

Childhood Sexual Abuse and HIV-Related Risks Among Men Who Have Sex with Men in Washington, DC

Gregory Phillips II · Manya Magnus · Irene Kuo · Anthony Rawls · James Peterson · Luz Montanez · Tiffany West-Ojo · Yujiang Jia · Jenevieve Opoku · Alan E. Greenberg

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Abstract Childhood sexual abuse (CSA) has been reported to be disproportionately higher among men who have sex with men (MSM) than among heterosexual men; it has also been found to be significantly positively associated with HIV status and HIV risk factors, including unprotected anal intercourse. The purpose of this study was to assess the correlates of CSA in a sample of community-recruited MSM, investigate race as a potential effect modifier, and describe the independent association between CSA and HIV infection in Washington, DC. A total of 500 MSM were recruited by venue-based sampling in 2008 as part of the National HIV Behavioral Surveillance. More than one-half of MSM identified as White, while one-third identified as Black. CSA was reported by 17.5 % of the 451 MSM, with the first instance of abuse occurring at a median age of 8.3 (interquartile range = 5.0, 11.0). In multivariable analysis, HIV-positive men were significantly more likely to report a history of CSA compared to HIV-negative men after adjusting for intimate partner violence in the last 12 months, having been arrested in the last 12 months, and depressive symptoms. HIV-positive MSM had more than four times the odds of reporting CSA after controlling for other

correlates (aOR = 4.19; 95 % CI 2.26, 7.75). Despite hypothesizing that race modified the effect of CSA on HIV infection we found this was not the case in this sample. More research is needed to investigate the potential pathway between a history of CSA and HIV infection, and how this contributes to driving the HIV epidemic among MSM in Washington, DC.

Keywords HIV · Sexual orientation · Men who have sex with men · Childhood sexual abuse · IPV · Behavioral surveillance

Introduction

Prior research has shown that a substantial proportion of men who have sex with men (MSM) report a history of childhood sexual abuse (CSA) (Mimiaga et al., 2009; Welles et al. 2011). However, due to differences in operationalization of the definition of CSA—“sexually coerced by age 17” (Paul et al. 2001), “sexual experience with a person at least 5 years older if the child was 12 and under, or 10 years or older if the child is between 13 and 16 inclusive” (Lenderking et al., 1997), “ever forced to have unwanted sexual activity with older males or females as a child or adolescent” (Welles et al., 2009)—it is difficult to compare findings across studies. Despite this limitation, many studies cite similar proportions of MSM reporting a history of CSA.

In a study involving a probability sample of urban MSM, 20 % reported CSA; 42.5 % of these incidents involved physical force and 77.8 % involved penetration (Paul et al., 2001). An earlier cross-sectional study revealed higher rates, with 35.5 % of MSM reporting a history of CSA (Lenderking et al., 1997). Consistent with these data, the longitudinal EXPLORE Study found that 39.7 % of MSM reported a history of CSA (Mimiaga et al., 2009). Although a multi-site

G. Phillips II · M. Magnus · I. Kuo · A. Rawls · J. Peterson · L. Montanez · A. E. Greenberg
The George Washington University School of Public Health and Health Services, Washington, DC, USA

G. Phillips II (✉)
Department of Medical Social Sciences, Feinberg School of Medicine, Northwestern University, 625 North Michigan Ave., Suite 2700, Chicago, IL 60611, USA
e-mail: glp2@northwestern.edu

T. West-Ojo · Y. Jia · J. Opoku
District of Columbia, Department of Health, HIV/AIDS, Hepatitis, STD and TB Administration, Washington, DC, USA

study of HIV-positive young racial/ethnic minority MSM did not directly assess a history of CSA, it was found that 19 % of MSM reported their age of sexual debut with men at 13 years old or younger, which is below the age of consent in any state in the U.S. (Outlaw et al., 2011). This potentially underestimates the prevalence of CSA among this sample since it did not take into account sexual encounters with women at a young age or any unwanted sexual encounters after the age of 13 years.

It has been found that MSM experience much higher rates of CSA compared to heterosexual men (Mimiaga et al., 2009; Roberts et al. 2013; Welles et al., 2011). Data from the National Epidemiologic Survey on Alcohol and Related Conditions showed that homosexual and bisexual men had significantly higher odds of having frequently or sometimes experienced CSA compared with heterosexual men (odds ratio [OR] = 9.51, 95 % confidence interval [CI]: 7.64, 11.84; OR = 12.79, 95 % CI 8.52, 19.20, respectively) (Sweet & Welles, 2012). This difference was supported by a cross-sectional study in Boston, which found that more self-identified MSM reported sexual abuse before the age of 11 compared to non-MSM (19 vs. 5 %, $p < .0001$) (Welles et al., 2009, 2011). Additionally, Andersen and Blosnich (2013) found that, compared with heterosexuals, gay men and lesbians were significantly more likely to report an array of adverse childhood experiences beyond CSA.

