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Male Childhood Sexual Abuse, Self-Compassion, and Trauma Symptoms

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Abstract:

Objectives: There is limited research that has examined self-compassion among adult males who have experienced childhood sexual abuse. The current study investigated the potential role of self-compassion on post-traumatic stress symptoms in this population. In addition, we helped advance knowledge in the area of childhood sexual abuse by focusing on a range of sexual abuse characteristics (e.g., duration, relationship between the child and perpetrator) and by including other experiences of maltreatment (given that most victimized individuals have been exposed to more than one type).

Methods: Participants were recruited from across Canada and the U.S. through websites for males with histories of childhood sexual abuse. Data were collected from 213 adult males who anonymously completed an on-line study.

Results: Regression analyses indicated that childhood sexual abuse that was longer in duration and involved the use (or threat) of physical violence was associated with greater post-traumatic stress, as were the presence of emotional abuse and the absence of exposure to intimate partner violence. Once self-compassion was taken into account, these associations were no longer significant, with the exception of emotional abuse. Moreover, greater self-compassion was associated with fewer symptoms of post-traumatic stress, and it predicted 18% of the variance.

Conclusion: Future research needs to continue examining the role of self-compassion on adult males' maltreatment-related psychosocial outcomes. It also needs to take into account sexual abuse characteristics and other forms of maltreatment, given the common co-occurrence of different maltreatment types among children who experience victimization.

Implications: Findings point to the importance of including self-compassion interventions as part of one's clinical work with adult males who have experienced childhood sexual abuse. It is also important to understand the full nature of individuals' sexual abuse experiences as well as any other forms of maltreatment to which they may have been exposed.

Keywords:

Sexual abuse, trauma, resilience, male mental health, sexual violence among males, sexual exploitation

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Introduction

The Criminal Code of Canada (1985, s.163.1) defines childhood sexual abuse as any sexual activity occurring before the age of 16. The sexual activity can include contact (e.g., penetration, sexual touching) or non-contact (e.g., exposure to sexual material) behaviours, and perpetrators can encompass family or non-family members that are adults, adolescents, or even older children (Berliner, 2011; Dube et al., 2005; Holmes & Slap, 1998). Research studies on the prevalence of childhood sexual abuse have considerable methodological variability in the definition of sexual abuse, the population from which the sample is drawn (e.g., clinical, community), and the data collection method (e.g., retrospective versus prospective design, self-report questionnaires versus child welfare data). Consequently, prevalence rates also show considerable variability. For males, Hopper's (2014) review indicated that the prevalence of childhood sexual abuse ranged from 4.8-28% among university students, 2.8-16% among community-based males, and 3-23% among clinical samples. Additional review studies suggest that the mean prevalence of male sexual abuse ranges from 7.9% (Pereda, Guilera, Forns, & Gomez-Benito, 2009) to 16% (Dube et al., 2005). In general, a well-accepted statistic is that approximately 1 in 6 males experiences sexual abuse during childhood (Romano & De Luca, 2014). This statistic, however, is likely an underestimation as there are roughly four times as many cases of childhood sexual abuse that are not reported to child welfare and/or criminal justice authorities (Justice Department of Canada, 2012; Romano & De Luca, 2014). Given that childhood sexual abuse is not uncommon among males and that this population has been relatively under-studied in the

childhood sexual abuse literature (Hopper, 2014; Spataro, Moss, & Wells, 2001), the current study focused on adult males with histories of childhood sexual abuse.

Childhood Sexual Abuse and Later Mental Health Functioning

The first objective was to examine the association between characteristics of childhood sexual abuse and post-traumatic stress symptoms. The link between childhood sexual abuse and later mental health impairments is well-established (Dube et al., 2005; Romano & De Luca, 2001; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Spiegel, 2003). In a review of meta-analyses conducted between 1985 and 2009 on the relationship between childhood sexual abuse and adult psychopathology (Hillberg, Hamilton-Giachritsis, & Dixon, 2011), findings from the seven identified meta-analyses indicated that individuals who had experienced sexual abuse during childhood were at increased risk for a variety of mental health difficulties, including anxiety, depression, substance use, post-traumatic stress, interpersonal problems, and suicidal behaviour. Moreover, the four meta-analyses that included sex-based analyses found similar levels of adult mental health problems for both males and females.

While childhood sexual abuse has been associated with a number of mental health outcomes, we focused on post-traumatic stress because it is well established in the research literature that children who experience sexual abuse are at risk of developing trauma-related symptoms such as post-traumatic stress disorder (PTSD; Berliner, 2011). Spataro et al.'s (2004) prospective study of children with sexual abuse histories found that anxiety and acute stress disorders (including PTSD) were the most frequent diagnoses for both adult males and females. In a literature review of 166 studies that focused on male childhood sexual abuse, PTSD rates were found to range from 25-30% (Holmes & Slap, 1998). These studies suggest that males who have experienced childhood sexual abuse are negatively impacted in many ways, including by way of trauma-related stress. In addition, there is evidence that males exhibit just as many post-traumatic symptoms as females (Garnefski & Arends, 1998; Maikovich-Fong & Jaffee, 2010; Spataro et al., 2004).

