MALE SEXUAL SHAME, MASCULINITY, AND MENTAL HEALTH

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ABSTRACT

Clinical experts suggest that sexual shame can lead to depression, addiction, violence, and sexual dysfunction in men. Shame may be associated with traditional masculinity – suggesting that men with this gender ideology may be particularly vulnerable. The purpose of this research was to examine the relationship between male sexual shame, traditional masculine ideology, and psychological symptomology. Data came from a large, international sample of 1082 men. Analyses revealed that greater endorsement of traditionally masculine values was associated with increased sexual shame, and that male sexual shame was predictive of symptomology associated with depression but not anxiety. Subscales were examined to determine which factors were predicative of the noted relationships. Results are discussed as relevant to research, clinical practice, and social implications.

Keywords: Sexuality, Shame, Depression, Anxiety, Traditional Masculinity, Violence

INTRODUCTION

Much has been written about the problems associated with traditional (hegemonic) masculinity within an evolving culture (e.g., Connell, 2005). Many of the noted concerns have to do with traditional masculinity's regard for and impact on women (e.g., Jenney & Exner-Cortens, 2018; McDermott, et al., 2015), its sociological impacts on men (e.g. Whitehead, 2005; Courtenay, 2000), and the society at large (e.g., Haider, 2016; Mabrouk, 2017). However, fewer of these works have been concerned with the effects of traditional masculinity on the individual psychologies of men within an evolving culture. Given the challenges that men face in a society with waning tolerance for traditional gender roles (Henderson, 2014; Hu, 2015), especially masculine ones (Gordon, 2014; Harris, 2012; Keller, 2018), it is concerning that more attention has not been paid to the potential problems and solutions that arise for men in the midst of this cultural juncture. This is especially surprising given the effects that poor mental health can have on the suffering individuals and their loved ones, communities, and (collectively) the societies to which the individual is connected. In particular, clinical depression in men has been linked to increased anger, aggression, violence, addiction, and suicidality (Dumais, et al., 2005; Wålinder & Rutz, 2001; Winkler, Pjrek, & Kasper, 2005). Importantly, the association between depression and hostility has been noted in boys and adolescent males as well as in adult men (Treuting & Hinshaw, 2001). Given the current interest in male violence and the stakes associated with its perpetuation, it is important to consider what issues may be contributing to poor mental health among men. This knowledge may serve as a step towards reducing these types of violence.

BACKGROUND

Within the current social context, men experience a number of barriers to seeking treatment for or for even acknowledging their own mental health concerns. This is despite their increased risk for suicide deaths, violence, psychosis, substance abuse, educational and learning issues, and incarceration (Gordon, 2013; Mental Health for Men, n.d.). Several studies have noted traditional masculinity's role in hindering men from seeking help, particularly when related to psychological issues (e.g., Möller-Leimkühler, 2002). Men may believe that admitting psychological concerns makes them appear weak, that seeking help is emasculating, or that (mental) health providers won't understand or be effective in addressing their concerns (Gordon,

2013). These barriers and others tend to be even more pronounced for low-working-class men, queer men, and men of color (Barber, Bridges, Jackson, & Flores, 2018; Galdas, Cheater, & Marshall, 2005).

However, barriers to help seeking aren't the only reasons why men's mental health issues require directed attention. For example, research on the effects of men's gender role conflict (GRC) has consistently demonstrated its relationship to psychological distress and mental illnesses, including depression, anxiety, substance abuse, negative attitudes towards help-seeking, and shame (Blazina & Watkins, 1996; Good & Mintz, 1990; Sharpe & Heppner, 1991; Thompkins & Rando, 2003; Zamarripa, Wampold, & Gregory, 2003). Most GRC research has primarily been concerned with the pressures men face to fit into traditionally masculine roles (Sharpe & Heppner, 1991), but have been less concerned with mounting pressures for men to eschew those same traditional roles. Even for those men who are capable of code-switching between modern and traditionally masculine styles, it can be difficult to predict when/where each code (or some combination thereof) is expected (Rosin, 2010). That all types of men may be affected by the noted cultural shifts underway highlights the importance of understanding their impact on men.

The facets of masculinity affected by these cultural changes are extensive and dynamic, most of which are beyond the scope of this paper. However, one important area where men may face particular tension between traditional and modern, gendered ideals is sexuality. Traditional masculine ideals promote a sexuality that is assertive, skilled, promiscuous, receptive to all advances from women, and exclusively heterosexual (Anderson, 2007, Crawford & Popp, 2003; Gordon, 2013; Jackson & Cram, 2003; Masters et al., 2013). However, this version of male sexuality faces increasing scrutiny due to its noted impacts on women, trans individuals and communities, and on men whose sexualities have been constrained by or are out of line with traditional ideals (Connell, 2005; McDermott, et al., 2015). For some men, such cultural shifts may bring welcomed relief from the limited types of sexual expression that had been exclusively promoted in the past. For other men, however, the shifts around gender and sexuality may be a source of frustration, confusion, and distress. This may be especially true for those men whose gender and sexual expressions are more traditional or otherwise less suited to modern ideals, and who have internalized the described modern ideals.

