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# Survivor Experiences of Male Childhood Sexual Abuse: A Literature Review

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**Abstract**

The World Health Organization (WHO) recognizes childhood sexual abuse (CSA) as a global health issue. CSA is a human violation that affects both female and male children and has a stronger detrimental impact on mental health than other traumatic childhood experiences. Despite a growing awareness of male survivors of CSA, male survivors are a marginalized group as most CSA research focuses on females. In addition, masculine norms can keep male adults from disclosing further, which can delay support and increase mental health issues. This meta-analysis reviews the current literature on this group of marginalized people and concludes with a summary and future research directions on the complexities of male experience with a history of CSA and advocates for awareness of this marginalized population.

*Keywords*: male childhood sexual abuse, depression, anxiety, sexuality, PTSD, relationship, suicide, disclosure, account-making, hope, resilience, resistance

# Introduction

Childhood sexual abuse (CSA) is a human violation that has become a global healthcare issue (World Health Organization, 2017). Research shows that the trauma endured from sexual abuse has a greater impact on mental health than other forms of trauma (Dworkin et al., 2017) with a 70% probability that survivors will suffer from mental health issues (Amado et al., 2015). Survivors of sexual abuse incur a 10%–40% increase in primary care and a 13%–43% increase in total health care including emergency room visits, number of hospitalizations, subspecialty referrals, and psychiatric evaluations (Chen et al., 2010).

The adverse effects that CSA has on a child's growth and development impact physical, psychological, social, and behavioral outcomes (Sivagurunathan et al., 2019). CSA is associated with long-lasting harmful mental health consequences that can include but are not limited to depression, anxiety, risky sexual behaviors, suicide, and posttraumatic stress disorder (PTSD) (McTavish et al., 2019). In a national study, Pérez-Fuentes et al. (2013) reported that CSA is correlated with 47% of all childhood-onset psychiatric disorders and up to 32% of adult disorders.

## What is Male CSA?

There is not a consistent description of CSA. Various definitions of CSA guide researchers' work (e.g., see Amado et al., 2015 and Easton, 2012a). Some researchers discussed the imbalance of power and control (Antonucci, 2014; Bartkiewicz, 2015; Easton & Parchment, 2021), while others noted the complexity of the experience and the physiological response (McTavish, 2019; Talmon & Ginzburg, 2018).

One of the most thorough descriptions of sexual abuse was summarized by the World Health Organization (2017) when it stated that sexual abuse involves either a male or female child in a sexual activity that they do not fully comprehend, or the child is not developmentally prepared

and cannot give consent, or that violates the laws of society. Perpetrators of sexual abuse are either adults or other children in a position of responsibility, trust, or power over a child with the intent to satisfy their needs over the child's. Child sexual abuse more often occurs with psychological, emotional, or material manipulation rather than physical force over more invasive repeated episodes or on a single event.

There are researchers that differentiate between adolescent and childhood sexual abuse. For this study, a child will include children from ages 0-12 and adolescents ages 12-18; thus, childhood is the time between when a person is born to 18 years of age.

While all the definitions give a better understanding of the complexity of CSA, it is crucial to leave space for an individual's narrative. Each survivor's experience is unique and significant and can provide further insight into the complexities of sexual abuse. This article focuses on the emotions and meanings of sexual abuse rather than specifying specific criteria such as contact versus non-contact or the age differential between perpetrator and child.

The purpose of this article is to center on the male experience, giving voice to this marginalized group, and diminishing the stigmatization of male survivors of CSA. This article uses binary terms of male and female interchangeably for both sex and gender. This broadens the understanding of how sociocultural and psychological experiences impact the mental health of male survivors. Centering on maleness is not to diminish the CSA experiences of people who are female, non-binary, or transgender: those stories are also important and powerful. However, this article intends to expand the understanding of the marginalized male experience of CSA.

**Stigmatization and Marginalization of Males**

One of the first publications about the effect of CSA was by French forensic physician Ambroise Tardieu in 1857 (Labbe, 2005). Tardieu studied cases of children's sexual abuse (622 female and 302 male) and reported both physical and psychological symptoms (Tardieu, 1857, as cited in Labbe, 2005). This book's title was *Etude Medico-Legale sur les Attentats Aux Mœurs* (*Forensic Study on Offenses Against Morals*) (Labbe, 2005). Physicians and society were not receptive to Tardieu's observations of sexual abuse, and recognition of the impact of sexual abuse did not occur before the end of the 1970s (Labbe, 2005).

In the 1970s, during the feminist sexual assault crisis movement, increased public awareness of the complex dynamics of sexual abuse and its prevalence promoted and increased sexual assault services for females (Azzaro, 2019). In 1974, Ann Burgess and Lynda Holmstrom first described Rape Trauma Syndrome (RTS) and its associated physical and psychological effects of sexual abuse on 146 female patients admitted to the emergency room (as cited in O'Donohue et al., 2014). Burgess and Holmstrom also developed a victim-counseling program for the affected females (O'Donohue et al., 2014). Even though there were gains made with the sexual assault crisis movement for females, the inclusion of male victims did not occur, and males were only recognized as the perpetrators of sexual assault (Azzaro, 2019).

Awareness of sexual abuse of male children has begun gaining attention over the last three decades due to highly publicized cases of abuse by Catholic clergy and Boy Scout leaders (Easton, 2012a; Weatherred, 2015). The media revealed a major sexual abuse scandal within the Boston Dioceses in 2002, which grabbed national attention (Weatherred, 2015). In response, the John Jay College of Criminal Justice (2004) conducted research regarding the nature and scope of the problem of sexual abuse of children by clergy. This study revealed that there were 10,667 children

victimized by clergy between 1950 and 2002 (John Jay College, 2004). Further examination showed that 81% of the victims were male children, and 42% of these male children did not disclose their abuse (John Jay College, 2004).