Characteristics of childhood sexual abuse. Despite empirical support for the deleterious impact of childhood sexual abuse, not all individuals who experience sexual abuse exhibit negative outcomes. Given individual variations in the response to childhood sexual abuse, several studies have explored specific abuse characteristics (e.g., duration, type of sexual acts) and the manner in which they might shape the development of psychopathology (or lack thereof). To date, studies have yielded mixed results on the impact of abuse characteristics on later outcomes (Paolucci, Genuis, & Violato, 2001), although researchers generally concede that contact forms of sexual abuse and earlier age of onset are associated with greater short- and longer-term impairments (Banyard, Williams, & Siegel, 2004; Briere & Elliott, 2003). Hillberg et al.'s (2011) review of meta-analyses found that 4 of the 7 included meta-analyses considered sexual abuse characteristics but not generally as potential moderating variables. These authors also noted that there were methodological limitations among those meta-analyses that did consider sexual abuse characteristics (e.g., operational definition of variables such as relationship to the perpetrator). As such, they

concluded that the impact of childhood sexual abuse characteristics on later mental health outcomes remains unanswered. In order to clarify the role of sexual abuse characteristics on psychological outcomes, we examined the influence of childhood sexual abuse duration, age of onset, severity, relationship to the perpetrator, emotional closeness to the perpetrator, presence of physical threat/violence, and disclosure on adult males' post-traumatic stress symptoms.

Childhood sexual abuse and other maltreatment. In examining the impact of sexual abuse characteristics on post-traumatic stress among adult males, we took into account other maltreatment experiences since research has indicated that children who experience sexual abuse often also experience other types of maltreatment (Babchishin & Romano, 2014; Felitti et al., 1998). For example, the U.S. Adverse Childhood Experiences (ACE) study included 9,509 adults who retrospectively reported on experiences of maltreatment and adversity from birth to 18 years. Among individuals who experienced childhood sexual abuse, findings indicated that 1 in 4 (24%) also experienced emotional abuse while 1 in 5 (22%) also had a history of physical abuse (Felitti et al., 1998). In males, childhood sexual and physical abuse appear to have a particularly strong relationship. Several retrospective studies have found that 36-68% of males with childhood sexual abuse histories also experienced physical abuse (Harrison, Fulkerson, & Beede, 1997; Hibbard, Ingersoll, & Orr, 1990; MacMillan et al., 1997). A more recent Canadian study involving 213 caregivers of 6-12 year olds found that children's lifetime experience of sexual abuse was not as common as other forms of maltreatment (e.g., exposure to intimate partner violence), based on caregiver reports. However, when sexual victimization did occur, it had a higher likelihood of occurring with other forms of maltreatment (Babchishin & Romano, 2014).

From a theoretical perspective, the ecological framework may be helpful in understanding the co-occurrence of maltreatment types because it emphasizes that children are impacted by the various systems in which they are embedded, such as family, school, and neighbourhood (Cicchetti & Lynch, 1993; Hamby & Grych, 2013). Among children who experience maltreatment, they are typically embedded in adverse systems that influence one another and place children at risk for multiple victimization experiences; however the exact way in which factors within these various systems interact to explain maltreatment is not well-described by the ecological model (Hamby & Grych, 2013). To this extent, several authors have noted the importance of considering both individual characteristics (e.g., cognitions related to the self and the use of aggression; affective processes such as anger and emotion regulation) and situational characteristics (e.g., socio-economic disadvantage; social isolation) and the way these two components might come together at a particular point in time to elicit maltreating behaviour (DeWall, Anderson, & Bushman, 2011; Hamby & Grych, 2013). In line with these suggestions, caregivers play an instrumental role on children's well-being, and research has indicated that childhood sexual abuse often occurs alongside caregiver mental health and substance use difficulties (Felitti et al., 1998). These caregiver difficulties may compromise parenting abilities and intimate partner relationships, which may subsequently place children at risk for various forms of maltreatment, such as physical abuse, neglect, and exposure to intimate partner violence (Walsh, MacMillan, & Jamieson, 2003). In addition, there may be limited monitoring and supervision of children, which may increase risk for sexual abuse and neglect. These examples illustrate how different types of co-

occurring maltreatment may have shared risk factors at both the individual (caregiver) and situational level, such as family instability, dangerous neighbourhoods, and limited parental abilities (Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007; Zielinski & Bradshaw, 2006).

Self-Compassion

While childhood sexual abuse has been linked with numerous negative outcomes, there are many factors that can moderate or mediate this association so that abuse-related mental health impairments are either exacerbated or mitigated. In recent years, there has been growing interest in the role of self-compassion among individuals with childhood abuse histories (Tanaka, Wekerle, Schmuck, Paglia-Boak, & The MAP Research Team, 2011; Vettese, Dyer, Li, & Wekerle, 2011). As such, the second objective of the current study was to examine the role of self-compassion on mental health outcomes (i.e., post-traumatic stress) among males with childhood sexual abuse histories. To our knowledge, there is no published study that has focused on self-compassion in this population.