The emergence of groups like the Involuntary Celibates (Incels), Red Pillers, Men Going Their Own Way (MGTOW), Pick-Up Artists, and the Proud Boys – all men's groups concerned with some aspect of male sexuality – suggests that many men are searching for ways to reconcile sex and gender expectations within the current cultural framework (Coulling, 2018; Ward, 2018). The collective theme of these groups is a belief among their members that their gender and sexual expression is not in line with masculine ideals. What is interesting is that some of these groups base this premise on feeling out of line with traditional masculine ideals (e.g. Incels, Pick-Up Artists); whereas other groups feel out of line with modern masculine ideals (e.g. Red Pillers, MGTOW). That some self-identified members of these groups have been accused of perpetrating and perpetuating misogynistic acts, racism, and violence against women (and some men) (Ward, 2018) suggests that more directed and informed guidance is needed on these issues, and also hints at a connection between gender & sexuality, mental health, and violence.

As with gender-role conflict, men may experience perceived failures to live up internalized sexual ideals as shame. Understanding this relationship is important because of shame's noted association to depression, anxiety, and other mental health concerns (Gilbert, 2000; Shepard & Rabinowitz, 2013). Osherson & Krugman (1990) suggest that men may be particularly vulnerable to shame and its negative effects on mental health, since it plays such a large role in masculine identity development. Clinical experts suggest that sexual shame in particular can lead to depression, anxiety, and sexual dysfunction in men (Hastings, 1998; McClintock, 2001). However, the relationship between sexual shame in men (or male sexual shame [MSS]) has yet to be demonstrated empirically and is the primary focus of this research.

Shame is a distressing emotional state that arises out of a negative evaluation of oneself when compared to a personal or societal ideal (Cohen, et al, 2011; Lewis, 1992). That the negative evaluation is directed towards the *self* is what distinguishes shame from similar emotions. For instance, guilt is experienced when the negative evaluation is directed towards the offending *action* or *non-action* rather than the self; while embarrassment is experienced when one feels in danger of having their self-image or social status undermined—with or without a negative evaluation of the self or action (Brown, 2006; Burton, 2015; Lewis, 1971). A study by Gordon (2017) highlighted a set of male sexual concerns associated with shame. The results of that research suggested that things like masturbation and pornography use, sexual experience, sexual

inexperience, body dissatisfaction, sexual performance concerns, and even sexual libidos can be can be sources of shame for some men. These concerns were the basis for the development of the Male Sexual Shame Scale (MSSS). The MSSS was found to be predictive of shame-proneness but not guilt-proneness – demonstrating its ability to discriminate between these two related emotional constructs. The availability of this scale presents the opportunity to better understand the effects of male sexual shame on mental health and how traditionally masculine gender roles influence this form of shame in men.

THE PRESENT STUDY

The purpose of the study described below was to assess the relationship between traditionally masculine ideals, male sexual shame, depression symptomology, and anxiety symptomology. It was hypothesized that (1) increases in traditionally masculine ideals would be associated with increases in male sexual shame; that (2) increases in male sexual shame would be predictive of increases in depression and (3) anxiety symptomologies; that (4) the degree of traditionally masculine ideology would influence (moderate) the relationship between male sexual shame and depression and anxiety symptomologies.

METHOD

Participants

Participants for the study were primarily recruited online, via a variety of social media outlets (e.g., Facebook, Twitter, Reddit, etc.), men's health message boards, and this writer's professional webpage.

A total of 1,082 participants responded to the survey battery, which also included surveys for an earlier study published by this author (see Gordon, 2017). One-hundred and ninety-five response sets were removed before analyses for incompleteness or failing to meet the demographic parameters set forth in this study (i.e., being cisgender male and eighteen years old or older).

Procedures and Materials

All portions of the survey battery were completed via the online research software Qualtrics. All participants completed the Male Sexual Shame Scale (MSSS) (Gordon, 2017) with its associated independent scales and a demographic questionnaire. Items on the MSSS were

randomized for each participant to diminish response bias. As a part of a split-ballot design, participants also completed some combination of the Conformity to Masculine Norms Inventory – 46 (CMNI-46) (Parent & Moradi, 2009), the Zung Depression Scale (ZDS) (Zung, 1965), and the Zung Anxiety Scale (ZAS) (Zung, 1971) (other data was collected for a different study). These measures and their items were also randomized. At the end of the survey battery participants were given the opportunity to provide comments.

The Male Sexual Shame Scale.

The MSSS is a thirty-item survey, which asks participants to rate the degree to which they experience shame related to aspects of their sexuality and sex-lives. Higher scores indicate more sexual shame. It includes six subscales: Sexual Inexperience Distress, Masturbation/Pornography Remorse, Libido Distain, Body Dissatisfaction, Dystonic Sexual-Actualization, and Sexual Performance Insecurity. The MSSS evidenced good reliability and validity during its development. Three independent scales (Perceived High Libido, Homoerotic Guardedness, and Sexual Harassment Stereotype Threat), which ask about other aspects of male sexuality, were also given to participants. These scales are not included in the MSSS's composite score. These scales also evidenced good reliability and validity during development (Gordon, 2017).

