Chapter 5
Childhood Sexual Abuse and Revictimization Among Gay Men: Implications for Those Who Are HIV Positive

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Since the beginning of the HIV/AIDS epidemic in the USA, gay and bisexual men have experienced disproportionate rates of HIV morbidity and mortality. The Centers for Disease Control and Prevention (CDC) reported that in 2013, gay, bisexual, and other men who have sex with men (MSM) accounted for 55% of people living with HIV in the USA despite comprising approximately 2% of the US population (CDC, 2016a). Among MSM, people of color and young MSM appear to be disproportionately impacted. African American and Latino MSM account for 38% (estimated 11,201) and 26% (estimated 7552) of new infections, respectively, while White MSM represent 31% (estimated 9008) of new infections among MSM (CDC, 2016b). Among the African American gay and bisexual men diagnosed with HIV, an estimated 39% (4321) were aged 13–24 (CDC, 2016b). Trauma histories, including childhood sexual abuse (CSA) and adult sexual abuse (ASA) especially in the form of intimate partner violence (IPV), are rarely examined among MSM despite being associated with increased mortality and morbidity. In this chapter, we: a) review the existing literature on child and adult sexual abuse among MSM in general, while emphasizing what research has been conducted with HIV positive gay men; b) explore the research and clinical challenges associated with the lack of operationalized abuse definitions and how it may impact the needs of HIV positive gay men; c) discuss sexual, mental, and physical health sequelae associated with trauma histories for MSM and specifically, for HIV positive gay men; and d) discuss

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implications for sexual risk reduction among HIV positive gay men with histories of CSA, ASA, and IPV. Since the literature is sparse in respect to trauma histories specifically among HIV positive gay men, we distinguish the research that has been conducted with MSM versus gay men.

Framing Risk Factors for HIV

There are several commonly identified risk factors that may contribute to HIV infection rates among gay and bisexual men. Utilizing Bronfenbrenner's (1979) ecological theory of development, Mustanski, Newcomb, Du Bois, Garcia, and Grov (2011) framed their review of HIV correlates and predictors for young MSM. The ecological theory of development places the individual at the center of a model comprised of multiple environmental systems with expanding relationships moving from the individual level to interpersonal and interrelational community levels, and enveloping all of these is the broadest level which incorporates cultural, structural, and societal norms. This model also examines these relationships over time, and thus has a developmental framework that can be applied across the lifespan.

At the individual or person level, factors such as alcohol and drug use, personality characteristics, and mental health were associated with sexual risk-taking among MSM (Mustanski et al., 2011). Relationships, in which individuals have direct contact with others such as family, friends, and sexual partners, would be examined at the microsystem level. The correlates specifically for HIV risk include such factors as characteristics of intimate partner relationships, experiences of sexual abuse, and the presence, type, and quality of social and emotional support. The mesosystem level includes the environment or context in which an individual exists and the ways in which these settings influence their behaviors. In regard to sexual risk-taking, social settings such as bars and clubs commonly provide the opportunity for alcohol and drug use behaviors to intersect with sexual partner seeking behaviors. Other examples of where the sociocultural context can be associated with sexual risk-taking among MSM include the degree to which men feel connected to the gay community, the prevalence and engagement in sex work and/or attending commercial sex venues (i.e., bath houses, sex clubs), and even the availability and access of sexual partners via the Internet (Binson et al., 2001; Halkitis et al., 2013; Halkitis & Parson, 2003; Van Beneden et al., 2002; Williams et al., 2003).

At the broadest level of Bronfenbrenner's (1979) theory is the macrosystem which is comprised of societal norms and ideological values. One example of an HIV correlate at this level may include the concept of minority stress, which entails the cumulative effect of stigma, internalized homophobia, and discrimination (Brofenbrenner, 1979; Meyer, 1995; Mustanski et al., 2011). The minority stress model was developed as a way to understand the unique experiences associated with being a member of a sexual minority group (Meyer, 1995, 2003). Perceptions of these experiences as stressful were based on the contrasting differences between the minority person's culture, beliefs, and norms as compared to those of the larger society. While minority stress has been associated with increased psychological

distress (Meyer, 1995), research has only recently begun to explore the effects of minority stress and other structural and institutional variables on sexual risk behaviors.

Bronfenbrenner's (1979) ecological theory of development helps to conceptualize these diverse systems and explore their relationships with health outcomes. However, these systems are multifaceted, overlapping, and dynamic. Thus, the level of complexity provides challenges to identifying key correlates of HIV risk behaviors. This is highly evident among Black MSM where racial/ethnic disparities in HIV continue to persist and where risk factors commonly associated with HIV fail or inadequately help to explain such disparities. A meta-analysis by Millett et al. (2012) found that Black MSM were more likely than other MSM to report the use of any preventive behavior against HIV infection, more likely to report HIV testing in the past year, and demonstrated no significant difference in substance use compared to other MSM. Black MSM were more likely to experience structural factors such as low education, unemployment, low income, and prior incarceration which may better explain racial disparities in HIV prevalence (Millett et al., 2012). Millett, Flores, Peterson, and Bakerman (2007) also found that sexually transmitted infections (STIs) were greater among Black MSM than White MSM. However, higher rates of HIV infections among Black MSM were not attributable to differences in substance use, sexual risk behaviors, nongay identity, or sexual disclosure (Millet, Peterson, Wolitski, & Stall, 2006; Millett et al., 2007). The challenge of addressing the HIV epidemic among Black MSM demonstrates the difficulty of identifying HIV correlates and predictors. Importantly, it supports the need to explore other factors that may be contributing to the HIV epidemic, such as past and present experiences of sexual abuse (Feldman, 2010; Glover, Williams, & Kisler, 2012; Mustanski et al., 2011). Moreover, it raises the issue of conceptualizing models of HIV risk for diverse populations, accounting for differences on variables such as race/ethnicity and HIV serostatus.

