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Childhood sexual abuse in black men who have sex with men: results from three qualitative studies.

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BRIEF REPORT

Childhood Sexual Abuse in Black Men Who Have Sex With Men: Results From Three Qualitative Studies

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This report describes the high prevalence and context of childhood sexual abuse (CSA) among Black men who have sex with men (MSM) across 3 independent qualitative studies. Semistructured one-on-one interviews were conducted with 87 Black MSM across 3 cities (Rochester, NY, $n = 28$; Lexington, KY /Atlanta, GA, $n = 30$; and Atlanta, GA, $n = 29$). A combined CSA prevalence of 32% (28/87) was found among the 3 samples, despite variation in geographic location, mean age, and sexual identification. Common themes emerging across the 3 samples included prolonged and repeated abuse by a close male relative; blaming of same-sex desire on CSA; and descriptions of adverse mental health reactions to CSA. Implications of CSA and its potential influence on the mental health and risky sexual behavior among Black MSM are discussed.

Keywords: childhood sexual abuse, Black MSM, HIV/AIDS

Background

Although only representing 13% of the U.S. population, Black Americans account for over 50% of HIV/AIDS cases (Centers for Disease Control and Prevention [CDC], 2006). The primary mode of HIV transmission for Black men is sexual intercourse with other men, with 49% of all cases attributable to this one risk factor (CDC, 2006). Black men who have sex with men (MSM) continue to be disproportionately affected by HIV, with a reported 46% prevalence in a recent study (CDC, 2005). Despite most studies finding comparable rates of unprotected anal intercourse (UAI) among Black MSM as those among MSM of other ethnicities (Millett, Peterson, Wolitski, & Stall, 2006), the racial disparity continues, and sufficient exploration of the social issues driving UAI among Black MSM has not followed.

Childhood sexual abuse (CSA) is one of these unexplored social issues, comprising sexual acts that are noncontact (e.g., sexual comments, flashing, voyeurism, showing child pornography), as well as contact sexual acts (e.g., touching genitals, frottage, digital or object penetration, oral sex, penile penetration). Current estimates of CSA prevalence range from 12% to 53% for girls and from 3% to 16% of boys in the general population, with some convenience samples reporting CSA prevalence up to 76% (Briere & Elliott, 2003; Finkelhor, Hotaling, Lewis, & Smith, 1990; Holmes & Slap, 1998; Molnar, Buka, & Kessler, 2001; Rind & Tromovitch, 1997).

CSA prevalence is higher among MSM than among heterosexual men (Doll et al., 1992; Lenderking et al., 1997; Paul, Catania, Pollack, & Stall, 2001) but comparable with CSA prevalence estimates among heterosexual women (Bartholow et al., 1994; Carballo-Dieguez & Dolezal, 1995; Paul, Catania, Pollack, & Stall, 2001). Moreover, Black and other MSM of color demonstrate a higher prevalence of CSA, compared with White men (Arreola et al., 2005; Carballo-Dieguez & Dolezal, 1995; Lenderking et al., 1997).

Among MSM, CSA is associated with sexual risk behavior and increased HIV prevalence (Bartholow et al., 1994; Carballo-Dieguez & Dolezal, 1995; Doll et al., 1992; Holmes, 1997; Jinich et al., 1998; Lenderking et al., 1997). Additionally, MSM with a history of CSA report problems with social adjustment, psychological disorders (anxiety, depression), and sexual identity confusion (Carballo-Dieguez & Dolezal, 1995; King, Coxell, & Mezey, 2002). Bartholow et al. (1994) found that gay and bisexual men

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with a history of CSA were more likely to have been paid for sex by another male, more likely to have engaged in UAI, and more likely to have higher rates of HIV infection than those with no CSA history. Among MSM of color, Puerto Rican MSM with a history of CSA were significantly more likely to engage in UAI than those without (Carballo-Dieguez & Dolezal, 1995). Finally, Paul et al. (2001) noted that the relationship between CSA and sexual risk among MSM is mediated by multiple variables (e.g., engaging in one-night stands, frequent substance use during sex, and having had a recent experience with an abusive relationship).

Given the current HIV/AIDS racial disparity among Black MSM, the dearth of published information on CSA among Black MSM, and the literature supporting a link between CSA and adult sexual risk behavior among MSM in general, an exploration of CSA among Black MSM is necessary to potentially inform future HIV prevention efforts in this population. The goal of this article is to describe the high prevalence and CSA experiences of a unique group of Black MSM who participated in three geographically distinct qualitative studies in the United States.

