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Article in *Child Abuse & Neglect* · January 2013

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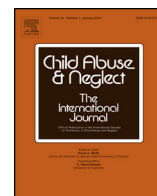


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Suicide attempts among men with histories of child sexual abuse: Examining abuse severity, mental health, and masculine norms[☆]

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ARTICLE INFO

Article history:

Received 28 March 2012

Received in revised form 30 July 2012

Accepted 19 November 2012

Available online 11 January 2013

Keywords:

Suicide attempts
Child sexual abuse
Male survivors
Masculine norms
Risk factors

ABSTRACT

Objective: Men who were sexually abused during childhood are at risk for a variety of long-term mental health problems, including suicidality. However, little is known about which factors are related to recent suicide attempts for this vulnerable, under-researched population. The purpose of this study was to examine the relationship between abuse severity, mental health, masculine norms and recent suicide attempts among men with histories of child sexual abuse (CSA).

Methods: We analyzed survey data gathered from a purposive sample of 487 men who were sexually abused during childhood. The age of the sample ranged from 19 to 84 years ($\mu = 50.4$ years). Recent suicide attempts served as the dependent variable in the study. Self-reported measures of sexual abuse severity, child physical abuse, mental health, masculine norms, and demographic information (age, race) represented the independent variables.

Results: The results from logistic regression modeling found that five variables – duration of the sexual abuse, use of force during the sexual abuse, high conformity to masculine norms, level of depressive symptoms, and suicidal ideation – increased the odds of a suicide attempt in the past 12 months.

Conclusion: To improve mental health services for men with histories of CSA, mental health practitioners should incorporate sexual abuse severity, current mental health, and adherence to masculine norms into assessment and treatment planning.

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Introduction

Globally, approximately one million people die from suicide each year (World Health Organization [WHO], 2012a). Between 1999 and 2007, suicide ranked as one of the top ten leading causes of death in the United States for age groups between 15 and 64 (Centers for Disease Control and Prevention [CDC], n.d.). Yet, these statistics do not include suicide attempts, which are nearly 20 times more frequent than completed suicides (WHO, 2012a). During 2008–2009, approximately 1 million US adults reported making a suicide attempt (CDC, 2011). Because men are more likely to complete suicide than women (Mościcki, 1994; WHO, 2012b), understanding factors contributing to suicide attempts is critical to addressing the high rate of mortality among men.

A growing body of research has found that child sexual abuse (CSA) is a salient risk factor for later suicide attempts among adolescent and adult males and females (Bedi et al., 2011; Dube et al., 2005; Martin, Bergen, Richardson, Roeger, & Allison,

[☆] The study received financial support from the John A. Hartford Foundation (Geriatric Social Work Initiative).

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2004; see also meta-analysis by Paolucci, Genuis, & Violato, 2001). Although prevalence rates vary depending on methodological issues, studies have found that approximately 15% of adult men reported a history of CSA (Briere & Elliot, 2003; Dube et al., 2005; Lisak, Hopper, & Song, 1996). Compared to men without histories of CSA, suicide attempts were 4–11 times higher for men with histories of CSA (Molnar, Berkman, & Buka, 2001). However, most studies that focused on the association between CSA and suicide attempts compared samples of individuals with and without histories of CSA. Consequently, little is known about which factors are associated with suicide attempts among adult survivors of CSA generally. Additionally, the majority of research on adult survivors of CSA has focused on females (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Holmes & Slap, 1998; Spataro, Moss, & Wells, 2001). Because men with histories of CSA are a vulnerable, under-researched group, the purpose of this study was to explore risk factors for suicide attempts within this population including characteristics of CSA, childhood physical abuse (CPA), gender norms, and mental health. The results of the current study will strengthen the knowledge base, provide directions for future research, and identify suggestions for clinical practice.