After the intense media coverage of the Catholic church, the focus shifted to the Jerry Sandusky scandal at Pennsylvania State University and the release of the Boy Scouts of America's (BSA) "perversion files" (Weatherred, 2015, p. 19). In 2012, the Oregon State Supreme Court ordered BSA to release sexual abuse allegations from the 1960s through the 1990s, which disclosed 2,379 cases during this period (Cubellis, 2015). By 2020, there were approximately 82,000 claimants, which forced BSA to declare bankruptcy (Association of Scout Council, 2023).

In general, Western society often assumes that males are perpetrators of sexual violence, and the idea that males could be victims of sexual abuse is downplayed if not ignored entirely. Myths about male sexual abuse include that males are strong enough to prevent from being sexually abused — only gay males are victims of sexual abuse, or they deserve to be sexually abused since they are immoral; males are not affected by sexual abuse as much as females; males are not sexually assaulted by females; and the sexual assault of males only happens in prison (Azzaro, 2019). In addition, sexually abused males view themselves according to societal norms of manliness that do not allow them to be victims and instead encourage them to be silent (Andersen, 2011). In other words, it is *unmanly* to seek help (Dorahy & Clearwater, 2012). When compared to females, male sexual abuse survivors maintain secrecy, carrying its burden longer (Easton, 2012c). It is common for male survivors to wait to disclose their abuse well into adulthood or not at all, which leads researchers to believe that the current rates of CSA among male children are underreported (O'Leary et al., 2015).

Delaying disclosure is correlated with two or more negative symptoms, such as depression, suicidality, or increased PTSD symptoms in adulthood, and can result in poorer mental health over time (Easton, 2014; Leslie, 2014; Wallis & Woodworth, 2020). Males who are more reluctant to disclose sexual abuse are more likely to have lower self-esteem and cope with substance abuse (Zarchev et al., 2021). Male survivors of CSA report higher severity of depression and anxiety which is associated with avoidant behaviors, poorer functioning, and trending toward comorbidity (Zarchev et al., 2021).

Even with these understandings, research on sexual abuse continues to focus on females (Cook et al., 2018) and studies on male survivors remain under-researched. Fifteen times more studies focus exclusively on females than on males or mixed samples (Zarchev et al., 2021). This underrepresentation is concerning since sexually victimized people are at risk for declining mental health. Additionally, the lack of studies on the male experience of CSA makes it challenging to begin establishing epidemiology (Zarchev et al., 2021).

**Prevalence**

For many years, awareness of childhood sexual abuse centered around females with the assumption that male children and male adults were rarely abused. Over the last 30 years, sexual abuse scandals by clergy, athletic coaches, and famous people have increased our awareness of the prevalence of CSA among male children. Globally, childhood sexual abuse is an extensive issue affecting one out of eight children (Collin-Vézina et al., 2015; Sivagurunathan et al., 2019). Global statistics of male children that experience CSA vary significantly across countries ranging from 7.6% to 45% (McTavish et al., 2019; Sivagurunathan et al., 2019; Wallis & Woodworth, 2020). In the United States, one out of six males reports being sexually abused before the age of 18 (Cook et al., 2018; Easton, 2012a). Based on the male population (n=151,781,326) from the 2010 US

Census, there could be over 24 million males in America who have experienced sexual abuse (Gallo-Silver, 2014).

## Current Study

The research question is *What are the experiences of male survivors of childhood sexual abuse?* The terms "male survivors of CSA," "male survivors of CSA disclosure barriers," "recovery experiences of male survivors of CSA," "sexual behaviors of male survivors of CSA," and," masculinity issues with male survivors of CSA" were searched on JSTOR, PsycINFO, PsychARTICLES (EBSCO), ProQuest Dissertations & Theses Global, World Cat. Those search phrases and engines resulted in 1,750 articles. After review, there were 46 relevant articles associated with the research question. The following is a description of the categories of articles related to this topic.

## Results

The chart below is a summary of the category of topics brought up in literature. The most prevalent topics were differences between male and female survivors, the long-term effects of CSA, disclosure and barrier issues, and processing childhood trauma.

The search resulted in these main categories of the experiences of male CSA: Impact of CSA, Masculinity & Manliness versus Victimization, Psychological Issues, Impact and Rates of Disclosure, Barriers to Disclosure, Recovery, and Posttraumatic Growth.

| **Article Category Type** | **Citation** | **# of Articles** |
|---|---|---|
| Barriers | • Andersen, 2011.<br>• Antonucci, 2014.<br>• Bartkiewicz, 2015.<br>• Collin-Vézina et al., 2015.<br>• Easton, 2012a.<br>• Easton, 2014.<br>• Easton et al., 2014. | 13 |

| Article Category Type | Citation | # of Articles |
|---|---|---|
| | • Fontes & Plummer, 2010<br>• Gagnier et al., 2017.<br>• McElvaney et al., 2021.<br>• Sivagurunathan et al., 2019.<br>• Wallis & Woodworth, 2020.<br>• Willis et al., 2014. | |
| Long-term effects of CSA | • Antonucci, 2014.<br>• Bartkiewicz, 2015.<br>• Chen et al., 2010.<br>• Easton, 2012b.<br>• Haskell & Randall, 2019.<br>• Nelson et al., 2011.<br>• Rice et al., 2022.<br>• Talbot et al., 2009.<br>• Talmon & Ginzburg, 2018.<br>• Willis et al., 2014. | 10 |
| CSA Definition | • Amado et al., 2015.<br>• Antonucci, 2014.<br>• Bartkiewicz, 2015.<br>• Easton & Parchment, 2021.<br>• McTavish, 2019.<br>• Talmon & Ginzburg, 2018.<br>• WHO, 2017. | 7 |
| Disclosure Rates and Timing | • Antonucci, 2014.<br>• Collin-Vézina et al., 2015.<br>• Easton, 2012a.<br>• Easton, 2012c.<br>• Easton, 2013.<br>• Easton et al., 2014.<br>• Fontes & Plummer, 2010.<br>• Wallis & Woodworth, 2020.<br>• Willis et al., 2014. | 9 |
| Depression and Anxiety | • Amado et al., 2015.<br>• Antonucci, 2014.<br>• Boudewyn & Liem, 1995<br>• Easton, 2012a.<br>• Gallo-Silver, 2014.<br>• Molnar et al., 2001.<br>• Nelson et al., 2002.<br>• O'Leary et al., 2015. | 8 |
| Posttraumatic Stress Disorder | • Antonucci, 2014.<br>• Azzaro, 2019. | 6 |