Self-compassion is defined as adopting a non-judgmental, kind, and empathic stance toward oneself in times of suffering, and it includes common humanity, self-kindness, and mindfulness (Neff, 2003a). Common humanity (versus isolation) is described as having the ability to see one's struggles as part of the human experience. Self-kindness (versus self-judgment) refers to being caring and understanding toward oneself during times of emotional struggle, and mindfulness (versus over-identification) is defined as being aware and tolerant of painful thoughts and/or feelings while not over-identifying with them (Neff, 2003a). Recent research has found that self-compassion may act as a mediating protective factor for individuals coping with their childhood maltreatment experiences (Miron, Orcutt, Hannan & Thompson, 2014; Tanaka et al., 2011; Vettese et al., 2011). It may be that self-compassion helps individuals regulate their emotions by cultivating awareness and acceptance of one's thoughts and feelings, a sense of connectedness with others, and kindness toward oneself (Gilbert & Proctor, 2006; Vettese et al., 2011). While shame and guilt have been associated with greater sexual abuse-related impairments (Romano & De Luca, 2014), self-compassion may lessen the impact of sexual abuse because it encourages individuals to view themselves in a realistic but kind manner and to focus on the here-and-now (Neff, 2003a). As such, it may facilitate resilient functioning because it helps alter individuals' reactions to their sexual abuse experiences by activating the caregiving system (secure attachment, safety) and deactivating the threat system (insecure attachment, defensiveness; Germer & Neff, 2013; Gilbert & Proctor, 2006).

Vettese et al. (2011) examined the relationship among childhood maltreatment, self-compassion, and emotion regulation in a cross-sectional sample of 81 youth (65.4% male) aged 16-24 years seeking substance use treatment. Findings indicated that higher self-compassion significantly predicted lower emotion dysregulation, even after accounting for such factors as maltreatment history, addiction severity, and psychological symptom severity. Moreover, self-compassion mediated the relationship between childhood maltreatment and emotional dysregulation. In a longitudinal study of 117 16-20 year old child welfare-involved youth (45.3% male), Tanaka et al. (2011) found that greater self-compassion significantly

predicted lower maltreatment-related impairment (e.g., problematic alcohol use, suicide attempt), even after controlling for age, sex, and maltreatment type. Thompson and Waltz (2008) explored the relationship between self-compassion and PTSD in a sample of 210 university students (62% female). Of the 100 who met criteria for PTSD based on completion of a self-report questionnaire, results indicated that greater self-compassion was significantly and negatively correlated with avoidance but not with re-experiencing or hyper-arousal post-traumatic symptoms. Finally, MacBeth and Gumley (2012) examined the relationship between self-compassion and adult psychopathology by way of a meta-analysis that included 14 studies which all used the Self Compassion Scale (Neff, 2003b). Findings indicated a large effect size showing that greater self-compassion was associated with lower levels of psychopathology (i.e., depression, anxiety, traumatic stress). One limitation, however, is that most included studies were cross-sectional in nature. As such, it was not possible to establish temporal ordering or causality; higher self-compassion may help decrease mental health impairments or it may be that individuals with better mental health have greater compassion toward themselves.

Research indicates that males and females tend to exhibit similar levels of self-compassion. Findings from a meta-analysis of 71 studies examining sex differences on total scores on the long and short form of the Self-Compassion Scale (Neff, 2003b; Raes, Pommier, Neff, & Van Gucht, 2011) showed that males scored higher in self-compassion than females; however the effect size was small (r = .18; Yarnell et al., 2015). In the meta-analysis by MacBeth and Gumley (2012), sex was not a significant moderator of the link between self-compassion and psychopathology. While self-compassion is an emerging field of study, existing findings regarding maltreated populations suggest that individuals who demonstrate compassion toward themselves have better outcomes following their maltreatment experiences. In this way, applied interventions that target self-compassion may serve to promote resilient functioning among individuals who have experienced childhood maltreatment (Germer & Neff, 2013).

Study Hypotheses

In addressing our first study objective examining the link between childhood sexual abuse characteristics and adult post-traumatic stress symptoms, we expected the following characteristics to be associated with greater symptoms: longer duration; earlier age of onset; greater severity; closer relationship to the perpetrator; greater emotional closeness to the perpetrator; presence of physical threat/violence; and lack of disclosure. For our second objective examining the link between self-compassion and post-traumatic stress symptoms, we expected higher self-compassion to be associated with lower post-traumatic stress, even after taking into account the influence of sexual abuse characteristics.