Research has shown that individuals who experienced sexual abuse in childhood are more likely to engage in higher risk sexual behaviors later in life. Although this association seems counterintuitive, a number of possible explanations for this connection have been suggested. People with a history of CSA are often more likely to use drugs or alcohol to cope with their past experiences, which in turn leads to a larger number of sex partners and unprotected sexual encounters (Senn et al. 2006, 2007, 2008). Finkelhor and Browne (1985) developed a traumagenic dynamics model, in which people who have experienced CSA develop traumatic sexualization and believe that sex is a requirement for affection in interpersonal interactions (Senn et al., 2007, 2008). These explanations might also help to understand why MSM who experienced CSA are more likely to engage in behaviors that place them at increased risk for HIV acquisition than MSM with no CSA history.

Mimiaga et al. (2009) found that CSA was associated with unprotected anal intercourse (UAI) and UAI with a serodiscordant partner among MSM at least 18 years of age. Among HIV-infected MSM in a cohort recruited from venues in New York and San Francisco, a history of CSA was significantly associated with insertive UAI (33 vs. 20 %) and receptive UAI (43 vs. 27 %) (O'Leary et al. 2003). O'Leary et al. found that increased engagement in UAI was mediated by mental health issues, such as anxiety and suicidality, but that these factors did not fully explain the association. Correspondingly, studies have found consistent associations between CSA and HIV infection (Brennan et al. 2007; Lenderking et al., 1997; Mimi-

aga et al., 2009), depression (Boudewyn & Liem, 1995; Mimiaga et al., 2009; Welles et al., 2009), substance use (Brennan et al., 2007; Mimiaga et al., 2009), and history of arrest (Kurtz, 2008). The interplay of these psychosocial conditions, known as a syndemic, has frequently been identified as one of the main drivers of HIV infection (Stall et al., 2003).

Much research has shown that individuals with a history of CSA are significantly more likely to experience intimate partner violence (IPV) as adults. The aforementioned negative sequelae of CSA, along with post-traumatic stress disorder and lack of self-worth, have been posited as an explanation for revictimization later in life (Balsam et al. 2011; Daigneault et al. 2009; Lalor & McElvaney, 2010; Senn et al. 2010). Little research, however, has specifically focused on this pattern of lifetime abuse among MSM. A cross-sectional study conducted in 1999 in Atlanta found that 30 % of MSM who experienced IPV had also experienced CSA, which was a significantly higher proportion than among MSM who had no history of IPV (18 %) (Kalichman et al., 2001). In a cross-sectional study of Black men in Boston in 2005–2006, a history of CSA among MSM was found to be significantly associated with being a victim and a perpetrator of IPV (Welles et al., 2011).

As with CSA, IPV has been shown to be associated with HIV risk behaviors and HIV infection. Dyer et al. (2012) found that Black MSM in the Multicenter AIDS Cohort Study who had experienced IPV were significantly more likely to use drugs (OR = 2.57; 95 % CI 1.5, 4.7). A clinic-based sample of MSM in Washington, DC found that IPV was significantly associated with HIV infection (OR = 1.67; 95 % CI 1.14, 2.45) although this association was not significant after controlling for other sexual risk-related behaviors (Li et al. 2012).

Although prior research has examined the correlates of CSA among MSM, no studies to date have investigated CSA in the context of IPV and racial differences and the role this might play in better understanding HIV risk behaviors and infections. This is important, especially in Washington, DC, where the magnitude of the HIV epidemic continues to increase among MSM, especially Black MSM. The second data collection year of MSM for the National HIV Behavioral Surveillance System (NHBS-MSM-2) in Washington, DC found that Black MSM were significantly more likely to be HIV-positive (26.0 vs. 7.9 % White and 6.5 % other) and to be newly diagnosed as HIV-positive (11.2 vs. 2.5 % White and 2.6 % other) (Magnus et al., 2010). Due to identified differences in history of CSA and HIV infection among MSM based on race, we hypothesized that race would be an effect modifier of the association between CSA and HIV infection. Therefore, in addition to describing the prevalence of CSA among a sample of community-recruited MSM and illustrating its association with HIV infection and IPV in Washington, DC, we sought to identify the potential of race as an effect modifier, with the aim of offering potential explanations for the burgeoning epidemic.

