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Chapter 1

EXPLORING CHILDHOOD SEXUAL EXPERIENCES AND VULNERABILITY TO INTIMATE PARTNER VIOLENCE AMONG AFRICAN AMERICAN MSMW: WAS THAT ABUSE OR LOVE?

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ABSTRACT

Background

Childhood sexual abuse among men who have sex with men (MSM) has been associated with increased sexual risk for HIV infection, poorer psychological outcomes, and adult sexual and physical revictimization through intimate partner violence (IPV). For non-gay identifying (NGI) African American men who have sex with men and women (MSMW), a less studied population, appraisal and self-definition of childhood sexual experiences may influence sexual identity and the ability to establish safe physical and sexual boundaries. Attention to the relationship between appraisal of early sexual

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experiences and adult physical and sexual abuse needs to be considered when developing HIV risk reduction interventions for HIV-positive NGI African American MSMW.

Methods

Two groups, each meeting twice for 90-minutes, of HIV-positive NGI African American MSMW participated in semi-structured focus group discussions on childhood sexual experiences, appraisal and self-definition of these experiences, intimate adult relationships, and being HIV-positive. Discussions were recorded, transcribed, and analyzed using consensual qualitative research and a constant comparison qualitative method.

Results

The overall sample included 16 men with a mean age of 40.5 years, who were predominantly high school educated. A little more than a third of the sample was employed with almost two-thirds earning an annual income of less than $20,000. Three major themes, each with two domains, were identified and included childhood sexual experiences, sexual identity, and intimate partner violence. The domains under childhood sexual experiences included appraisal and sexual decision-making, which focused on how these men defined and associated sexual abuse with current sexual decisions and behaviors. Approximately one-third of the sample did not perceive childhood sexual experiences to be traumatic, but the majority believed these experiences affected sexual decision-making subsequently. The domains for sexual identity included undeclared and declared sexual identities and focused on whether these men experienced difficulties in defining their sexual identities. Approximately half of the sample believed childhood sexual experiences contributed to confusion and high-risk exploration of their sexuality. Intimate partner violence included the domains of normative behavior and abuse equates to love and focused on how the men framed their adult experiences with abuse and its association to childhood experiences. Intimate partner violence was viewed to be commonplace throughout African American relationships in general, due to mirroring behaviors displayed by parents and violence being a proxy for manhood, strength, and love. Men reported being both victim and perpetrator in both male-female and male-male relationships with approximately half of the sample believing that IPV was not a reason to terminate a relationship.

Conclusion

Understanding how HIV-positive NGI African American MSMW interpret early sexual experiences may have an impact on sexual decision-making, sexual identity formation, and the ability to form healthy adult intimate relationships. The impact of early sexual experiences, with attention on appraisal of the incidents, must be considered when developing HIV risk reduction interventions for HIV-positive NGI African American MSMW.

Keywords: African American MSMW, sexual abuse, intimate partner violence, HIV interventions.

INTRODUCTION

HIV/AIDS continues to be a devastating epidemic that has disproportionately impacted some populations greater than others. Blacks in the United States account for 52% of all diagnoses of HIV infections (Centers for Disease Control and Prevention [CDC], 2010) but comprise only 12.9% of the population (U.S. Census Bureau, 2010). The cumulative estimate of AIDS diagnoses through 2008 for Blacks (452,916), Hispanics/Latinos (180,061), and Whites (419,905) illustrates the HIV/AIDS disparity that is heavily impacting Blacks (CDC, 2010). Among Blacks, the transmission route of male-to-male sexual contact continues to be the greatest HIV risk category with 63% of new infections (CDC, 2008). Black men who have sex with men (MSM), aged 13-29 years, had 1.6 times the number of new HIV infections than among White and 2.3 times the number among Hispanic MSM (CDC, 2008). Efforts to address this epidemic have included prevention and risk reduction strategies largely based on the premise that knowledge influences behavior and that by providing HIV education and access to condoms, HIV infection rates would decrease. Unfortunately, behavior change is complicated and multifaceted, influenced by any number of personal, environmental, historical, and institutional factors (Williams, Wyatt, & Wingood, 2010). Identification of moderating and mediating variables that influence sexual behaviors and HIV transmission is critical to risk reduction if HIV interventions are to be successful in the many diverse African American communities.

The Need to Address CSA in HIV Interventions

One important variable, experiences of childhood sexual abuse (CSA), has commonly been neglected within HIV prevention and risk reduction interventions for MSM and men who have sex with men and women (MSMW), despite the growing literature citing its negative contributions to mental, physical, and sexual health. Whiffen and MacIntosh (2005) found that a history of CSA was significantly associated with adult emotional distress, including significant symptoms of generalized distress, anxiety, and post-traumatic stress disorder (PTSD) (Whiffen, Benazon, & Bradshaw, 1997). Furthermore, forms of childhood maltreatment, which include experiences of childhood sexual abuse, are associated with symptoms of major depression, anxiety, and PTSD, as well as borderline and antisocial personality disorders and alcohol and substance abuse (Beitchman et al., 1992; Harrison, Edwall, Hoffman, & Worthen, 1990; Holmes, Foa, Sammel, 2005; Holmes & Slap, 1998; Langevin, Wright, & Handy, 1989; Mimiaga et al., 2009; Nagy, Adcock, & Nagy, 1994; Nelson, Higginson, & Grant-Worley, 1994; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997; Whiffen & MacIntosh, 2005; Windle, Windle, Scheidt, & Miller, 1995). Adults with histories of CSA have also been found to have difficulties with romantic interpersonal adult relationships, possibly due to insecure attachments established through abusive relationships in childhood (Alexander, 1992) and are at an increased risk for revictimization (Roche, Runtz, & Hunter, 1999; Rumstein-McKean & Hunsley, 2001; Whiffen & MacIntosh, 2005).

