



The relationship between childhood sexual abuse and mental health outcomes among males: Results from a nationally representative United States sample

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ABSTRACT

Background: Few studies have examined the associations between childhood sexual abuse (CSA), co-occurrence with other types of maltreatment and adult mental health outcomes, specifically among males. The objectives of this study were to: 1) determine the prevalence of males who have experienced a) childhood maltreatment without CSA; b) CSA without other forms of childhood maltreatment; and c) CSA along with other forms of childhood maltreatment; and 2) determine the relationship between CSA among males and mood, anxiety, substance and personality disorders and suicide attempts.

Methods: Data were drawn from the 2004–2005 National Epidemiological Survey on Alcohol and Related Conditions (NESARC) and limited to males age 20 years old and older ($n = 14,564$). Child maltreatment included harsh physical punishment, physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect and exposure to intimate partner violence (IPV).

Results: Emotional abuse, physical abuse, and exposure to IPV were the most common forms of maltreatment that co-occurred with CSA among males. A history of CSA only, and CSA co-occurring with other types of child maltreatment, resulted in higher odds for many mental disorders and suicide attempts compared to a history of child maltreatment without CSA.

Conclusions: Child maltreatment is associated with increased odds of mental disorders among males. Larger effects were noted for many mental disorders and suicide attempts for males who experienced CSA with or without other child maltreatment types compared to those who did not experience CSA. These results are important for understanding the significant long-term effects of CSA among males.

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1. Introduction

Child sexual abuse (CSA) is common in the United States (U.S.) with an estimated prevalence between 2.5%–7.8% in males and 11.4%–13.5% in females (Finkelhor, Turner, Shattuck, & Hamby, 2013; Molnar, Buka, & Kessler, 2001). The long-term consequences of experiencing CSA can be devastating and have been well documented in the literature. Those who experience CSA are more likely to be diagnosed with mental disorders, (Afifi et al., 2011, 2014; Afifi, Henriksen, Asmundson, & Sareen, 2012; MacMillan, Tanaka, Duku, Vaillancourt, & Boyle, 2013; Molnar, Buka et al., 2001; Pérez-Fuentes et al., 2013; Walker, Carey, Mohr, Stein, & Seedat, 2004) have suicide-related behaviour (Afifi et al., 2014; Devries et al., 2014; Easton, Renner, & O'Leary, 2013; Holmes & Slap, 1998), and be at increased likelihood for experiencing adult victimization (Afifi et al., 2009; Desai, Arias, Thompson, & Basile, 2002).

Although research focusing on CSA has increased dramatically in the last three decades (Fergusson, McLeod, & Horwood, 2013), much of this literature considers only females, or uses samples that combine males and females. Only a small portion of literature has focused on CSA specifically among males, with many of these studies using small or non-representative samples (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Dimok, 1988; Easton et al., 2013; Ellerstein & Canavan, 1980; Fromuth & Burkhart, 1989; Holmes & Slap, 1998; Nalavany, Ryan, & Hinterlong, 2009; Valente, 2005). Results from these studies are further limited by restricted measures of other types of child maltreatment, most often only including physical abuse as a co-occurring type of abuse.

Experiencing CSA can result in negative outcomes in childhood, but can also result in long-term conditions that persist into adulthood. Research examining the long-term mental health sequelae following CSA has focused on comparing males to females or using non-stratified samples. These methodologies shift attention away from the relationship between CSA in males and long-term mental health sequelae, and towards the relative difference or similarities in mental health sequelae between males and females (Dhaliwal et al., 1996; Dube et al., 2005; Fergusson et al., 2013; Spataro, Mullen, Burgess, Wells, & Moss, 2004). Although it is understood that CSA is related to long-term mental disorders, it is currently unknown how CSA is linked to anxiety, substance use, mood, and personality disorders as well as suicide attempts in adulthood specifically among males using a representative general population sample.

The co-occurrence of different types of child maltreatment is common (Dong, Anda, Dube, Giles, & Felitti, 2003; Higgins & McCabe, 2001). However, it is unknown how often CSA among males occurs on its own and with other types of maltreatment. A previous study using a non-stratified sample of males and females showed that physical abuse, physical maltreatment, and physical neglect were significantly more prevalent among individuals with CSA than among those who did not experience CSA (Pérez-Fuentes et al., 2013). Experiencing more than one type of child maltreatment and/or childhood adversity can have cumulative effects and has been shown to increase the likelihood of emotional harm (De Marco, Tonmyr, Fallon, & Trocmé, 2007), suicidality (Afifi et al., 2014; Bryant & Range, 1996), and mental disorders (Afifi et al., 2014). It is unknown to what extent child maltreatment without CSA, CSA only, and CSA with other experiences of child maltreatment may increase the likelihood of long-term mental health sequelae. Additionally, most studies do not look at the co-occurrence of six types of child abuse and neglect (i.e., harsh physical punishment, physical abuse physical neglect, emotional abuse, emotional neglect, and exposure to intimate partner violence (IPV)) with the experience of CSA, which does not provide a complete picture of the relationship between CSA alone and in combination with other types of maltreatment and later mental health outcomes.