Method

This report is a product of the Collaborative HIV Prevention Research in Minority Communities Program at the Center for AIDS Prevention Studies and the University of California, San Francisco (UCSF). The program trains underrepresented minority academic faculty in HIV research methodology and grant writing, comprising 2-month training sessions over three successive summers in San Francisco. All three studies received oversight approval from the Committee on Human Research at UCSF, in addition to approval from the institutional review board from each investigator's respective universities (University of Rochester, Emory University, and the University of Kentucky).

Original Purpose, Format, Sampling and Locations

Sonja Feist-Price conducted qualitative, semistructured, one-on-one interviews with 30 Black men who have sex with men and women (MSM/W) in Lexington, KY, and Atlanta, GA, between April 2003 and April 2004. This study sought to explore sexual risk behaviors among MSM/W and identify issues relevant to developing a culturally appropriate HIV prevention intervention for this population. Participants in this study were recruited through flyer distribution and the use of a key informant in both cities. Inclusion criteria were as follows: (a) self-identification as Black or African American, (b) an age of 18 years or older, (c) residence in either Atlanta or Lexington, (d) having had sex with both men and women in the past 3 months, and (e) the ability to speak English.

David Malebranche conducted qualitative, semistructured, one-on-one interviews with 29 self-identified Black MSM in Atlanta between May 2003 and September 2003. This study sought to describe (a) the subjective life experiences of Black MSM, (b) the social context in which Black MSM shape their notions of what it means to be a man or masculine, and (c) the social context of high-risk sexual behavior among Black MSM. Participants were recruited through the Internet, intercept method at a local park, and snowball methods. Inclusion criteria were as follows: (a) self-identification as Black or African American, (b) an age over 18 years, (c) residence in the Atlanta or surrounding area, (d) having had sex with another man in the past 3 months, and (e) ability to speak English.

Sheldon D. Fields conducted 28 qualitative, semistructured, one-on-one interviews with young (18- to 24-year-old) self-identified Black MSM in Rochester between February 2004 and May 2005. The study had four original research aims: (a) to describe the general life experiences of young Black MSM, (b) to identify and explore the social connections of young Black MSM, (c) to explore how social connections influence the mental health of young Black MSM, and (d) to explore how social connections and mental health influence the HIV risk behaviors of young Black MSM. Participants were recruited through a local community-based organization, flyer distribution, and snowball methods. Inclusion criteria were as follows: (a) self-identification as Black or African American, (b) an age between 18 and 24 years, (c) having had sex with another man within the past 6 months, and (d) the ability to speak English.

Data Collection and Analysis

All interviews were conducted in private settings (offices, hotel room, cars, and cafes) with just the interviewer and participant present. Each investigator used an interview protocol designed to explore each study's respective specific aims. We utilized local agencies in each study's respective city to audio-record interviews and transcribe them verbatim. Interview lengths varied from 60 min to 120 min, and with the exception of David Malebranche's study, which had a research assistant conduct 9 of the 29 interviews, the authors conducted all the interviews themselves. Demographic information was also collected from participants.

Interview transcripts conducted by each investigator were individually organized and coded using constant comparative methods, strategies based on Grounded Theory (Patton, 2002; Strauss & Corbin, 1990) and with the aid of Atlas TI or NVivo, software that aids in the organization, coding, and analysis of qualitative data. All studies incorporated a second coder for assistance in analysis and to ensure 85% or greater agreement in coding analysis. Specific results reflecting the aims from each individual study are presented elsewhere.

Each author noted a high prevalence of reported CSA experiences among the participants in their respective studies. CSA was defined to include passages of text that described childhood incidents of unsolicited or nonconsensual sexual touching, oral sex, or penetrative sex by an adult older than themselves. Although Sheldon D. Fields's and David Malebranche's studies described CSA as an "emerging code," which was not asked about directly in their original interview guides, Sonja Feist-Prices's interview guide had a specific question on CSA and was entered as a preexisting code. Fields extracted text from each study under the CSA code, and subcodes were developed according to themes showing consistency throughout all three data sets. Passages of text from all three studies were then reviewed independently by each of the authors, and subcodes demonstrating over 90% agreement were highlighted for this article.

Results

Table 1 shows descriptive findings for the 87 Black MSM, with a combined CSA prevalence of 32% (28/87) across the three studies.