Method

Participants and Procedure

This study was part of a larger one currently being conducted through the Children's Well-Being Laboratory at the University of Ottawa (Ontario, Canada). University ethics approval for the larger study was obtained in January 2014. The current study includes

participants who completed questionnaires up until May 2015. Participants were recruited through an anonymous on-line questionnaire hosted by Fluidsurveys, and the recruitment script containing the web-link to the questionnaire was posted on various male survivor websites (e.g., 1in6.org, 1in6.ca, themensproject.org). In order to participate, males were required to be fluent in English, to reside in Canada or the U.S., and to have had a sexual experience before the age of 16. All participants provided consent on-line before proceeding to the questionnaire, and no identifying information (e.g., names, IP addresses) was collected. The questionnaire took approximately 40-50 minutes to complete, and it inquired about childhood maltreatment and family functioning during childhood as well as current psychological functioning (e.g., post-traumatic stress, self-compassion). As several questions were sensitive in nature, relaxation techniques and a list of psychological resources were provided at the bottom of every questionnaire page.

Table 1: Socio-Demographic Characteristics (N = 213)

Variable	N	%	M(SD)	Range
Age	212	-	40.58 (13.35)	0-76
Ethnicity				
Caucasian	185	86.9		
Hispanic	7	3.3		
South Asian	5	2.3	-	-
East Asian	4	1.9		
Native	3	1.4		
Middle Eastern	3	1.4		
Black	1	0.5		
Other	5	2.3		
Country				
Canada	73	34.3	-	-
United States	140	65.7		
Education				
Elementary	8	3.8		
High School	63	30.0		
Trade Program	26	12.3	-	-
University - Undergraduate	56	26.7		
University - Graduate	44	21.0		
Other	13	6.2		
Household Income				
Less than $9,999	18	8.5		
$10,000 - $29,999	45	21.1		
$30,000 - $49,999	41	19.2	-	-
$50,000 - $69,999	28	13.1		
$60,000 - $89,999	27	12.7		
$90,000 - $109,999	20	9.4		
Over $110,000	34	16.0		
Employment				
Unemployed	15	7.0		
Employed	114	53.5		
Attending School	12	5.6	-	-
Attending School and Employed	17	8.0		
Recovering from Illness/Disability	26	12.2		
Retired	13	6.1		
Other	16	7.6		

Note: M = Mean; SD = Standard Deviation

From the 228 males who completed the on-line study, 14 were removed from the analyses because they did not report experiences that were consistent with the study's definition of childhood sexual abuse. One participant was removed because his data represented a multivariate outlier. There were no statistically significant socio-demographic differences between excluded males and those retained in the study (N = 213). Table 1 indicates that the average age of male participants was 40.58 years (SD = 13.35). They were primarily Caucasian (86.9%) and U.S. residents (65.7%). There were various levels of education, with the largest proportion (30%) of males reporting that their highest educational level was high school. Similarly, household income varied among participants, with the most common ranges between $10,000-29,999 (21.1%) and $30,000-49,999 (19.2%) in Canadian or U.S. funds. Finally, the majority of participants (53.5%) reported that they were employed on a full-time basis.

Measures

The four following measures were used: Sexual Victimization Survey (SVS; Finkelhor, 1979); Post-Traumatic Stress Checklist-Specific Version (PCL-S; Weathers, Litz, Herman, Huska, & Keane, 1993); Self-Compassion Scale-Short Form (SCS-SF; Raes et al., 2011); and the childhood maltreatment subscale from the Adverse Childhood Experiences Study (ACE; Felitti & Anda, 1997).

Sexual victimization. Information on males' childhood sexual abuse experiences was collected using a modified version of the SVS (Finkelhor, 1979). The SVS was modified so that participants could provide details for a maximum of three different sexual experiences that occurred before the age of 16. For each of these experiences, participants provided information on the perpetrator (i.e., sex, relationship to the participant), type of sexual acts, frequency, duration, age of onset, disclosure and use of violence/threat of violence. Participants also rated the emotional closeness of their relationship to the perpetrator on a 5-point Likert scale, ranging from 1 (very distant) to 5 (very close; Schultz, Passmore, & Yoder, 2000).

Given that some childhood sexual experiences can be consensual and more exploratory in nature, two research assistants separately coded each sexual experience reported by participants to determine whether it could be defined as abuse. To do this, we relied on the definition of childhood sexual abuse provided in the Canadian Criminal Code (Criminal Code, 1985). Specifically, individuals who endorsed experiences that were coercive and/or non-consensual, that occurred with an individual who was at least 5 years older, and that involved sexual activities beyond what would be considered explorative (e.g., oral or anal penetration) were coded as abuse. The agreement rate between research assistants was 93%, and disagreements were resolved by a third coder (i.e., the study's first author).

Post-traumatic stress. The PCL-S (Weathers et al., 1993) measures PTSD symptoms in response to a specific event. In the current study, participants were asked to respond to the items in relation to an early sexual experience. Participants then indicated how often they were bothered by 17 symptoms over the past month (e.g., repeated, disturbing dreams of the sexual experience) along a 5-point Likert scale, ranging from 1 (not at all) to 5

(extremely). Scores were summed to create a total score, ranging from 17 to 85, with higher scores indicating greater PTSD symptoms. According to Weathers et al. (1993), a score of 50 or above indicates a probable diagnosis of PTSD (at least in combat veterans). The PCL-S has demonstrated high internal consistency (Weathers et al., 1993) and test-retest reliability (Ruggiero, Del Ben, Scotti & Rabalais, 2003) in previous studies. In the current sample, the sample mean was 53.1 (SD = 16.7), and internal consistency was excellent (α = .93).