In regard to physical health, among a representative population-based sample of men and women, a strong relationship was found between a history of CSA and health behavior

indicators including smoking, alcohol problems, and obesity (Chartier, Walker, & Naimark, 2009). More specifically, heavy drinking was found to be significant among males who had a history of CSA (OR=2.0) (Bensley, Van Eenwyk, & Simmons, 2000). Furthermore, a history of CSA has been found to be a risk factor for eating disorders, with the association of bulimia nervosa being slightly stronger than that of anorexia nervosa (Wonderlich, Brewerton, Jocic, Dansky, & Abbott, 1997). Mental and physical health status can not be ignored when developing HIV prevention and risk reduction interventions, as overall health status may influence sexual decision-making and well-being.

Numerous studies have identified an association between CSA and sexual health, both in adolescence and later in life. Among a sample of high-risk youth who had experienced childhood maltreatment and had witnessed violence, a history of CSA was found to be linked to initiation of HIV risk behaviors, such as alcohol use and sexual intercourse (Jones et al., 2010). As an adult, sexual performance and satisfaction were also found to be negatively impacted by having a history of CSA (Burns-Loeb et al., 2002; Senn, Carey, & Vanable, 2008). Within a review of the CSA literature on males, Holmes and Slap (1998) found that abused men, in comparison to non-abused men, were more likely to engage in high-risk sexual behaviors, have more lifetime sexual partners, use condoms less frequently, have higher rates of sexually transmitted diseases, and have up to a two-fold increase in the rate of HIV. More specifically, Jinich and colleagues (1998) found that gay and bisexual men who reported CSA, as defined by having sexual experiences with someone at least five years older prior to age 13 or with someone 10 years older when between the ages of 13 and 15, were more likely to have unprotected anal intercourse, more sexual events and partners, and more sexual episodes under the influence of drugs than men not reporting CSA. Paul, Catania, Pollack, and Stall (2001) also found that MSM with CSA histories were more likely than those without CSA histories to be HIV-positive, engage in unprotected anal intercourse with a non-primary partner or a partner with an unknown history or who was serodiscordant, and use drugs while engaging in sexual activity. Other studies have found similar high-risk behaviors among HIV-positive MSM (O'Leary, Purcell, Remien, & Gomez, 2003), as well as among MSM in a longitudinal behavioral intervention (Mimiaga et al., 2009). Unfortunately, these studies did not include significant samples of African American MSM or more specifically, MSMW.

CSA and Sexual Identity

A history of CSA has been hypothesized to impact gender and sexual identity. Several studies have found support for higher rates of gender role confusion and fears regarding intimate relationships with both men and women among men with histories of CSA (Holmes & Slap, 1998; Hunter, 1991; Jacobson & Herald, 1990; Janus, Burgess, & McCormack, 1987; McCormack, Janus, & Burgess, 1986; Sansonnet-Hayden, Haley, Marriage, & Fine, 1987). For instance, Richardson, Meredith, and Abbot (1993) found that among a sample of 90 sexually abused adolescent boys, gender roles were defined as undifferentiated (52%), masculine (23%), androgynous (19%), and feminine (6%). Further, abused boys, especially those who were victimized by males, were up to seven times more likely to self-identify as gay or bisexual than their non-abused counterparts (Johnson & Shrier, 1985; Johnson & Shrier, 1987). In terms of sexual identity, men with documented histories of CSA were more

likely than those with histories of childhood physical abuse and/or childhood neglect to report having had same-sex sexual partners in their lifetime (Wilson & Widom, 2010). A significant limitation in understanding the effect of CSA on sexual identity is that establishing causal relationships require longitudinal studies, which are lacking. Importantly, gender role confusion that precedes experiences of sexual abuse makes it difficult to establish a linear pathway to a defined sexual identity.

Some research has been conducted in an attempt to assess whether experiences of CSA influence adult sexual identity. Holmes and Slap (1998) have suggested that exploration of sexuality may physically place adolescents at increased risk for being sexually abused, while numerous studies with gay, lesbian, and bisexual youth have found that these adolescents are often disproportionately physically and verbally abused due to their sexual orientation (Faulkner & Cranston, 1998; Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Hunter, 1990; Pilkington & D'Augelli, 1995; Wilson & Widom, 2010). It has also been suggested that gender non-conforming behavior in childhood may be associated with same-sex sexuality later in life (Bailey & Zucker, 1995) and that this behavior contributes to these children being targeted and susceptible to being abused (Balsam, Rothblum, & Beauchaine, 2005; Corliss, Cochran, & Mays, 2002). The impact of CSA on sexual identity continues to pose many questions and remains poorly understood.