Method

Participants

Data for this study were collected at the Washington, DC site of the National HIV Behavioral Surveillance System (NHBS). The methodology for the study has been described elsewhere (Centers for Disease Control and Prevention [CDC], 2005, 2011; Gallagher et al. 2007). Briefly, cross-sectional data for NHBS were collected in cycles of serial data collection years focusing on three groups at high risk for acquisition of HIV: MSM, injection drug users, and heterosexuals at increased risk of HIV infection. Recruitment for the second round of the MSM cycle of NHBS (MSM-2) began

in July 2008 and concluded in December 2008. Venue-based sampling (VBS) using random time-space sampling was employed to recruit participants into the survey. In this method of sampling, venues, dates, and times were selected at random on a monthly basis. Methodology for The George Washington University's (GWU's) implementation of NHBS-MSM-2 in Washington, DC has been reported elsewhere (Magnus et al., 2010). Participants were compensated \$25 for completing the survey and \$10 for providing a sample for HIV testing. All protocols and procedures were approved by the GWU and District of Columbia Department of Health Institutional Review Boards. A total of 500 men were recruited for NHBS-MSM-2; 49 men did not complete questions on CSA history.

Table 1 Correlates of having experienced childhood sexual abuse (CSA) among a sample of MSM recruited in NHBS-MSM-2 (Washington, DC, 2008)

	CSA (<i>n</i> = 79) <i>n</i> (%)	No CSA (<i>n</i> = 372) <i>n</i> (%)	Unadjusted OR (95 % CI)	Adjusted OR (95 % CI)
Race/ethnicity (row %)				
White	31 (13.3)*	202 (86.7)*	1.00 (–)	– ^c
Black/African-American	36 (23.8)*	115 (76.2)*	2.04 (1.20, 3.47)*	
Other	12 (17.9)	55 (82.1)	1.42 (0.69, 2.95)	
Age				
18–34	44 (55.7)	239 (64.3)	1.00 (–)	– ^c
35+	35 (44.3)	133 (35.8)	1.43 (0.87, 2.34)	
Education				
Less than college	45 (57.0)**	145 (39.0)**	1.00 (–)	– ^c
At least college	34 (43.0)**	227 (61.0)**	0.48 (0.30, 0.79)**	
HIV-positive	24 (32.9)**	40 (11.2)**	3.88 (2.15, 6.99)**	4.19 (2.26, 7.75)**
If positive, unaware of status	10 (41.7)	18 (45.0)	0.87 (0.31, 2.43)	– ^c
Sexual identity ^a				
Gay	68 (87.2)	322 (86.6)	1.00 (–)	– ^c
Bisexual/straight	10 (12.8)	50 (13.4)	0.95 (0.46, 1.96)	
Health insurance				
Ever homeless	6 (7.6)	16 (4.3)	1.83 (0.69, 4.83)	– ^c
CES-D score \geq 16	26 (34.2)*	76 (20.6)*	2.00 (1.17, 3.43)*	1.74 (0.96, 3.16)
Intimate partner violence, last 12 months	12 (15.2)**	13 (3.5)**	4.95 (2.16, 11.3)**	3.54 (1.41, 8.92)**
UAI, last sex ^b	24 (40.7)	106 (40.9)	0.99 (0.56, 1.76)	– ^c
Number of sex partners, last 12 months:				
1–4	42 (53.2)	221 (59.4)	1.00 (–)	– ^c
\geq 5	37 (46.8)	151 (40.6)	1.29 (0.79, 2.10)	
Ever in jail	22 (27.9)**	53 (14.3)**	2.32 (1.31, 4.11)**	– ^c
Arrested, last 12 months	12 (15.2)**	20 (5.4)**	3.15 (1.47, 6.75)**	2.48 (1.02, 6.03)*
Binge drinking, last 12 months	57 (75.0)	273 (77.1)	0.89 (0.50, 1.58)	– ^c
Non-injection drug use, last 12 months	45 (57.0)	189 (50.8)	1.28 (0.79, 2.09)	– ^c
Ever injected drugs	6 (7.6)	13 (3.5)	2.27 (0.84, 6.17)	– ^c

^a Missing data for one participant

^b *n* = 318

^c Adjusted ORs and 95 % CIs not calculated for correlates with *p* > .10 within model

* *p* < .05; ** *p* < .01

Of the 451 MSM included in this analysis, half were White (51.7 %) and nearly two-thirds were under the age of 35 years (62.8 %) (Table 1). White MSM were significantly less likely to be unemployed or have an annual income under \$40,000, but more likely to have post-graduate education, compared with Black or other race MSM. HIV seroprevalence among this sample was 14.9 %, and 43.8 % of those individuals reported being unaware of their positive HIV status prior to entering the study. Both binge drinking and non-injection drug use in the last 12 months were common in this sample (76.7 and 51.9 %, respectively).