Child Sexual Abuse as a Risk Factor for HIV

In discussing the sexual behaviors of gay men as it relates to HIV risk, much emphasis is often placed on current behaviors with a focus on sexual risk reduction and condom use and sexual decision-making (Williams, Wyatt, & Wingood, 2010). However, the understanding of current sexual behaviors necessitates inquiry into the role that early experiences with sex and the exploration of one's sexuality had in shaping adult behaviors (Williams et al., 2008). This is particularly important for men whose initial and/or early sexual experiences could be defined as being sexual abuse. Understanding the relationship between childhood sexual experiences and adult sexual behaviors may have implications in the overall well-being of gay men. Providing credence to this idea is research that supports the association between CSA and poor psychological, physical, and sexual health outcomes (Bartholow et al., 1994; Brennan, Hellerstedt, Ross, & Wells, 2007; Catania et al., 2008; Holmes & Slap, 1998; Jinich et al., 1998; Lloyd & Operario, 2012; Mimiaga et al., 2009;

O'Leary, Purcell, Remien, & Gomez, 2003; Paul, Catania, Pollack, & Stall, 2001; Welles et al., 2009). While there is a paucity of research on CSA specifically among gay and bisexually identified men, there is increasing recognition that CSA may be an additional risk factor for HIV infection and transmission and that there are psychological and physical health implications among MSM (Metzger & Plankey, 2012). Research on CSA supports that abused men, as compared to nonabused men, were more likely to engage in high-risk sexual behaviors, have more lifetime sexual partners, use condoms less frequently, have higher rates of STIs and exchange sex, and have up to a twofold increase in the rate of HIV (Holmes & Slap, 1998; Lloyd & Operario, 2012) as well as higher depression symptomatology, and alcohol and illicit substance use (Brennan et al., 2007; Catania et al., 2008; Jinich et al., 1998; Mimiaga et al., 2009; O'Leary et al., 2003; Paul et al., 2001; Welles et al., 2009).

In this chapter, we review the current literature on CSA among gay men, focusing on those who are living with HIV and the associated health implications. We also examine ASA and intimate partner violence (IPV), as research supports that individuals who were abused as children are often revictimized as adults (Classen, Palesh, & Aggarwal, 2005). While the chapter's intent is to focus on the experiences of gay men, there are limitations in the literature involving research conducted with this population. Research since the early 1990s has more commonly used the "MSM" term to identify men at increased HIV transmission risk due to behaviors. Thus, the use of the MSM terminology often prevents the distinction of CSA research specifically with gay identified men.

Prevalence of Sexual Abuse

Sexual assault within the USA, which includes child and adult sexual abuse and intimate sexual partner violence, is a significant public health concern (Hornor, 2010; Rothman, Exner, & Baughman, 2011). The US Department of Health and Human Services estimates that of the 695,000 children who experienced maltreatment in 2010, 9% of them were sexually abused (US Department of Health and Human Serivces, 2011). However, a limitation of this information is that much of the literature on CSA tends to focus on the experiences of women and girls. There continues to be inadequate attention on the sexual experiences of men and boys, who may also experience CSA (Bartholow et al., 1994; Homma, Wang, Saewyc, & Kisnor, 2012). For example, an early study conducted by Finkelhor (1987) found that 3–31% of men experienced sexual abuse before the age of 18. Additional studies reported similar CSA prevalence rates among men ranging from 3% (Lodico & DiClemente, 1994) to 29% (Zierler et al., 1991). A review by Rothman et al. (2011) found variable rates of sexual assault among men and reported prevalence rates ranging from 4.1% to 59.2% for CSA, 10.8% to 44.7% for ASA, 11.8% to 54% for lifetime sexual assault, 9.5% to 57% for intimate partner sexual violence, and 3% to 19% for hate-crime-related sexual assault.

The prevalence of CSA among gay and bisexual men has been reported to be significantly greater than that of their heterosexual counterparts. In a nonclinical

sample of 329 men, 49% of homosexual men reported histories of molestation, compared to 24% of heterosexual men (Tomeo, Temple, Anderson, & Kotler, 2001). Also, histories of same-sex perpetrators were significantly greater among gay men (46%) than heterosexual men (7%). A study examining histories of sexual abuse among male college students found that lifetime prevalence of sexual abuse was significantly greater among students who identified as gay (12%) than those that identified as heterosexual (4%) (Duncan, 1990). The implications of these findings are not clear as patterns of male sexual assault have not been adequately examined (Stermac, Sheridan, Davidson, & Dunn, 1996). Importantly, challenges with disclosure which include stigma regarding male sexual assault and sexual orientation may influence reporting. While additional research among all men is needed, it is particularly necessary among gay men where associations between sexual abuse and negative health outcomes have been repeatedly supported (Williams, Kisler, Glover, & Sciolla, 2011).

Variability in CSA Prevalence Rates and Its Implications

CSA prevalence rates are highly variable among men. Reasons for this variability may be due to a lack of consistency in the definition of CSA and to underreporting as a consequence of CSA stigma and issues related to masculinity (Senn, Carey, & Vanable, 2008; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). As a result, it is likely that reported prevalence rates underestimate the true occurrence of CSA among men and boys.

The diverse ways in which CSA is defined across studies result in sexual experiences being defined as sexual abuse in some studies but not in others (Relf, 2001). Rates of CSA prevalence among gay men may differ, in part, due to this lack of consistency, as well as the difficulties inherent in assessing CSA among men (Kisler & Williams, 2012; Williams et al., 2011; Williams et al., 2008). While it is largely understood that sexual abuse involves the sexual conduct of an adult or a significantly older child with another child, there is a large range in the ways in which histories are obtained and the specific details which constitute an experience as abusive (Hornor, 2010). Holmes and Slap (1998) examined and identified the various ways in which information about CSA was collected across studies involving men with histories of sexual abuse. Three types of questioning methods were identified: none, subjective, and objective. In cases where histories of sexual abuse were not asked directly, investigators often relied on previously collected information (i.e., child sexual abuse registries), or failed all together to report how such information was collected. Subjective methods involved asking subjects whether they had been sexually abused, assaulted, or victimized. However, these terms were not defined, leaving the interpretation of past sexual experiences up to the individual. Objective methods asked about histories of sexual abuse while offering definitions and, in some cases, providing descriptions through the use of vignettes. The method in which information is collected is important as it is directly related to the ability to reliably assess CSA prevalence rates. For example, computerized and written

questionnaires completed by a sample of 200 male undergraduate students yielded rates of 14% and 8%, respectively, with 90% of subjects reporting more honestly when using computerized methods (Bagley & Genuis, 1991). Given the sensitivity of discussing CSA histories, particularly for men, the assessment of CSA may be especially sensitive to collection methodologies.