The Conformity to Masculine Norms Inventory – 46.

The CMNI-46 (CMNI) is a forty-six-item Likert-style survey that assesses traditionally masculine gender roles. Higher scores indicate a more traditionally masculine ideology. The CMNI includes nine subscales: Winning, Emotional Control, Risk Taking, Violence, Power over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self-Presentation. The CMNI evidenced good reliability and validity during its development (Parent & Moradi, 2009).

The Zung Self-Rating Depression Scale.

The ZDS is a thirty-item self-administered survey that assesses affective, psychological, and somatic symptoms associated with depression. Research using this scale has evidenced good reliability and validity. Higher scores indicate more endorsed depression symptomology (Zung, 1965).

The Zung Self-Rating Anxiety Scale.

The ZAS is a twenty-item self-administered survey that assesses the cognitive, autonomic, motor, and CNS symptoms associated with anxiety. Research using this scale has evidenced good reliability and validity. Higher scores indicate more endorsed anxiety symptomology (Zung, 1971).

RESULTS

Demographic Results

The 887 respondents to the survey included a broad demographic of men. Their ages ranged from 18 to 77 years old, with a mean age of 29.3 years (SD = 11.2). Ethnically, 83.3% were of European descent; 4.2% were of African descent; 7.0% were of Latin/Hispanic descent; 4.5% were of Asian descent; and the remaining 9.0% identified as Native, Middle-Eastern, or selected "other" as their ethnicity. More than a third of respondents (35.9%) grew up outside of the United States. Those within the U.S. (63.1%) grew up in the Northeast (15.0%), Mid-Atlantic (4.6%), Southeast (8.7%), Midwest (15.4%), Plains (1.8%), Southwest (4.6%), Northwest (3.7%), and West Coast (9.9%) regions. Twenty-six percent were from rural arears; 54.9% were from small cities or suburbs; and 25.8% were from medium to large urban areas. In general, the respondents were a relatively educated group. Doctoral degrees were held by 4.6%, Master's degrees by 14.1%, Bachelor's degrees by 31.5%, and Associate's degrees by 5.4%. Twenty-nine percent had incomplete or in-progress college degrees, 9.6% had a high school diploma, and 1.5% had less than a high school education. Forty-nine percent of participants identified as single/never married; 21.3% were in a relationship with a woman; 18.6% were married to a woman; 2.7% were divorced or separated from a woman; 5.1% were in a relationship or married to a man; and 1.8% reported that they were in more than one relationship. Sixty-five percent of the respondents identified themselves as "straight (heterosexual)," 15.9% were "mostly straight," 7.0% were "bisexual," 2.8% were "mostly gay," 7.1% were "gay (homosexual)," and 1.8% selected "other."

Descriptive Statistics & Reliability Analyses

Descriptive statistics, item frequencies, and scale reliabilities were calculated for the measures used in this study. Means, standard deviations, and reliabilities were examined to detect the presence of outliers. There were no noted outliers and all remaining response sets

were retained. The means and standard deviations for each measure are reported in Table 1.

The internal consistencies of the MSSS (and its Independent Scales), the CMNI, the ZDS, and the ZAS were examined using tau-equivalent reliability analyses (Cronbach's alpha). The results indicated moderate to strong reliability for all measures (Table 1).

Table 1 Measure Descriptive Statistics and Reliability Analyses

Scale	Mean	SD	Cronbach's α
Male Sexual Shame Scale	2.62	0.44	0.93
• Perceived High Libido*	2.86	0.90	0.82
• Sexual Harassment Stereotype Threat*	2.62	0.91	0.76
• Homoerotic Guardedness*	2.95	1.04	0.80
Conformity to Masculine Norms Inventory-46	41.38	5.06	0.69
Zung Depression Scale	41.64	9.87	0.87
Zung Anxiety Scale	36.53	8.05	0.84
* = MSSS Independent Scales, not included in full scale α			

Demographic Predictors

Multiple regression and correlation analyses was computed to determine if any demographic characteristics were predictive of sexual shame, traditional masculine ideology, depression symptoms, and anxiety symptoms in men. For the regression analyses, age, ethnicity, relationships status (recoded to single=1 or not single=0), number of children, sexual identity, hometown political leanings during childhood, hometown population density during childhood, importance of religion during childhood, and education level were regressed onto the composite outcome variable averages using a stepwise method. Preliminary zero-order correlations between demographic variables and the outcome variables are presented in Table 2. The MSSS multiple regression analysis results were significant ($F(3, 790) = 24.75$, $p < 0.001$). The indicated that being single, growing up in a less populated/more rural areas, and growing up in a more religious or spiritual household were predictive of male sexual shame (Table 3).