This study fills several important gaps in the literature by using a large, representative sample of males from the U.S., using a widely used and validated measure of CSA, examining the co-occurrence between six types of child maltreatment and CSA, and measuring the relationship between child maltreatment and mental disorders and suicide attempts using an additive child maltreatment variable that includes experiences of child maltreatment with and without CSA and CSA alone. The objectives of this study were to: 1) determine the prevalence of males who have experienced a) childhood maltreatment without CSA; b) CSA without other forms of childhood maltreatment and; c) CSA along with other forms of childhood maltreatment and; 2) determine the relationship between CSA among males and mood, anxiety, substance, personality disorders, and suicide attempts while adjusting for sociodemographic factors and history of family dysfunction.

2. Methods

2.1. Data and sample

Data were drawn from the second wave of National Epidemiological Survey on Alcohol and Related Conditions (NESARC) collected between 2004 and 2005. The second wave of the NESARC is a cross-sectional sample of 34,653 adults aged 20 years and older living in households and non-institutionalized settings. In this study, analyses were restricted to male respondents, resulting in a final sample of 14,564. Data were weighted to adjust for non-response, the selection of one person per household, the oversampling of specific groups, and then further adjusted to be representative of the U.S. population based on 2006 Census data (Grant et al., 2004). Data were collected through face-to-face interviews by trained lay interviewers of the U.S. Census Bureau. The response rate was 86.7%. Further details on the NESARC have been described elsewhere (Grant et al., 2003, 2004; Ruan et al., 2008).

2.2. Measures

2.2.1. Child maltreatment. Several types of child maltreatment, including sexual abuse, harsh physical punishment, physical abuse, exposure to IPV, physical neglect, emotional abuse, and emotional neglect, were assessed using questions adapted from the Adverse Childhood Experiences (ACE) survey (Dong et al., 2003; Dube et al., 2003). The original ACE questions were based on items from valid, psychometrically established measures designed to assess adverse childhood experiences using a survey methodology, including the Conflict Tactics Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Straus, 1979), the Childhood Trauma Questionnaire (Bernstein et al., 1994), and childhood sexual abuse items adapted from Wyatt (1985). All child maltreatment items, with the exception of childhood emotional neglect, were measured on a 5-point ordinal scale (*never, almost never, sometimes, fairly often, and very often*), and respondents were asked to report on experiences that occurred before the age of 18 years. Psychometrically established dichotomous coding was used to indicate the presence or absence of each type of child maltreatment based on the following criteria.

Sexual abuse was coded as present if the respondent reported having ever (i.e., any response other than *never* on the 5-point ordinal scale) experienced any unwanted sexual touching or fondling, or any attempted or actual intercourse by an adult or other person that was unwanted or occurred when the respondent was too young to understand what was happening.

Harsh physical punishment was coded as present if the respondent reported having *sometimes, fairly often, or very often* been pushed, grabbed, shoved, slapped, or hit by their parents or any adult living in their home. Physical abuse was coded as present if the respondent reported having ever (i.e., any response other than *never* on the 5-point ordinal scale) been hit so hard that it left marks, bruises, or caused an injury by a parent or other adult living in the home. Physical neglect was coded as present if the respondent reported having ever (i.e., any response other than *never* on the 5-point ordinal scale) been left alone or unsupervised before age 10; gone without needed things such as clothes, shoes, or school supplies because a parent or other adult living in the home spent the money on themselves; been made to go hungry or did not have regular meals prepared; and/or had a parent or other adult living in the home ignore or fail to get the respondent medical treatment.

Exposure to IPV was coded as present if the respondent reported having *sometimes, fairly often, or very often* witnessed their mother's partner (a) push, grab, slap, or throw something at their mother, or (b) kicked, bit or hit their mother with a fist or something hard, or if the respondent reported having ever (i.e., any response other than *never* on the 5-point ordinal scale) witnessed their mother's partner (c) repeatedly hit their mother for at least a few minutes or (d) threatened her with a knife or gun, or used a knife or gun to her hurt. Maternal perpetration of IPV was not assessed in the survey.

Emotional abuse was coded as present if the respondent reported having *fairly often* or *very often* experienced a parent or other adult living in the home swear at or insult the respondent; threaten to hit or throw something at the respondent, but didn't do it; and/or act in any other way that made the respondent feel afraid. Childhood emotional neglect was assessed on a similar 5-point ordinal scale (*never true, rarely true, sometimes true, and very often true*) based on the following five items: (a) the respondent felt there was someone in the family who wanted them to be a success, (b) someone in the respondent's family made them feel special or important, (c) the respondent's family was a source of strength or support, (d) the respondent felt part of a close knit family, and (e) someone in the respondent's family believed in them. Consistent with past research, these items were reverse-coded and summed; emotional neglect was coded as present if the total score for the emotional neglect items was 15 or greater (Afifi et al., 2011; Dong et al., 2003; Dube et al., 2003).

