-5 with 1 being very unhelpful and 5 being very helpful
23. What was your relationship to the person with whom you had your most productive discussion of the sexual abuse?  
**Multiple Choice Options:** Friend, Mother/Maternal Caregiver, Father/Paternal Caregiver, Sibling, Other Family Member – Fill In, Clergy Member, Spouse/Partner, Another Survivor or Survivor Organization, Mental Health Professional, Medical Professional, Etc., Other – fill in

*Appendix E. Social Reactions Questionnaire (SRQ).*

The following will ask you to indicate how often people responded to your voluntary disclosure of your sexual abuse experience in various ways. The following is a list of behaviors that other people responding to a person with this experience often show. Please indicate how often you experienced each of the listed responses from other people by placing the appropriate number in the blank next to each item.

How other people responded...

0: Never

1: Rarely

2: Sometimes

3: Frequently

4: Always

1. Told you it was not your fault
2. Pulled away from you
3. Wanted to seek revenge on the perpetrator
4. Told others about your experience without your permission
5. Distracted you with other things
6. Comforted you by telling you it would be all right or by holding you
7. Told you he/she felt sorry for you
8. Helped you get medical care
9. Told you that you were not to blame
10. Treated you differently in some way than before you told him/her that made you uncomfortable
11. Tried to take control of what you did/decisions you made
12. Focused on his/her own needs and neglected yours
13. Told you to go on with your life
14. Held you or told you that you are loved
15. Reassured you that you are a good person
16. Encouraged you to seek counseling
17. Told you that you were to blame or shameful because of this experience
18. Avoided talking to you or spending time with you
19. Made decisions or did things for you
20. Said he/she feels personally wronged by your experience
21. Told you to stop thinking about it
22. Listened to your feelings
23. Saw your side of things and did not make judgments
24. Helped you get information of any kind about coping with the experience
25. Told you that you could have done more to prevent this experience from occurring
26. Acted as if you were damaged goods or somehow different now
27. Treated you as if you were a child or somehow incompetent
28. Expressed so much anger at the perpetrator that you had to calm him/her down
29. Told you to stop talking about it
30. Showed understanding of your experience

31. Reframed the experience as a clear case of victimization
32. Took you to the police
33. Told you that you were irresponsible or not cautious enough
34. Minimized the importance or seriousness of your experience
35. Said he/she knew how you felt when he/she really did not
36. Has been so upset that he/she needed reassurance from you
37. Tried to discourage you from talking about the experience
38. Shared his/her own experience with you
39. Was able to really accept your account of your experience
40. Spent time with you
41. Told you that you did not do anything wrong
42. Made a joke or sarcastic comment about this type of experience
43. Made you feel like you didn't know how to take care of yourself
44. Said he/she feels you're tainted by this experience
45. Encouraged you to keep the experience a secret
46. Seemed to understand how you were feeling
47. Believed your account of what happened
48. Provided information and discussed options

*Appendix F. Global Appraisal of Individual Needs- Short Screener (GAIN-SS).*

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following statements, please tell us the last time you had this problem, if ever, by selecting: in the past month (3), 2-12 months ago (2), 1 or more years ago (1), or never (0).

1. When was the last time you had significant problems...
  - a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?
  - b. with sleeping, such as bad dreams, sleeping restlessly or falling asleep during the day?
  - c. with feeling very anxious, nervous, tense, fearful, scared, panicked or like something bad was going to happen?
  - d. when something reminded you of the past, and you became very distressed and upset?
  - e. with thinking about ending your life or committing suicide?
2. When was the last time you did the following things two or more times?
  - a. Lied or conned to get things you wanted or to avoid having to do something?
  - b. Had a hard time paying attention at school, work or home?
  - c. Had a hard time listening to instructions at school, work or home?
  - d. Were a bully or threatened other people?
  - e. Started fights with other people?
3. When was the last time...
  - a. you used alcohol or drugs weekly?
  - b. you spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?
  - c. you kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?
  - d. your use of alcohol or drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?
  - e. you had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems?
4. When was the last time you...
  - a. had a disagreement in which you pushed, grabbed, or shoved someone?
  - b. took something from a store without paying for it?
  - c. sold, distributed or helped to make illegal drugs?
  - d. drove a vehicle while under the influence of alcohol or illegal drugs?
  - e. purposely damaged or destroyed property that did not belong to you?

*Appendix G. Conformity to Masculinity Norms Inventory (CMNI-46).*

Thinking about your own actions, feelings and beliefs, please indicate how much you personally agree or disagree with each statement by circling SD for "Strongly Disagree", D for "Disagree", A for "Agree", or SA for "Strongly agree" to the left of the statement. There are no right or wrong responses to the statements. You should give the responses that most accurately describe your personal actions, feelings and beliefs. It is best if you respond with your first impression when answering.

1. In general, I will do anything to win
2. If I could, I would frequently change sexual partners
3. I hate asking for help
4. I believe that violence is never justified
5. Being thought of as gay is not a bad thing
6. In general, I do not like risky situations
7. Winning is not my first priority
8. I enjoy taking risks
9. I am disgusted by any kind of violence
10. I ask for help when I need it
11. My work is the most important part of my life
12. I would only have sex if I was in a committed relationship
13. I bring up my feelings when talking to others
14. I would be furious if someone thought I was gay
15. I don't mind losing
16. I take risks
17. It would not bother me at all if someone thought I was gay
18. I never share my feelings
19. Sometimes violent action is necessary
20. In general, I control the women in my life
21. I would feel good if I had many sexual partners
22. It is important for me to win
23. I don't like giving all my attention to work
24. It would be awful if people thought I was gay
25. I like to talk about my feelings
26. I never ask for help
27. More often than not, losing does not bother me
28. I frequently put myself in risky situations
29. Women should be subservient to men
30. I am willing to get into a physical fight if necessary
31. I feel good when work is my first priority
32. I tend to keep my feelings to myself
33. Winning is not important to me
34. Violence is almost never justified
35. I am happiest when I'm risking danger

36. It would be enjoyable to date more than one person at a time
37. I would feel uncomfortable if someone thought I was gay
38. I am not ashamed to ask for help
39. Work comes first
40. I tend to share my feelings
41. No matter what the situation I would never act violently
42. Things tend to be better when men are in charge
43. It bothers me when I have to ask for help
44. I love it when men are in charge of women
45. I hate it when people ask me to talk about my feelings
46. I try to avoid being perceived as gay