Measures

HIV-Status Assessment

Individuals participated in a 30–40 min anonymous, interviewer-administered questionnaire conducted using Hand-held-Assisted Personal Interview, along with an anonymous oral rapid HIV screening test (OraQuick ADVANCE ½, OraSure Technologies, Bethlehem, PA). An oral sample was collected from participants who self-reported being HIV-positive or who tested preliminary positive on the screening test for confirmatory Western Blot testing (OraSure Technologies). All persons screening HIV-positive were immediately referred into care.

CSA Assessment

The survey assessed demographics, sexual and substance use behaviors, and utilization of local HIV service providers. Age of participants was dichotomized at 18–34 years versus 35 years and older, consistent with previously published data (Magnus et al., 2010; Phillips et al., 2013). The question “Did you ever experience sexual abuse during childhood?” was used to assess history of CSA. Six more questions to determine details of the participants’ CSA experience were adapted from those used by Paul et al. (2001) in the Urban Men’s Health Study: (1) “How old were you the first time sexual abuse occurred?,” (2) “Was the perpetrator(s) a family or non-family member?,” (3) “Was the perpetrator(s) male, female, both?,” (4) “Did the abuse involve physical force?,” (5) “Did the abuse involve penetration?,” and (6) “Was the penetration oral, anal, or oral and anal?”

IPV Assessment

Recent violence was assessed by the question “Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone important to you?” The identity of the person who committed the violence was then assessed using the following options: spouse, ex-spouse, boyfriend, girlfriend, stranger, others. In order to narrow this down to recent

IPV, we excluded participants who reported the perpetrator of the violence as only a stranger or some other person.

Sexual Behavior Assessment

Participants were asked about their sexual behaviors during the prior 12 months and at the last sexual encounter. In order to assess the number of male partners in the prior year, they were asked “In the past 12 months, with how many different men have you had oral or anal sex?” Based on prior published research, number of partners was dichotomized as 1–4 partners versus 5 or more partners (Magnus et al., 2010; Phillips et al., 2013). For the most recent sexual encounter, participants were asked “When you had sex that last time, did you have receptive anal sex where he put his penis in your anus (butt)?” If they answered yes, they were asked “During receptive anal sex that last time, did he use a condom?” Additionally, participants were asked “When you had sex that last time, did you have insertive anal sex where you put your penis in his anus (butt)?” If they answered yes, they were asked “During insertive anal sex that last time, did you use a condom?” UAI was defined as not using a condom during either receptive or insertive anal sex at the last encounter.

Substance Use Assessment

Past year non-injection drug use was assessed using the question “In the past 12 months, have you used any non-injection drugs, other than those prescribed for you?” A history of injection drug use was assessed by the question “Have you ever in your life shot up or injected any drugs other than those prescribed for you? By shooting up, I mean anytime you might have used drugs with a needle, either by mainlining, skin popping, or muscling.” In order to determine binge drinking in the prior year, participants were asked “In the past 12 months, how often did you have 5 or more alcoholic drinks in one sitting?” Anyone who reported a frequency of “less than once a month” to “more than once a day” was considered to have engaged in binge drinking.

Depression Assessment

Depressive symptoms were measured using the Center for Epidemiologic Studies Depression Scale (CES-D), a 20-item self-report scale for depressive symptomatology (Radloff, 1977). Each item has four possible responses: (1) “Rarely or none of the time (less than 1 day),” (2) “Some or a little of the time (1–2 days),” (3) “Occasionally or a moderate amount of time (3–4 days),” and (4) “Most or all of the time (5–7 days).” Items were given a score ranging from 3 for “Rarely or none of the time” to 0 for “Most or all of the time,” with the exception of four items that were reverse scored. These individual scores were summed and final scores of 16 or greater were

considered to be indicative of depressive symptoms (Radloff, 1977).