Childhood physical abuse and sexual abuse severity

Adverse events experienced during childhood, which include CSA, have been linked with later suicide attempts (Afifi et al., 2008; Dube et al., 2001). After controlling for the effects of mental health disorders and other adverse childhood events in a nationally representative sample ($N = 5,877$; ages 15–54), Molnar et al. (2001) found that 8–12% of suicide attempts were independently attributed to CSA. Focusing on the effects of different types of child abuse, Joiner et al. (2007) found that childhood physical and violent sexual abuse imposed greater risk for future suicide attempts than molestation and verbal abuse. Andover, Zlotnick, and Miller (2007) found that individuals with a history of suicide attempts were more likely to report histories of CSA or CPA compared to individuals without a history of attempts. Brezo et al. (2008) found that young adults who experienced both CSA and CPA had 5–14 times greater risk of suicide attempts. Similarly, Fergusson, Boden, and Horwood (2008) found that both CSA and CPA were associated with suicidal ideation and attempts; however, the effects of CPA were weaker and less consistent.

These findings lend some support to the interpersonal theory of suicidal behavior (Joiner, 2005; Van Orden et al., 2010). The core idea behind this theory is that, in order to die by suicide, individuals must acquire the capability for suicide through a reduced fear associated with suicidal behaviors. The capability for suicidal behavior emerges through habituation in response to repeatedly painful and fearful experiences, and over time, an individual can tolerate increasingly painful and potentially lethal forms of self-harm (Van Orden et al., 2010). Experiences of childhood abuse, especially when severe, have the potential to be both fear-inducing and extremely physically painful (Joiner et al., 2007). In a sample of men with histories of CSA, O'Leary and Gould (2009) found that physical injuries and invasive sexual abuse (i.e., penetration) were positively correlated with both suicidal ideation and suicide attempts. Thus, according to the theory, types of childhood abuse that are more painful and more severe – such as physical and sexual abuse – are more salient risk factors for suicide than other, less physically painful, forms of abuse. In the current study we hypothesized that the use of physical force during CSA, the frequency of CSA, and having experienced CPA would be positively related to suicide attempts.

Gender norms

The experience of CSA can profoundly impact the gender identity of male survivors by causing identity confusion, self-blame, and shame (Holmes & Slap, 1998; Hunter, 1991; Lisak, 1994; Nasjleti, 1980). One reason for this is that CSA violates many socially sanctioned gender expectations in Western culture which include dominance, winning, heterosexuality, emotional control or stoicism, and pursuit of status (Mahalik et al., 2003). Male survivors who adhere to these expectations may believe that being a victim is wholly un-masculine (Lisak, 1993). Being abused by another male may heighten feelings of stigma, shame, and internalized homophobia (Heath, Bean, & Feinhauer, 1996; Mahalik et al., 2003; Spataro et al., 2001) and increase the survivor's fear that he won't be believed or will be labeled a homosexual if he discloses the sexual abuse (Alaggia, 2005; Banyard, Williams, & Siegel, 2004). Men with histories of CSA often delay disclosure for years and even decades (Holmes & Slap, 1998; O'Leary & Barber, 2008; Spataro et al., 2001; Ullman & Filipas, 2005). Rather than attempting to understand, address, and reconcile the internal conflict over masculinity, some male survivors adopt a different approach: hegemonic masculinity or hyper-masculinity (Dorais, 2002; Lisak, 1994). In these cases, men guard the secret of CSA through behaviors designed to prove or reassert their masculinity according to stereotypical norms (i.e., excessive conformity).

A consistent pattern is emerging in the literature on male gender norms: conformity to traditional masculine norms is positively related to psychological distress. Mahalik et al. (2003) found that conformity to masculine norms predicted global psychological distress and that several types of traditional male norms (e.g., dominance, self-reliance, risk-taking) were related to specific mental health problems such as depression, somatization, hostility and anxiety. Theodore and Lloyd (2000) found that norms, such as emotional restrictiveness, were positively related to depression, anxiety, and stress and negatively related to well-being. Although our literature review identified some studies that focused on masculinity and suicidal thoughts (e.g., Hunt, Sweeting, Keoghan, & Platt, 2006), we did not identify any studies that examined the relationship between conformity to masculine norms and suicidality among men with histories of CSA. Men who adhere to traditional norms such as emotional control or restrictiveness may isolate themselves from others. Furthermore, norms such as risk-taking and violence may propel an individual to take drastic actions and transition from suicidal ideation to a

suicide attempt. For these reasons, in the current study we hypothesized that high conformity to masculine norms will be related to an increased risk of a suicide attempt in the past year.