| **Article Category Type** | **Citation** | **# of Articles** |
|---|---|---|
| | • Cook et al., 2018.<br>• Dworkin et al., 2017.<br>• Easton, 2014.<br>• Gallo-Silver, 2014 | |
| Sexuality | • Bigras et al, 2021.<br>• Cook et al, 2018.<br>• Ménard & MacIntosh, 2021.<br>• MacIntosh & Ménard, 2021a.<br>• O'Leary et al, 2015.<br>• World Health Organization, 2010; | 6 |
| Gendered differences to CSA | • Amado et al., 2015,<br>• Cook et al., 2018.<br>• Easton, 2012a.<br>• O'Leary et al., 2015.<br>• Rice et al., 2022; | 5 |
| Processing Trauma | • Antonucci, 2014.<br>• Bartkiewicz, 2015.<br>• Easton, 2013.<br>• Easton, 2012a.<br>• Willis et al., 2014 | 5 |
| Substance Abuse | • Antonucci, 2014.<br>• Easton, 2012a.<br>• MacIntosh & Ménard, 2021b.<br>• Pérez-Fuentes et al., 2013.<br>• Zarchev et al., 2021 | 5 |
| Suicide | • Antonucci, 2014.<br>• Bedi et al., 2011.<br>• Easton et al, 2013b.<br>• Pérez-Fuentes et al., 2013.<br>• Willis et al., 2014; | 5 |
| Relationship issues | • Godbout et al., 2014.<br>• MacIntosh & Ménard, 20121a.<br>• Ng et al., 2020<br>• Nielsen et al, 2018; | 4 |
| Disclosure | • Antonucci, 2014.<br>• Easton, 2012a.<br>• Easton et al., 2014 | 3 |

## Narrative Results of the Literature

### Gender Differences

Both female and male survivors suffer from both physical and psychological long-term consequences of sexual abuse; however, research has shown noteworthy differences in the mental health of male survivors of CSA (Amado et al., 2015). Rice et al. (2022) discussed how male survivors are at elevated risk of maladaptive coping behaviors including aggression, substance misuse, and risk-taking. In addition, male survivors of CSA are at increased risk for high-risk sexual activities, relationship problems, abusing others, and re-victimization (Easton, 2012a). O’Leary et al. (2015) discussed how male survivors can battle masculine identity and sexuality issues. Cook et al. (2018) selected a focus group for a qualitative study where males expressed concern about how sexual abuse affected their sexual activity. They claimed difficulties with sexual dysfunction, sexual orientation, gender identity confusion, and hypersexuality or compulsive behaviors.

In comparison with females, CSA affects the mental health of males at a higher rate (O’Leary et al., 2015). Sexually abused males are at increased risk for specific psychological problems including depressive and anxiety disorders, posttraumatic stress disorder (PTSD), and personality disorders (Easton, 2012a). Sexually abused male children were also 2.5 times more likely to report PTSD symptoms than female children (Cook et al., 2018). Another study showed that males who had been sexually abused were more likely to report suicidal ideation than the control group (Easton, 2012a).

## Long-Term Effects of CSA

Experiencing CSA is a physiological trauma that can imprint itself on both the mind and body (Bartkiewicz, 2015; Haskell & Randall, 2019). The body of the survivor acts as a living memorial and "remembers" abusive events, impacting both how an individual functions and copes with life in the present as well as how they imagine their future (Bartkiewicz, 2015; Talmon & Ginzburg, 2018). CSA can impact victims physically and psychologically over both the short and long term (Haskell & Randall, 2019) and continue to undermine males' mental health throughout their lives into their 60s, 70s, and 80s (Easton, 2012b; Rice et al., 2022). Sexual assault is not necessarily violent, yet it violates a person's sense of self and security, overwhelming a person's ability to adapt to life (Haskell & Randall, 2019).

In a quantitative study that measured the association between CSA and health outcomes, Talbot et al. (2009) concluded that the impact of "CSA is profound even into later life, and future research on the mechanisms and remediation of its effects is warranted" (p. 7). Nelson et al. (2011) reported 'medically unexplained' impacts, such as irritable bowel syndrome (IBS), chronic fatigue, fibromyalgia, etc. They also found that the burden of physical illness had the same effect as shortening a survivor's lifespan by eight years, and the more impaired bodily pain had the same effect as shortening their lifespan by 20 years.

Males with a history of CSA are 10 times more likely than males without a history of CSA to receive several mental disorder diagnoses (Antonucci, 2014) and have a higher risk of a lifetime of psychiatric disorders than males without a history of CSA (Willis et al., 2014). The following sections address some of the most prominent psychological problems of male survivors of CSA.

### *Depression and Anxiety*

Depression and anxiety are two of the most common mental health symptoms of CSA (Antonucci, 2014; Molnar et al., 2001; Nelson et al., 2002). Using 8,098 random participants, aged 15 to 54 years, Molnar et al. (2001) examined the relationship between CSA and psychiatric disorders. They found that 82% of male survivors of CSA (n=2,945) reported at least one psychiatric disorder including depression. This study also reported that after controlling other childhood adversities, sexual abuse was associated with a higher prevalence of mood disorders (depression, dysthymia, and mania), anxiety disorders, and substance abuse than those who did not report. In a mixed sample of college-age students, Boudewyn and Liem (1995) found that CSA was a predictor of depression and self-destructive behaviors. In addition, higher frequency, greater severity, longer duration, and overt coercion of sexual abuse were related to greater depressive symptoms.