Appraisal of Sexual Experiences

Assessment of the impact of CSA on sexual identity is further complicated due to self-definitions of the experiences. The level of emotional and psychological awareness and the manner in which an individual appraises and defines childhood sexual experiences can influence current sexual decision-making and risk behaviors. Unfortunately, very few studies have specifically explored CSA appraisal and self-definition solely among gay/bisexual men (Dolezal & Carballo-Dieguez, 2002; Holmes, 2008; Stanley, Bartholomew, & Oram, 2004). However, in a study conducted by Holmes (2008) with a sample of heterosexual and gay/bisexual men, men who defined their sexual experiences as CSA were called 'definers,' while those who did not appraise the experience as CSA were termed 'non-definers.' Holmes found no significant differences in rates of self-defining early sexual experiences as CSA between heterosexual and gay/bisexual men. Importantly, among the sample of heterosexual and gay/bisexual men, non-definers were significantly more likely to engage in high-risk sexual behaviors than their definer counterparts. That is, a higher proportion of non-definers reported having sex under the influence and having more lifetime partners than definers. Since all non-definers were significantly more likely to engage in sexual risk behaviors than the definers and those men who lacked CSA, it was concluded that histories of CSA and non-appraisal of these experiences as abuse, regardless of sexual identity, placed individuals at significant sexual health risk. In contrast, Dolezal and Carballo-Dieguez (2002) found that among their sample of Latino gay/bisexual men, definers reported higher rates of alcohol use, unprotected anal intercourse, and more male sex partners than their non-definer counterparts. This conflicting evidence, along with the statistics that only 38% to 59% of gay/bisexual adult males self-define childhood sexual experiences as sexual abuse and, only 18% define the experience to be sexual abuse at the time of the incident (Holmes, 2008), warrants further

investigation into how individuals frame their childhood sexual experiences and its potential impact on future sexual risk behaviors.

CSA and Adult Revictimization

There is a significant body of literature which supports the finding that women with histories of CSA are at increased risk to experience sexual abuse again later in childhood or in adulthood, and this phenomenon is defined as revictimization (Balsam, Lehavot, & Beadnell, 2010; Burns-Loeb et al., 2002; Cloitre, Tardiff, Marzuk, Leon, & Potera, 1996; Wyatt, Gutherie, & Notgrass, 1992). In a review with approximately 90 empirical studies, it was estimated that two-thirds of individuals abused in childhood were later revictimized (Classen, Palesh, & Aggarwal, 2005). In one study with predominantly White gay identifying MSM, one-third of the sample experienced CSA and unwanted sexual coercion as an adult (Kalichman et al., 2001). Balsam, Lehavot, and Beadnell (2010) found that 19.7% of their sample of predominantly White lesbian, gay men, and heterosexual women had both histories of CSA and adult sexual abuse, specifically adult rape. Despite these findings, research that examines revictimization among MSM and MSMW populations in general, or among African American MSM and MSMW specifically, are lacking.

Another problematic area of research surrounding sexual abuse is that recurrent episodes of sexual abuse later in childhood and adulthood is only one part of revictimization. There is the additional problem of intimate partner violence (IPV), defined as a pattern of controlling, abusive behavior within an intimate relationship that may include physical, emotional, verbal, or sexual abuse (Basile & Saltzman, 2002). Victims of CSA may be at risk for revictimization as experienced through IPV. That is, individuals with histories of CSA may be more likely to externalize personal control and thus be at risk for revictimization through IPV. IPV, however, has received much less attention among same-sex couples than their heterosexual counterparts, despite incidence rates being estimated at equal to or greater than that of heterosexual women (Renzetti & Miley, 1996; Greenwood et al., 2002, respectively). In a review article by Relf (2001), it was concluded that being the victim of IPV may be linked to unprotected sexual risk behaviors and seroconversion and importantly, that being an HIV-positive MSM may also be linked to becoming a victim of IPV.

Limited research that examines pertinent socio-cultural factors affecting sexual risk behaviors has been conducted specifically with non-gay identifying HIV-positive African American MSMW, a population that is heavily infected and affected by HIV/AIDS. Currently, there is only one best-evidence HIV intervention listed in the CDC's *Compendium of Evidence-Based HIV Prevention Interventions* that specifically targets Black MSM (CDC, 2009). In an effort to address the sexual health needs of non-gay identifying HIV-positive African American MSMW with histories of CSA and to develop a culturally congruent HIV risk reduction intervention, the purpose of this formative qualitative study was to: 1) explore childhood sexual experiences before the age of 18 and the manner in which these experiences were appraised; 2) explore sexual identity and the meaning of manhood and masculinity for African American bisexual men; and 3) identify risks for intimate partner violence. These three objectives were examined within the context of potentially being mediating or moderating variables for sexual risk reduction and thus, are conceptualized as important

variables to consider when developing an HIV risk reduction intervention for non-gay identifying African American MSMW with histories of CSA.

