Mediating Factors in the Relationship between Childhood Sexual Abuse and HIV Sexual Risk Behaviour among Men Who Have Sex with Men

by

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Declaration:

In accordance with Rule G4.6.3, I hereby declare that the above-mentioned treatise/dissertation/thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

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# Table of Contents

Declaration by Student ii  
Acknowledgements iii  
List of Tables ix  
List of Figures x  
Abstract xi  

Chapter 1: Introduction 1  
Introduction 1  
Prevalence of Child Sexual Abuse 2  
Defining Child Sexual Abuse 6  
Types of sexual abuse 8  
Legal Definitions 9  
Rape 9  
Sexual assault 10  
Incest 10  
Chapter Overview 10  

Chapter 2: The Long-term Effects of Childhood Sexual Abuse 12  
Introduction 12  
Posttraumatic Stress 13
Chapter 3: Mediating Factors in the Relationship between CSA and HIV Sexual Risk Behaviour
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>27</td>
</tr>
<tr>
<td>Conceptual Models Linking CSA and HIV Risk Behaviour</td>
<td>31</td>
</tr>
<tr>
<td>CSA-related Mental Health Outcome Measures and their Association with HIV Sexual Risk Behaviour</td>
<td>37</td>
</tr>
<tr>
<td>Dissociation</td>
<td>37</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>38</td>
</tr>
<tr>
<td>Depression</td>
<td>39</td>
</tr>
<tr>
<td>Sexual compulsivity</td>
<td>40</td>
</tr>
<tr>
<td>Impaired interpersonal regulation</td>
<td>44</td>
</tr>
<tr>
<td>Submissive sexual scripts</td>
<td>45</td>
</tr>
<tr>
<td>Chapter Overview</td>
<td>48</td>
</tr>
<tr>
<td>Research Aims</td>
<td>48</td>
</tr>
<tr>
<td>Chapter 4: Methodology</td>
<td>51</td>
</tr>
<tr>
<td>Research Design and Setting</td>
<td>51</td>
</tr>
<tr>
<td>Participants</td>
<td>51</td>
</tr>
<tr>
<td>Measures</td>
<td>53</td>
</tr>
<tr>
<td>Demographic information</td>
<td>54</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>55</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>55</td>
</tr>
</tbody>
</table>
Variables and Unprotected Anal Intercourse

Aim 4a: Creating a Model to Predict Number of Sexual Partners 83
Aim 4b: Creating a Model to Predict Unprotected Anal Intercourse 88
Aim 5: Testing for Mediation 92
   Number of male sexual partners as the dependent variable 92
   Unprotected anal intercourse as the dependent variable 98

Chapter 6: Conclusion, Limitations, and Implications 100
   Conclusion 100
   Limitations 101
   Directions for Future Research 103
   Clinical and Policy Implications 103

References 107

Appendix A: DSM-IV Diagnostic Criteria for Posttraumatic Stress Disorder 123
Appendix B: Information Letter 125
Appendix C: Questionnaire Package 127
Appendix D: Debriefing Form 142
**List of Tables**

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1: Demographic Characteristics of the Sample and Comparisons by Group</td>
<td>65</td>
</tr>
<tr>
<td>Table 2: Sample Prevalence Rates for CSA, Binary CSA-related Mental Health Outcomes and Unprotected Anal Sex</td>
<td>66</td>
</tr>
<tr>
<td>Table 3: Comparison of CSA and non-CSA group on CSA-related Mental Health Outcomes (Mediators) and the Two Sexual Risk Behaviour Variables</td>
<td>70</td>
</tr>
<tr>
<td>Table 4: Associations Between CSA-related Mental Health Outcomes and Two Dependent Variables</td>
<td>77</td>
</tr>
<tr>
<td>Table 5: Results of Hierarchical Linear Regression on Number of Male Sexual Partners</td>
<td>85</td>
</tr>
<tr>
<td>Table 6: Results of Hierarchical Logistic Regression on Unprotected Anal Intercourse</td>
<td>89</td>
</tr>
</tbody>
</table>
List of Figures