O'Leary et al. (2015) found males suffering from depression differ from females due to their pronounced sense of not measuring up to societal norms of masculinity. O'Leary and his colleagues conducted a mixed methods study of 147 participants measuring the emotional well-being of males. They observed that male-sensitive items measured in the negative identity and psychological well-being included "not feeling worthy to be a man" and "needing to prove I'm a real man."

Male survivors of CSA can have a sense of feeling hopeless and difficulty envisioning a future where they belong. They can experience feelings of loss, helplessness, and powerlessness (Antonucci, 2014). Feelings of powerlessness can make healthcare environments particularly stressful (Gallo-Silver, 2014). The power differential between a survivor and a healthcare provider can provoke feelings of powerlessness while increasing anxiety and fear about their condition or

symptoms (Gallo-Silver, 2014). Males treated for substance abuse or depression often have overwhelming feelings of inferiority preventing them from disclosing underlying issues such as CSA (O'Leary et al., 2015).

### *Suicide*

In a national study conducted between 2004-2005, Pérez-Fuentes et al. (2013) found that survivors of CSA were associated with a broad range of psychiatric disorders, and suicide attempts were significantly elevated. The prevalence of suicidality in male survivors of CSA is almost 11 times more likely than non-abused males to report suicidality, and five times more likely than female survivors (Antonucci, 2014; Bedi et al., 2011; Easton et al, 2013b; Willis et al., 2014). Male survivors are more likely to experience suicidal ideation at a younger age and have a high probability of suicide attempts between the ages of 12 and 15 when compared to non-abused males (Antonucci, 2014). Survivors report suicidality at a rate of 10–55% (Antonucci, 2014).

Easton et al. (2013b) conducted a study that examined the factors associated with suicidal attempts of males with histories of CSA. They found five variables that increased suicidal risk: frequency of sexual abuse, use of force during sexual abuse, high conformity to masculine norms, level of depressive symptoms, and suicidal ideation. They concluded that these results were in line with previous studies and that male survivors of CSA were at higher risk for suicidal behavior.

### *Posttraumatic Stress Disorder*

In the 1970s researchers found that several females admitted to hospitals with "sexual abuse trauma syndrome" included various symptoms such as acute somatic reactions and emotional reactions like fear and self-blame. By 1980, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) included posttraumatic stress disorder describing other trauma-related syndromes (e.g., "combat fatigue") (Dworkin et al., 2017). This diagnosis helped prompt

further research into the impact of sexual abuse. Dworkin et al. (2017) discussed an epidemiological study that assessed trauma-related psychopathology to PTSD and found that 80% of sexual abuse survivors suffered from PTSD.

Recent research suggests that sexual abuse survivors are the largest group of people with PTSD (Azzaro, 2019) and are considered one of the most common diagnoses of male survivors (Antonucci, 2014). PTSD symptoms revolve around concerns of intrusive thoughts associated with the event, avoidance of situations that may remind the survivor of the experience, persistent and exaggerated beliefs of themselves, others, or the world (e.g. “I am bad”, “No one can be trusted”, “The world is dangerous”), and alterations in sensitivity or reactivity to stimulus creating hyperarousal symptomology (Gallo-Silver, 2014, American Psychiatric Association, 2013). In addition, the research found a link between an increase in PTSD symptoms in adulthood and a delay in disclosure (Easton, 2014).

Cook et al. (2018) examined how female children were more likely to report physical injury and penetration yet the relationship between sexual abuse and PTSD is greater for male children. This implies that male survivors develop PTSD or other mental health problems differently than females. Research also suggests that male children and adult survivors may not meet a full PTSD diagnosis yet are more vulnerable to developing symptoms related to PTSD such as re-experiencing through a manifestation of thoughts, avoidance or numbing, and hyperarousal symptoms (Antonucci 2014).

In a Bayesian network analysis, McNally et al. (2016) studied PTSD symptoms with adults reporting a history of CSA. This study included 89 male and female participants who experienced CSA prior to 16 years old. Participants completed a self-report questionnaire. Results of the Bayesian network approach showed that symptoms of intrusive re-experiencing are a driving force

in PTSD, especially physiological and emotional reactivity to reminders of the trauma. Symptoms of avoidance, loss of interest, concentration difficulty, anger/irritability, social disconnection, and emotional numbness arise as direct or indirect consequences.

### *Substance Abuse*

Male survivors had difficulties disclosing sexual abuse leading to mal-adaptive behaviors such as substance abuse (Pérez-Fuentes et al., 2013; Zarchev et al., 2021) as a means of self-medicating or numbing the emotional impact of CSA (Easton, 2012a). Antonucci (2014) discussed how addiction is most often rooted in painful childhood experiences such as childhood sexual abuse. Sexual abuse survivors were three times more likely to self-soothe and regulate emotional pain through alcohol abuse.

MacIntosh and Ménard (2021b) explained that research draws a direct link between CSA and alcohol and substance use later in life. Research also showed a connection between the severity of the sexual abuse experience and greater substance abuse; CSA survivors are more vulnerable to substance abuse yet may be less likely to seek out treatment. They also noted the need for more sexual abuse screening in substance abuse programs.

### *Sexuality*

MacIntosh and Ménard (2021a) discussed the impact of CSA on sexuality and intimacy ranging from risky sexual behaviors and sexual wellbeing. In a literature review, Ménard and MacIntosh (2021) reviewed 82 studies to examine the impact of CSA on adult sexual risk behavior. They found that risk behaviors were most consistently associated with sex under the influence of substances, concurrent sexual partners, and infidelity. CSA affected the "sexual debut," the age of first voluntary sexual activity, for males more than females, and survivors were more likely to engage in sexual activity before the age of 14 (Ménard & MacIntosh, 2021). CSA history was also

associated with a higher number of sexual partners and unprotected intercourse (Ménard & MacIntosh, 2021).

Regarding sexual well-being, Bigras et al. (2021) noted that there is little research in this area especially for males. The World Health Organization (2010) defined sexual well-being as self-perceived sexual health, which includes physical, emotional, mental, and social well-being in relation to sexuality. This includes being satisfied with one's sexual orientation and ability to protect and enhance both positive and negative coercion aspects (World Health Organization, 2010).