Current mental health

Among adults, having a depressive disorder has been cited as a risk factor for suicide attempts. Using data from the National Comorbidity Survey, Nock and Kessler (2006) found that risk factors for suicide attempts included being male and having a major depressive episode. Another study found that among individuals with a major depressive disorder, the recognition of having a mental health condition increased the risk of suicidal ideation and attempts (Gonzalez, 2008). A growing body of research has found that CSA is related to long-term mental health problems for men including depression (for reviews, see Holmes & Slap, 1998; Putnam, 2003; Spataro et al., 2001). In one study, O'Leary (2009) found that men with histories of CSA were up to 10 times more likely to be classified as meeting clinical thresholds for psychiatric complaints, including severe depression, than men from a comparison community sample. Thus, we hypothesized that the level of depressive symptoms would be related to an increased risk of a suicide attempt in the past year.

Suicide ideation has also been found to be related to suicidal behavior. The results of a cross-national study with data from 17 countries revealed the lifetime prevalence of suicidal ideation, suicide plans and suicide attempts to be 9.2%, 3.1% and 2.7%, respectively (Nock et al., 2008). The probability of a suicide attempt is greater for individuals who express suicidal ideation with a plan compared to those who express suicidal ideation without a plan (Nock et al., 2008). Because suicidal behavior often follows a progression from thoughts through attempts (van Heeringen, 2001), we hypothesized that suicidal ideation in the past year would be related to an increased risk of a suicide attempt in the past year.

As previously noted, few studies have concentrated on identifying risk factors for suicide attempts specifically within a sample of men with histories of CSA. Thus, the purpose of this study was to identify risk factors among this under-researched population. Using aspects from the interpersonal theory of suicide and previous empirical research to guide our selection of salient risk factors, we included characteristics of the sexual abuse, the presence of CPA, depressive symptoms, suicidal ideation, and masculinity. Research that identifies risk factors for suicide attempts for this population can inform suicide prevention and treatment services.

Methods

Data source

This study used a cross-sectional survey design with purposive sampling from three national organizations devoted to raising awareness of CSA among men. The three organizations were the Survivors Network of those Abused by Priests (SNAP), MaleSurvivor, and 1in6.org. Founded in 1989, SNAP is the nation's oldest and largest support and advocacy organization for adults who were sexually abused by religious authority figures (e.g., priests, ministers, rabbis, nuns). The organization has approximately 9,000 members who belong to local affiliates in each state. Although demographic information was not available on its membership, SNAP leaders estimated that approximately two-thirds of its members are CSA survivors (B. Dorris, personal communication, October 13, 2008). MaleSurvivor was incorporated in 1995 by a group of mental health professionals committed to helping men recover from sexual victimization through education, research, treatment, and advocacy. Due to privacy concerns, membership information was not available to the researchers. However, most members are mental health professionals, survivors, advocates or family members. The third organization (1in6.org) was founded in 2007 and is dedicated to helping men recover from unwanted or abusive sexual experiences from childhood. This organization does not have a formal membership. Instead, most of its efforts focus on providing online resources to promote recovery (e.g., educational materials, therapist locator, training for support group facilitators).

Each organization posted a study announcement on their website home page and SNAP also sent recruitment emails to its members. Potential participants were directed to a survey website with a welcome message, consent letter, and eligibility screening questions. Participants were eligible for inclusion in the study if they were: male, 18 years of age or older, and sexually abused before the age of 18. Interested, eligible participants then completed an anonymous, internet-based survey during an eight week period in the summer of 2010. There was no compensation for participation in the study.