Self-compassion. The SCS-SF (Raes et al., 2011) includes 12 items that cover six domains of self-compassion, namely self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. Participants rate the frequency of behaviours (e.g. I'm disapproving and judgmental about my own flaws and inadequacies) along a 5-point Likert scale from 1 (almost never) to 5 (almost always). Items are summed to create a total score ranging from 12-60, with higher scores indicating greater self-compassion. The sample had a mean of 28.4 (SD = 10). The SCS-SF has been found to be a reliable and valid measure of self-compassion, and it has a near perfect correlation with the longer scale (r = .97; Raes et al., 2011). The internal consistency in the current study was excellent (α = .91).

Adverse childhood experiences. A modified version of the maltreatment subscale of the ACE questionnaire (Felitti & Anda, 1997) was used to measure the presence of physical abuse, emotional abuse, emotional neglect, physical neglect, and exposure to intimate partner violence (IPV). In terms of modifications, we combined emotional neglect and physical neglect into one neglect variable. We also removed the childhood sexual abuse subscale because this form of maltreatment was already assessed in the SVS. Finally, the original measure only asks about father-perpetrated IPV, but not mother-perpetrated violence. As such, we added three questions to assess this latter construct. After these modifications, there were a total of 14 items, with 2 items assessing physical abuse, 2 for emotional abuse, 4 for neglect, and 6 for IPV. Participants answered yes or no to each item. Items were summed to create a total score, with each maltreatment subscale ranging from 0-2, with the exception of exposure to IPV which ranged from 0-6. Subscale scores were dichotomized so that a score of 0 was coded as absent, and all other scores were coded as present. In prior studies, the ACE questionnaire has demonstrated good internal consistency (α = .81), test-retest reliability, and validity (Bruskas & Tessin, 2013; Dube, Williamson, Thompson, Felitti, & Anda, 2004; Felitti et al., 1998). In the current study, the internal consistency for the total scale was good (α = .83).

Statistical Analyses

As mentioned, participants could report on a maximum of three childhood sexual experiences. Past studies have tended to only include the most severe sexual experience in their analyses (e.g., the sexual experience with the longest duration), but this method does not account for the potential impact of other sexual abuse experiences, and it also relies on researchers determining which experience was the most severe. In the current study, in cases where participants indicated more than one abusive sexual experience, two research assistants independently examined participants' data across multiple experiences and coded each abuse characteristic on the response that indicated the greatest severity. Specifically, if a participant indicated that he experienced two or more sexual experiences

(which were determined to meet definitional criteria for abuse), one of which began during early childhood and the other two of which began in adolescence, the "age of onset" variable was coded as early childhood because it reflects greatest severity based on past research. If a participant endorsed three sexually abusive experiences, two of which were perpetrated by individuals outside the family and one of which was perpetrated by a family member, the "relationship to the perpetrator" variable would be coded as "both" to capture the greatest severity, namely that the participant had perpetrators that were both related and unrelated to him. For the "sexual acts" variables, we adopted the following severity scale: non-contact (0); fondling (1); involvement in pornography (2); oral-genital contact (3); and penetration (4). For the remaining variables, greater perceived emotional closeness to the perpetrator, longer duration, presence of physical threat/violence, and lack of disclosure were considered more severe. Agreement between the two research assistants on severity coding across multiple sexual experiences ranged from 92-97%. Disclosure (yes or no) had the highest rate of agreement, and emotional closeness to the perpetrator had the lowest rate of agreement. The study's first author coded cases in which there was disagreement.

To address our study objectives, we conducted a hierarchical linear regression, using post-traumatic stress symptoms as the outcome variable. The first block included childhood sexual abuse characteristics (i.e., duration, age of onset, severity, relationship to the perpetrator, emotional closeness to the perpetrator, presence of physical threat/violence, and disclosure). To examine the extent to which sexual abuse characteristics would still be significantly linked with post-traumatic stress once other types of maltreatment were considered, we included these variables in the second block. Finally, to examine the potential influence of self-compassion, we included this variable in the third block. Adequate statistical power (≥ .80) was maintained with the inclusion of all predictor variables. Analyses were conducted using SPSS version 21.0, and a probability level of .05 was used to establish statistical significance.

Missing data across variables ranged from 0.4% on post-traumatic stress symptoms to 1.9% on the exposure to IPV subscale. A Little's MCAR test indicated that the data were missing at random, and expectation maximization (EM) was used to impute missing data for the predictor variables and outcome variable. Assumptions of linear regression were checked prior to conducting analyses. Findings indicated no issues with multicollinearity, normality, skewness, or homogeneity of variance. There were 3 univariate outliers on the abuse severity variable. These cases were transformed to values equivalent to 3.29 standard deviations above the mean (Tabachnick & Fidell, 2007). Finally, there was one multivariate outlier, and this participant's data were omitted from all subsequent analyses.