Table 2 MSSS & Demographic Zero-Order Correlations

Demographic Variable	MSSS	CMNI	ZDS	ZAS
	r	R	r	r
Age	-0.16**	-0.09*	-0.20**	-0.18**
Ethnicity: European Descent	-0.07	0.05	-0.05	0.04
Ethnicity: African Descent	0.03	0.03	0.04	-0.03
Ethnicity: Latino/a	0.04	0.00	-0.02	-0.05
Ethnicity: Native American	-0.04	-0.04	-0.01	-0.04
Ethnicity: Asian Descent	0.04	-0.04	0.06	0.05
Ethnicity: Middle-Eastern Descent	-0.02	-0.04	0.09	0.16**
Ethnicity: "Other"	0.03	-0.02	0.06	0.00
Education Level	-0.12**	0.01	-0.16**	-0.14**
Relationships Status: Single	0.26**	0.13**	0.32**	0.21**
Number of Children	-0.05	-0.00	-0.23**	-0.24
Childhood Population Density	-0.09*	-0.08	-0.02	-0.04
Childhood Political/Cultural Environment	-0.04	-0.05	-0.07	0.00
Childhood Religious/Spiritual Importance	-0.08*	-0.00	-0.00	-0.00
Sexual Identity	0.03	0.25**	-0.07	-0.15
** = Correlation is significant at the 0.01 level (2-tailed). * = Correlation is significant at the 0.05 level (2-tailed).				

Table 3 Multiple Regression Analysis of MSSS Demographic Predictors

	B	SEB	β	t	p	ΔR2
Step 1					**< 0.001**	
Being Single – Never Married	0.226	0.030	0.259	7.54	< 0.001	0.067
Step 2					**< 0.001**	
Being Single – Never Married	0.229	0.030	0.263	7.68	< 0.001	0.067
Hometown Population Density during Childhood	-0.024	0.008	-0.098	-2.87	0.004	0.010
Step 3					**< 0.001**	
Being Single – Never Married	0.232	0.030	0.267	7.82	< 0.001	0.067
Hometown Population Density during Childhood	-0.025	0.008	-0.105	-3.07	0.002	0.010
Religious or Spiritual Importance during Childhood	-0.032	0.011	-0.097	-2.85	0.004	0.009
Total R2 = 0.086						
Non-significant Variables: Age, Ethnicity, Sexual Identity, Education Level, Hometown Political Leanings						

The CMNI multiple regression analysis results were significant ($F (3, 455) = 13.77$, $p < 0.001$), indicating that being single, identifying as more heterosexual, and growing up in a less populated area were predictive of more traditionally masculine ideals as measured by the CMNI (Table 4).

Table 4 Multiple Regression Analysis of CMNI Demographic Predictors

	B	SEB	β	t	p	ΔR^2
Step 1					**< 0.001**	**0.060**
Sexual Identity	0.487	0.090	0.246	5.40	< 0.001	
Step 2					**< 0.001**	**0.014**
Sexual Identity	0.483	0.089	0.244	5.40	< 0.001	
Being Single – Never Married	0.619	0.226	0.124	2.74	0.006	
Step 3					**< 0.001**	**0.009**
Sexual Identity	0.495	0.089	0.250	5.54	< 0.001	
Being Single – Never Married	0.622	0.225	0.124	2.77	0.006	
Hometown Population Density during Childhood	-0.134	0.062	-0.097	-2.15	0.032	
Total $R^2 = 0.083$						
Non-significant Variables: Age, Ethnicity, Education, Hometown Political Leanings, Religious Importance, Number of Children						

The ZDS multiple regression analysis results were significant ($F (2, 442) = 28.31$, $p < 0.001$), indicating that being single and having fewer children were predictive of more depression symptomology (Table 5).

Table 5 Multiple Regression Analysis of Zung Depression Scale Demographic Predictors

	B	SEB	β	t	p	ΔR^2
Step 1					**< 0.001**	**0.102**
Being Single- Never Married	6.26	0.882	0.319	7.09	< 0.001	
Step 2					**< 0.001**	**0.012**
Being Single – Never Married	5.33	0.959	0.272	5.55	< 0.001	
Number of Children	-1.21	0.504	-0.118	-2.41	0.016	
Total $R^2 = 0.114$						
Non-significant Variables: Age, Ethnicity, Education, Hometown Political Leanings, Religious Importance, Population Density, Sexual Identity						

The ZAS multiple regression analysis results were significant ($F(3, 445) = 14.83$, $p < 0.001$), indicating that having fewer children, being more homosexual, and being single were predictive of more anxiety symptomology. See Table 6.