In a literature review of 18 selected studies, Bigras et al. (2021) documented five primary areas of sexual outcomes in reviewing the relationship between CSA and sexual well-being. The themes identified included 1) sexual function (i.e., sexual desire, arousal, orgasm); 2) sexual satisfaction; 3) sex-related cognitions such as sexual thoughts, sexual self-esteem, and excitatory/inhibitory processes; 4) sexual behaviors such as compulsivity and avoidance; and 5) effective components of sexuality such as anxiety and distress during intercourse. Review findings suggested that CSA is associated with sexual dysfunction and comorbidity with other psychological disorders that are related to sexual difficulties such as PTSD. This review noted the underrepresentation of male survivors of CSA in research affecting our knowledge of sexual experiences. Bigras et al. expressed concern about the significant gaps in research and a need for further rigorous longitudinal studies on CSA and its relation to sexual well-being.

Males in a qualitative focus group addressed this lack of research. Males voiced concern about the impact of CSA on their sexual function (Cook et al., 2018) and were interested in the extent of sexual disorders, sexual addiction, hyper/hypo sexuality, and paraphilia. In a qualitative study of a 20-male focus group, O'Leary et al. (2015) found that males reported confusion about

their sexual identity, experiencing sexual difficulties or avoidance of sexual intimacy, and feelings of needing to prove themselves sexually.

***Relationship Issues***

Survivors of CSA struggle with adult intimate relationships and parenting. Nielsen et al. (2018) found 16 studies published between 2000 and 2017 that examined how CSA manifests in intimate relationships. They identified three main categories that challenge adult intimate relationships including relationship satisfaction, sexual satisfaction, and communication and trust. Spouses with a history of CSA reported more depressive symptoms (Nielsen et al., 2018) and increased relationship dissatisfaction over time in comparison with couples without a history of CSA, especially in male partners (MacIntosh & Ménard, 2021a). Spouses with CSA have a higher level of distress, a greater fear of intimacy, and lower sexual satisfaction (Nielsen et al., 2018). When one partner has a history of CSA, results show elevated emotional intensity in communication and defensiveness between couples. Additionally, survivors of CSA have difficulty regulating and controlling emotions (Nielsen et al., 2018).

Ng et al. (2020) explained that trust is a fundamental factor in marriage and a critical component to improving intimacy and marital quality and longevity, which explains how CSA has been shown to be associated with negative impacts on marriage stability and the quality of intimate relationships. In a statistical analysis of biological markers and self-report scales, Ng et al. found that trust in a partner helped mediate the impact of CSA in adulthood. In addition, MacIntosh and Ménard (2021a) discussed how CSA survivors have a higher rate of separation and divorce, and how being in a relationship with a CSA survivor can negatively affect their partners' mental health.

In a quantitative study, Godbout et al. (2014) questioned 348 males and females to examine the role of parental intervention. In this study, 71% of parents were unaware of sexual abuse. In

males, they found CSA survivors with parental support were associated with less attachment avoidance and lack of support linked to psychological distress. In adulthood, this led to anxiety about abandonment and avoidance of intimacy with their partners.

**Disclosure**

Detailed disclosure and the supportive response of others to disclosure can impact the CSA survivor's long-term mental health (Antonucci, 2014). As discussed, CSA can have long-term detrimental impacts on the physical, mental, and social health of male survivors and typically worsen with delayed disclosure (Easton et al., 2014). Researchers found that an increased number of details given at the time of disclosure lowered related PTSD symptoms (Easton, 2012a). To assist this marginalized population, it is imperative to understand the disclosure barriers for males (Easton et al., 2014).

**Disclosure Rates and Timing**

Both male and female children who have experienced sexual abuse frequently delay disclosure and use avoidance coping behaviors (Easton, 2012a). However, research shows male survivors have a significantly lower rate of disclosure compared with female survivors (Easton, 2013). Avoiding and denying the CSA experience can continue well into adulthood.

Easton (2012c) discussed how the percentage of male survivors who never disclose sexual abuse history is higher than female survivors. In a study of incest cases, males kept the abuse a secret for 25.8 years compared to 19.5 years for females (Easton, 2012c). According to Willis et al. (2014), survivors disclosed an average of 21 years after the sexual abuse, and it took an average of 28 years to have an in-depth discussion about the abuse. Survivors who waited longer than 1 year to have an in-depth discussion about their abuse had more mental health symptoms in adulthood (Easton, 2012c).

In a quantitative regression analysis of 164 adults on child sexual assault cases (148 female cases and 16 male cases), Wallis and Woodworth (2020) studied the impact of child characteristics (i.e., age and gender) and abuse characteristics (i.e., severity and frequency of abuse, the relation between perpetrator and child, etc.) have on disclosure. They confirmed that the abuse severity and frequency increased the time until disclosure. More incidents and higher intensities of abuse were associated with delayed disclosure in younger children. Wallis and Woodworth speculated that frequent abuse may also be attributed to the use of manipulation to gain secrecy. They found that many offenders practice grooming to ensure that children remain compliant in keeping the abuse secret. Grooming is the rapport-building with a child increasing contact and trust preceding the abuse (Wallis & Woodworth, 2020). Fontes and Plummer (2010) described grooming as beginning with touches that lead to increasingly exploitative and abusive incidents. As the abuse escalates, a child can feel responsible or guilty for not talking about the abuse sooner, and the child can become acclimated to the abuse (Fontes & Plummer, 2010). Wallis and Woodworth (2020) found that the closer the bond between the child and the perpetrator, the longer the time before disclosure. In other words, disclosure is associated with the abuser's role in the life of the child.

Wallis and Woodworth (2020) also learned that a child's age and gender significantly impact disclosure. Younger children (ages 1-6) may have difficulties understanding that what is happening is wrong or inappropriate, and children younger than three lack the verbal and/or cognitive abilities to communicate the abuse. This research found that older children aged 13-18 had the shortest lengths of delay. Study results also supported that females report sexual abuse more often and with shorter delays than males. In addition, they found that males delayed disclosure two times longer than female survivors.