A four-category additive child maltreatment variable was also computed based on participant's responses to all of the individual child maltreatment items. For this variable, respondents were placed into one of four mutually exclusive categories: (1) no child maltreatment, (2) child maltreatment without CSA, (3) CSA only, and (4) CSA with other child maltreatment.

2.2.2. Family history of dysfunction. Family history of dysfunction was also based on items from the ACE study (Dong et al., 2003; Dube et al., 2003). A family history of dysfunction was coded as present if the respondent reported that a parent or other adult living in the home had a problem with alcohol or drugs, went to jail or prison, was treated or hospitalized due to mental illness, and/or attempted or completed suicide before the respondent was 18 years old.

2.2.3. Mental disorders. Lifetime diagnoses of mental disorders were made using a fully structured interview protocol called the Alcohol Use Disorder and Associated Disabilities Interview Schedule – Fourth Edition (AUDADIS-IV) (Grant et al., 2001; Ruan et al., 2008), based on DSM-IV criteria. Reliability and validity of the AUDADIS-IV have been established (Grant et al., 2003, 2004; Ruan et al., 2008). Dichotomous coding was used to assess the presence or absence each individual mental disorder based on AUDADIS-IV criteria. Mental disorders that were assessed in this study included mood disorders (i.e., major depression, dysthymia, mania, and hypomania), anxiety disorders (i.e., panic disorder, social phobia, specific phobia, generalized anxiety disorder, and post-traumatic stress disorder (PTSD)), and substance use disorders (i.e., alcohol abuse or dependence or illicit drug abuse or dependence). In addition, the personality disorders assessed included Cluster A personality disorders (i.e., paranoid, schizoid, and schizotypal), Cluster B personality disorders (i.e., antisocial, borderline, histrionic, and narcissistic), and Cluster C personality disorders (i.e., avoidant, dependent, and obsessive-compulsive). Composite variables for each of the different mental disorder categories were also created.

2.2.4. *Suicide attempt.* Each respondent was asked if they ever attempted suicide in their lifetime. This item was measured as a dichotomous yes or no variable.

2.2.5. *Sociodemographic covariates.* Sociodemographic covariates included age, marital status, race/ethnicity, education, past year household income, and a proxy indicator of childhood socioeconomic status (SES). Childhood SES was based on participant's response to the question: "Before you were 18 years old, was there ever a time when your family received money from government programs like welfare, food stamps, general assistance, Aid to Families with Dependent Children, or Temporary Assistance for Needy families?" (yes or no).

2.3. Statistical methods

Statistical weights were applied in all analyses to ensure that the NESARC data were representative of the general U.S. population. To account for the complex sampling design of the NESARC, Taylor series linearization was used as a variance estimation technique using Stata software. First, descriptive statistics were computed using cross tabulations and logistic regression models to examine the distribution of sociodemographic characteristics by CSA. Second, descriptive statistics using cross tabulations were computed to examine the co-occurrence of CSA with other types of childhood maltreatment and a family history of dysfunction. Logistic regression models were also computed to examine the association between CSA and other types of child maltreatment and a family history of dysfunction. Models were first run unadjusted (OR), and then adjusted for sociodemographic covariates (AOR). Third, descriptive statistics using cross tabulations were computed to examine the distribution of mental disorders by the four-level childhood maltreatment variable (i.e., no maltreatment; child maltreatment without CSA; CSA only; and CSA with other types of child maltreatment). Finally, multivariable logistic regression models were computed to examine the association of the four-level childhood maltreatment variable by mental disorders. Multivariable logistic models were adjusted for sociodemographic covariates and a family history of dysfunction. Additive effects of the four-category child maltreatment variable were tested by changing the reference groups in the multivariable logistic regression models. Significant differences between the child maltreatment groups are indicated by differing superscripts in the tables. Results at $p \leq 0.05$ were considered statistically significant and 95% confidence intervals are reported for all models. To account for the multiple comparisons, P values of $p \leq 0.01$ and $p \leq 0.001$ are also provided to interpret the models at a stricter statistical level for the more conservative reader.

3. Results

The prevalence of CSA among males was 5.3%. The four-category child maltreatment variable indicated that 58.1% of males experienced no child maltreatment, 36.7% experienced child maltreatment without CSA, 1.3% experienced CSA only, and 4.0% experienced CSA with other forms of maltreatment. The distribution of CSA by sociodemographic characteristics is provided in Table 1. The prevalence of CSA was significantly higher among respondents aged 40–69 years (vs. 70 years and older), those who were currently separated or divorced (vs. married or common-law), respondents self-identifying as American Indian or Alaskan Native, Black, and Hispanic (vs. White), and among respondents with both lower childhood SES and past-year total household incomes.