METHODS

Design

After receiving University Institutional Review Board approval at the University of California, Los Angeles (UCLA), two semi-structured focus group discussions with HIV-positive NGI African American MSMW were conducted by the principal investigator/lead author. Each focus group met twice for 90-minutes. Thus, group A met twice for a total of three hours, as did group B. Recruitment fliers were posted in four community based organizations in Los Angeles County, which provide diverse services such as HIV counseling and testing, medical care including HIV/AIDS treatment, substance abuse counseling and treatment, and residential housing. Additionally, fliers were distributed at local health and community events. The fliers, screeners, and informed consent process explained that this was a research study exploring and discussing childhood sexual experiences, appraisal and self-definition of these experiences, intimate adult relationships, and being an HIV-positive bisexual African American man. The initial meeting focused on introducing these topics, while the second meeting allowed for a more in-depth exploration. The focus group discussions were recorded, transcribed verbatim, and analyzed with consensual qualitative research (CQR) and a constant comparison qualitative method.

To ensure confidentiality, no personal identifiers were included in the transcripts of the group discussions or on the post-group demographic surveys. Once informed consent was obtained, nametags were distributed, whereby participants were free to print a pseudonym. After completing the group, participants were asked to complete a short demographic survey including items asking about age, education, income, and what sexual label they felt most comfortably described them (i.e., gay, straight, bisexual, etc.). While eligibility criteria required that participants were behaviorally bisexual and non-gay identifying, research suggests that there is often a discordant reporting of sexual behavior and labels (Pathela et al., 2006; Simon et al., 1999; Stokes, McKirnan, Doll, & Burzette, 1996; Wohl et al., 2002). Thus, a description of sexual behavior and sexual self-identity was assessed. Participants were compensated $30 per meeting and thus, received a total of $60 for their time. Light refreshments were provided during the focus groups.

Participants

Potential participants who responded to the recruitment fliers were screened for eligibility. Participants had to qualify on eight inclusion criteria which were that they had to be: 1) self-identifying Black or African American; 2) English-speaking; 3) 18 years or older; 4) HIV-positive (verified through test results, medical records, antiretroviral medication prescriptions, etc.); 5) a sexually active male with both male and female partners in the past 90 days; 6) a male with a sexual experience before the age of 18 where someone used force or

threat of force to have sex or had a sexual experience with someone at least 5 years older; 7) a male who had not used a condom during vaginal or anal sex at least once in the past 90 days; and 9) non-gay identifying.

To screen for CSA, seven questions inquiring about sexual experiences prior to the age of 18 were utilized. This screener included language such as, "before the age of 18, did anyone attempt to have intercourse with you against your will." The investigators avoided the use of the term "childhood sexual abuse," as potential participants may not appraise their experiences as abuse despite fulfilling definitions of CSA. For this study, CSA was defined as, before the age of 18, experiencing any unwanted or forced sexual contact (ranging from touching and fondling to intercourse) and/or having sexual experiences with someone at least 5 years older. Eligible participants, therefore, were HIV-positive African American men who had histories of sexual contact before the age of 18 years, defined as CSA by the investigators, had engaged in unprotected sex with both male and female partners in the prior 3 months, and were non-gay identifying.

Measures

The semi-structured focus group interview guide was developed by the research team. Thirteen questions specifically targeting HIV-positive NGI African American MSMW with histories of childhood sexual abuse were included. Questions were conceptualized and explored general (5 items) and sexual health (6 items), as well as gender role issues (2 items). The specific topics discussed focused on main health issues for African American men and MSMW in particular, sexual behaviors and sexual identity, cultural and gender roles, intimate partner relationships including casual and "one-night stands" to "serious/main/primary" or monogamous relationships, risks for HIV/AIDS, and attitudes and behaviors of people in the African American community.

The discussion on childhood sexual experiences was introduced with the following: "Sometimes, children or adolescents before age 18 have sexual experiences with an adult or someone older than them. By 'sexual' I mean behaviors ranging from someone touching their body to someone having intercourse with them. These experiences may involve a relative, a friend of the family, or a stranger. Some experiences are very upsetting and painful while others are not. Some may occur against someone's will and may have happened a long time ago." This language allowed the investigator to avoid the term childhood sexual abuse, as a specific objective of this formative study was to assess appraisal of sexual experiences prior to the age of 18, which by definition would be CSA. Probes were used when necessary to solicit additional or more detailed responses.

Data Analysis

Consensual qualitative research (Hill, Thompson, & Williams, 1997) and a constant-comparison method of data analysis, based in grounded theory (Strauss & Corbin, 1998), were used in the data analysis. The analysis team consisted of four members including the principal investigator, two co-investigators, and the project director. In the first phase of analysis, members read the sections of each focus group transcript and identified sections

discussing childhood sexual experiences before the age of 18, sexual identity, the meaning of manhood and masculinity, and intimate partner violence. Major themes identified in each transcript were summarized in a matrix format and circulated to the group for feedback. In the second phase of analysis, the group met to discuss the major themes identified across transcripts and to identify common subthemes, called domains, which were then applied consistently to quotations across all transcripts using Atlas.tiTM software to code and manage the data. Consensus of themes and domains were required prior to the coding of qualitative data.