Researchers have found issues that delay disclosure for both female and male survivors, but there were factors that uniquely obstructed the disclosure process for males (Easton et al., 2014). Three principal areas categorized these sources of barriers: personal barriers, interpersonal barriers (barriers with others), and sociopolitical barriers (Collin-Vézina et al., 2015; Easton et al., 2014; Willis et al., 2014).

***Personal Barriers***

Willis et al. (2014) defined personal barriers as the interpretation of emotional, cognitive, physical, and behavioral challenges. In a qualitative study of 487 males with a history of CSA ranging in age from 18 to 84, Easton et al. (2014) analyzed sources of barriers. Results showed that there were three key themes: internal emotions, lacking insight, and questioning sexual orientation.

**Internal Emotions.** Easton et al. (2014) found participants identified with a lengthy list of strong negative emotions that deterred disclosure. These emotions included shame, embarrassment, humiliation, fear, guilt, low self-esteem, anger/hate/rage, loss of control, confusion, pain, disgust, self-blame, self-hatred, self-doubt, and self-denigration (Easton et al., 2014; Willis et al., 2014). Many males reported a sense of worthlessness, of being contaminated, and of being permanently damaged (Easton et al., 2014).

This internal turmoil echoes findings by Collin-Vézina et al. (2015) where embarrassment and shame were often related to self-blame and feelings of responsibility. Perpetrators instilled inaccuracies regarding responsibility for the abuse and self-blame for the abuse which were one of the most frequent barriers mentioned (Easton et al., 2014).

Shame related to CSA can lead to increased feelings of isolation and alienation or avoidance (Collin-Vézina et al., 2015). McElvaney et al. (2021) explained how avoidance is a

human response and a common coping strategy to protect the self from distress. They further describe how individuals avoid social contact as a means of regulating their experiences of intolerable shame which is a key barrier to disclosing. They also noted that no other trauma group is blamed for their ordeal as frequently as sexual assault survivors.

**Naming the Experience as "Sexual Abuse."** For some survivors, they were unable to recognize the event as abusive hindering their ability to name the personal experience as abusive (Easton et al., 2014) or that their maltreatment was not normal (Willis et al., 2014). At the time the abuse occurred, some survivors were ill-equipped to comprehend the situation hampering their ability or willingness to report their abuse (Collin-Vézina et al., 2015). Other survivors repressed memories or tried to block or avoid experiencing and expressing intense emotions (Easton et al., 2014). Antonucci (2014) notes that male survivors fear confrontation and aggressive behaviors of self and others.

Willis et al. (2014) explained how males struggled to identify their relationship with abuse history. They described males filled with intense anger and other disturbing emotions and not understanding the meaning behind their feelings. This lack of insight further confused survivors (Willis et al., 2014). To numb and suppress emotions and memories, many males used substances whereas others used silence or denial coping mechanisms to delay disclosure (Easton et al., 2014).

**Perpetrator Gender Difference.** The gender expression of the perpetrator shows varied reactions in the literature. Easton et al. (2014) found that most perpetrators are males, which led survivors to question their sexual orientation. This questioning can be extremely disturbing given that sexual orientation is a core part of one's identity and can contribute to feelings of shame (Easton et al., 2014).

If the perpetrator was female, survivors could feel confused about their negative views of the abuse when outsiders mistakenly view the sexual abuse as enviable (Wallis et al., 2020). Also, male survivors abused by a female may experience a sense of helplessness in future interactions with females (Antonucci, 2014).

Willis et al. (2014) interviewed 52 adult male survivors of CSA to explore the challenges and understand the full range of barriers males experience in healing. They found that males often suffer personally behind a "masculine veneer" (p. 572). Due to social masculine norms, males created a "mask" or "bottled-up" feelings to hide their abuse and negative feelings about themselves (Willis et al., 2014, p. 572). Some survivors try to guard the secret of CSA by overly asserting masculinity in accordance with stereotypical norms (Easton et al., 2014).

***Interpersonal Barriers***

Easton et al. (2014) described interpersonal barriers as social interaction with others or social relationships. Males with a history of CSA can have more difficulty initiating and maintaining relationships compared to non-abused males (Antonucci, 2014). Some key dimensions of poor relationships experienced by CSA males include mistrust and isolation from others, fear of being labeled "gay," abusive factors, and unsupportive responses from others (Easton et al., 2014; Willis et al., 2014).

**Mistrust and Isolation from Others.** A major disclosure barrier was that male survivors had difficulty trusting others since many males were abused by someone they trusted (Easton et al., 2014; Willis et al., 2014). Males described mistrust as not trusting or having difficulty establishing trust in relationships (Bartkiewicz, 2015; Willis et al., 2014). Many males had an overpowering sense of fear of rejection, abandonment, or potential for a change in a relationship, which increased their mistrust of others (Bartkiewicz, 2015; Easton et al., 2014). Male survivors

did not trust others to respond appropriately and were overwhelmingly concerned that others would minimize, misunderstand the experience, or offer little help (Easton et al., 2014).

Other males expressed that isolation is lacking connection, being distant, or feeling separate from others impeding healing (Willis et al., 2014). Males created distance in intimate relationships to protect themselves from exposing the truth or further self-harm (Willis et al., 2014).

**Fear of Being Labeled "Gay."** Easton et al. (2014) explained that males who have experienced CSA by male perpetrators often had internal personal struggles with sexual orientation and feared/avoided exposing the identity of their abusers for fear that people would question their sexual orientation. Additionally, some males identify as gay that delayed disclosure for fear that others would believe that abuse by a man "made me gay" (Easton et al., 2014, p. 465).

**Power Dynamics.** CSA involves a power imbalance between the perpetrator and the child, which acts as a barrier to disclosure (Easton et al., 2014). Perpetrators can use several methods to silence a child including physical threats, demanded secrecy, privileges, threats of disclosure (Easton et al., 2014), and manipulation through grooming, and/or manipulation by a direct threat (Collin-Vézina et al., 2015) In addition, a perpetrator can use their position or authority to become invisible (Andersen, 2011). These tactics can delay disclosure for years.