Table 1
Pilot Studies of Black MSM: Descriptive Findings

Variable	Lexington, KY, & Atlanta, GA (n = 30)	Atlanta, GA (n = 29)	Rochester, NY (n = 28)	Total (n = 87)
Mean age	38	28.8	22.5	29.7
Sexual identification	33% bisexual 67% heterosexual	31% gay 69% nongay	85% gay 10% bisexual 5% other	
Believe homosexuality is a sin	14 (47%)	12 (41%)	11 (38%)	37 (43%)
History of CSA	10 (33%)	9 (28%)	9 (31%)	28 (32%)
HIV positive	6 (20%)	2 (7%)	3 (11%)	11 (13%)
Religion				
Protestant	1 (3%)	17 (59%)	15 (54%)	33 (40%)
Catholic	6 (20%)	3 (10%)	1 (1%)	10 (11%)
Spiritual	19 (63%)	3 (10%)	9 (32%)	31 (36%)
Muslim	1 (3%)	0 (0%)	0 (0%)	1 (1%)
Other	3 (10%)	6 (21%)	3 (11%)	12 (14%)
Education				
High school	11 (37%)	4 (14%)	12 (43%)	27 (31%)
Some college	12 (40%)	11 (38%)	14 (50%)	37 (43%)
College degree	4 (13%)	10 (34%)	0 (0%)	14 (16%)
Graduate degree	3 (10%)	3 (10%)	0 (0%)	6 (7%)
Technical school	0 (0%)	1 (3%)	2 (7%)	3 (3%)
Income ($)				
<15,000	16 (53%)	3 (10%)	21 (75%)	40 (46%)
15,000–30,000	11 (37%)	11 (38%)	7 (25%)	29 (33%)
30,000–60,000	3 (10%)	14 (48%)	0 (0%)	17 (20%)
>60,000	0 (0%)	1 (3%)	0 (0%)	1 (1%)

Note. CSA = childhood sexual abuse.

Study 1: Understanding the Life Experiences, Sexual Practices, and HIV Prevention Needs of Heterosexually Identified Black Men Who Have Sex With Women and Men

For the Black MSM/W interviewed in Lexington, Kentucky, and Atlanta, who reported a history of CSA (10/30), the male perpetrator was often described as an older family figure or mentor, such as a teacher (participant's age in parentheses):

> I was at the 6th grade going to the 7th. My teacher approached me. "Why don't I give you a ride home?" I said, "Yeah." Gave me a ride home, or nearby home. We kind of went in circles. And then we stopped—there was this road we called, like, the back road. The back way going to school and home. And he pulled over to the side and he said some things like, "Do you want me to touch it for you?" And I said, "Yeah." Just because at the time, I was thinking, more like—is it supposed to be this way? Something not right? He started kissing on the crotch area, and a car passed by, and all of a sudden he stopped. He said, "OK, zip up your pants." And it went on for about three months after that—kind of off and on. Not all the time . . . . Every time he would slide me $5. (Atlanta, 44)

For this participant, his CSA experience was couched in secrecy, nonverbal communication, and associated with a monetary exchange. He later described the immediate impact that these experiences had on him:

> I remember I was playing football and if someone would say, "You sissy. Catch the ball." I would fight him. You know. If they called me a certain name like that. They don't know, you know what I'm saying? But, the guy would, if I'm playing basketball or something, "You sissy . . . ." People used to wonder why I would fight like that. Words would just tick me off. I would just start fighting. (Atlanta, 44)

The increased sensitivity to being teased and resulting violent outbursts may be how he coped with the stress of being teased. Another participant described his CSA experiences involving his father:

> Well my actual first time, I was molested, so it was with a guy [his biological father] . . . I was maybe five or six. I was coming out of kindergarten and going into the first grade and part of my second grade year. It stopped like [during] my third grade year totally . . . We actually got into a fight . . . . It got to . . . most of it was oral, but when it came to penetration, I tried to fight him off and my uncle actually stopped it and he overheard it and he walked in and was like, "What are you doing to your son?" (Lexington, 25)

The same participant later described his reaction to this experience:

> I stayed depressed a lot. And my therapist made me realize that until I forgave my father, or let go of whatever animosity I had toward him, I would stay in that depression. And I had to do that. (Lexington, 25)

Participants commonly described feelings of isolation, depression, withdrawal, and social anxiety as reactions to their CSA experiences. Five of the 10 participants (50%) who reported CSA believed that their current same-sex sexual behavior was connected to the CSA they experienced. The remaining 5 did not attribute their current same-sex behavior to their CSA experiences.