The study received human subjects approval from the Institutional Review Board at a Midwestern university. Due to the sensitive nature of the survey topics, several safeguards were instituted to protect the safety and privacy of the participants (e.g., suicide prevention hotline, therapist locator, list of community mental health centers). Prior to implementation, the study survey was pre-tested in three phases over a two-year period with input from national sexual abuse and trauma experts, clinicians, and graduate students in social work. The final survey consisted of 137 items and the current study utilized a subset of items from the larger survey.

Sample

The sample consisted of 487 men with histories of CSA ranging in age from 19 to 84 years ($\mu = 50.4$ years). The majority of participants identified their race as Caucasian (90.9%). The remaining participants indicated that they were bi-racial (2.9%), African-American (1.0%), Native-American (1.0%), Asian (0.4%), Pacific Islander (0.4%), or belonged to another race (3.3%). A

separate question measured ethnicity; 5.6% of participants indicated that they were Hispanic. The mean age that participants were first sexually abused was 10.3 years. Most participants were abused by a clergy member (61.5%); approximately one in ten participants was abused by a biological family member (11.4%). Most of the participants were members of SNAP (59.3%), MaleSurvivor (15.9%), or both groups (5.6%).

Measures

Suicide attempts. The dependent variable, suicide attempts, was measured using one item from the General Mental Health Distress Scale (GMDS; Dennis, White, Titus, & Unsicker, 2007). The GMDS is a symptom count of internal sources of distress that were experienced in the past 12 months related to depression, anxiety, somatization, and suicidal thoughts. The scale has high internal consistency ($\alpha = .90$), has demonstrated an ability to detect differences in symptom patterns by gender, race, age, and other factors, and has produced scores that generally increase with age (Conrad, Dennis, Riley, & Funk, 2009). The item for suicide attempts stated: “During the past 12 months, have you attempted to commit suicide?” (no = 0, yes = 1).

Childhood abuse variables. Three variables measured characteristics of abuse during childhood: *frequency* (of sexual abuse), *use of force* (during sexual abuse), and *physical abuse*. The item for *frequency* asked “About how many times were you sexually abused by the abuser?” The five response choices ranged from one time (1) to more than 20 times (5). The item for *use of force* (during the sexual abuse) read: “Did the abuser use physical force?” (no = 0, yes = 1). After responding to questions pertaining to experiences of CSA, *physical abuse* was later measured with the following item: “Were you physically abused by someone close to you (while you were a child or a teenager)?” (no = 0, yes = 1).

High conformity to masculine norms. The Conformity to Masculine Norms Inventory (CMNI-22; Mahalik et al., 2003) is an abbreviated version of the original 94-item Conformity to Masculine Norms Inventory (CMNI; Mahalik, 2000; Mahalik et al., 2003) and is used to measure overall conformity to 11 traditional male norms such as emotional control, risk-taking, self-reliance, primacy of work, and heterosexuality. For each item, participants were asked how much they agreed with statements based on a 4-point Likert scale ranging from strongly disagree (1) to strongly agree (4). Some examples of statements included: “My work is the most important part of my life,” “It is important to me that people think I am heterosexual,” and “I tend to share my feelings.” Nine of the items were reverse-coded so that higher agreement on each item equated to higher conformity to masculine norms. Scores on the 22 items were then added together to create a total score (range = 22–88). The total score was later transformed into an average score (CMNI Average) which ranged from 0 to 4. The CMNI-22 has demonstrated good internal consistency in prior studies (Burns & Mahalik, 2008; Rochlen, McKelly, Suizzo, & Scaringi, 2008) and good reliability in the current sample (Cronbach’s $\alpha = .71$).

During diagnostic testing, it appeared that there was a curvilinear relationship between CMNI and the dependent variable. A polynomial term (CMNI Squared) was created that confirmed this u-shaped distribution. A visual inspection of the distribution of CMNI Squared using a scatterplot diagram found that most of the action occurred on the right side of the curve (i.e., high conformity). A new dichotomous variable, *CMNI High* (no = 0, yes = 1), was created which identified whether participants scored in the top 20% on conformity to masculine norms.