The presence of other forms of child maltreatment and a family history of dysfunction were strongly associated with CSA (Table 2). That is, the odds of experiencing CSA were significantly elevated in homes where other forms of child maltreatment or a family history of dysfunction were also present (odds ratios (ORs) range from 2.98 to 5.84, all $p \leq 0.001$). These relationships were attenuated, but remained statistically significant, after adjustment for sociodemographic covariates (adjusted odds ratios (AORs) ranged from 2.71 to 5.22, all $p < 0.001$).

The association between the four-level categorical child maltreatment variable and mood, anxiety, and substance disorders and suicide attempts is provided in Table 3. Child maltreatment increased the odds of all mental disorders and suicide attempts. With the exception of hypomania, alcohol abuse/dependence, and any substance use disorder, experiencing CSA only was significantly related to an increased odds of all mental disorders and suicide attempts compared to not experiencing child maltreatment after controlling for sociodemographic variables and a family history of dysfunction (AORs range from 1.77 to 8.57, $p \leq 0.05$). Examination of the differences across the child maltreatment categories indicated that CSA only and CSA with other types of maltreatment had significantly higher odds of major depression, dysthymia, mania, any mood disorder, panic disorder, generalized anxiety disorder, any anxiety disorder, and suicide attempts compared to child maltreatment without CSA. The strength of the association between CSA only was not statistically different from child maltreatment without CSA and was significantly lower compared to CSA with other types of child maltreatment for PTSD, alcohol abuse/dependence, and any substance use disorders.

The association between CSA, based on the four-category child maltreatment variable, and personality disorders is provided in Table 4. With the exception of schizoid personality disorder and borderline personality disorder, experiencing CSA only was associated with all personality disorders after adjusting for sociodemographic factors and family history of dysfunction (AORs ranged from 2.46 to 5.96 $p \leq 0.05$). Examination of the differences across child maltreatment categories indicated that CSA only and CSA with other types of maltreatment categories had significantly higher odds of schizotypal personality disorder, any Cluster A personality disorder, borderline personality disorder, narcissistic personality disorder, any Cluster B personality disorder, any Cluster C personality disorder, and any personality disorder compared to child maltreatment

Table 1
Sociodemographic Characteristics by Childhood Sexual Abuse History in a Nationally Representative Sample of Adult Males from the United States.

Sociodemographic Covariate	No Sexual Abuse % (n)	Sexual Abuse % (n)	OR (95% CI)
Age (years)			
20–29	95.7 (2020)	4.3 (96)	1.04 (0.72, 1.49)
30–39	94.4 (2492)	5.6 (161)	1.36 (0.98, 1.89)
40–49	94.3 (3067)	5.7 (217)	1.41 (1.05, 1.89) [†]
50–59	94.2 (2502)	5.8 (175)	1.44 (1.03, 2.00) [†]
60–69	94.2 (1691)	5.8 (103)	1.43 (1.04, 1.96) [†]
70 or older	95.9 (1814)	4.1 (93)	1.00
Marital Status			
Single (never married)	94.3 (2876)	5.7 (187)	1.22 (0.98, 1.52)
Separated/Divorced	91.8 (1869)	8.2 (166)	1.81 (1.42, 2.29) ^{***}
Widowed	94.6 (588)	5.4 (31)	1.16 (0.69, 1.94)
Married/Common-law	95.3 (8250)	4.7 (461)	1.00
Race/Ethnicity			
American Indian/Alaskan Native	89.6 (208)	10.4 (25)	2.32 (1.36, 3.98) ^{**}
Asian/Native Hawaiian/Pacific Islander	96.1 (398)	3.9 (20)	0.81 (0.48, 1.39)
Black	92.4 (2137)	7.6 (162)	1.66 (1.29, 2.13) ^{***}
Hispanic	93.8 (2504)	6.2 (186)	1.32 (1.02, 1.72) [†]
White	95.3 (8336)	4.7 (452)	1.00
Education			
Less than High School	94.3 (2107)	5.7 (126)	1.17 (0.89, 1.55)
High School	95.0 (3636)	5.0 (221)	1.02 (0.81, 1.28)
Some College/University	93.8 (2816)	6.2 (207)	1.29 (1.01, 1.64) [†]
Post-Secondary Degree	95.1 (5024)	4.9 (291)	1.00
Past Year Household Income			
Less than \$20,000	92.8 (2302)	7.2 (173)	1.63 (1.22, 2.18) ^{***}
\$20,000–\$39,999	94.3 (3332)	5.7 (222)	1.28 (1.04, 1.57) [†]
\$40,000–\$69,999	95.1 (3752)	4.9 (215)	1.08 (0.85, 1.36)
\$70,000 or more	95.5 (4197)	4.5 (235)	1.00
Government Assistance Receipt in Childhood			
Yes	90.1 (1740)	9.9 (201)	2.28 (1.86, 2.79) ^{***}
No	95.4 (11,723)	4.6 (631)	1.00

[†] ≤0.05.