Table 1. Participant Characteristics

	n	%
Employment		
Fulltime	4	25
Part-time	2	12.5
Unable to Work/Unemployed	8	50
Retired	2	12.5
Education		
High school and some college	11	68.75
College degree	3	18.75
Graduate degree	2	12.5
Income (total annual household)		
Less than $5,000	5	31.25
$5,000 – 9,999	1	6.25
$10,000 – 19,999	4	25
$20,000 – 29,999	2	12.5
$30,000 – 40,000	2	12.5
Greater than $40,000	2	12.5
Sexual Identity Label		
Heterosexual	0	0
Bisexual	3	18.75
Gay	8	50
Same gender loving (SGL)	5	31.25
Down-Low (DL) / Homosexual / Queer	0	0

RESULTS

The overall sample included 16 men, all who participated in the two focus groups with the mean age being 40.5 years. As illustrated in Table 1, the majority had a high school education, with 62.5% earning an annual income of less than $20,000. Since the 2009 U.S.

Department of Health and Human Services poverty guidelines (2009) state that an annual income of $22,050 for a household of four is considered the poverty line for the 48 contiguous states and the District of Columbia, by definition, the majority of the participants were living below the poverty line. Only 37.5% were currently working either full or part-time and half the sample were either unable to work or unemployed. Thus, the participants included a middle-age sample of high-school educated, financially vulnerable men. Also, while eligibility criteria required all participants to be non-gay identifying and behaviorally bisexual, on the post-group demographic survey, 50% specifically identified as gay and 31.25% as same gender loving.

Three major themes, each with two domains, were identified and included childhood sexual experiences, sexual identity, and intimate partner violence. The domains under childhood sexual experiences included appraisal and sexual decision-making. The domains for sexual identity included undeclared and declared sexual identities, while intimate partner violence included normative behavior and abuse equates to love.

CHILDHOOD SEXUAL EXPERIENCES

Appraisal

Under the major theme of childhood sexual experiences, different forms of appraisal were identified. Two-thirds of the sample viewed their childhood sexual experiences negatively while the remaining sample reported it as less traumatic with some framing it positively. The following example illustrates a participant who defined the experience as traumatic at the time of the incident.

> Yes, I have experienced it (forced sex). I'm an Air Force brat so we kind of traveled a lot when I was younger. There was a period when my father was stationed overseas, and my mother was working, so we had to stay with a babysitter…this one particular babysitter she had older sons that were in their mid 20s, early 30s, living at home and a daughter. She was maybe 18 or so, and I think I was about eight or nine. And sometimes when her mother, who was the babysitter, would leave, she would leave her daughter in charge of us…a few times…I walked in on her oldest son and his [male] lover in bed, naked, they were asleep. But around that same time, the daughter made me lay down on the bed, and she climbed over my face and made me lick it [her vagina] and she would not let me up until she got satisfied. And I never told anyone, not my parents, but I hated going over there…it was disgusting to me at the time. I guess that kind of sickened my opinion about women at an early age. It was disgusting to me. I couldn't tell anybody. [FG1A]

In contrast, the following participant appraised his experience as positive and one that he sought to revisit with both the same men, as well as with others.

> …my first one was this guy down the street, I don't know how he thought I would do this [sex with a man], but he did. But anyways …I knew I wanted it, I was already feeling that way. It really didn't matter if it was a molestation or whatever because I knew what I wanted. [FG1B].

The following participant not only appraised his experience in a positive manner, but spoke of how he held power over his adult uncles who were the perpetrators and used the opportunity to negotiate what he wanted.

> I had sex with my uncle when I was really young, this is my father's brother. He had like nine of them. I used to constantly have sex with most of them; one of them I didn't because I didn't like him. I used to charge money - I was going to tell my aunt we did something if he didn't give me money. This is how I grew up. These are my uncles on my father's side, and my two uncles on my mother's side. Now we all go to the house, all the boys in that room, and all the girls in this room. I said yeah. All night we would fondle each other, all night long until the next morning...That's how my life grew up. [FG1C].

The following participant acknowledged that there is a large difference in age between him and the man that he identified as his partner. Additionally, this participant normalized the relationship despite being an adolescent who was living with a significantly older adult male, by stating that his mother was aware of the relationship.

> I had a much older guy in my life when I was about 16 years old, he was about 40…he was very much boyfriend, husband, or however its call. I would stay over. My mom knew I was staying over there and if she needed to call or check up and see where I was, she'd say hey, is [he] over there, oh yeah, he's right here, here's the phone. It was never an issue of me being there at my age, at 16, although he was much older. He and my mom grew to be very good friends and he would take my mom around and do things. [FG2A].

Sexual Decision-Making

Another domain that was identified under the theme of childhood sexual experiences was association with sexual decision-making. While some participants attributed their high-risk sexual behaviors later in life to their childhood sexual experiences, others, despite the experiences being negative, believed the physical pleasure of an orgasm contributed to them seeking out other sexual experiences. That is, an orgasm, regardless of the circumstances in which it was achieved, would influence an individual to relive that experience.

> …after you get your first one, you screw like a rabbit and don't give a damn about the recourse. [FG1D]

> I think it…influenced me on how my decisions are made today because…when I got that first nut, it was on. Hey, I'm ready. And so I became this fast person and opened up to diseases like HIV and stuff. I think if I was growing up today I would probably wait a little bit longer… being a teenager you couldn't have sex at home, so where did you have sex, in the park, on the pier, where ever you could have sex…And there was no one there. There wasn't a guide book on how to, so when we were having unprotected sex during the early part of the HIV epidemic, it was a little too late for a lot of us. So can a 14, 15, 16 year old make the right decisions for themselves? No. So you did risky things. [FG1B].