Table 6 Multiple Regression Analysis of Zung Anxiety Scale Demographic Predictors

	B	SEB	β	t	p	ΔR2
Step 1					**< 0.001**	**0.057**
Number of Children	-2.02	0.389	-0.238	-5.19	< 0.001	
Step 2					**< 0.001**	**0.019**
Number of Children	-1.92	0.387	-0.227	-4.97	< 0.001	
Sexual Identity	-0.96	0.315	-0.140	-3.06	0.002	
Step 3					**< 0.001**	**0.015**
Number of Children	-1.44	0.425	-0.169	-3.382	0.001	
Sexual Identity	-1.00	0.313	-0.145	-3.185	0.002	
Being Single – Never Married	2.14	0.797	0.134	2.684	0.008	
Total $R^2 = 0.091$						
Non-significant Variables: Age, Ethnicity, Education, Hometown Political Leanings, Religious Importance, Population Density						

Regression & Correlation Analyses

To examine the relationships between traditional masculine ideology, depression symptomology, anxiety symptomology, and male sexual shame a series of correlation and regression analyses were performed.

Initial Correlations

First, a set of correlations were computed to examine the relationships between traditional masculine ideology, depression symptomology, and anxiety symptomology. The results indicated a weak but significant correlation between traditional masculine ideology (as CMNI) and depression symptomology (as ZDS), $r = 0.15$, $n = 292$, $p = 0.013$; a strong, significant correlation between depression symptomology and anxiety symptomology (as ZAS), $r = 0.781$, $n = 284$, $p < 0.001$; and no significant correlation between traditional masculine ideology and anxiety symptomology, $r = 0.09$, $n = 296$, $p = 0.124$. The results indicated that male sexual shame (as MSSS) was significantly correlated with all other variables. Male sexual shame was moderately correlated with traditionally masculine ideology ($r = 0.28$, $n = 463$, $p < 0.001$), moderately correlated with depression symptomology ($r = 0.49$, $n = 449$, $p < 0.001$), and

moderately correlated with anxiety symptomology (r = 0.42, n = 455, p < 0.001). See Table 7.

Table 7 Variable Correlation Matrix

Factor	1	2	3	4
1. Male Sexual Shame Scale				
2. Conformity to Masculine Norms Inventory	0.28**			
3. Zung Depression Scale	0.49**	0.15*		
4. Zung Anxiety Scale	0.42**	0.09	0.78**	
** = Correlation is significant at the 0.01 level (2-tailed). * = Correlation is significant at the 0.05 level (2-tailed).				

Regression Analyses

To better understand what factors of traditional masculine ideology were predictive of depression symptomology, a hieratical multiple regression analysis was conducted by regressing the CMNI subscales on the ZDS. The results were significant (F (4, 287) = 12.41, p < 0.001), and suggested that increases in self-reliance, violence, and emotional control were predictive of increased depression symptomology, while an increase in risk taking was predictive of decreased depression symptomology (Table 8).

A multiple regression analysis was computed to determine if depression and anxiety symptomology were predictive of male sexual shame, while accounting for one another. To do this the ZDS and ZAS were regressed onto the MSSS. The results were significant (F (2, 281) = 51.30, p < 0.001), and indicated that depression symptomology was predictive of male sexual shame, but not anxiety symptomology (Table 9).

Next, the CMNI subscales were regressed onto MSSS composite scores in a stepwise method to help determine what aspects of traditional masculinity may be predictive of male sexual shame. The results were significant (F (2, 460) = 38.06, p < 0.001), and indicated that increases in heterosexual self-presentation and self-reliance were associated with increases in male sexual shame (Table 10).

Table 8 Multiple Regression Analysis – CMNI Subscale Predictors of Depression Symptomology

	B	SEB	β	t	p	ΔR^2
Step 1					**< 0.001**	**0.080**
CMNI: Self-Reliance	4.53	00.900	0.283	5.03	< 0.001	
Step 2					**< 0.001**	**0.033**
CMNI: Self-Reliance	4.26	00.889	0.266	4.78	< 0.001	
CMNI: Risk-Taking	-3.08	00.934	-0.183	-3.30	0.001	
Step 3					**< 0.001**	**0.022**
CMNI: Self-Reliance	3.05	00.987	0.191	3.09	0.002	
CMNI: Risk-Taking	-2.95	00.926	-0.175	-3.18	0.002	
CMNI: Emotional Control	2.22	00.825	0.166	2.69	0.007	
Step 4					**< 0.001**	**0.012**
CMNI: Self-Reliance	2.94	00.983	0.184	2.99	0.003	
CMNI: Risk-Taking	-3.44	00.952	-0.205	-3.61	< 0.001	
CMNI: Emotional Control	2.10	00.823	0.157	2.55	0.011	
CMNI: Violence	2.64	1.304	0.115	2.02	0.044	
Total $R^2 = 0.147$						
Non-significant CMNI Subscale Variables: Winning, Power over Women, Playboy, Primacy of Work, Heterosexual Self-Presentation						

Table 9 Multiple Regression Analysis - ZDS & ZAS as Predictors of MSSS

	B	SEB	β	t	p
Zung Depression Scale	0.020	0.003	0.469	5.73	< 0.001
Zung Anxiety Scale	0.003	0.004	0.060	0.74	0.463
Total $R^2 = 0.267$					