In addition to the manner in which histories of sexual abuse were obtained, Holmes and Slap (1998) identified other criteria that were used to determine if a sexual experience was abuse. The age differential between the perpetrator and the victim, which could be fixed, graded, or unspecified, was often assessed. A fixed age differential existed when the age difference between the perpetrator and the victim, typically 5 years, remained the same regardless of the age of the victim. For example, the same 5 year age differential would be used with an 8-year-old individual as it would be for a 13-year-old individual. In contrast, the graded differential takes the ages of the individuals involved into account such that for boys under 13 years of age, the perpetrator had to be at least 5 years older in order for a situation to be designated as abuse. For boys between 13 and 16, a minimum of a 10-year age difference was needed. Studies that employed an unspecified age differential simply asked the participant if, as a child, he ever had a sexual experience with an adult. Under such criterion, a 17-year-old boy could be victimized by an 18-year-old based upon the age difference.

Other criteria used to define CSA included: (1) the appraisal of the experience as "negative"; (2) the presence of force/coercion or the perception of the perpetrator as more powerful; (3) the sexual activity occurring with an authority figure; (4) the presence of physical contact; and (5) the presence of anal penetration of the child or anal or vaginal penetration of the perpetrator by the child. In total, more than 30 combinations of CSA criteria were identified. Such varied definitions and inconsistency in what constitutes CSA and the manner in which CSA histories are assessed have implications for CSA prevalence estimates and relatedly for the need of health interventions (Fromuth & Burkhart, 1987; Holmes & Slap, 1998; Senn et al., 2008; Stoltenborgh et al., 2011). As an example, in a study of 200 male college students, the requirement of physical contact yielded a CSA prevalence of 8%, the use of a graded age differential and presence of coercion yielded 10%, the use of a graded age differential alone yielded 14%, and having either a graded age differential or the presence of coercion yielded 22% (Fromuth & Burkhart, 1987). The large degree of diversity in operationalized definitions has the potential to result in an over- or underestimation of early experiences of sexual abuse and creates a significant challenge to understanding the true prevalence of CSA among gay and bisexual men.

CSA Among Gay Men

The presence of CSA histories among gay men has been consistently demonstrated at significant levels in several large-scale studies. Among nearly 3000 gay men participating in a study in an urban area, the CSA prevalence was 20% (Paul et al., 2001). Similarly, in a study of nearly 2000 gay and bisexual men recruited at gay

bars and through household telephone surveys, 28% reported histories of CSA (Jinich et al., 1998). In an ethnically diverse sample of 1001 homosexual and bisexual men recruited from STI clinics in three major cities, 37% (n = 369) reported sexual contact with an older or more powerful individual before the age of 19 years (Doll et al., 1992). Comparable prevalence rates have also been revealed in smaller community samples of gay and bisexual men. Among a sample of 327 well educated, middle aged, predominately White gay men, 36% reported at least one experience of CSA (Lenderking et al., 1997). Rothman et al. (2011) found that overall, the prevalence of CSA reported by gay and bisexual men in the current literature ranged from 4.1 to 59.2% (median, 22.7%).

Research has also attempted to identify whether men were sexually abused more commonly by male versus female perpetrators. There has been some data suggesting that gay male CSA survivors were more commonly abused by men than women. This was demonstrated in studies by both Lenderking et al. (1997) and Jinich et al. (1998), in which 96% of the perpetrators in both studies were men. In addition, the majority of the perpetrators in those studies, 63% and 70%, respectively, were men that were unrelated to the victim (i.e., extrafamilial abuse). In the study conducted by Jinich et al. (1998), only 15.7% of the extrafamilial perpetrators were strangers, challenging the notion that most abusers are unknown to the victim.

Data has also supported that men abused as children largely report being victimized during early adolescence prior to their teenage years, when they may be particularly vulnerable. Lenderking et al. (1997) found that 63% of men experienced abuse prior to age 13, with 37% experiencing abuse between 13 and 16. Similarly, 71% of the men in Jinich et al.' (1998) study reported abuse prior to the age of 12, while 29% reported being sexually abused between 13 and 15 years of age. Consistent with these findings, the median age at time of first contact among the men who reported being abused as children in a study conducted by Doll et al. (1992) was 10, with ages ranging from 2 to 17 years of age. The median age difference between the victim and the perpetrator was 11 years (range: 0–55), with the age differential being significantly higher for those boys younger than 6 and those older than 15 years of age. Similarly, among a sample of 137 HIV positive African American and Latino MSM and men who have sex with men and women (MSMW) with histories of CSA and who identified with various gay and bisexual identity labels, the mean age of first CSA incident was 10.6 years (Williams et al., 2008).

The type and severity of abuse reported by gay men varies. Among the sample of 1001 gay and bisexual men in the study conducted by Doll et al. (1992), oral to genital (39%) and anal to genital (33%) contact were the most prevalent forms of sexual abuse reported compared to kissing (2%), exposing genitals (2%), and touching genitals (21%) (Doll et al., 1992). Other studies have found that sexual abuse without bodily contact was the most frequent (65.5%), and most commonly involved indecent exposure (Lenderking et al., 1997). Among the experiences involving bodily contact, the most frequent were being masturbated (60%) and sexualized nongenital contact (56%) (Lenderking et al., 1997). Among a sample of HIV positive African American and Latino MSM and MSMW, 12.4% reported CSA that included touching, fondling, or frottage, while 87.6% reported CSA that included performing and/or receiving oral or anal sex, digital penetration or

penetration with objects (Williams et al., 2008). Among this latter group which reported more severe CSA, 53% reported anal penetration, 37% reported performing or receiving oral sex against their will, and 10% reported both. Taken together, these findings suggest that gay and bisexual men with histories of CSA may be exposed to a spectrum of sexual abuse experiences, from non-bodily to bodily contact with severe forms including penetration.