Recognition of past experiences and having been in unsafe situations did not necessarily influence participant's current sexual decision-making or their risk for HIV infection. The

following examples illustrate participants who repeatedly placed themselves in unhealthy situations.

> I believe there have been some times that I got into situations and I didn't necessarily want to just go through with having sex and the person basically pretty much just raped me. I look at it now - some of it I wanted to do, but at some point I wanted to say, I want to stop right now. [FG2B].
>
> I've done things with people that I won't say I accidentally regretted, let's just say that at the end of the day it's something that didn't benefit me, and it might have benefited the other person more, cause I might not have been looking out for my own interests. [FG2C].
>
> I know there were some things that I didn't want to do but yet I still went through with them…I got tired of having that feeling of egg in my face… so I became angry… but I think living with HIV taught me how to stop the violation. I didn't know how to say no years ago, I got HIV…when the individual who raped me deposited, this is graphic, his first load in me, I was compelled to go back the second time from guilt. He gave me money…now I can see how sick it was but back then the attention was something I wasn't getting at home. [FG2D].

One participant shared how he repeatedly placed himself in danger despite knowing some of the risks for his physical safety. He described being sexually "molested" by a male perpetrator and then becoming sexually active, seeking out partners in the park.

> …[I] kept a lot of secrets. Stress…it created some unhealthy behaviors in that I held on to a lot of stuff. And going to the park and stuff. A lot of people didn't make it out of Palmer Park -- they fished them out. And I was thinking about …I never thought about running into a Dahlmer …but I could have ran into a Dahlmer. [FG2E].

Further, one participant framed his forced sexual experience as the start of a relationship with a "boyfriend."

> I've had sexual experiences…at 9 or 10, and it wasn't rape to me, even though the boy was older, I enjoyed it. So, now, did I feel guilty about it, absolutely, because it's not – you know, it's not a normal thing. But you know that you like it. And so, for me being who I was growing up…it was like I brought the boyfriend home. [FG2F].

Sexual Identity

For these NGI African American MSMW with histories of CSA, two domains were observed under the theme of sexual identity. These domains focused on those who questioned their sexual identity or had gender role confusion (*undeclared sexual identity*) and those who comfortably identified with a sexual identity despite possibly changing identities depending on the situation (*declared sexual identity*).

Undeclared Sexual Identity

The following participant shared that in his adolescence he dated girls, but when he was placed into foster care group homes, he began having sexual experiences with his older male

roommate. In retrospect, this participant appraised the experience as sexual abuse and currently, questions his sexual identity.

> …the staff that would come in throughout the day or night. We'd go in there and find out they're having sex with the boys that are in these group homes and foster homes. So it's kind of mixed feelings about what is right. You go to church and you hear about this. That it's not right. But if you have all these people that's doing this. I guess whatever feels good or whatever you're comfortable with, that's what you go with. And I think I'm comfortable with a male. [FG2G].

One participant shared his belief that childhood sexual experiences, which he would define as sexual abuse, cause men to be ambivalent and confused about their sexuality.

> …And some of them who have [guilt], they try to hold that guilt in from having had it [sexual abuse] happen to them. So they suppress it. Even married - a lot of them end up divorced because of whatever issues. They have issues [about their sexuality], they just don't talk about it [being abused], even with their friends who are heterosexual. They don't talk about what happened to them when they were molested. It's not anything they want known. [FG2H].

Declared Sexual Identity

The following quotation is from a participant who remembers his incident of being sexually abused by an older male perpetrator to coincide with the time that he started to become attracted to girls and how it may have deterred him from exploring his sexuality in a manner and timeframe where he was in control. Currently, he identifies his sexual identity as a man who has sex with men and expresses no ambivalence or confusion despite being behaviorally bisexual.

> …I was also molested when I was about 12. It was right around that time when I was getting…interested in girls. There was a girl in the neighborhood I used to play with and I'd pat her on the butt and all this stuff. When this guy, who was a friend of my brothers, actually forced himself on me, then that triggered a thing that's like, OK, well after we performed the act it's like - this ain't bad. That was the beginning of me really exploring my sexuality, for myself, cause I've never had sex with a woman at that time. [FG2B].

Another participant similarly reported feeling more comfortable with male partners after being sexually abuse by a male perpetrator.

> For me I was molested when I was about 11 or 12, and I guess it kind of shaped who I am today, in that society always had said it wasn't right to…in the bible, for two men to have sex. However, I had tons of girlfriends, I always thought I had the prettiest girls in school, but once I had got molested…I found something that fit. [FG2E].

In contrast, this participant described feeling more comfortable being bisexual. He also reported having enjoyed the incident of "molestation."

> For me, I think that I had no boundaries as it related to sex because I was free spirited and so whoever wanted to get down, whether it was male or female, I did…We're kind of like, and I know from my generation, I am a child of the 60s and 70s, we were the first ones. I had a boyfriend and a girlfriend. We lived together, the three of us…that's just how we rolled, we're doing what we're doing. As far as the molesting thing, I guess I was molested, but I asked for it. I literally - I seduced this man. I did, the women too…I was 10…I just don't feel bad about feeling good. [FG2I].

Intimate Partner Violence

Under the theme of IPV, the domains of *normative behavior* and *abuse equates to love*, were reported in both focus group discussions.