Table 10 Multiple Regression Analysis – CMNI Subscale Predictors of Male Sexual Shame

	B	SEB	B	t	p	ΔR^2
Step 1					**< 0.001**	**0.112**
CMNI: Heterosexual Self-Presentation	0.206	0.027	0.335	7.63	< 0.001	
Step 2					**< 0.001**	**0.030**
CMNI: Heterosexual Self-Presentation	0.190	0.027	0.308	7.05	< 0.001	
CMNI: Self-Reliance	0.113	0.028	0.175	4.00	< 0.001	
Total $R^2 = 0.142$						
Non-significant Subscale Variables: Winning, Emotional Control, Risk-Taking, Power over Women, Playboy, Primacy of Work, Violence						

The MSSS subscales and independent scales were regressed onto the CMNI composite scores in a stepwise method to help determine what aspects of male sexual shame were predictive of traditionally masculine ideology. The results were significant ($F(4, 458) = 34.98$, $p < 0.001$), and indicated that increases in homoerotic guardedness, a perceived high libido, self-disparagement of sexual inexperience, and dystonic sexual actualization were associated with increases in traditionally masculine ideals (CMNI) (Table 11).

Table 11 Multiple Regression Analysis – MSSS Subscale Predictors of Depression Symptomology

	B	SEB	B	t	p	ΔR^2
Step 1					**< 0.001**	**0.174**
Homoerotic Guardedness	1.02	0.104	0.417	9.86	< 0.001	
Step 2					**< 0.001**	**0.029**
Homoerotic Guardedness	1.000	0.102	0.408	9.78	< 0.001	
Perceived High Libido	0.50	0.122	0.172	4.12	0.001	
Step 3					**< 0.001**	**0.019**
Homoerotic Guardedness	0.90	0.105	0.367	8.56	< 0.001	
Perceived High Libido	0.50	0.121	0.173	4.20	< 0.001	
Self-Disparagement of Sexual Inexperience	0.34	0.100	0.145	3.38	0.001	
Step 4					**< 0.001**	**0.011**
Homoerotic Guardedness	0.85	0.106	0.348	8.05	< 0.001	
Perceived High Libido	0.46	0.121	0.157	3.79	< 0.001	
Self-Disparagement of Sexual Inexperience	0.36	0.099	0.153	3.58	< 0.001	
Dystonic Sexual Actualization	0.38	0.145	0.109	2.60	0.010	
Total $R^2 = 0.234$						
Non-significant MSSS Subscale Variables: Masturbation/Pornography Remorse, Libido Distain, Body Dissatisfaction, Sexual Performance Fears, Sexual Harassment Stereotype Threat						

The MSSS subscales and independent scales were regressed onto ZDS composite scores in a stepwise method to determine what aspects of male sexual shame were predictive of depression symptomology. The results were significant ($F(4, 444) = 90.47$, $p < 0.001$), and indicated that increases in body dissatisfaction, sexual performance fears, libido distain, and sexual harassment stereotype threat were associated with increases in depression symptomology (Table 12).

Table 12 Multiple Regression Analysis – MSSS Subscale Predictors of Depression Symptomology

	B	SEB	B	t	p	ΔR^2
Step 1					**< 0.001**	**.350**
Body Dissatisfaction	5.59	0.360	0.592	15.52	< 0.001	
Step 2					**< 0.001**	**0.060**
Body Dissatisfaction	3.75	0.440	0.396	8.51	< 0.001	
Sexual Performance Fears	2.79	0.416	0.313	6.71	< 0.001	
Step 3					**< 0.001**	**0.030**
Body Dissatisfaction	3.26	0.443	0.341	7.29	< 0.001	
Sexual Performance Fears	2.36	0.416	0.264	5.67	< 0.001	
Libido Distain	2.30	0.472	0.196	4.86	< 0.001	
Step 4					**< 0.001**	**0.009**
Body Dissatisfaction	3.05	0.444	0.323	6.87	< 0.001	
Sexual Performance Fears	2.20	0.416	0.246	5.28	< 0.001	
Libido Distain	2.17	0.471	0.186	4.61	< 0.001	
Sexual Harassment Stereotype Threat	1.18	0.428	0.105	2.76	0.006	
Total $R^2 = 0.449$						
Non-significant MSSS Subscale Variables: Self-Disparagement of Sexual Inexperience, Masturbation and Pornography Remorse, Dystonic Sexual Actualization, Perceived High Libido, Homoerotic Guardedness						

Mediation & Moderation Analyses

Moderation Analysis

To test if traditional masculine ideology moderated the relationship between male sexual shame and depression symptomology, a set of analyses were conducted to determine if the observed correlation between the MSSS and the ZDS (Table 7) would be modified when CMNI scores were included. To do so centered variables (residuals) were calculated for CMNI composite scores and MSSS composite scores by subtracting individual composite scores from their respective composite mean scores. The two centered CMNI and MSSS scores were then multiplied by one another, creating a centered product score. This centering technique, as described by Aiken & West (1991), minimizes the effects of multicollinearity on the moderation analysis.