^{**} ≤0.01.

^{***} ≤0.001.

Table 2
Co-Occurrence of Childhood Sexual Abuse with Other Forms of Maltreatment and Family History of Dysfunction in a Nationally Representative Sample of Adult Males from the United States.

Type of Childhood Maltreatment	No Sexual Abuse % (N)	Sexual Abuse % (N)	OR (95% CI)	AOR ^a (95% CI)
Harsh Physical Punishment	86.8 (2280)	13.2 (360)	4.02 (3.36, 4.81) ^{***}	3.70 (3.09, 4.43) ^{***}
Physical Abuse	81.1 (859)	18.9 (200)	5.18 (4.10, 6.55) ^{***}	4.43 (3.48, 5.63) ^{***}
Exposure to IPV	82.1 (1073)	17.9 (252)	5.10 (4.11, 6.32) ^{***}	4.37 (3.48, 5.50) ^{***}
Emotional Abuse	79.8 (860)	20.2 (215)	5.84 (4.59, 7.43) ^{***}	5.22 (4.08, 6.68) ^{***}
Emotional Neglect	87.4 (1055)	12.6 (173)	2.98 (2.37, 3.74) ^{***}	2.71 (2.13, 3.46) ^{***}
Physical Neglect	89.2 (3412)	10.8 (464)	3.57 (2.94, 4.33) ^{***}	3.30 (2.73, 3.98) ^{***}
History of Family Dysfunction	89.6 (3259)	10.4 (417)	3.12 (2.59, 3.76) ^{***}	2.77 (2.30, 3.34) ^{***}

^{***} ≤0.001.

^a AOR = Odds ratio adjusted for: age, marital status, race/ethnicity, education, income, and government assistance in childhood.

without CSA (AOR range from 2.68 to 7.86 $p \leq 0.001$). The odds for CSA only and CSA with other types of child maltreatment were not significantly different for any of the personality disorders.

4. Discussion

The significant findings from this study are: 1) of the males who experience CSA (5.3%), most experience CSA along with other types of child maltreatment (4.0%); 2) emotional abuse, physical abuse, and exposure to IPV were the most common forms of maltreatment that co-occurred with CSA; 3) a history of CSA only and CSA co-occurring with other types of child maltreatment, resulted in higher odds for many mental disorders and suicide attempts compared to a history of child maltreatment without CSA.

First, CSA more commonly occurred with other types of maltreatment than on its own. The odds of experiencing CSA were the largest with emotional abuse, physical abuse, and exposure to IPV after adjusting for sociodemographic variables

Table 3

The Association between Childhood Sexual Abuse History and Mood, Substance, Anxiety Disorders and Suicide Attempts in a Nationally Representative Sample of Adult Males from the United States.