**Unsupportive Responses from Others.** Male survivors described negative events and harsh responses to disclosure (Easton et al., 2014). Some males stated that they were told that they were lying or evil, while others were told not to tell anyone because of the disgrace (Easton et al., 2014). Counselors and therapists who deny or avoid CSA discussion were not helpful to survivors (Willis et al., 2014).

***Sociopolitical Barriers***

Sociopolitical barriers are social values such as gender norms that can impact the rate of disclosure which tangibly impacts the availability of resources (Easton et al., 2014). These social values can negatively influence social environments where males live and function including working environments, community characteristics, and societal attitudes (Willis et al., 2014). Negative influences can include a culture of silence, masculine social norms, and a lack of access to quality resources for healing.

There is limited research regarding how cultural values contribute to the sociopolitical barriers experienced by male survivors. Fontes and Plummer (2010) discussed how cultural scripts such as shame, sexual scripts, honor, and respect may silence disclosures. Children who experience sexual assault can feel shame when coerced if they are raised in a culture that inadequately educates children about their bodies and sexuality. A cultural sexual script that views males as always wanting sexual interaction can make it difficult to disclose sexual assaults by females or reframe the sexual assault to make themselves seem more powerful or active in the assault. In addition, cultures that expect children to uphold the strong values of honor and respect for elders can inhibit disclosures.

**Masculinity.** Andersen (2011) addressed how our social and cultural perception of manliness affects male victimization. In a focus group of 15 Nordic males ages 25 to 65, he captured their stories through narrative interviewing and found that if males understood masculinity as powerful, self-reliant, and resolute, then sexual abuse symbolized that they failed as a man. Andersen (2011) continued to explain that typical masculinity considers males as the sexual initiative takers and conquerors. Sociocultural understanding of masculinity does not consider males as victims or in a victim role, thus siding with the abuser. The traditional

understanding of manliness does not allow males to be in a position of needing help or of weakness, which hinders males from acknowledging their experience of abuse or seeking help.

Previous research showed that CSA affects masculine identity and what it means to be a man resulting in identity confusion (Easton, 2012a). In a cross-sectional survey of 487 males from three national organizations helping survivors of CSA, Easton et al. (2014) measured strict adherence to "masculine norms," which included emotional stunting, disdain for homosexuality, and radical self-reliance. They found that conformity to masculine norms was associated with poorer psychological and physical health outcomes for males in general. The stronger a man identified with these "masculine norms," the more likely they were to have poorer health outcomes. Survivors felt that disclosing would reveal another level of weakness, where not disclosing was preserving a sense of masculinity (Easton, 2014). Males also stated they felt that disclosing would elicit uncontrollable emotions, which also violated masculine norms (Easton, 2014).

**Limited Resources.** Societal values of masculinity influence our attitude toward male survivors of CSA impacting available services such as male-oriented counseling practices or sexual assault crisis centers (Easton et al., 2014). Society understands the sexual assault of a woman but cannot comprehend the assault of a man. Lack of awareness or biases about male sexual abuse contributes to the lack of male-centered services (Easton et al., 2014). Male survivors feel that society provides support and resources for female needs but not for males (Willis et al., 2014). Survivors noted an absence of services in mainstream education and a lack of information on available help (Collin-Vézina et al., 2015).

Gagnier et al. (2017) studied how male survivors experienced obtaining services. After interviewing seventeen males, they found that males reached out for services for the first time due

to personal crises or breakdowns. Male survivors reported having difficulties accessing proper services since most services focused on females or there were longer waiting lists to obtain male services. When males received services, they were satisfied and experienced a sense of support and empowerment when they were able to build a trusting relationship and feelings of safety with professionals.

**Processing Trauma**

Past traumatic events can prevent survivors from accessing alternative meanings or behaviors that empower change in the present; thus, many survivors lose a purposeful course of action and become stuck using ineffective coping mechanisms (Bartkiewicz, 2015). According to Willis et al. (2014), when survivors heal from CSA, liberation from the preoccupation of abuse occurs. This allows them to experience and maintain a sense of peace and well-being in the present. While recovering from CSA, they experience increased self-acceptance, self-confidence, and self-care. Easton et al. (2013a) stated that the recovery process includes survivors processing events, interpreting, and creating meaning, and learning to adjust after the trauma. As survivors gain a better understanding of sexual abuse and experience positive life changes, posttraumatic growth can occur.

Typically, improvement and growth are found in three main areas of an individual's life: their view of self (e.g., a greater sense of personal strength and compassion toward themselves); their life philosophy (e.g., greater appreciation for life and sense of meaning, changed sense of priorities); and more positive and meaningful interpersonal relationships (Easton et al., 2013a; Tedeschi & Calhoun, 2004; Tummala-Narra et al., 2012). The following sections expand on the stages of processing trauma and ways to promote growth.

### *Account-Making*

Account-making is a useful framework for describing the recovery process. Easton (2013) explained that the account-making theory suggests that trauma survivors progress through six distinct stages: outcry, denial, intrusion, working through, completion, and identity change. During the outcry stage, the survivor is in shock or numb from the event whereas the denial stage embodies extreme avoidance and maladaptive coping behaviors. In the intrusion stage, the survivor initiates trying to interpret and understand the event and may experience intrusive thoughts that can lead to hypervigilance, somatic complaints, and concentration difficulties. Working through this stage is an active account-making effort with private reflection, journaling, self-help groups, and sharing with others. In the completion stage, a survivor can express the story of the event explaining the cause and its impact without distress. Lastly, in the identity change the survivor develops adequate coping skills to attain self-efficacy.