Study 2: Masculinity and HIV Risk Among Black MSM

All of the Black MSM in the Atlanta study who reported a history of CSA (9/29) stated that the perpetrator was a male relative, such as an older brother, cousin, uncle, father, or stepfather. As one participant noted:

> I was 7 or 8. He [male cousin] molested me all the way up until I was like 17 or something. (Atlanta, 28)

Participants reported an insidious and long-term nature to their CSA experiences, representing a pattern of behavior that happened so frequently and over such a prolonged period of time that for one participant, it seemed like a routine part of life:

> I thought it [CSA] was natural. All my cousins were doing it. (Atlanta, 22)

Participants linked their adult problems with verbal communication, interactions with people, and overall comfort with self with their CSA experiences. Additionally, many described being threatened by the abuser if they told anyone about the abuse, and if they did disclose the CSA to a family member, many reported that no one believed them. Several described how these experiences influenced their social interactions as adults:

> It [CSA] came back to haunt me years later. I began to fear being around other guys. (Atlanta, 39)

> I guard sexuality in its complete form. I don't feel comfortable hugging people. (Atlanta, 24)

Specifically, several participants perceived that their CSA experiences influenced their adult same-sex desire, as with the following participant who, as an adult, confronted his cousin who had molested him for several years as a child:

> So I was like, I'm gay, this, that, and the other. Ya know, I don't have no problems with my sexuality now. And furthermore, I think it's all because of you. He was like, "how do you figure that?" I was like, because the way you used to manipulate me when I was younger. And—it just made, my very first experience it just made it more comfortable with the person doing it with me because I was kinda like used to it. (Atlanta, 28)

Finally, the emotional impact of experiencing CSA was described by a participant who was molested by his cousin:

> I did him [had insertive penetrative sex], came in him and everything. He's like "Man, you too good to be young." And after that, it was like nothing but suicidal thoughts. I wanted to kill myself. (Atlanta, 31).

He describes his suicidal ideation that followed his CSA experience, which was also devoid of condom use.

Study 3: Social Connections, Mental Health, and HIV Risk Behaviors Among Young Black MSM

The Black MSM who reported CSA from Rochester (9/28) were the youngest among the three samples and described similar themes to those found in the other two studies: repeated CSA experiences with an older male relative, nonverbal communication with the perpetrator and nondisclosure to other family members, and perceived link between CSA and adult same-sex desire. One participant stated:

> Um, like, it wasn't my choice but like, um, like one of my cousins, like, when I was younger [chuckle] like, um, . . . pretty much like, I guess you would say, like molest or whatever. But that went on for like a couple years. (Rochester, 24)

Another described being sexually molested by the deacon in his church, never telling anyone about the incident:

> It was . . . it was one day after Sunday school, he . . . he used to always take all the kids out anyway, so . . . . But, um, this one day after Sunday school, he took me out, we got somethin' to eat and he was . . . comin' on to me and things and it just happened. He was threatening and told me not to tell. At the time, which I thought, you know, I did not know, so, I thought I was gonna get in trouble and things and stuff like that. So, I kept it in my whole life. (Rochester, 22)

Again, the CSA was a prolonged series of traumatic experiences that occurred over years without anyone else in the family knowing. The same participant went on to say:

> But, um, . . . like I remember the last couple times and I was into it. I'm sorry, I mean I'm not gonna lie like, [chuckle] as far as like going down or whatever, like I did not mind it. But when it stopped, I kinda like tried to block everything out. (Rochester, 22)

Although not directly speaking on the notion of what came first, the same-sex desire or the CSA, this participant noted that he "did not mind" the experience of CSA. However, in an attempt to deal with it, he "blocked" everything out.

Finally, one participant who had been molested by his uncle described how he perceived his current psychological state:

> I think I'm bipolar. Sometimes I feel happy, then the next second, I'm totally pissed off. (Rochester, 19)

This description demonstrates his perceived current psychological state, which is potentially linked to his prior CSA experiences.

Discussion

The results from these qualitative studies add key points to the literature on described CSA experiences and potential implications for adult mental health and HIV sexual risk behavior among Black MSM. First, we found a high combined CSA prevalence among the participants in these three diverse samples. Second, CSA experiences often involved older male relatives and were prolonged and repetitive in nature. Third, many viewed their current same-sex desire as rooted in their CSA experiences. Finally, descriptions of depressive symptoms, social isolation, suicidality, "acting out," and other adverse mental health responses were common. This report is one of the first to report a high prevalence of CSA and qualitatively explore CSA experiences among a diverse sample of exclusively Black MSM. Despite participants not directly describing the influence of their CSA experiences on their adult sexual risk behavior, the high prevalence of CSA in these samples and its documented association with high-risk sexual behavior among MSM of other ethnicities suggest that this is an area worthy of future study.