Mental Disorders	No Child Maltreatment	Child Maltreatment without Sexual Abuse	Sexual Abuse Only	Sexual Abuse with Child Maltreatment
Major Depression				
% (n)	12.1 (1022)	18.7 (1037)	30.5 (56)	39.1 (228)
AOR ¹ (95% CI)	1.00	1.52 ^a (1.34, 1.71) ^{***}	3.22 ^b (2.13, 4.85) ^{***}	3.54 ^b (2.82, 4.45) ^{***}
Dysthymia				
% (n)	2.3 (192)	4.7 (274)	8.4 (18)	10.9 (74)
AOR (95% CI)	1.00	1.90 ^a (1.46, 2.48) ^{***}	3.80 ^b (2.08, 6.94) ^{***}	3.70 ^b (2.54, 5.41) ^{***}
Mania				
% (n)	2.9 (234)	6.5 (345)	13.4 (23)	16.0 (94)
AOR (95% CI)	1.00	2.01 ^a (1.59, 2.54) ^{***}	5.51 ^b (3.14, 9.68) ^{***}	4.15 ^b (2.84, 6.08) ^{***}
Hypomania				
% (n)	3.2 (266)	4.3 (236)	4.4 (8)	9.2 (51)
AOR (95% CI)	1.00	1.34 ^a (1.08, 1.67) ^{**}	1.46 ^{ab} (0.64, 3.35)	2.76 ^b (1.80, 4.25) ^{***}
Any Mood Disorder				
% (n)	15.6 (1297)	24.0 (1336)	35.7 (68)	47.0 (282)
AOR (95% CI)	1.00	1.56 ^a (1.41, 1.74) ^{***}	3.09 ^b (2.08, 4.59) ^{***}	3.66 ^b (2.89, 4.64) ^{***}
Panic Disorder				
% (n)	3.5 (295)	5.6 (296)	13.3 (24)	15.9 (84)
AOR (95% CI)	1.00	1.47 ^a (1.19, 1.82) ^{***}	4.18 ^b (2.45, 7.13) ^{***}	3.81 ^b (2.57, 5.65) ^{***}
Social Phobia				
% (n)	4.4 (363)	7.2 (398)	7.7 (18)	15.2 (95)
AOR (95% CI)	1.00	1.58 ^a (1.30, 1.92) ^{***}	1.81 ^{ab} (1.04, 3.17) [*]	2.91 ^b (2.09, 4.05) ^{***}
Specific Phobia				
% (n)	8.5 (714)	11.6 (652)	15.0 (32)	18.9 (109)
AOR (95% CI)	1.00	1.35 ^a (1.18, 1.56) ^{***}	1.87 ^{ab} (1.12, 3.11) [*]	2.09 ^b (1.52, 2.86) ^{***}
GAD ²				
% (n)	3.6 (305)	5.7 (308)	10.8 (22)	16.2 (97)
AOR (95% CI)	1.00	1.39 ^a (1.14, 1.69) ^{**}	3.09 ^b (1.72, 5.56) ^{***}	3.53 ^b (2.56, 4.85) ^{***}
PTSD				
% (n)	2.3 (213)	6.0 (350)	5.5 (16)	13.5 (87)
AOR (95% CI)	1.00	2.33 ^a (1.84, 2.94) ^{***}	2.33 ^a (1.25, 4.37) ^{**}	4.66 ^b (3.34, 6.52) ^{***}
Any Anxiety Disorder				
% (n)	16.6 (1389)	24.6 (1340)	35.6 (71)	42.8 (266)
AOR (95% CI)	1.00	1.53 ^a (1.38, 1.70) ^{***}	2.78 ^b (1.89, 4.10) ^{***}	3.00 ^b (2.36, 3.81) ^{***}
Alcohol Abuse/Dependence				
% (n)	43.8 (3537)	52.6 (2840)	46.8 (97)	60.9 (385)
AOR (95% CI)	1.00	1.40 ^{ab} (1.27, 1.54) ^{***}	1.13 ^a (0.80, 1.61)	1.72 ^b (1.37, 2.15) ^{***}
Drug Abuse/Dependence				
% (n)	12.5 (976)	19.6 (1031)	23.4 (44)	32.5 (205)
AOR (95% CI)	1.00	1.59 ^a (1.41, 1.78) ^{***}	2.32 ^{ab} (1.47, 3.65) ^{***}	2.53 ^b (1.92, 3.34) ^{***}
Any Substance Use Disorder				
% (n)	45.8 (3677)	55.5 (2990)	49.1 (104)	64.3 (407)
AOR (95% CI)	1.00	1.45 ^{ab} (1.32, 1.59) ^{***}	1.15 ^a (0.82, 1.63)	1.80 ^b (1.44, 2.26) ^{***}
Any Mood, Anxiety, or Substance Use Disorder				
% (n)	55.7 (4511)	67.2 (3670)	68.2 (140)	80.8 (511)
AOR (95% CI)	1.00	1.59 ^a (1.45, 1.73) ^{***}	1.77 ^{ab} (1.23, 2.55) ^{**}	2.80 ^b (2.00, 3.91) ^{***}
Suicide Attempt (Lifetime)				
% (n)	0.9 (79)	3.1 (191)	7.0 (13)	12.7 (76)
AOR (95% CI)	1.00	2.82 ^a (1.93, 4.11) ^{***}	8.57 ^b (3.81, 19.26) ^{***}	9.27 ^b (5.73, 15.00) ^{***}

Adjusted AOR with different superscripts indicate that the odds ratios were statistically significantly different at $p \leq 0.05$ (i.e., the same superscript letter indicates that the odds ratios were not statistically different from each other).

* ≤ 0.05 .

** ≤ 0.01 .

*** ≤ 0.001 .

¹ AOR = Odds ratio adjusted for: age, marital status, race/ethnicity, education, income, government assistance in childhood and history of family dysfunction.

² GAD = generalized anxiety disorder.

(AORs = 5.22, 4.43 and 4.37, respectively). This finding is important for health care practitioners so that inquiries about CSA are made when other types of maltreatment are disclosed. This may be especially important for discovering CSA among males, because it is an underreported type of abuse (Holmes & Slap, 1998). Stigma, confusion, and fear associated with CSA among males strongly contributes to secrecy and non-disclosure (Spataro, Moss, & Wells, 2001), therefore, normalizing and increasing the conversation around CSA among males in health care settings may facilitate higher disclosure rates. Without disclosure, the individual will not receive services, which may increase the likelihood of better mental health outcomes following experiences of CSA. Health care professionals should recognize the commonality of co-occurrence between other

Table 4

The Association between Childhood Sexual Abuse History and Personality Disorders in a Nationally Representative Sample of Adult Males from the United States.