While these studies have focused on CSA experiences among gay and bisexual samples, several additional studies reported associations between CSA and being HIV positive. Arreola, Neilands, Pollack, Paul, and Catania (2008) conducted a study with gay and bisexual men which included three categories of childhood sexual experiences, those who reported no sex before age 18, consensual only (sex before age 18 that was not forced), and forced sex (having been "forced or frightened by someone into doing something sexually" before the age of 18). The prevalence of being HIV positive was higher among the forced and consensual groups as compared to the no sex group. The forced and consensual groups also had higher rates of substance use and transmission risk than the no sex group. The forced sex group had significantly higher rates of frequent drug use and high-risk sex as compared to the consensual group (Arreola et al., 2008). In another study, men who were recruited from a gay pride venue and who reported histories of CSA were more likely to report unprotected receptive anal intercourse, engage in exchange sex for drugs or money, experience nonsexual relationship violence, and report being HIV positive (Kalichman, Gore-Felton, Benotsch, Cage, & Rompa, 2004).

Consistent with these findings, gay and bisexual men who reported having "regular" CSA experiences were more likely to be HIV positive, engage in exchange sex, and be a regular user of sex-related drugs (Brennan et al., 2007). Similarly, in a study conducted by Jinich et al. (1998), gay and bisexual men with CSA histories were more likely to engage in high-risk sexual behaviors such as unprotected anal intercourse with non-primary partners. Also, perceptions of being coerced were associated with increased sexual risk behaviors and the degree of coercion was positively associated with self-reported HIV serostatus. That is, 16% of nonabused men reported being HIV positive, while 19% of men who reported no/mild coercion and 22% of men who reported strong coercion/physical force reported being HIV positive.

CSA Among Gay Men of Color

Examination of gay men by race/ethnicity reveals that gay men of color typically report higher rates of CSA and other forms of trauma (Feldman, 2010; Mimiaga et al., 2009). In the study by Doll et al. (1992), Black (52%) and Hispanic (50%) men were significantly more likely than White men (32%) to report sexual contact with an older or more powerful partner. In a study of 569 young MSM in New York, Black (28%) and Latino (49%) MSM were more likely than White (13%) MSM to report experiencing childhood victimization, including both physical and sexual

abuse (Gwadz et al., 2006). However, the literature regarding racial/ethnic differences of CSA prevalence rates is not entirely consistent. Siegel, Sorenson, Golding, Burnam, and Stein (1987) found that non-Hispanic Whites (6.5%) had a higher rate of sexual abuse than Hispanics (3.2%). Nevertheless, given the findings of significant prevalence of CSA among Black and Latino gay and bisexual men, as well as the association between histories of CSA and risky behaviors, it is likely that CSA among gay men of color may contribute to racial disparities in HIV prevalence and needs further examination (Feldman, 2010).

The Sequelae of CSA

Herman (1992) states, "Repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality." CSA has implications on the health of gay and bisexual men. Having a history of CSA has been associated with engaging in high-risk sexual behaviors, externalizing sexual decision-making to partners, and experiencing difficulties in the ability to form healthy intimate relationships, as some of the most damaging effects of CSA are intrapsychic (Burns-Loeb et al., 2002; Herman, 1992). Consequently, CSA is a risk factor for a wide range of sexual, psychological, and physical health issues in both childhood and adulthood (Burns-Loeb et al., 2002; Kendall-Tackett, 2004).

CSA and Sexual Health

There is a well-documented association between early adverse experiences, including CSA and high-risk sexual behaviors in adulthood (Paul et al., 2001; Relf, 2001; Rosario, Schrimshaw, & Hunter, 2006; Stevenson, 2000; Wilson, 2010; Zierler et al., 1991). In comparison to their nonabused peers, gay and bisexual men who experience CSA are more likely to engage in unprotected sex (Bartholow et al., 1994; Carballo-Dieguez & Dolezal, 1995; Dolezal, 2002; Feldman, 2010; Jinich et al., 1998; Strathdee et al., 1998), have more sexual partners (Dolezal, 2002; Jinich et al., 1998; Rosario et al., 2006), have more sexual episodes under the influence of recreational drugs (Jinich et al., 1998), have multiple anonymous sex partners (Zierler et al., 1991), and engage in commercial sex work/exchange sex (Bartholow et al., 1994; Zierler et al., 1991).

The relationship between CSA and high-risk sexual behaviors has also been found to be mediated by substance use during sex, engaging in anonymous sex, and intimate partner violence (Paul et al., 2001). Importantly, in one study that examined the relationship between a history of CSA and unsafe sexual behaviors, CSA was found to be the only significant predictor of unprotected receptive anal intercourse (Lenderking et al., 1997). Engaging in high-risk sexual behavior can be

particularly costly for gay men by placing them at increased risk for HIV/AIDS and other STIs and influencing overall well-being across the lifespan. Research supports that being coerced sexually as a child is associated with high incidence rates of adult HIV infection (Jinich et al., 1998), and sexually abused men are twice as likely to be HIV positive as their nonabused peers (Zierler et al., 1991). It is also possible that CSA has an indirect effect on HIV risk behaviors by promoting more sexual partners, more sexual encounters, and a greater likelihood of engaging in HIV sexual risk behaviors (Rosario et al., 2006).

For the individual who experiences CSA, its impact may be experienced over their lifespan. In particular, early experiences of sexual trauma may influence an individual's sexual decision-making as an adult. Male survivors of CSA may have difficulties negotiating sexual activities and may externalize control of sexual behaviors to their sexual partners (Burns-Loeb et al., 2002; Williams et al., 2008). Relf (2001) suggests that the significant role of engaging in casual one-night stands as a mediator between CSA and risky sexual behavior for gay men is likely an indication of a lack of interpersonal regulatory ability, as well as poor risk appraisal skills. Wright (2001) describes gay men with histories of CSA as engaging in a "spiral of risk," in which men engage in high-risk sexual behaviors out of a need to feel that they belong and to avoid feelings of abandonment. While understanding the processes that drive decision-making and actions are important, there is also a critical need to recognize sexual behaviors as being potentially deleterious with long-term health implications. Despite most studies of sexual abuse being limited in examining causal effects, there is significant data that supports the relationships between CSA and the overall health of gay and bisexual men. It has been suggested that the consequences of CSA on men's self-esteem and health, both physical and mental, and the repeated engagement in unhealthy, high-risk sexual behaviors may be exacerbating the history of trauma which the men are actually trying to ameliorate (Wright, 2001). The relationship between CSA and health outcomes is important to understand especially among HIV positive gay men whose sexual behaviors may place them at increased risk for HIV reinfection, acquiring other STIs, or transmission to sexual partners.