Figure 1: Mediation Model for Drug Abuse 93

Figure 2: Mediation Model for Drug Abuse in Sexual Contexts 94

Figure 3: Mediation Model for One-night Stands 94
Abstract

Previous studies have indicated an association between childhood sexual abuse (CSA) and an increased risk of engaging in unsafe behaviours during adulthood, including risky sexual practices. This study examined the relationship between CSA and adult HIV sexual risk behaviour among a sample of South African men who have sex with men (MSM). Potential pathological long-term mental health outcomes of CSA, including dissociation, sex-related substance abuse, depression, sexual compulsivity, impaired interpersonal communication, and over-reliance on submissive sexual scripts, were treated as variables mediating the relationship between CSA and sexual risk behaviour. Men frequenting a gay internet dating site were randomly selected to complete an electronic version of the anonymous survey. Results indicate that one-fourth of participants reported a history of CSA. Men with a history of unwanted sexual activity during childhood were more likely to report recreational substance abuse, sex-related substance abuse, sexual compulsivity, and adult revictimisation experiences. Men who were abused were also more likely to engage in unprotected anal intercourse compared to those who were not abused. Mediation analyses revealed that MSM who are survivors of CSA are particularly susceptible to drug abuse, sex-related drug abuse, and sexual compulsivity, and these sequelae in turn predict higher reported numbers of male sexual partners. The current data suggest that CSA is widespread among men at high risk for HIV infection, and that it may have a devastating influence on the quality of life and health risk behaviour of these men. These results also highlight the importance of mental health services and new approaches in HIV prevention for MSM who have been sexually abused as children. Further research is needed into the contextual factors of the childhood abuse experience which account for the variability in long-term negative mental health outcomes of CSA survivors.
Keywords: childhood sexual abuse, HIV sexual risk behaviour, men who have sex with men, long-term mental health outcomes, mediation analyses
CHAPTER 1
Introduction

1.1 Introduction

The sexual abuse of children has long been a taboo and misunderstood subject in both popular culture and in clinical literature, and sexual victimisation\(^1\) of all children has consistently been denied in society (Gartner, 1999). The sexual abuse of boys, however, is even more universally underrated, underestimated, and ridiculed than the abuse of girls.

In the surge of books and papers on child sexual abuse (CSA) that have appeared since the early 1980s, the focus has almost consistently been on sexually abused girls and their reactions to the abuse as women. While these clinicians, researchers, and writers accept that boys are also likely to experience sexual abuse, the emphasis on women has deceptively implied that the prevalence of sexual abuse among boys is rare. Gartner (1999) adds that it has even been suggested in the literature since the 1980s that the scarcity of published material about sexually abused boys reflects a low incidence rate. In addition, it is assumed that boys’ experiences and reactions to sexual abuse are similar to girls’.

Over two decades ago, David Finkelhor (1984) reviewed the existing literature on the sexual abuse of boys. He concluded that the area of sexual abuse of boys is “in crying need of research” (p.230) and stated that the most serious question in need of research in regard to boys is “how their response to victimisation differs from that of girls and how clinicians can take this difference into account” (p.230). Finkelhor (1984) added that “even purely descriptive accounts of work with sexually abused boys would be an important resource given the current state of ignorance on the subject” (p. 230). Urquiza and Capra (1990)

\(^1\) For the purposes of this research, the term *victimization* will be used interchangeably with term child sexual abuse (CSA). The term *survivor* will be used when referring to adults sexually abused as children (Briere, 1992). The term *victim* will be used only in reference to children at the time that they experienced the abusive event.
paralleled Finkelhor’s (1984) justified proclamation by stating that “if the body of literature concerning female victims is still in its infancy, the parallel body of literature concerning males may best be described as in an embryonic stage” (p. 126).

Fortunately, the literature on CSA among males has steadily progressed since the early 1980s. In addition to books intended for non-professionals, scholarly knowledge about sexually abused men has been enhanced by the professional writings of well-known clinicians and researchers in the field. This literature deals with many of the questions concerning the sexual abuse of boys, and supports the notion that men sexually abused as boys, form a distinct population with distinct reactions to their victimisation experiences. Thus, sexual abuse has different meanings for boys and girls, and these different meanings have implications for how the child defines it, reacts to it, and experiences it as an adult (Gartner, 1999).

In this chapter, the current knowledge concerning the sexual abuse of both males and females will be reviewed. Incidence and prevalence rates will be conceptualised both within the South African context, as well as internationally. For the incidence and prevalence rates of child sexual abuse to be accurate, an unambiguous definition of what constitutes child sexual abuse needs to be provided. Thus, this chapter will delineate international as well as South African definitions of child sexual abuse. Legal definitions, as well as research definitions deriving from seminal authors in the field (Finkelhor, 1994), will be considered.