Personality Disorders	No Child Maltreatment	Child Maltreatment without Sexual Abuse	Sexual Abuse Only	Sexual Abuse with Child Maltreatment
Paranoid PD ¹				
% (n)	2.4 (191)	4.7 (283)	7.2 (18)	11.4 (76)
AOR ² (95% CI)	1.00	1.81 ^a (1.40, 2.34) ^{***}	3.21 ^{ab} (1.60, 6.41) ^{***}	3.58 ^b (2.56, 5.01) ^{***}
Schizoid PD				
% (n)	2.3 (185)	3.9 (223)	4.4 (9)	7.1 (44)
AOR (95% CI)	1.00	1.56 ^a (1.19, 2.05) ^{**}	1.94 ^a (0.85, 4.41)	2.26 ^a (1.38, 3.69) ^{**}
Schizotypal PD				
% (n)	2.0 (188)	5.8 (340)	10.4 (23)	19.4 (114)
AOR (95% CI)	1.00	2.63 ^a (2.02, 3.43) ^{***}	5.59 ^b (3.29, 9.50) ^{***}	7.86 ^b (5.32, 11.63) ^{***}
Any Cluster A PD				
% (n)	5.7 (488)	11.5 (675)	16.5 (39)	27.5 (171)
AOR (95% CI)	1.00	1.93 ^a (1.61, 2.31) ^{***}	3.32 ^b (2.10, 5.25) ^{***}	4.54 ^b (3.31, 6.24) ^{***}
Antisocial PD				
% (n)	3.5 (258)	8.2 (428)	9.2 (17)	19.9 (106)
AOR (95% CI)	1.00	2.26 ^a (1.82, 2.80) ^{***}	3.09 ^{ab} (1.62, 5.90) ^{***}	5.10 ^b (3.61, 7.20) ^{***}
Borderline PD				
% (n)	3.1 (265)	7.5 (443)	15.3 (30)	21.1 (140)
AOR (95% CI)	1.00	2.16 ^a (1.75, 2.67) ^{***}	5.96 ^b (3.68, 9.64) ^{***}	5.25 ^b (3.84, 7.18) ^{***}
Histrionic PD				
% (n)	1.0 (80)	2.6 (133)	4.0 (8)	6.3 (44)
AOR (95% CI)	1.00	2.47 ^a (1.72, 3.55) ^{***}	4.34 ^{ab} (1.63, 11.61) ^{**}	4.83 ^b (2.80, 8.33) ^{***}
Narcissistic PD				
% (n)	5.0 (429)	10.2 (605)	16.4 (31)	20.3 (142)
AOR (95% CI)	1.00	2.00 ^a (1.68, 2.39) ^{***}	3.60 ^b (2.19, 5.90) ^{***}	3.76 ^b (2.88, 4.92) ^{***}
Any Cluster B PD				
% (n)	10.2 (826)	20.8 (1170)	28.2 (58)	43.4 (271)
AOR (95% CI)	1.00	2.14 ^a (1.87, 2.45) ^{***}	3.67 ^b (2.51, 5.38) ^{***}	5.17 ^b (4.06, 6.59) ^{***}
Avoidant PD				
% (n)	1.3 (96)	2.3 (125)	2.9 (8)	5.2 (34)
AOR (95% CI)	1.00	1.65 ^a (1.15, 2.36) ^{**}	2.46 ^{ab} (1.15, 5.24) [*]	2.85 ^b (1.70, 4.79) ^{***}
Dependent PD				
% (n)	0.2 (14)	0.3 (16)	0.3 (1)	1.6 (9)
AOR (95% CI)	1.00	1.03 ^a (0.36, 2.99)	1.11 ^{ab} (0.11, 11.17)	3.73 ^b (1.003, 13.87) [*]
Obsessive-Compulsive PD				
% (n)	6.3 (498)	9.6 (521)	15.1 (25)	17.8 (113)
AOR (95% CI)	1.00	1.50 ^a (1.28, 1.75) ^{***}	2.57 ^{ab} (1.49, 4.24) ^{***}	2.72 ^b (2.00, 3.70) ^{***}
Any Cluster C PD				
% (n)	7.1 (557)	10.8 (586)	17.0 (30)	19.8 (126)
AOR (95% CI)	1.00	1.49 ^a (1.28, 1.73) ^{***}	2.68 ^b (1.62, 4.34) ^{***}	2.66 ^b (2.00, 3.55) ^{***}
Any PD, n (%)				
% (n)	17.0 (1392)	29.2 (1636)	37.1 (80)	53.6 (335)
AOR (95% CI)	1.00	1.83 ^a (1.65, 2.04) ^{***}	2.94 ^b (2.06, 4.19) ^{***}	4.29 ^b (3.37, 5.46) ^{***}

Adjusted AOR with different superscripts indicate that the odds ratios were statistically significantly different at $p \leq 0.05$ (i.e., the same superscript letter indicates that the odds ratios were not statistically different from each other).

* ≤ 0.05 .

** ≤ 0.01 .

*** ≤ 0.001 .

¹ PD = personality disorder.

² AOR = Odds ratio adjusted for: age, marital status, race/ethnicity, education, income, government assistance in childhood and history of family dysfunction.

types of maltreatment and CSA, which can lead to greater awareness of the prevalence of CSA and aid with the disclosure of CSA among males.