Statistical Analyses

Unadjusted correlates of lifetime report of CSA were examined using bivariable analyses to generate Chi square test statistics and *p*-values. Participants who did not provide a response for the CSA question, either due to not being asked the section of the questionnaire which contained the question (*n* = 41) or their refusal to answer (*n* = 8), were excluded from the analysis. Variables associated with history of CSA on the bivariable analysis with *p* value < .20 were included in a multivariable logistic regression model to assess correlates of CSA. In the full model, correlates with *p*-values > .10 were eliminated using a manual, stepwise technique, starting with the variable with the largest *p*-value. In order to assess race as a potential effect modifier, the interaction term was included in the multivariable model and was excluded from the model if *p*-value < .10 in the final adjusted model. All analyses were performed using SAS Version 9.2 (Cary, NC).

Results

Prevalence and Description of CSA

CSA was reported by 17.5 % of the sample, with the first instance of abuse occurring at a median age of 8.3 years (interquartile range [IQR] = 5.0, 11.0). The perpetrator of the first abuse was evenly distributed between a family member (51.3 %) and a non-family member (47.4 %). The perpetrator's gender was predominantly male (88.5 %), with four participants reporting abuse by a female (5.1 %) and five reporting abuse by both males and females (6.4 %). More than half of participants who reported CSA stated that the first incident involved physical force or penetration (60.3 % and 55.8 %, respectively). Of the 43 MSM who reported penetration during CSA, over half (54.8 %) reported both oral and anal penetration.

Correlates of CSA

In unadjusted analysis, Black MSM had significantly higher odds of reporting CSA compared to white MSM; there was no significant difference when MSM of other race/ethnicity were compared to white MSM (Table 1). HIV prevalence was significantly higher among MSM reporting CSA compared to MSM who did not report CSA (32.9 vs. 11.2 %; *p* < .0001), with MSM reporting CSA having nearly four times the odds of being HIV-positive when compared to MSM who did not report CSA (OR = 3.88; 95 % CI 2.15, 6.99). All MSM who were aware of their HIV infection received their diagnoses

many years after the first instance of CSA (*M* = 19.9 years; *SD* = 4.8 years). MSM who reported CSA had significantly higher odds of reporting depressive symptoms, having MSM debut before the age of 18, having been arrested in the last 12 years, and having ever injected drugs (Table 1). There were no significant associations between reporting a history of CSA and having an older male sex partner, type of sex partner at last sex, engaging in exchange sex, and having only oral sex at last encounter (data not shown).

Nearly two-thirds of MSM who reported CSA (64.6 %) responded that they had experienced IPV and 15.2 % reported IPV in the last 12 months. MSM who reported CSA were significantly more likely to report IPV in the last 12 months when compared to MSM without a history of CSA (OR = 4.95; 95 % CI 2.16, 11.3).

In multivariable analysis, a report of CSA was significantly associated with HIV-positivity after adjusting for IPV in the last 12 months, having been arrested in the last 12 months, and CES-D score (Table 1). HIV-positive MSM had more than 4 times the odds of reporting a history of CSA compared with HIV-negative MSM (aOR = 4.19; 95 % CI 2.26, 7.75). A history of CSA was also significantly associated with IPV in the last 12 months (aOR = 3.54; 95 % CI 1.41, 8.92) and having been arrested in the last 12 months (aOR = 2.48; 95 % CI 1.02, 6.03). There were no significant associations between a report of CSA and CES-D score, age, possessing health insurance, having ever been in jail, educational attainment, history of injecting drugs, and race/ethnicity. There was also no significant effect modification of race/ethnicity on the association between CSA and HIV-status.

Discussion

Although nearly one-fifth of MSM in this study reported a history of CSA, this prevalence was lower than those cited by other studies (Lenderking et al., 1997; Mimiaga et al., 2009). This finding could be associated with the different ways in which CSA was assessed across studies; our study used a single question to assess CSA whereas other studies have used multiple questions to determine a history of CSA. The directness of the question in our study, specifically the phrase “sexual abuse during childhood,” might have been stigmatizing and could have led to under-reporting of CSA in our sample.

We found that a reported history of CSA was associated with HIV infection after adjusting for confounders and other characteristics associated with elevated HIV prevalence (CDC, 2005, 2011; Magnus et al., 2010). This finding was consistent with other CSA studies (Brennan et al., 2007; Lenderking et al., 1997; Li et al., 2012; Mimiaga et al., 2009; Welles et al., 2009) and provides evidence of the relationship between a history of CSA and acquisition of HIV among

MSM in Washington, DC. However, the mechanism for this observed association is unclear since the prevalence of high risk sexual behaviors (multiple partners, UAI, etc.) were similar between MSM with a history of CSA and MSM without a history of CSA.