Normative Behavior

IPV, including physical, emotional, verbal, or sexual abuse, was reported to be commonplace with men being both victim and perpetrator in relationships with both male and female partners. Some participants stated that because it was what they witnessed frequently throughout their lives, they were more likely to accept it in their adult interpersonal relationships.

> I grew up in an abusive household where my father and stepfather at one point in time, all I saw everyday, being the oldest of five, was my mother get beat, like bloody beat. [FG1D].
>
> I watched my mother get up and go to work with her eyes dotted, her lips busted and then my father has to come past me and my brothers and we're downstairs with butcher knives wanting to take out my father. That to me, with all the other stuff [sexual abuse], goes from trauma to trauma to trauma. If you're not dealing with it and getting counseling, by the time you get to a lover who puts his hands on you, you don't know [what you will do]. [FG2E]
>
> My mother used to beat my father's ass. That's where I get too much self-esteem from … I've been through the little domestic violence thing. I had someone who thought they could hit me and I tried to take his head off with a skillet, and that left, for me, a bitter taste in my mouth. [FG2H]
>
> I've had girlfriends get physical with me, and it's just at that point, because you're a female, I may grab you, throw you into a wall and walk off. [FG1C].

For some participants, physically fighting with your partner was how they defined their manhood. This was especially emphasized as a form of conflict resolution between two men.

> That's part of defining you as a man, whether you're black, white, straight, or gay, you have to have such - the threat of violence within you whether or not you could step up to it or not, you just can't be a p-ssy. You can't be soft like that and take it lying down. Anybody, you just don't take it, that defines to me, manhood. [FG2B]
>
> When I got in relationships with guys I noticed that there would be angry aggression when we get into arguments and stuff, and they were going to hit me. I remember the first time. I was with this guy for three years … He misunderstood something. We got into an argument and his big tall ass, because he's about 6'7" hit me on the side of my head, which I carry the knot to this day, and he hit me on the side of my head…I just ran to the kitchen and grabbed the butcher knife and we were tussling…once somebody hits me or threatens me, it's like it turns on a switch. [FG2H].

For some participants, there was a normative process to the relationship becoming abusive and one that mirrored heterosexual relationships.

> Mine was a progressive thing. My ex…He was very controlling. In the beginning it was I'll take care of everything and whatever he didn't take care of, I took care of. We were a team in the beginning. But slowly but surely, he wanted to be more demanding. You need to wear this and wear that. We needed to go here, we needed to go there. Just basically… had to regulate everything. Then he used to disrespect me in front of company. It's these little things that started building up…he's very bad tempered. You can't have a decent conversation with him. He gets upset and he hears nothing. It's like he goes black. Communication was very limited. After awhile, it got worse and worse. We even got into a couple of fist fights. It didn't happen all the time, but he would get that angry and after that last one that we had, physical, we just decided…to go separate places, go cool out. Then come back later or the next day. I'm sorry for this, I'm sorry for that. But after awhile, it happened 3 or 4 times, well, 4 or 5 times. I'll never do it again…It was a progressing thing. It wasn't one little thing, or one big thing. Like bam it's over, it just built up. [FG1B].

Abuse Equates to Love

The meaning of abuse was significant for some participants and was a proxy for love.

> …dealing with a male partner and that probably is because of the age…but when we had some disagreements, me at 50 years old…me with my old ass fighting this 25 year old. Which is really not my character -- somewhere in there, the sex and love was really good. So, that's something that probably will need to be dealt with. [FG2D].

While some participants believed that their partners only abuse those with whom they have meaningful relationships, others recognized it as being unhealthy.

> My last lover used to try to draw me into beating him down. And I beat him…I punched him out…he fell over the table. Then we talked about it. I apologized for getting that escalated, and we laid down and went to bed. I used an excuse that I had to go take my meds to get out of there. You know what…if I gotta hit you - if it came to this, it's got to stop. [FG2E].
>
> I'm an angry person…I still go to therapy monthly because I know that there's some anger there from childhood stuff that I haven't dealt with and I always take it out on the closest person to me. So you're gonna get that anger cause I still have a misconception of what love is. I know how it is to love you, but to receive it back, I don't know that. I still think that maybe if I hit you, you'll understand where I'm coming from. My goal was to love and if we're not enjoying each other and not being loving and affirming, there's something that's a dysfunction there. I like us, but I love me, and so I can easily start from scratch. [FG2F].

DISCUSSION

The HIV epidemic has taken a huge toll on African American communities. Despite three decades of addressing this crisis, efforts have been limited in making significant strides. Innovative strategies are being recommended that go beyond simply developing interventions that promote condom use (The White House Office of National AIDS Policy, 2010; Williams,

Wyatt, Wingood, 2010). While many interventions focus on sexual risk (CDC, 2009), additional attention must be placed on exploring less commonly studied variables that may nonetheless influence sexual decision-making. Research supports that CSA is associated with negative mental, physical, and sexual health outcomes (Chartier, Walker, & Naimark, 2009; Harrison, Edwall, Hoffman, & Worthen, 1990; Holmes, Foa, & Sammel, 2005; Holmes & Slap, 1998; Langevin, Wright, & Handy, 1989; Mimiaga et al., 2009; Nagy, Adcock, & Nagy, 1994; Nelson, Higginson, & Grant-Worley, 1994; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997; Whiffen & MacIntosh, 2005; Windle, Windle, Scheidt, & Miller, 1995). Research must further explore how experiences of childhood sexual abuse impact sexual decision-making, sexual identity, and risk for revictimization, especially among populations at great risk. As stated in the *National HIV/AIDS Strategy for the United States*, everyone is not at equal risk for HIV, possibly due to where they live or to risk behaviors (The White House Office of National AIDS Policy; 2010). Thus, attention must be placed on populations that are at increased HIV-related morbidity and mortality, such as HIV-positive African American men who are bisexual and who have histories of CSA.