Second, for many mental disorders and for suicide attempts, experiencing CSA only or CSA with other types of maltreatment resulted in a greater odds ratio compared to experiencing child maltreatment without CSA after adjusting for sociodemographic factors and family history of dysfunction. The lack of a significant difference between experiencing CSA only and CSA along with other types of child maltreatment may indicate that CSA has a particularly detrimental impact on mental health outcomes and suicide attempts compared to other types of maltreatment. Other studies have also found that CSA on its own has a strong relationship with mental disorders; however, these studies only measured one or two other types of maltreatment, unlike the six other types of maltreatment included in this study (Briere & Elliott, 2003; Molnar, Buka et al., 2001). Since alcohol abuse/dependence was highly prevalent across all groups in the four-level child maltreatment variable, there was a lack of variance between the groups which resulted in a non-significant odds ratio for CSA only. This should not be interpreted to mean that CSA is not associated with alcohol abuse/dependence, but rather that alcohol abuse is prevalent among all males in the U.S., regardless of experiences of child maltreatment.

There was a large and significant increase in the odds ratio associated with suicide attempts and CSA only compared to maltreatment without CSA (AOR = 2.82 for maltreatment without CSA and AOR = 8.57 for CSA only). Other studies have confirmed that CSA is associated with increased suicide attempts (Afifi et al., 2008; Molnar, Berkman, & Buka, 2001); however, no studies have looked at the relative difference in odds ratios between maltreatment without CSA, CSA only, and maltreatment with CSA. No other mental disorder included in this paper showed such a large difference in odds ratios between maltreatment without CSA and CSA with or without other types of maltreatment. This shows that CSA specifically has a significant and strong relationship with suicide attempts. It is important for health care practitioners to understand the association between CSA in males and suicide attempts so that suicidal behaviours are assessed and monitored in this population.

There are several factors associated with CSA that may contribute to the strong relationship between CSA and many mental disorders and suicide attempts. These include stigma, embarrassment, shame, and secrecy. Experiences of CSA among males challenge current masculine roles endorsed by Western society including dominance, being emotionally stoic, pursuit of status, winning, and heterosexuality (Easton et al., 2013; Mahalik et al., 2003). Experiences of CSA are often associated with feelings of fear, vulnerability, helplessness, and confusion which are not consistent with these masculine stereotypes (Spataro et al., 2001). Some male CSA victims may decide to over-assert their masculinity in attempts to internally reconcile their compromised masculine roles (Easton et al., 2013). However, strong adherence to masculine roles has been shown to be associated with greater psychological distress, but less willingness to seek treatment (Mahalik et al., 2003). Men who uphold the importance of adhering to masculine roles may feel embarrassed or ashamed of their experiences and refrain from disclosing abuse (Easton et al., 2013; Spataro et al., 2001). Secrecy associated with CSA experiences may lead to reluctance to seek mental health treatment and increased risk of experiencing mental health impairment including suicide attempts. Reducing the stigma and secrecy associated with CSA by increasing the frequency of conversation about CSA among males and understanding the prevalence and co-occurrence with other types of abuse may be an important first step in reducing the poor health outcomes associated with CSA among males.

There are several strengths of this study including: 1) the use of a large, representative data set from the general U.S. population; 2) the assessment of seven forms of child abuse and neglect using psychometrically established tools; 3) the adjustment for a family history of dysfunction; and 4) the examination of numerous mood, anxiety, substance use and personality disorders along with suicide attempts. There are also several important limitations in this study. First, the study is retrospective and cross-sectional in nature, resulting in the inability to produce causal inferences. Second, all data are self-report. Third, although the study adjusted for a family history of dysfunction, it did not adjust for adult stressors that could affect the presentation of mental disorders. Fourth, PTSD is no longer classified as an anxiety disorder in the DSM-V criteria, however, these data are based on the DSM-IV criteria, therefore we have included PTSD in our composite measure of any anxiety disorder. Fifth, there was a low prevalence of some mental disorders including hypomania, schizoid personality disorder and dependent personality disorder, leading to possibly underpowered analyses and the presentation of non-significant findings when significant ones may exist.

5. Conclusions

This research contributes to the small, but growing, literature on CSA among males. It is important to recognize the prevalence of CSA among males and its relationship to long-term mental health outcomes. CSA among males commonly co-occurs with other types of maltreatment, which is important knowledge for health care providers and to inform effective intervention strategies. However, it is also important to recognize that CSA can occur on its own. Experiencing CSA is related to increased odds of many mood, anxiety, substance and personality disorders, as well as suicide attempts. In many cases, the effect sizes for these poor mental health outcomes are stronger when CSA is experienced compared to other experiences of child maltreatment that do not include CSA. Focusing on prevention of CSA, intervention strategies to reduce stigma and secrecy associated with CSA, and promotion of resilience following CSA could potentially mitigate some of the mental health impairments among males.

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