Results

Characteristics of Male Childhood Sexual Abuse and Other Adversities

On average, males provided information on 2.2 sexual experiences (SD = .86). Sixty-three men (29.6%) reported on one sexual experience, 51 (23.9%) reported on two sexual experiences, and 99 (46.5%) reported on three sexual experiences. Table 2 shows that the average age of sexual abuse onset was middle childhood (M = 7.68; SD = 3.36). Males experienced a range of sexual abuse acts, often at high frequencies (e.g., half reported

Table 2: Sexual Abuse Characteristics

Variable	N	%	M(SD)	Range
Age of Onset of Childhood Sexual Abuse	191	-	7.68 (3.36)	0-15
Types of Sexual Acts				
Non-contact	193	90.6		
Fondling	201	94.4		
Oral-genital	142	66.7	-	-
Penetration	106	49.8		
Pornography	35	16.4		
Relationship to Sexual Abuse Perpetrator				
Extrafamilial	107	49.8	-	-
Intrafamilial	50	23.5		
Both	57	26.8		
Emotional Closeness to Sexual Abuse Perpetrator	213	-	3.31(1.38)	1-5
Threat/Violence from Sexual Abuse Perpetrator	127	60.1	-	-
Disclosure of Childhood Sexual Abuse	185	86.9	-	-
Duration of Childhood Sexual Abuse				
Few Days	37	17.5		
Few Weeks	15	7.1	-	-
Few Months	37	17.5		
Few Years	72	34.0		
Many Years	51	24.1		
Other Types of Childhood Abuse				
Physical Abuse	131	61.8		
Emotional Abuse	141	66.8	-	-
Neglect	149	70.3		
Exposure to Intimate Partner Violence	45	21.3		

Note: M = Mean; SD = Standard Deviation

having experienced penetration). The perpetrator was primarily an individual outside the home (49.8%), although slightly more than one-quarter (26.8%) also reported sexual abuse by both family and non-family members. Males reported that they were moderately close with their perpetrator(s) prior to the sexual abuse onset, and 6 in 10 (60.1%) indicated that physical threat/violence was used by the perpetrator as a way to engage them in the sexual abuse activity. The majority disclosed their sexual abuse experience (86.9%). With regard to duration, most males reported long-term sexual abuse spanning a few years (34%) to many years (24.1%). Table 2 also indicates that childhood sexual abuse often occurred in the context of other types of maltreatment, most notably emotional and/or physical neglect (70.3%) followed by emotional abuse (66.8%), physical abuse (61.8%), and exposure to IPV (21.3%).

Correlations Among Variables

Table 3 shows a number of statistically significant correlations between variables, all in the expected direction. Greater post-traumatic stress symptomatology was significantly associated with less self-compassion, greater duration of childhood sexual abuse, presence of threat/violence during the sexual abuse experience, and disclosure. Greater post-traumatic stress symptomatology was also significantly associated with the presence of physical abuse, emotional abuse, and neglect.

In terms of sexual abuse characteristics, earlier age of onset was significantly associated with longer duration and intrafamilial abuse. Longer sexual abuse duration was significantly

Table 3: Bivariate Correlations Among Predictor and Outcomes Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Post-Traumatic Symptoms	-											
2. Self-Compassion	-.51**	-										
3. Sexual Abuse Age of Onset	-.03	.02	-									
4. Sexual Abuse Severity	.05	.05	-.03	-								
5. Sexual Abuse Duration	.25**	-.09	-.22**	.20**	-							
6. Relationship to Perpetrator	.07	.03	-.28**	.16*	.28**	-						
7. Emotional Closeness to Perpetrator	-.02	.05	-.05	.15*	.26**	.20**	-					
8. Threat/Violence from Perpetrator	.17*	-.03	-.07	.17*	.16*	.03	.01	-				
9. Disclosure of Sexual Abuse	.15*	-.08	.02	.09	.06	.08	-.07	.14*	-			
10. Physical Abuse	.19**	-.14*	-.05	.25**	.03	.11	.05	.11	.18**	-		
11. Emotional Abuse	.30**	-.14*	-.03	.14	.13	.20**	-.04	.06	.20**	.60**	-	
12. Neglect	.26**	-.14*	-.01	.14*	.10	.01	-.07	.10	.20**	.49**	.51**	-
13. Exposures to IPV	-.06	.03	.14	-.01	-.04	.05	-.10	.05	.03	.22**	.24**	.24**

Note: IPV = Intimate Partner Violence * $p < .05$ ** $p < .01$ *** $p < .001$

associated with more severe abuse, intrafamilial abuse, the presence of threat/violence on the part of the perpetrator, and greater perceived emotional closeness to the perpetrator. This latter variable was also significantly associated with greater abuse severity and intrafamilial abuse. Finally, the presence of threat/violence was significantly associated with more severe abuse and disclosure of the victimization.