CSA and Mental Health

Generally, CSA has been found to be associated with psychological health issues including fear, anxiety, depression, insomnia, self-destructive behaviors, headaches, aggression, anger, hostility, poor self-esteem, substance abuse, suicidal ideations and attempts, sexual maladjustment, and problems with obesity (Wilson, 2010). Gay men with histories of CSA are twice as likely as their nonabused peers to suffer from a mental health disorder (George, 1996) and have an elevated risk of substance abuse, attempted suicide, and anxiety and mood disorders (Brady, 2008; Chen et al., 2010). In a study conducted with young MSM ages 18–30 years of age, men with histories of nonconsensual sex had a higher depression score (OR = 2.08; 95% CI,

1.34–3.22), lower social support (OR = 1.94; 95% CI, 1.24–3.00), and were more likely to use recreational drugs than men who were not abuse (Strathdee et al., 1998). Also, borderline personality disorder, dissociate identity disorder, and bulimia nervosa have all been linked with CSA (Putman, 2003). While research is not able to support a causal relationship between CSA and sexual identity development, a review of the literature does suggest the need to examine the context of sexual exploration and sexual identity development and experiences of sexual abuse as these past experiences may impact psychological well-being (Relf, 2001).

Post-traumatic Stress Disorder (PTSD). While a direct causal link is difficult to establish, individuals with histories of CSA have an increased likelihood for the development of post-traumatic stress disorder (PTSD) (Rodriguez, Ryan, Rowan, & Foy, 1999; Spies et al., 2012). Psychopathology among HIV-infected individuals who have histories of CSA is highly prevalent. For example, among a sample of 247 people living with HIV, 117 of whom were gay and bisexual men, and who had histories of CSA, 40% met diagnostic criteria for PTSD (Sikkema et al., 2008).

Contributing to the complication of establishing a causal link between CSA and mental health outcomes is the presentation of sequelae not occurring in close temporal proximity to the sexual abuse. That is, symptoms such as those of PTSD may be delayed for months or possibly, for years. Also, the triggers of PTSD may be diverse. For example, among children and adolescents, triggers may include developmental milestones such as their first sexual intercourse, also known as sexual debut (Hornor, 2010). For gay men abused by other men, it is possible that engaging in sex with other men in adulthood acts as a trigger for traumatic memories associated with early abuse. Therefore, it is plausible that substance use before and during sex may act as a way for such men to numb the emergence of the traumatic feelings associated with sex. It may also explain, in part, why CSA is associated with drinking before sex (Lodico & DiClemente, 1994). Intimacy with other men in adulthood may trigger traumatic memories of early abusive experiences and possibly explain some of the challenges that gay men with CSA histories face in developing healthy intimate relationships.

Depression. CSA has been found to be strongly associated with the onset of depression in adulthood (DiLillo & Long, 1999; Paolucci, Genuis, & Violato, 2001), especially among gay men (Relf, 2001). In addition to being angry with their abuser, gay men with histories of CSA may be frustrated with society's lack of attention to sexual abuse among gay men, as well as the gay community's perceived insensitivity to survivors of CSA (Anderson, 1982). Such feelings can have negative consequences for gay men, including depression (Anderson, 1982).

Among a sample of 439 young gay and bisexual men, aged 18–30, those classified as risk-takers as compared to non-risk-takers, were significantly more likely to have a history of nonconsensual sex, greater depressive symptoms, and report using recreational drugs during the previous year (Strathdee et al., 1998). Similarly, gay and bisexual men who experienced CSA involving either strong coercion or physical force had significantly higher depressive symptoms than did men who reported no coercion or mild coercion and the nonabused men (Jinich et al., 1998). In comparison to their nonabused peers, gay men with histories of CSA are more likely to

be hospitalized for depression, suggesting an elevated risk for depression overall, as well as for more severe depression (Bartholow et al., 1994; Relf, 2001).

The recognition of depression among individuals with histories of CSA is challenging as experiences of sexual abuse have the potential to change the clinical presentation of depression. That is, the neurovegetative symptoms characteristic of the typical presentation of depression may be reversed for those with histories of CSA, resulting in increased appetite, weight gain, and hypersomnia when compared to individuals with depression that lack CSA histories (Putman, 2003). Furthermore, a history of sexual abuse is often associated with an earlier onset of depressive episodes, as well as an altered response to standard treatments for depression (Hornor, 2010). The nature of the sexual abuse (i.e., penetrative vs. non-penetrative) and the relationship between the victim and the perpetrator, may also affect the development and severity of depression (Trickett, Noll, Reiffman, & Putman, 2001). While it has been suggested that emotional abuse appears to pose a greater risk for depression than sexual or physical abuse (Chapman et al., 2004), multiple forms of abuse tend to co-occur with CSA (Dong, Anda, Dube, Giles, & Felitti, 2003). Thus, it is likely that men will have experienced emotional abuse along with sexual abuse, and possibly, physical abuse or threat of abuse as well, further compounding their risk for adulthood depression.

The impact of CSA and its association with depression may also have physical health implications. One of the health consequences of depression is its ability to affect immune functioning (Irwin & Miller, 2007; Kiecolt-Glaser & Glaser, 2002; Raison & Miller, 2003). This may be of particular importance to the health of gay male survivors of CSA who are living with HIV. Such impairment in the already compromised immune system of individuals living with HIV has implications for disease progression, development of opportunistic infections, and general ability to remain healthy. Therefore, the effects of CSA, HIV, and depression may interact in ways that significantly affect men's mental and physical well-being. This complex relationship illustrates the need for interventions to address sexual health and in particular, the sexual risk behaviors of gay men, and mental and physical health, without ignoring past experiences of CSA (Gore-Felton et al., 2006).