1.2 Prevalence of Child Sexual Abuse

According to Hopper (1998), the word prevalence refers to the total number of existing cases or percentage of people at a given time who have experienced abuse. Incidence refers to the number of new cases that have been reported each year. According to the Community Agency for Social Enquiry (CASE, 2005), there is no central monitoring system
to record statistics relating to child sexual abuse in South Africa, making it difficult to determine the extent of the problem. However, the experience of child social services organisations and the crime statistics that are available suggest that CSA is pervasive. Childline, a nonprofit organisation that runs a child helpline and provides therapeutic services to child victims of abuse and their families, has noted a 400% increase in the number of reported cases of child sexual abuse over the past 10 years (CASE, 2005). According to crime statistics from the South African Police Service (SAPS, 1998), 40% of all rape cases reported to the police in 1998 in the Northern Province were children. Furthermore, the three most common crimes committed against children under 18 years in 2000 and 2001 were rape, attempted rape, common assault, and assault with intent to do grievous bodily harm (SAPS, 2001). More than 15 500 cases of child rape or attempted rape were reported to police in the period from January to September 2001. Furthermore, 40.8% of rapes in 2004 / 2005 were of children (SAPS, 2005), and the number of reported rapes against children increased by 4% from 2003 / 2004 (SAPS, 2004). In 2005 / 2006, this trend continued with a 1.9% increase in the proportion of reported rape of children, bringing the total to 42.7% of the total reported cases (SAPS, 2006). In 2007 / 2008, the proportion was 44%. Moreover, in 2007 / 2008, more than half of all reported cases of indecent assault (52%) related to children (SAPS, 2007). Indecent assault includes serious crimes such as anal rape (sodomy) and oral rape; these figures were incorporated into the rape numbers when the Sexual Offences Act of 2007 was implemented and these crimes were legally recognized as rape and not indecent assault.

These figures indicate that the extent of CSA in South Africa is pervasive. However, there are several problems with using crime statistics to determine the prevalence of CSA. Firstly, crime statistics refer only to reported cases, and rape and sexual assault are widely recognised as under-reported crimes (CASE, 2005). Furthermore, crime statistics reflect only specific categories of reportable crimes and do not reflect the full range of behaviours that
constitute CSA. A further issue is that crime statistics may reflect increasing levels of awareness and reporting, rather than increased levels of CSA per se. It is thus evident that crime statistics are controversial in determining the prevalence estimates of CSA. Thus, the following paragraphs will focus on historical and current research studies that document the prevalence of CSA both nationally and internationally. Specific attention will be given to gender differences in the prevalence of CSA.

The results of surveys since the mid 1980s documenting the occurrence of CSA are alarming. Earlier American studies (Russell, 1983, 1984, 1986) found that almost one-third of a sample of 900 female participants reported contact childhood sexual abuse (i.e. actual or attempted intercourse, oral or manual genital contact, sexual kissing or touching). When noncontact abuse (abuse involving no physical contact, such as exhibitionism or exposure to pornography) was included in the definition, the figure increased to over half. Historical findings concerning male populations are similarly alarming. For example, Bruckner and Johnson (1987) found that 33 percent of Canadian men are sexually abused at some point in their lives. Of these, 75 percent of the victimisations occurred to boys under the age of 17. Furthermore, in a national telephone survey of men aged 18 years or older in the United States, Finkelhor et al. (1990) found that 16% reported a history of sexual abuse in response to objective questioning. In 1994, Finkelhor further reported that 5% to 15% of men experienced contact sexual abuse during childhood.

The prevalence of contact forms of sexual abuse among a sample of South African female university students has been reported to be 30.9% (Levett, 1989) and 34.8% (Collings, 1997). For both contact and noncontact forms of abuse, the prevalence has been reported to be 43.6% in female university students in South Africa (Levett, 1989). For male university students, Collings (1991) reported a rate of 28.9% for contact and noncontact forms of abuse. In a more recent study, which limited itself to contact forms of abuse only, the prevalence
rate of sexual abuse among a sample of South African university students was 25.6% (Madu, 2001). The study yielded a prevalence rate of 21.7% for males and 23.7% for females. These figures indicate that the sexual abuse of boys constitutes a sizeable and emerging problem in South Africa. However, these figures are not limited to university samples only. For example, Madu and Peltzer (2001) reported a prevalence of 60% for contact forms of abuse among male secondary school students, compared to 53.2% for female students (Madu & Peltzer, 2001). A further recent study conducted in South Africa (Magojo & Collings, 2003) indicated that up to two-thirds of their sample of high-school males reported that they had been sexually abused as children. These figures indicate that the prevalence rates of CSA among males are comparable to those of females, and suggest that the sexual abuse of boys cannot be underestimated and underemphasised in the South African context. Furthermore, university samples are likely to under-represent minority groups and men of lower socio-economic background, and it is thus suggested that prevalence rates of CSA are even higher than is reported in many South African studies.