The centered product scores along with CMNI and MSSS composite scores were regressed (stepwise) onto ZDS scores to detect the presence of an interaction (moderation) effect. If a

moderating affect was present, the centered product score would significantly predict the outcome (ZDS) in the multiple regression analysis. It did not. While the overall regression analysis was significant ($F(3, 288) = 30.12$, $p < 0.001$, $R^2 = 0.489$), the centered product score (moderation) did not significantly predict the outcome ($t = 1.47$, $p = 0.142$). These results suggest that traditional masculine ideology does not significantly moderate the relationship between male sexual shame and depression symptomology. However, given the significant results of the overall regression analysis, it was suspected that an un-hypothesized mediating effect was present.

Mediation Analysis

Given the significant correlations between MSSS and CMNI, between MSSS and ZDS, and between CMNI and ZDS described above (Table 7), the final step in the mediation analysis was conducted by regressing MSSS composite scores and CMNI composite scores on ZDS scores. A significant mediation would be evidenced by a significant reduction of covariance in one of the independent variables (CMNI or MSSS) when compared to the above correlation results. The results indicated that CMNI was no longer a significant predictor of ZDS, after controlling for MSSS (mediator). These results suggest that the association between traditional masculine ideology and depression symptomology was fully meditated by male sexual shame in this sample (Figure 1, Figure 2).

Figure 1 CMNI-46 and ZDS Correlations

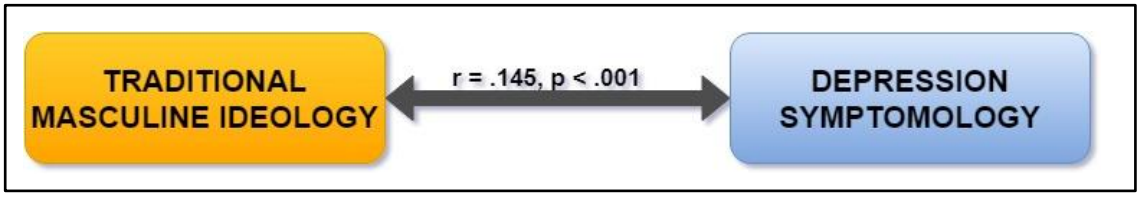

Figure 2 MSSS' Mediation of CMNI-46 and ZDS

DISCUSSION

The effect of sexual shame on mental health has primarily been regarded as a women's issue (Ringrose & Harvey, 2015) and has not been well researched as it relates to men. This is despite suggestions that shame is especially impactful on the psychologies of men (Osherson & Krugman, 1991) and that unmanaged shame is associated with a broad array of psychological concerns (Gilbert, 2000; Shepard & Rabinowitz, 2013). Yet, academic and popular media have not given much attention to the current crisis of men and mental health even with the noted cultural shifts that are directly affecting them. What is ironic, is that in the midst of what is seemingly a renegotiation of gender norms in many western societies, old (traditional) norms persist in contextualizing *how* we have these conversations and whose concerns are important to attend to. The absence of mainstream discussion on the effects of emerging gender and sexual norms on men could be viewed as an artifact of traditional gender norms. Norms that suppose that men are (or should be) psychologically impervious, emotionless, and have a regard for sexuality that is generally flippant, and therefore are (or should be) unaffected by the changing tides. Yet, this is could not possibly be true, and the results of this research offer some evidence to rebut these outdated notions. Importantly, these gender and sexual concerns may well be linked to the increases in violence perpetrated by and towards young men. Unfortunately, this research only represents a very small part of these large and dynamic issues, which is why it is important to pursue more research in this area in order to discover potential solutions.

LIMITATIONS

While the results of this study illuminate some important associations related to men's mental health, sexual shame, and traditional masculine ideology, it is important to note some limitations of this research. First, this research was conducted using self-reported surveys, which are more susceptible to deception and response bias than some other methodologies. However, research suggests that self-administered surveys (Catania, Gibson, Chitwood, & Coates, 1990), anonymous surveys, and online surveys (Joinson, 1999), like this one, are less likely to produce social desirability bias than in-person, paper-and-pencil surveys. Also, research on response trends suggests participants are no more biased when responding to sex/uality surveys than to surveys of other types (Johnson & Delamater, 1976).

Second, because the sample for this research was primarily made up of self-selected participants, it is difficult to say how generalizable the results are. While this method of sampling did result in a large, relatively diverse, international sample, most of the participants were of European descent (83%) and may have been distinctive from the general population in other, undetected ways. Further, because of the diversity of regions and cultures among the men in this sample, perceptions and expectations of gender/masculinity were likely broadly varied. It will be important for researchers and clinicians to consider these limitations when attempting to generalize these results to the broader population.

Lastly, this research assessed depression and anxiety symptomology using a non-clinical population. It also did not diagnose or distinguish diagnosable levels of symptomology. Therefore, it may be difficult to discern how/if these results can be applied directly to clinical populations.