CSA and Physical Health

CSA is often co-occurring with physical and emotional abuse (Dong et al., 2003). Survivors of such concurrent experiences may have an increased vulnerability to stress and to deleterious acute and chronic health consequences (Wilson, 2010). The stress and trauma of the experience, combined with the shame and pressure to not disclose the abuse, may be linked to immune functioning which predisposes or exacerbates health problems among survivors of CSA (Wilson, 2010). Consequently, CSA is frequently associated with negative health outcomes in adulthood with the odds of having poor health being 1.63 times greater when a history of CSA is present (Golding, 1999). Examples of health issues correlated with CSA histories

include complications with gastrointestinal functioning, sexual dysfunction, psychogenic seizures, and nonspecific chronic pain (Paras et al., 2009).

Consistent with having increased physical illness, adults with histories of CSA also report more health symptoms and doctor visits than their nonabused peers (Newman et al., 2000). Those with CSA histories report more somatic symptoms including headaches, sinus pain, muscle pain, migraines, cough, fever, abdominal pain, and other gastrointestinal symptoms (Newman et al., 2000). While the association between CSA and physical health has been established, somatization must be considered as a potential explanation of poor health. Anecdotal evidence such as that reported by Brady (2008) supports a relationship between CSA and somatization. Brady (2008) explored this issue in a case study with a gay male client who had chronic health issues which healthcare providers were unable to adequately treat given their inability to identify the source of the client's pain. Treatment explored the relationship between the client's history of CSA and his experiences of psychosomatic complaints. Though the symptoms did not completely dissipate, they were significantly reduced after the client was able to recognize the link between his experience of sexual trauma and the somatic symptoms (Brady, 2008). It is important to note that the limitation in examining the effects of CSA using experimental design weakens the ability to definitively suggest that physical or psychiatric health issues are the direct result of early experiences of sexual trauma. However, the strong correlations between CSA and poor health outcomes indicate a significant association between the two, although the relationship may not be causal (Wilson, 2010).

Coping Strategies

Gay men with histories of early sexual trauma may engage in various coping strategies. High levels of substance use among gay men in sexual situations may serve to manage negative emotions and the potential re-emergence of traumatic memories related to the experiences of CSA (Relf, 2001). Relf (2001) also suggested that casual sexual encounters such as one-night stands among gay male survivors of CSA may act as a mediator between CSA and HIV.

Among adolescent males with experiences of sexual abuse, an association between CSA and externalizing behaviors such as violence, delinquency, substance use, and heavy drinking has been identified (Dube et al., 2003; Hornor, 2010; Mullers & Dowling, 2008). Externalizing behaviors may serve as a way for adolescent males to exert control when they otherwise feel helpless. Dube et al. (2003) suggested that substance use may serve as a form of coping, through avoidance/escape or dissociation, to deal with the feelings of helplessness and instability that are often characteristic of CSA. Furthermore, if the perpetrator of the abuse was male, externalizing behaviors may be a way to assert and reclaim the sense of masculinity that men and boys may feel is lost due to the male-male sexual abuse.

Developing healthy coping strategies to deal with past experiences of sexual abuse is beset with difficulty. However, being a sexual minority and being HIV positive may pose additional challenges for a man who has experienced sexual abuse. Research needs to explore the impact of CSA among HIV positive gay men and assess whether these stressors are additive and contribute to worsening health outcomes.

Adult Sexual Abuse (ASA) Among Gay Men

In addition to CSA, Rothman et al.' (2011) review of the literature on sexual assault among gay, lesbian, and bisexual individuals indicated that gay and bisexual men are at risk for experiencing diverse forms of sexual victimization throughout their lifetime. Among gay and bisexual men, adult sexual abuse (ASA) ranged from 10.8 to 44.7% (median, 14.7%) and lifetime sexual assault ranged from 11.8 to 54% (median, 30.4%). Additionally, intimate partner sexual assault ranged from 9.5 to 57% (median, 12.1%), and hate-crime related sexual assault ranged in prevalence from 3 to 19.8% (median, 14%) (Rothman et al., 2011). These findings suggest that gay and bisexual men are not only at increased risk for CSA, but that they also have an increased risk for a lifetime of sexual violence victimization. It is possible that sexual revictimization is related directly and indirectly to sequelae of early sexual trauma (Anderson, 1982; Classen et al., 2005; Fillipas & Ullman, 2006). Additional research needs to examine sexual revictimization specifically among HIV positive gay men, as being HIV-infected may increase their vulnerability to trauma exposure.

Intimate Partner Relationships Among Gay Men with CSA

Similar to their heterosexual peers, the majority of gay and bisexual men with histories of CSA were abused by other men (Brady, 2008). However, unlike their heterosexual peers who primarily have intimate partner relationships with women, gay and bisexual men must be able to establish healthy intimate relationships with other men. Histories of CSA by male perpetrators pose potential problems with many gay men in developing the ability to be intimate with other men (Brady, 2008). Furthermore, given the high incidence of CSA among gay men, evidence suggests that abused men are likely to choose abused partners (King, 2001). The intra- and interpersonal difficulties that are often the result of CSA, combined with the lack of support for gay male survivors to manage these issues, can make sex, love, and intimacy particularly difficult to manage in gay male relationships (King, 2001).

Survivors of CSA report less relationship satisfaction, poorer communication and interpersonal skills, and lower levels of trust in relationships (Wilson, 2010). Gay male survivors of CSA may be challenged in establishing healthy intimate and sexual relationships with other men due to the fact that their initial sexual experiences

with men may have involved coercion, physical assault, and distrust. This could potentially lead gay men to generalize their early traumatic experiences to all their relationships with men, and potentially alter their understanding of what it means to be in a healthy relationship with another man. As a result, gay men with histories of CSA may experience intimate partner victimization, both sexual and physical, and may themselves perpetrate sexual abuse toward their partners (Brady, 2008).

Revictimization Among Gay Men of Color

Gay men of color, particularly Black and Latino men, tend to have higher rates of CSA than their White peers (Feldman, 2010; Kalichman et al., 2004; Mimiaga et al., 2009). However, an area that appears to be underexplored is the unique ways in which gay men of color manage the experience of early sexual trauma, particularly when the perpetrator is also a person of color. It is possible that racial/ethnic minority gay men who were abused by minority perpetrators experience difficulty establishing relationships with men of their same racial/ethnic group. That is, racial/ethnic concordance between the perpetrator and victim may further complicate the ability for sexually abused gay men to develop healthy intimate relationships with other men.