Mental health variables. *Depressive symptoms* were measured using the nine-item Depression Symptom Scale derived from the GMDS (Dennis et al., 2007). Some of the items included: “feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future,” “feeling tired, having no energy, or feeling like you could not get things done”, and “losing or gaining ten or more pounds when you were not trying.” Participants received a score of one for each endorsed item (no = 0). The scores for the nine items were then added to create the Depression Symptom Scale (range = 0–9) with higher scores indicating a higher level of depression. The Cronbach’s α for this measure in the current study was .80. *Suicidal ideation* was measured using one item from the GMDS (Dennis et al., 2007). The item for suicidal ideation stated: “During the past 12 months, have you thought about ending your life or committing suicide?” (no = 0, yes = 1).

Control variables. To measure the level of *education*, participants were presented with eight response choices ranging from 1 (less than high school diploma) to 8 (doctorate or professional degree). The item on race asked participants to choose from six response choices. Because of small cell size, a new variable (*racial minority*) was created which combined participants who reported a race other than white/Caucasian (no = 0, yes = 1). To control for the time that had elapsed since the first sexual abuse event, a new variable (*time since sexual abuse*) was created by subtracting current age from age at the time of the first sexual abuse.

Data analysis

Data were cleaned and imported into a data file in SPSS 19.0. There were very little missing data in this study (<3%) and data appeared to be missing at random. Diagnostic tests were conducted prior to inferential testing to examine potential problems such as influential outliers, nonlinearity, and multicollinearity. Unless otherwise indicated, the results indicated that the assumptions were met for statistical tests. After performing univariate and bivariate analyses, logistic regressions were conducted.

Table 1
Descriptive statistics for key variables.

Variable	%	Mean (SD)	Range
Education		5.33 (1.78)	1–8
Race (% minorities)	9.1		
Time since sexual abuse (years)		40.1 (10.9)	9–76
Current age		50.37 (10.82)	19–84
Frequency of child sexual abuse			
One time	17.3		
2–5 times	22.8		
6–10 times	7.4		
11–20 times	6.4		
More than 20 times	46.1		
Use of force (during sexual abuse)	36.3		
Childhood physical abuse	45.4		
High conformity to masculine norms	20.9		
Depressive symptoms		5.68 (2.56)	0–9
Suicidal Ideation	44.2		
Suicide Attempts	4.6		

Table 2
Logistic regression results for suicide attempts.

Variable	β	SE	O/R	(95% CI)
Education	-.42*	.15	.66	(.49, .88)
Racial minority	.90	.72	2.47	(.60, 10.13)
Time since sexual abuse	.01	.03	1.01	(.95, 1.06)
Frequency of sexual abuse	.56*	.23	1.74	(1.11, 2.74)
Use of force (during sexual abuse)	1.13*	.57	3.08	(1.01, 9.42)
Childhood physical abuse	-.10	.61	.91	(.27, 3.00)
High conformity to masculine norms	1.18*	.60	3.27	(1.02, 10.52)
Depressive symptoms	.54*	.20	1.71	(1.15, 2.56)
Suicidal ideation	2.05*	.80	7.79	(1.62, 37.57)

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Results

Table 1 presents the descriptive results for the variables of interest in the study. Table 2 presents the results of the multivariate logistic regression model. Of the three variables related to characteristics of child abuse, two were positively related to suicide attempts: the use of force by the abuser during the sexual abuse and the frequency of the sexual abuse. The use of force variable had a coefficient of 1.13 and an odds ratio of 3.1 (CI = 1.01, 9.42). This indicated that if the abuser used physical force during the sexual abuse, the odds of a suicide attempt in the past year by the survivor increased by slightly more than 200%. The frequency of the sexual abuse had a coefficient of .56 and an odds ratio of 1.74 (CI = 1.11, 2.74). This indicated that if the sexual abuse occurred more than one time, then the odds of a suicide attempt in the past year increased by 74% for each of the other four frequency categories. Interestingly, physical abuse during childhood was not significant.