Since HIV and CSA prevalence in our sample were significantly higher among Black MSM compared to other MSM, we hypothesized that race was acting as an effect modifier in the association between history of CSA and HIV infection. However, we found that this was not the case, meaning the association between history of CSA and HIV infection was driven by more than just racial differences in Washington, DC.

Similar to other studies, MSM in this study with a history of CSA were more likely to have experienced recent IPV, report depressive symptoms, report a history of incarceration, and have been arrested in the last 12 months (Boudewyn & Liem, 1995; Kalichman et al., 2001; Kurtz, 2008; Mimiaga et al., 2009; Welles et al., 2009, 2011). Unlike findings from previous studies (Mimiaga et al., 2009; Welles et al., 2009), MSM who reported CSA were not significantly more likely to have had UAI at last sex when compared to MSM who did not report CSA. While this finding could be unique to MSM in Washington, DC, it could also be due to the fact that only two-thirds of our sample engaged in anal sex at last sex. Additionally, several characteristics that have been tied to CSA in previous studies, such as substance use (Brennan et al., 2007; Mimiaga et al., 2009), were not significantly associated with CSA in this study. Since substance abuse, especially binge drinking, was prevalent among this population, power was not an issue in assessing the association. Thus, while we found a syndemic effect of CSA with other psychosocial characteristics on HIV infection, not all previously identified associations consistent with syndemic theory were detected in this sample of MSM and other unmeasured factors might assist with explaining the HIV epidemic among MSM in Washington, DC.

Limitations

As with other studies of sexual behaviors and CSA, this study relied on self-report except for determination of HIV-status (Brennan et al., 2007; Mimiaga et al., 2009; Welles et al., 2009, 2011). This could have resulted in social desirability bias, differential recall or recall bias (Delgado-Rodriguez & Llorca, 2004). Participants who experienced substantive trauma from their CSA may recall their experiences differentially based on the degree of trauma, resulting in misclassification, although research has shown that retrospective reports of CSA are a reliable and valid measure (Whitmire et al., 1999). This study assessed history of CSA through one question whereas other studies have utilized other measures; therefore, a comparison between this study and other studies on a history of CSA among MSM might not be precise. Additionally, not all participants

might have interpreted the initial CSA question similarly, specifically with the meanings of “sexual abuse” and “childhood,” and thus the true prevalence of CSA in this population might be underreported. Since the survey was administered by interviewers and not self-administered, there was potential for under-reporting of CSA due to social desirability. However, interviewers were trained to develop rapport with study participants and ensure they were comfortable with answering sensitive questions, so we believe unwillingness to report CSA was not a significant problem.

While most questions were time-anchored to the last 12 months or the last instance in order to improve recall, and staff members were extensively trained to minimize bias, these represent possible limitations to the analysis. Participants for this study were recruited using VBS at venues composed of at least 75 % MSM. Since venue-recruited MSM have been shown to be more likely to engage in high risk sexual behaviors than the general population of MSM (Dodds et al. 2006; Xia et al., 2006), behavioral findings from this study might not be representative of the entire MSM community. In addition, this should be considered a community-based convenience sample and findings may not be generalizable outside the venue-attending MSM population of Washington, DC. As with all cross-sectional studies, there is an inability to assess temporality or causality.

Despite these limitations, this is one of the first studies to investigate the association between CSA and HIV-related sexual risks in Washington, DC and could prove invaluable to understanding the underlying factors of the HIV epidemic among MSM in the District.

Conclusions

CSA represents a common experience among MSM, especially Black MSM, in Washington, DC. More research is needed to investigate the potential pathway between a history of CSA and HIV infection and how this contributes to driving the HIV epidemic among MSM in Washington, DC. Many of the MSM who experienced CSA reported recent IPV. Future research should be conducted to identify needs of and provide services for MSM with a lifetime history of abuse. Such programs may be able to assist MSM with a history of CSA by providing them with the means to limit future violence and address the consequences of CSA that place them at increased risk for acquiring HIV. Additionally, the high frequency of depression among MSM with a history of CSA identifies the need for integration of mental health counseling into any program to assist these men with preventing IPV and decreasing HIV risk behaviors.

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