Racial concordance between the perpetrator and victim was explored by Brady (2008) in a case study of a HIV positive Black gay man with a history of CSA. While the patient did not have an issue reconciling his sexuality with his history of abuse, psychotherapy with the patient explored his aversion to dating other Black men, as well as his preference for White partners. Through the course of therapy the patient realized that, for him, Black men represented the Black perpetrator who had sexually abused him. As a result, the patient found himself conflicted, simultaneously being attracted to and fearing Black men. These feelings led him to perceiving White men as safe and to him only engaging in high-risk substance use and sexual behavior with other Black men anonymously (Brady, 2008).

The exploration of this issue is in no way intended to suggest that interracial relationships are a manifestation of internalized racism among minority gay male survivors of CSA with histories of racially concordant perpetrators. However, in a society where men of color, particularly Black and Latino, are stereotyped as being hypersexual and aggressive (Bush, 1999; Kisler & Williams, 2012; Majors & Billson, 1992; O'Neil, 1990; Pitt, 2010; Rasheed & Rasheed, 1999; Reese, 2004), it may be important to consider how such social heuristics interact with the experience of sexual trauma. When men of color are sexually abused by men of their racial/ethnic group, the experience may be interpreted as confirming negative racial stereotypes and generalized to the entire group. Such an experience likely differs for White gay men who are sexually abused by other White men, given the absence of a social narrative of White men as hypersexual, aggressive, or even predatory. As a result, the experience of CSA between White men and boys may be interpreted much more individually, whereas the experience between racial/ethnic minority

men and boys may be seen as confirming negative stereotypes regarding racial/ethnic minority men's sexual prowess, promiscuity, violence, and aggression. As seen in Brady's (2008) case study, such early experiences of sexual abuse between men of color may have implications for men's partner selection in adulthood. For gay men of color, the relationships between early sexual abuse, internalized racism, appraisal of the trauma experience, and later partner selection are complex. These issues warrant greater examination if the potentially unique experiences of these men, including those who are HIV positive, are to be fully understood.

Sexual Abuse, Masculinity, Gender Roles, and Sexual Identity Development

One proposed theory for the increased incidence of sexual abuse among gay men is related to the idea that gay men, as children, were more likely to display "gender atypical behavior" (Brady, 2008). It has been suggested that boys who behave in a gender atypical or feminine manner are at an increased risk for being stigmatized and ostracized, and potentially to be at an increased risk for sexual, physical, and emotional abuse (Brooks, 2001). It has also been suggested that gender nonconforming behavior in childhood may be associated with homosexuality 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). This idea of being stigmatized for not exhibiting masculine attributes is not only seen with boys, but also exists among men (Kisler & Williams, 2012; Reese, 2004; Robertson, 1997). Unfortunately, masculine attributes and sexuality are commonly erroneously linked together and perceived as being the same. That is, those who do not demonstrate "traditional" male gender roles and characteristics are believed to be gay.

Gay men with histories of CSA experience abuse within a larger cultural context that stigmatizes, devalues, and punishes homosexuality (King, 2001). Early experiences of being mistreated due to gender atypical behavior, early sexual trauma, and adulthood experiences of stigma associated with being a sexual minority interact in complex ways in the lives of gay men (King, 2001). Add to this the stigma and maltreatment commonly associated with being HIV positive, and such experiences can make it particularly challenging for gay male survivors of CSA living with HIV to develop an affirmative identity (Brady, 2008).

The experience of being abused by a man potentially creates difficulties for men who may struggle with the implications of the abuse for themselves as men (Brady, 2008). This can include issues around self-identity, sexuality, and concerns about becoming a perpetrator (Brady, 2008). Men may also externalize such feelings, which can manifest as homophobia. In a review of the literature, Relf (2001) found that gay and heterosexual men abused by men were: (1) "intensely" homophobic; (2) fearful of homosexuals; (3) expressing disdain of homosexuality and homosexual behavior; and (4) hostile toward homosexuality. Relf (2001) stressed that these

results were from clinical samples, possibly exaggerating the intensity of homophobia and limiting the generalizability. Nevertheless, it will be important to consider the ways in which gay men, including those who are HIV positive, appraise and understand their sexual experiences, sexuality, and sexual behaviors.

Sexual identity development is a normal part of growth. However, it is not clear how trauma experiences such as sexual abuse impacts sexual identity development. It has been hypothesized that having a history of CSA impacts gender and sexual identity (Relf, 2001). For example, a qualitative study of 26 men with CSA histories identified issues surrounding sexuality and homosexuality as common themes among the participants (Lisak, 1994). Other research has also documented 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). Among a sample of sexually abused adolescent boys, diverse gender roles were defined and identified as undifferentiated (52%), masculine (23%), androgynous (19%), and feminine (6%) (Richardson, Meredith, & Abbot, 1993). 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 nonabused counterparts (Johnson & Shrier, 1985, 1987). Among men, those with 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). Unfortunately, it is difficult to identify a causal link between sexual abuse and sexual identity due to the lack of longitudinal studies. To further complicate the issue is that gender role confusion preceding experiences of sexual abuse makes it difficult to establish a linear pathway to a defined sexual identity. That is, the process of identity development for men with histories of sexual abuse may largely be affected by the chronology of the abuse and the individual's stage of identity development. Men who have engaged in sexual behaviors prior to experiencing sexual abuse may have a different experience with sexual identity development than those whose first sexual experience was within the context of CSA (Bartholow et al., 1994). For gay men whose first sexual experience was within the context of abuse, the process of questioning gay identity occurred at an earlier age and proceeded differently than for nonabused men (Bartholow et al., 1994).