The results of this qualitative study highlight the need to address CSA in sexual risk reduction interventions. For this sample, which included NGI HIV-positive African American men who are bisexual, there was a range of how they appraised their childhood sexual experiences. Despite one-third of the sample not viewing the experiences as negative or traumatic, the majority of the sample acknowledged these experiences as contributing to their high-risk sexual behaviors and possibly to them becoming HIV-infected.

Some research has supported that cognitive appraisal and coping responses mediate CSA effects (Bal, Crombez, De Bourdeaudhuij, & Van Oost, 2009; Spaccarelli, 1994). Understanding the meaning of appraisal in trauma research is essential, as appraisal may influence diverse coping strategies (Bal, Crombez, De Bourdeaudhuij, & Van Oost, 2009). Unfortunately, little is known as to how coping strategies translate into sexual risk behaviors. That is, positive versus negative appraisal of an event may illicit very different coping strategies which then result in a spectrum of behaviors, including diverse sexual risk behaviors. Among our sample, it is not possible to conclude causal relationships between histories of childhood sexual experiences and becoming HIV-infected. Nevertheless, many of the men in this study were aware that they engaged in high-risk sexual behaviors subsequent to their childhood sexual experiences, some while trying to revisit experiences, specifically physical stimulation, encountered during the abuse.

A large amount of what is known about the effects of CSA is derived from studies with adult survivors. This is a limitation, as little is known about childrens' initial responses and appraisal of childhood sexual experiences subsequently but proximal to the abuse (Spaccarelli, 1994). Interventions that specifically address the meaning of trauma and the manner in which individuals frame that experience are greatly needed. Also, research needs to explore the temporal implementation of such interventions, as support and care may possibly have a more beneficial impact closer to the event. For many of the men in this study, choices made regarding sexual risks were retrospectively appraised as being physically and emotionally harmful.

Consequences, including short- and long-term effects of CSA, need continued examination (Beitchman et al., 1992; Burns-Loeb et al., 2002). Healthy sexual identity formation may be affected among boys who are victims of CSA, as abuse interrupts sexual autonomy and independent sexual exploration. Importantly, appraisal of the childhood sexual

experiences and the meaning of an orgasm which may occur during the incident needs to be addressed. For some of the men in the study, the physical stimulation of an orgasm was interpreted to mean that they were gay and that they enjoyed the incident (i.e., "it could not be abuse because I came, I enjoyed it"). For others, defining their sexual identity was less important than "just doing what felt good, whether it be with a man or woman." While some men were clear in stating their sexual identities, others were more ambivalent. Regardless, even among those who were comfortable with certain sexual identities, many acknowledged changing their identities and sexual partners throughout their lives. The post-group demographic survey revealed that only 18.75% identified with a bisexual label despite being behaviorally bisexual. The remainder of the sample identified with gay or same gender loving labels. A possible explanation may be that the men felt more comfortable with the MSM labels after having participated in a group with other men who also acknowledged having sex with men. Research needs to explore the meaning of sexual labels, sexual identities, and sexuality in general for African American men, as they may impact sexual decision-making and risk for HIV infection, re-infection, and transmission over the lifespan. Further, this research must examine the childhood sexual experiences of African American boys, as these can shape and define their identities and behaviors as they become men.

Finally, for many of the men in this study, IPV was reported as being prevalent among African American couples regardless of sexual orientation. Thus, there was a normalization of IPV. Importantly, the experience of IPV in addition to their histories of CSA only reinforced the commonality of abuse. While it is not possible to link experiences of CSA to adult revictimization in this small qualitative study, findings do suggest the need to examine the impact of CSA among HIV-positive African American MSMW. Previous research has already found that victims of IPV may be linked to unprotected sexual risk behaviors and seroconversion and that being an HIV-positive MSM may also be linked to becoming a victim of IPV (Relf, 2001). Thus, for HIV-positive African American MSMW who have histories of CSA and IPV, the vulnerability to HIV re-infection and transmission to sexual partners is significant. Additionally, these men are at increased risk for co-morbid mental and physical health consequences.

CONCLUSION

Understanding how HIV-positive NGI African American MSMW interpret childhood sexual experiences may have an impact on sexual decision-making, sexual identity formation, and the ability to form healthy adult interpersonal relationships. The impact of childhood sexual experiences, including both positive and negative appraisal, must be considered when developing HIV risk reduction interventions for HIV-positive NGI African American bisexual men. Strategies that are innovative and holistic, in that they address mental, physical, and sexual health and go beyond simply advocating for condoms and increasing access to care, are not only long overdue but are also in line with the National HIV/AIDS Strategy for the United States.

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