Table 4: Predictors of Post-Traumatic Stress Symptoms

Variable	Model 1		Model 2		Model 3	
	β	SE	β	SE	β	SE
Sexual Abuse Age of Onset	.11	.38	.22	.37	.23	.33
Sexual Abuse Severity	-.30	1.54	-1.25	1.52	-.40	1.35
Relationship to Sexual Abuse Perpetrator	.84	1.49	.66	1.48	1.09	1.31
Emotional Closeness to Sexual Abuse Perpetrator	-.26	.93	-.17	.91	.15	.80
Threat/Violence from Sexual Abuse Perpetrator	4.97	2.57	5.12*	2.49	4.18	2.20
Duration of Childhood Sexual Abuse	2.47*	.97	2.22*	.95	1.59	.84
Disclosure of Childhood Sexual Abuse	6.16	3.64	2.65	3.61	.79	3.20
Physical Abuse			1.19	3.34	-.48	2.96
Emotional Abuse			6.98*	3.30	6.02*	2.92
Neglect			4.91	3.05	4.06	2.70
Exposure to IPV			-6.48*	3.00	-4.75	2.66
Self-Compassion					-.77***	.11
R^2	.09		.18		.36	
ΔR^2	.09		.09**		.18***	

Note: β = Unstandardized Estimate; SE = Standard Error; IPV = Intimate Partner Violence * $p < .05$ ** $p < .01$ *** $< .001$

Interestingly, self-compassion was not significantly associated with any of the sexual abuse characteristics. However, greater self-compassion was significantly associated with the absence of physical abuse, emotional abuse, and neglect. Finally, Table 3 shows a number of significant associations among the various types of maltreatment.

Predictors of Post-Traumatic Stress Symptoms

Table 4 indicates that, for the first model which included childhood sexual abuse characteristics, longer abuse duration predicted greater self-reported post-traumatic stress ($\beta = 2.47$, SE = .97, $p < .05$). There was also a statistical trend for the use of threat/violence by the perpetrator to predict post-traumatic stress symptoms ($\beta = 4.97$, SE = 2.57, $p = .06$). When other types of maltreatment were placed into the regression (Model 2), the use of perpetrator threat/violence and longer duration of males' childhood sexual abuse significantly predicted greater post-traumatic stress symptoms ($\beta = 5.12$, SE = 2.49, $p < .05$ and $\beta = 2.22$, SE = .95, $p < .05$, respectively). The presence of emotional abuse also significantly predicted greater post-traumatic stress symptoms ($\beta = 6.98$, SE = 3.30, $p < .05$). Model 2 also indicated that the presence of exposure to IPV was predictive of less post-traumatic stress ($\beta = -6.48$, SE = 3.00, $p < .05$). Finally, to examine the potential influence of self-compassion, it was included in Model 3 along with all other childhood maltreatment variables. This final model was statistically significant (F (12,175) = 8.25, $p < .001$) and indicated that greater self-compassion predicted fewer post-traumatic stress symptoms, even after controlling for all other variables in the model ($\beta = -.77$, SE = .11, $p < .001$). With the inclusion of self-compassion, perpetrator threat/violence and sexual abuse duration were no longer statistically significant, although they showed a statistical trend ($p = .06$). However, the presence of emotional abuse continued to predict greater post-traumatic stress ($\beta = 6.02$, SE = 2.92, $p < .05$).

Model 1, which included sexual abuse characteristics, explained 9% of the variance in post-traumatic stress. Model 2, which included other childhood maltreatment experiences, significantly added to the prediction of post-traumatic stress by explaining an additional 9% of the variance in the model ($\Delta R^2 = .09$, F change (4, 176) = 4.47, $p < .01$). Finally, the addition of self-compassion to Model 3 resulted in an approximate two-fold increase in R2 and this variable alone explained an additional 18% of the variance in the model ($\Delta R^2 = .18$, F change (1, 175) = 50.46, $p < .001$).

Discussion

The objective of this study was to examine the contribution of childhood sexual abuse characteristics, other maltreatment types, and self-compassion on adult males' self-reported post-traumatic stress symptomatology. This study contributed to advancing knowledge in the field of childhood sexual abuse in several ways. First, we focused on adult males with sexual abuse histories. This population has received relatively little attention, which is unfortunate given that they experience rates of sexual abuse that are concerning. In addition, there are unique circumstances for males (e.g., differences in the sexual abuse characteristics, gender socialization assumptions) so one cannot assume that the experiences of females with sexual abuse histories can be generalized to those of males. Second, we focused on a range of sexual abuse characteristics to better understand the way they are associated with mental health

outcomes, in particular post-traumatic stress symptoms. Sexual abuse represents a highly heterogeneous experience so it would seem important to tease apart the factors within that experience that may be making a particularly strong contribution to mental health functioning. Third, we examined the impact of sexual abuse characteristics alongside other experiences of childhood maltreatment. This is critical as there is a growing body of recent research showing that victimization experiences rarely occur in isolation of one another. By including multiple forms of maltreatment, one can develop a more comprehensive understanding of maltreatment impacts while also not over-emphasizing the potential impact of any single type of victimization (Hamby & Grych, 2013). Finally, self-compassion is a relatively new area of study and one which has received virtually no attention among adult males who have experienced childhood sexual abuse.