The impact of CSA on sexual identity continues to pose many questions and remains poorly understood. Some adolescent males who are exploring and questioning their sexual identities may seek out and engage in sexual relationships with older men. While these encounters have the potential to be coercive in nature, for many adolescent males, there are limited avenues in which to safely engage in sexual exploration. For adolescent boys exploring their same-sex attraction, efforts to initiate contacts with other boys in their peer groups and social circles (i.e., schools, church, neighborhood) could lead to violence and harassment (Relf, 2001). Consequently, such boys who seek relationships with older men in an effort to explore their sexuality may be putting themselves at risk for sexually abusive relationships, even if they do not realize the true nature of these relationships.

Men as Victims and Social Norms

Historically, the sexual abuse of male children and adolescents has been minimized, ignored, and even denied (Anderson, 1982). As a result, clinicians, advocates, and policy makers have often neglected the needs of male survivors of sexual abuse. Societal gender role expectations pose a significant hindrance in acknowledging, identifying, and addressing CSA among male children (Bartholow et al., 1994). Such social norms dictate that males are to be dominant, strong, and even aggressive (Bush, 1999; Kisler & Williams, 2012; Majors & Billson, 1992; O'Neil, 1990; Pitt, 2010; Rasheed & Rasheed, 1999; Reese, 2004), and experiencing sexual abuse falls outside of the realm of expected social behaviors. This is particularly true when the perpetrator is a man, often causing the male victim to question his manhood and ability to live up to gender expectations. However, when the perpetrator is female, male victims are often expected to normalize the experience as nonabusive and desirable (Kisler & Williams, 2012). As a result, male survivors of CSA often experience self-blame, guilt, shame, and humiliation (Lisak, 1994).

Adult Sexual Abuse (ASA) and Intimate Partner Violence (IPV)

Victims of CSA are more likely to be sexually revictimized later in adolescence as well as in adulthood (Hornor, 2010; Roche, Runtz, & Hunter, 1999; Rumstein-McKean & Hunsley, 2001; Whiffen & MacIntosh, 2005). Adult sexual abuse (ASA) is four times more likely among those with a history of CSA (Fillipas & Ullman, 2006). Adults with histories of CSA have been found to have difficulties with romantic interpersonal adult relationships, possibly due to insecure attachments established through abusive relationships in childhood (Alexander, 1992). It is possible that victims of CSA are less able to negotiate sexual activities as adults due to these previous experiences. These findings suggest that CSA may increase the likelihood of experiencing ASA because it leads to an inability to negotiate sexual activities and the likelihood of engaging in high-risk sexual behavior. Sexual trauma must therefore be explored within the context of HIV. In particular, attention must be placed on addressing the needs of HIV-infected individuals who have histories of sexual abuse as they may be vulnerable to reinfection and for transmitting HIV to sexual partners.

Implications of Sexual Trauma Histories: Developing Sexual Risk Reduction Interventions

Effective sexual risk reduction interventions for HIV positive gay men must address the psychosocial and cultural issues that are relevant to sexual decision-making (Williams et al., 2008). This includes CSA and ASA, which are sensitive issues that are often neglected in discussions of current sexual risk behaviors (Williams et al., 2008). However, to adequately address HIV risk behavior among gay men, interventions are needed that address mental health and focus on reconciling issues

related to sexual abuse (Gore-Felton et al., 2006). Furthermore, interventions aimed at sexual risk reduction should consider addressing issues beyond the scope of sexual behavior that may not seem relevant, but that are pertinent to risk behaviors and HIV (Relf, 2001). Specifically, early adverse life experiences involving childhood sexual, physical, and emotional abuse as well as abuse within a family and community context may influence sexual risk behaviors and should be addressed in interventions for gay men (Relf, 2001).

In addition to being correlated with sexual risk behavior, CSA influences stress and immune responses, as well as physical and mental health. Therefore, the sequelae of CSA may be best conceptualized using a holistic paradigm. Understanding the broader context in which abuse and adverse events occur, while assessing for resiliency factors such as personal assets and resources, will better inform the overall health needs of gay men (Arreola, Ayala, Díaz, & Kral, 2013). For many gay men, particularly those who are HIV positive, their immune status becomes the focus of their health. Unfortunately, sexual abuse survivors make up a sizeable percentage of primary care practices, accounting for roughly 13–26% (Kogan, 2004; Priebe & Swedin, 2008). However, only 5% of sexual abuse survivors report their history of abuse to their physicians (Walker, Katon, Roy-Byrne, Jemelka, & Russo, 1993). While patients consider it appropriate for physicians to ask questions regarding sexual abuse history, such questions are not routinely asked (Wendt et al., 2007). The healthcare system can be an important avenue to provide screenings for, and interventions with males who have previously experienced or who are currently experiencing sexual abuse (Chen et al., 2010). Pediatric and primary care physicians who provide healthcare to adolescent boys need to be trained on assessing for sexual abuse and for anticipating their physical and mental health needs (Hornor, 2010). Importantly, attention to these health issues must also be contextualized for the lives of HIV positive gay men and boys.

Wilson (2010) asserts that holistic perspectives that permit a greater understanding of the health consequences of CSA are essential to the healing process. Familial support, especially parental belief in the abuse allegation, acts as a significant buffer against the development of the negative sequelae often associated with CSA (Tremblay, Hebert, & Piche, 1999). Interventions which utilize resiliency factors, including support from intimate sexual partners, family, friends and community, and appropriately trained healthcare professionals, need to be developed to address the holistic health needs of HIV positive gay men with sexual abuse histories. Importantly, strategies to routinely implement these interventions into diverse venues, such as primary care settings and service agencies, are essential. Community based organizations that offer HIV testing and health programs must be prepared to address sexual health that includes experiences of sexual abuse. By contextualizing the meaning of past experiences, HIV positive gay men will be better able to assess what influences their sexual decision-making.

In conclusion, sexual abuse has been associated with negative sexual as well as mental and physical health outcomes. Addressing the health needs of gay men and specifically those who are HIV positive must include the assessment of histories of CSA and ASA. Programs that offer HIV interventions are ideal opportunities

for screenings, assessments, and appropriate referrals and treatment. HIV risk reduction interventions administered in community settings and through health maintenance visits with primary care providers are excellent opportunities to explore sexual health within the context of overall health. For HIV positive gay men, this holistic paradigm ensures that health needs, such as the sequelae of sexual abuse, are not ignored.

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