Considering the high reporting of CSA experiences among these samples, some central issues and questions emerge. First, is this

reflective of the CSA prevalence among larger Black MSM samples or among the general population of Black men in the United States? And if so, is a history of CSA part of a larger pathway to adult HIV sexual risk similar to those documented among other populations? We know that certain physical (e.g., being uncircumcised), medical (e.g., high prevalence of STI and late HIV testing), and genetic factors (e.g., CCR5 receptor expression) may influence the high rates of HIV among Black MSM, despite their having UAI rates comparable with those of MSM of other ethnicities (Millett et al., 2006). However, social variables such as CSA and mental health may be affecting condom use and sexual risk behavior among Black MSM. Knowledge of genetic or biological predispositions to HIV susceptibility will not improve our HIV prevention efforts among Black MSM unless it is combined with further exploration of the social context that exploits these predilections.

Additionally, the common link of CSA among the men in these studies, despite representing different sexual identities, age groups, and geographical locations is important. Our findings suggest that, despite various sexual identities among the Black MSM interviewed, similar CSA experiences adversely affected their mental health. How one sexually self-identifies may not ultimately have the most significant impact on adult HIV risk behavior among Black MSM (Crawford, Allison, Zamboni, & Soto, 2002; Hart & Peterson, 2004). However, investigating the potential relationship between CSA, mediating psychological variables, and adult sexual risk behavior may be a more productive avenue by which to inform future HIV prevention efforts.

Finally, participants' descriptions of depressive symptoms, social isolation, and suicidality associated with CSA underscores the need for earlier screening of CSA as an overall social initiative. Moreover, alcohol use, exchanging sex for money, and physical violence were commonly reported details of these experiences. This described context of CSA among the Black MSM in this report also highlights essential issues of poor mental health that may be going unaddressed in our currently public health efforts. Many of the perpetrators of CSA were male relatives whom participants trusted or felt safe with as children, and the experiences went on repeatedly over a prolonged period of time, creating persistent trauma to the victims. Although the findings in this report cannot confirm a direct connection between CSA and adult sexual risk behavior, it is possible that modeling from these experiences may be creating a "norm" for the context of their adult sexual behavior. Future HIV prevention efforts for Black MSM should consider educating families, guardians, and close loved ones about CSA, its potential impact on mental health, and how to use useful communication strategies with children and resources for counseling referrals if CSA is suspected.

Limitations

This report has a few limitations. First, direct associations between CSA prevalence and adult sexual risk behavior cannot be made from these qualitative findings. Second, the results are from small samples of Black MSM recruited using convenience sample strategies and may not be generalizable to the larger Black MSM population. Third, the principal investigators of the three studies were the primary interviewers and also participated in data analysis. However, the presence of additional coders/analysts for this process decreases this potential bias. Finally, this report did not address additional factors beyond CSA that could contribute to the mental health descriptions among these men. Despite these issues, the similar CSA prevalence and described context among these diverse samples of Black MSM deserves increased attention as a serious public health issue.

Conclusions and Implications

From a research perspective, future studies are needed with larger population-based samples to ascertain the extent of CSA prevalence and its possible impact on the mental health and adult sexual risk behaviors of Black men of all sexualities. Additionally, further qualitative explorations of the contexts of CSA experiences among Black MSM should be undertaken. For HIV prevention interventions, medical, public health, and social service facilities should consider routinized screening, counseling, and culturally relevant treatment practices for CSA and mental health among Black MSM.

Finally, the majority of research on CSA among MSM focuses on the victim's perspective and resultant consequences of the abuse. More data are needed on the perpetrators of CSA: who these men are, their motivations and mental health, how they select the children they abuse, their sexual risk behaviors, and their own personal histories of experiencing CSA as victims. Only if we target our research and social interventions on the contexts surrounding both CSA victims and perpetrators can we truly make progress on improving upon the underwhelming attention to the recognition and treatment that this issue is currently receiving.

CSA and HIV/AIDS are interrelated epidemics that are disproportionately affecting Black MSM in the United States. Future mental health initiatives and HIV prevention efforts targeting this population must acknowledge and investigate these "elephants in the room" and how we may better use this understanding as a means to improving the overall health of this population.

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