Our first hypothesis that childhood sexual abuse characteristics would significantly predict greater post-traumatic stress symptoms, even after the inclusion of other variables, was partially supported. Specifically, longer sexual abuse duration was significantly linked with greater post-traumatic stress even after other maltreatment types were considered (but not when self-compassion was included in the model). This variable was significantly correlated with a number of other childhood sexual abuse characteristics, namely earlier age of onset, greater severity, intrafamilial abuse, the presence of threat/violence, and greater perceived emotional closeness to the perpetrator. From an applied point of view, this finding suggests that inquiring about the duration of childhood sexual abuse is particularly important for purposes of assessing maltreatment-related impacts (in this case post-traumatic stress) because it is related to other abuse characteristics that are indicative of a more severe experience. This makes intuitive sense because sexual abuse that lasts longer typically begins earlier in the life of the child and is more likely to occur with a close family member since such an individual (e.g., primary caregiver, sibling) is more likely to have access to a young child (Trickett, Reiffman, Horowitz, & Putnam, 1997). Finally, if the sexual abuse occurs over a longer period of time, it is more likely to evolve to include more intrusive sexual acts that would more likely include the use of force or threat of force (Yancey, Naufel, & Hansen, 2013). Longer sexual abuse duration also would be related with greater maltreatment-related impairments because key developmental processes such as attachment, emotion regulation, sense of agency, and self-identity would be disrupted in a child who experiences sexual abuse over a number of years (Blaustein & Kinniburg, 2010). In terms of the presence of physical threat/violence, its significant link with post-traumatic stress symptoms can also be understood by way of its co-occurrence with longer sexual abuse duration and more severe sexual acts. In addition, literature reviews have found that the use of physical force is particularly predictive of the developmental of post-traumatic stress symptomatology (e.g., Kendall-Tackett et al., 1993; Tyler, 2002).

Our second hypothesis that self-compassion would be a significant predictor of post-traumatic stress, even after controlling for maltreatment experiences, was supported. Findings indicated that males who reported greater self-compassion also indicated fewer post-traumatic stress symptoms. Moreover, self-compassion contributed to 18% of the variance in post-traumatic stress. This finding is in line with previous research which has found greater self-compassion to be associated with better outcomes across various domains

of functioning (Miron et al., 2014; Tanaka et al., 2011; Vettese et al., 2011). However, these past studies did not include adult males with childhood sexual abuse histories and did not examine post-traumatic stress. As such, findings from the current study are important in expanding current knowledge about the important positive influence that self-compassion can have on maltreatment-related outcomes.

Limitations and Implications

The current study had several limitations. First, data were cross-sectional in nature so we cannot make any firm conclusions about the temporal ordering of variables or about causality. Second, data were based on self-report questionnaires so there may have been issues with recall bias which could affect data accuracy. Third, data were derived from convenience sampling so it would seem important to gather data from a more representative sample of adult males with histories of childhood sexual abuse to test for the generalizability of findings.

There are several preliminary implications based on the study's findings. In terms of research on childhood sexual abuse, one needs to consider characteristics of the sexual abuse experience (in particular the duration of the abuse and whether physical threat/violence was involved) because they can have differential impacts on such outcomes as post-traumatic stress. Similarly, other forms of maltreatment need to be taken into account because the reality is that, among children with victimization histories, most have experienced more than one form of maltreatment. This was evidenced in the current study, which showed a number of significant correlations among maltreatment types as well as between maltreatment types and sexual abuse characteristics. In particular, emotional abuse appeared to be a particularly salient predictor of post-traumatic stress.

With regard to self-compassion, one of its features is that of common humanity, which refers to our ability to relate to others and recognize our suffering as part of the human experience. Given that children who experience sexual abuse are often isolated from family members and/or friends by their perpetrators, they may grow up having difficulty relating to others and may feel that they are intrinsically different. Moreover, research has shown that children often blame themselves for their sexual abuse experience (Romano & De Luca, 2014). As such, males may continue to blame themselves for the abuse and/or other subsequent victimizations. The development of self-compassion may help individuals view their childhood sexual abuse experiences through a more helpful perspective, which may then facilitate the development of greater self-kindness and less negative self-perception and ultimately better mental health functioning. Clinicians may consider incorporating self-compassion into trauma-focused interventions for adults with maltreatment-related distress. Specific techniques include self-compassion breaks (Neff & Germer, 2013) in which individuals are encouraged to breathe deeply and slowly repeat mantras that highlight mindfulness (e.g., "This is a moment of suffering") and self-kindness (e.g., "May I be kind to myself") when they are experiencing trauma-related distress. Likewise, when practiced over time, self-compassion meditation (Neff, 2011), can help individuals with trauma histories feel safe in the presence of trauma symptoms (Germer & Neff, 2013). Finally, individuals may benefit from structured programs that directly or indirectly teach self-compassion, such

as mindful self-compassion training (Germer & Neff, 2013) and mindfulness-based stress reduction (Kabat-Zinn, 1991).

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