Two variables measuring current mental health were significant in the model: depressive symptoms and suicidal ideation. With a coefficient of .54 and an odds ratio of 1.71 (CI = 1.15, 2.56), each depressive symptom increased the odds of a suicide attempt in the past year by 71%. If the participant indicated that he had thought about suicide in the past year, then the odds of a suicide attempt in that timeframe increased dramatically ($\beta = 2.05$; O/R = 7.79; CI = 1.62, 37.57). High conformity to masculine norms was also related to suicide attempts ($\beta = 1.19$; O/R = 3.30; CI = 1.02, 10.52). Participants whose responses to masculine norms met the criteria for high conformity were 230% more likely to endorse a suicide attempt in the past year than participants who did not meet the criteria for high conformity to masculine norms. One of the control variables – level of education – was negatively related to suicide attempts ($\beta = -.42$, O/R = .66).

Discussion

Based on the interpersonal theory of suicidal behavior (Joiner, 2005; Van Orden et al., 2010), adverse child events such as severe CSA and CPA may reduce the fear of self-harm and increase the likelihood of suicidal behavior. Additional factors such as mental health problems (e.g., depressive symptoms, suicidal ideation) and high conformity to masculine norms may further contribute to the risk of suicide attempts. However, few scholars have explored these factors among adult male survivors of CSA. Thus, the purpose of this study was to identify factors that were associated with recent suicide attempts within a sample of men with histories of CSA.

Of the nine variables included in our model, five variables were related to an increased risk of a suicide attempt in the past year: frequency of the sexual abuse, use of force during the sexual abuse, high conformity to masculine norms, level of depressive symptoms, and suicidal ideation. The finding that the level of education was negatively related to a recent suicide attempt was somewhat expected. The age-adjusted prevalence of suicide attempts has been found to decrease with higher levels of educations (Dube et al., 2001) and a larger percentage of suicides occur among people with lower levels of education (Fernquist, 2001).

In this sample, men who were more frequently sexually abused and whose experience of CSA involved the use of force had a higher risk of a suicide attempt in the past year. These findings were consistent with the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) and prior empirical studies (Boudewyn & Liem, 1995). These male survivors endured more severe forms of sexual abuse which may have contributed to a habituation to pain. As a result, these men may have been less fearful of pain (or even death) due to self-harm later in life than other men in the sample whose CSA was not as frequent or did not involve the use of force. In clinical work with male survivors of CSA, mental health practitioners should assess for the frequency of sexual abuse and the use of force during the sexual abuse. Although it may be emotionally difficult for men to recount details of CSA when seeking clinical services, the findings in this study suggest that knowledge of CSA characteristics could be important in suicide assessment and prevention.

Although CPA was correlated with a recent suicide attempt in our bivariate analysis, it was not significant in our multivariate model. This finding was unexpected and inconsistent with other empirical studies (Andover et al., 2007; Fergusson et al., 2008; Joiner et al., 2007). It is possible that a higher frequency of CSA or the use of force was enough to habituate the men to pain, thereby increasing the odds of a suicide attempt in our sample. More research is needed to clarify the role of physical abuse and suicide attempts among men with histories of CSA.

In this study, men who met criteria for high conformity to masculine norms had an increased risk of attempting suicide in the past year. This finding was consistent with previous research in the general population (Good et al., 1995; Mahalik et al., 2003; Theodore & Lloyd, 2000). However, the current study extended this research to men with histories of CSA. Although many men with histories of CSA are internally conflicted and struggle with issues of self-blame, anger, and shame, those who adhere to rigid gender norms may restrict their emotional expression and refuse to discuss their feelings with others. Furthermore, there are numerous obstacles to help-seeking for male survivors of CSA (Spataro et al., 2001) such as fears of not being believed, being blamed, or being labeled as a homosexual. It is plausible that male survivors with high conformity to masculine norms isolate themselves from others, and isolation has been found to be related to suicide attempts for this population (O'Leary & Gould, 2009). Public health initiatives focused on men's mental health and high rate of suicidality should include a history of CSA as a contributing factor and education programs should promote community awareness of the occurrence of CSA for boys and its potential impact on mental health and suicidality for adult survivors.