In a 2010 study, Easton (2013) surveyed 487 males aged 19 to 84 with histories of CSA, to assess account-making development with mental distress. He defined account-making as story-like accounts to describe, interpret, and create meaning from the event. He found that there is a beneficial mental health effect to account for development. He also noted that recovery was not a linear process through the stages and survivors could go through regression loops. He suggested that survivors finally reach a turning point that intensifies account-making in the working-through stage. Easton et al. (2013a) found that experiencing a turning point was positively related to posttraumatic growth. He recommended that further research include investigative questions relating to turning points; for example, what precipitates these turning points? When did they occur? Do turning points occur after years of struggle or through a series of less dramatic events?

***Hope***

Antonucci (2014) studied the understanding of hope in a six-person focus group of male survivors with a history of sexual abuse. She found four main themes emerge from this study: thinking hope, hope as an embodied emotion, hope in action, and hope in relationship and connection. She explained that participants characterized hope as a desired goal or a meaningful future outcome and secondly, that hope considered multiple possibilities and perspectives. When participants experienced a shift in their perspective, it allowed for unexpected possibilities, which strengthened and sustained their connection to hope (Antonucci, 2014). Hope embodies an internalized experience where participants felt positive and a sense of physical energy manifested (Antonucci, 2014). A high connection or meaningful relationship with self, others, and a spiritual entity increased participants' hope (Antonucci, 2014).

***Resilience and Resistance***

Studies show that using a strengths-based narrative approach can illuminate resilience in male survivors and instill hope (Bartkiewicz, 2015). Illuminating a survivor's resources and strengths can empower survivors to identify, foster, and mobilize their capacity for resilience and recovery (Bartkiewicz, 2015). In a non-empirical study, Bartkiewicz (2015) found that mobilizing a capacity for resilience and recovery can empower survivors toward recovery. She found that highlighting resilience can shift a survivor from pathologizing to focusing and recognizing past efficacy and strengths, increase healing resources, and foster posttraumatic growth. She also found that during trauma recovery, male survivors were able to reconnect to what they value, renegotiate self-worth and self-efficacy by clarifying responsibility for the sexual abuse, and illuminate a survivor's informed resistance.

In general, actively disclosing and discussing abuse with capable, supportive individuals is crucial for initiating a survivor's healing process (Antonucci, 2014; Easton, 2012; Willis et al., 2014). Willis et al. (2014) described four stages of healing from trauma (i.e., CSA): grappling with the meaning of CSA, figuring out the meaning of CSA, tackling the effects of CSA, and laying claim to one's life. Willis et al. (2014) discussed that male survivors could accelerate healing by making meaning of their lives within the context of abuse; sharing about their CSA experience, especially with fellow male survivors; helping others; and maintaining a daily spiritual life.

## Discussion of Literature

### Implications of Current Literature

The experience of male survivors of CSA is complex and complicated. Current literature implies that males often do not tell anyone about their experiences internalizing feelings of shame, self-blame, self-hatred, and feelings of responsibility. This inner turmoil can lead to several physical or mental health issues delaying disclosure. Supportive response to male disclosure can impact a survivor's long-term mental health. However, extended disclosure rates can increase severity and impact their mental health. Disclosure rates impact not only personal and interpersonal barriers but also sociopolitical barriers. How we, as a society, view masculinity can limit a male adult's ability to accept and acknowledge their abuse. This sociocultural view can also hinder males from accepting their emotions around the abuse. When males disclose and can discuss their abuse openly, they can start to understand the meaning of the CSA and its effects on their lives. In other words, they can start to heal and experience posttraumatic growth (Easton et al., 2013).

The literature further indicated that the traditional socialization of males held them in positions of strength and power, which rejected the idea of males as victims. This view means that

sexual abuse victimhood is reserved for females, which increases the marginalization of males (Andersen, 2013). The way males are socialized decreases their willingness to disclose their abuse as well as inhibits their understanding of the way CSA impacts their lives, which has a systemic rippling effect on families and partnerships over generations.

This means that there is an underrepresentation of the male experience leads to a lack of services for those in need. When males start to reach out for help, they find services that only serve females or health care providers that are unsupportive. This can hinder recovery or cause regression. In addition, CSA has an economic effect on our healthcare system and our workforce.

### Literature Limitations and Future Directions

There were gaps in the research regarding cultural issues that impact disclosure as well as gaps in research on how the CSA of one individual family member by someone outside the family affects the dynamic of the family system. There is also a lack of ethnic diversity in research samples across the literature; this is not to say that non-Anglo communities do not experience male CSA, but rather it is not being talked about or studied. On average, studies that included ethnicity in this paper reported samples that were 85% white.

Further studies should examine factors that facilitate disclosure, explore helpful responses to disclosure, and understand survivors' history of disclosure. More research should include how disclosure affects long-term health and recovery. More research should study the male turning points towards recovery if recovery started after years of struggle or through less dramatic events. There is also potential for further research on the sexual well-being of male survivors of CSA.

## Conclusion

This meta-analysis revealed the underrepresentation of research on male survivors of childhood sexual abuse. Data shows that childhood sexual abuse can have long-term effects on a

person's mental, social, and physical health affecting their ability to adapt. Males with a history of CSA deal with immense shame, guilt, and low self-worth leading to maladaptive coping mechanisms such as avoidance and substance abuse. Research shows that males are more likely to struggle with PTSD, anxiety, depression, and suicide. There is also concern about the impact of CSA on the development of males' sexual well-being. Sexual well-being, emotional dysregulation, low self-esteem, and lack of trust can translate into relationship issues.

Secrecy perpetuates sexual abuse as abusers manipulate or threaten victims into silence. As a society, we avoid discussions of sexual abuse and/or keep them private. If this subject remains hidden, sexual abuse will continue to spread, and the victimization of children will continue. In other words, society is responsible for barriers to treatment, lack of support, delayed disclosure rates, and the mental well-being of males. Societal changes need to continue to shift to make room for male voices and their experiences.

Moving forward, how can we change the ways we talk about CSA as a society? How can we address the multifaceted stigma associated with it? How can we remain open to disclosures, while helping diminish shame and self-blame? How can we broaden our view of masculinity? How can we break the barrier of secrecy?

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