SUMMARY OF RESULTS

The purpose of this research was to evaluate the relationship between male sexual shame (as measured by the MSSS), traditional masculine ideology (as measured by the CMNI-46), and depression and anxiety symptomologies (as measured by the ZDS and ZAS, respectively). The initial results indicated that traditional masculine ideology, male sexual shame, and depression symptomology were all correlated with one another. Anxiety symptomology was also correlated with male sexual shame; however, subsequent regression analyses revealed that when depression symptomology was taken into account, anxiety symptomology was no longer significantly predictive of male sexual shame. These results confirm the first three hypotheses described in the Introduction. (The results of the fourth hypothesis are discussed later in this section.)

Because the instruments used to measure male sexual shame and traditional masculine ideology were made up of several factors, it was of interest to consider how those factors (i.e. subscales) contributed to the associations described above. The following paragraphs describe the relationships between these (sub-)factors and the larger constructs.

The correlation between traditional masculine ideology and depression symptomology was weak ($r = 0.15$). Subsequent analysis revealed that some aspects of traditional masculinity (i.e., self-reliance, emotional control, and risk taking) were particularly associated with depression

symptomology. Reported depression symptoms were found to increase with increases in self-reliance and emotional control; whereas, depression symptoms were found to decreases with an increase in risk-taking. This negative correlation was unexpected. These results suggest that while some aspects of traditional masculinity are associated with depression symptoms, other aspects of this gender role may be innocuous or even be preventive to developing depression symptoms. Of course, causation cannot be inferred from these findings, and more research is needed to verify these potentialities.

There was also a weak-moderate correlation between traditional masculine ideology and male sexual shame (r = 0.28). Subsequent regression analysis revealed that two aspects of traditional masculinity were predictive of male sexual shame on their own – these were heterosexual self-presentation and self-reliance. Increases in these factors was predictive of increases in male sexual shame. From the other perspective, the components of male sexual shame that were significant predictors of traditional masculine ideology were homoerotic guardedness, perceived high libido, self-disparagement of sexual inexperience, and dystonic sexual actualization. Increases in these aspects of male sexual shame were associated with increases in traditional masculine ideology.

Male sexual shame was moderately correlated with both depression (r = .49) and anxiety (r = 0.42) symptomology. However, when accounting for both symptomologies in a subsequent regression analysis, only depression symptomology was found to be predictive of male sexual shame. Further analysis revealed that body dissatisfaction, sexual performance fears, libido distain, and sexual harassment stereotype threat were the components of male sexual shame that were found to be predictive of depression symptomology. Increases in these aspects of male sexual shame were associated with increases in depression symptomology.

The final hypothesis of this study predicted that the relationship between male sexual shame and depression symptomology would be moderated by traditional masculine ideology. However, the moderation analysis indicated that the relationship between male sexual shame and depression symptomology was not significantly influenced by traditional masculine ideology. Although the results of that analysis suggested that another relationship was at work regarding these three variables. A subsequent mediation analysis revealed that the relationship between traditional masculine ideology and depression symptomology was fully mediated by

male sexual shame. This suggests that in the absence of sexual shame (as measured here), traditional masculinity has no significant association to depression symptomology. It is important to note that this finding was surprising and warrants additional research before being widely generalized.

IMPLICATIONS & DIRECTIONS FOR FUTURE RESEARCH

The results of this research suggest that sexual shame and masculine ideology are relevant factors in understanding men's mental health issues. The relationship between sexual shame and depression may be of particular importance given the strength of the findings here. This may also be relevant to the ongoing conversations on men's violence, given some men's proneness toward anger, aggression, and suicide when clinically depressed (Wålinder & Rutz, 2001; Winkler, Pjrek, & Kasper, 2005; Dumais, et al., 2005).

Given these relationships, it may be important for clinicians, educators, and researchers interested in men's mental health to inquire about sex, sexuality, and gender issues to determine if such issues are contributors to or manifestations of presented problems. It also may be important for these professionals to be attentive to indications of shame related to sex, sexuality, and gender – particularly those aspects of sexual shame and traditional masculinity that were found to be associated with depression symptomology (i.e., self-reliance, emotional control, and risk taking, body dissatisfaction, sexual performance fears, libido distain, sexual harassment stereotype threat).

These findings are important because they elucidate areas that are often not viewed as relevant to men's mental health concerns and may be overlooked in assessing what factors contribute to psychological symptomology. Additionally, they suggest two, related areas of exploration (i.e, gender and sexuality) in addressing modern concerns about men's mental health, (and potentially) suicide, and violence.

Future research on this topic should assess the found associations among a clinical population of men. Given these findings, it may also be important to assess the relationship between sexual shame, traditional masculine ideology, and other mental health concerns not measured here. It may be that sexual shame and traditional masculine ideology contribute to psychological symptomologies beyond depression and anxiety. Finally, it will be important to

consider what type of interventions could be helpful in addressing the distress and harmful outcomes related to these issues.

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