In clinical work, mental health providers could assess the client's level of adherence to traditional gender norms. For men who highly conform to traditional masculine expectations, practitioners can help men deconstruct these norms and understand how they may impair mental health or recovery from CSA. Mental health providers can also help connect the client to support and recovery resources such as national survivor organizations, support groups, or self-help books to help lessen feelings of isolation.

As expected, both the level of depressive symptoms and the presence of suicidal ideation increased the risk of suicide attempts in the past year among our sample. These findings were consistent with previous research that has established a relationship between depression and suicide attempts (Nock & Kessler, 2006). One common feature of depression is a pervasive feeling of hopelessness or despair, an important mechanism in the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010). Given that suicidality often follows a progression from thoughts to plans to attempts (van Heeringen, 2001), the duration of the suicidal process is shorter for men than women (Schrijvers, Bollen, & Sabbe, 2012), and the highest risk for a suicide attempt is within the first year after the onset of suicidal ideation (Nock et al., 2008), it is imperative that men with histories of CSA who exhibit signs of depression be carefully screened for both suicidal ideation and attempts in a timely manner and provided intervention services in concordance with the level of suicidal risk.

Limitations

In interpreting the results of the study, there are several limitations that should be considered. First, the analysis is based on data collected through retrospective self-reports from adult men with a history of CSA. Because several of the variables measured events that occurred many years (or even decades) prior to the study, it is possible that memory deterioration reduced the accuracy of responses. Due to privacy and logistic concerns, it was not possible to triangulate the data through other sources in the current study. However, the survey items were reviewed by a panel of experts and written to elicit meaningful responses in light of the retrospective design.

Second, the study was based on a purposive sample of men with histories of CSA and is not necessarily representative of male CSA survivors in the general population. Because of the recruitment strategy to reach this population, most participants were members of a survivor organization (81.8%) and sexually abused by a member of the clergy (61.5%). It is possible that male survivors of CSA with more severe mental health problems are more inclined to join such organizations to manage mental distress. Additionally, due to privacy concerns and lack of organizational data on members, it was not possible to calculate a survey response rate in this study. Although this recruitment strategy introduced selection bias (e.g., non-response bias, survivor group membership bias) that limits generalizability of the results, it was essential to reach a stigmatized,

hidden, and understudied population. Furthermore, post hoc analyses indicated that neither membership in a survivor organization nor abuse by a clergy member was related to a suicide attempt in the past year. Nonetheless, future research should build on this study and explore suicidality with a probability sample of male CSA survivors.

Third, measurement issues should be considered when interpreting the results of this study. For example, some of the concepts that were measured were not explicitly defined in the survey (e.g., use of force during CSA, the occurrence of CPA). Although the items for these two measures were situated in different sections of the survey, it is possible that some participants had difficulty differentiating between them. To increase the accuracy of results, future studies should incorporate operational definitions of the concepts. Additionally, some concepts were measured using single items (e.g., suicidal ideation, suicide attempts) drawn from the same instrument. Although this may not be ideal in terms of data analysis, including suicidal ideation in predicting recent suicide attempts is supported by the notion of suicidal progression. However, future research could utilize standardized, multiple-item measures of these concepts (e.g., Scale for Suicidal Ideation; Beck, Steer, & Ranieri, 1988) to increase the validity of the results.

Despite these limitations, the current study makes important contributions to our understanding of suicidal behavior among men with histories of CSA. The results provide practitioners with insights into factors that can heighten the risk for attempting suicide for this vulnerable population. Consistent with previous studies and theory, we found that two factors related to CSA (i.e., higher frequency, use of force) and two factors related to mental health (i.e., depressive symptoms, suicidal ideation) significantly increased the odds of a suicide attempt in the past year. Previous studies have found that adherence to traditional masculine norms can impair mental health for men in the general population and complicate recovery from CSA. This study, however, extended our knowledge by finding that rigid adherence to masculine norms can potentially be life-threatening. Moreover, this research adds to a growing body of evidence that underscores the importance of improving public health policies and service provision to meet the needs of men who were sexually abused in childhood.

Acknowledgment

The authors are grateful for the generosity and courage of the men who participated in this study.

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