The above-mentioned national figures regarding the high incidence and prevalence of male CSA also compare to international findings. In a seminal, methodologically robust study of a nonclinical population, Lisak, Hopper, and Song (1996) surveyed approximately 600 male university students in America. They administered questionnaires carefully phrased to enquire about early sexual experiences, omitting the words “sexual abuse” so as to prevent eliciting judgements about those events. Of the men in their sample, 18% reported direct sexual abuse by the age of sixteen, and when noncontact abuse was included, the figure rose to 28%. In other words, approximately one in six men reported direct inappropriate sexual interaction by age sixteen, and an additional one in ten reported inappropriate noncontact sexual experiences by that age. This means that an estimate of one in four men has a sexual abuse history. Although these may seem to be enormous, somewhat inflated numbers, on the
contrary, the figures for men are likely to be underreported (Gartner, 1999; Mendel, 1995). More currently, Dube et al. (2005) found that 25% of women and 16% of men reported any type of CSA. However, among those who met the definition of childhood sexual abuse, 42% of the men and 23% of the women reported intercourse sexual abuse. Furthermore, a recent review of English-language articles published after 1989 that contained data on CSA, reported prevalence rates of 16.8% and 8% for adult women and men, respectively (Putnam, 2003).

The research on CSA among men further shows that the prevalence of CSA is higher among gay and bisexual men than heterosexual men (Arreola, Neilands, Pollack, Paul, & Catania, 2008; Paul, Catania, Pollack, & Stall, 2001). Some studies estimate that the prevalence of CSA among gay and bisexual men approximates that of women (Doll et al., 1992; Jinich et al., 1998). This recognition of high rates of CSA among gay men and the fact that experiences of CSA may differ by gender has led to an increasing interest in how CSA affects long-term health outcomes of men who have sex with men\(^2\) (MSM).

1.3 Defining Child Sexual Abuse

It has long been emphasised in the CSA literature that prevalence studies lack consistency, and this is particularly evident in studies of male sexual abuse (Holmes & Slap, 1998). The inconsistency of research findings about the prevalence of male sexual abuse is due not only to research design, but also to varied definitions of sexual abuse (Holmes & Slap, 1998). Definitions of abuse differ across a number of dimensions. According to Collings (1995), these dimensions include:

- the age range that is used to define childhood;

\(^2\) According to the UNAIDS, men who have sex with men (MSM) is a term often used in medical literature and social research to describe male persons who engage in sexual activity with members of the same sex, regardless of how they identify themselves. MSM thus refers to sexual activities between men, regardless of social identity, whereas gay and bisexual can include those activities but is more broadly seen as a cultural identity. It thus refers to behaviour rather than a specific group of people.
• the range of behaviour that is regarded as being sexual;
• the criteria for defining behaviour as abusive; and
• the victim-perpetrator relationships in which the abuse occurs.

Professionals differ in their definitions of child sexual abuse. Some definitions focus on the developmental immaturity of the child who does not fully understand sexual activities and is unable to give informed consent (Davel, 2000), whereas others consider the adult’s advantage of authority and power over the child (Diaz & Manigat, 1999; Finkelhor, 1994). Ackard and Neumark-Sztainer (2002) provide a different definition of child sexual abuse, and state that it is an unwelcome sexual experience, which need not necessarily include incidents where penetration took place and where the deed was classified as rape. Thus, in this definition, the term child sexual abuse does not include rape.

Faller (1988) defines sexual abuse as any act for the sexual gratification of the perpetrator, and states that the perpetrator must be at a more advanced developmental stage. This is in line with Finkelhor’s (1994) research definition, which maintains that abusive conditions exist when the child’s partner has a large or maturational advantage over the child, or the child’s partner is in a position of authority, or the activities are carried out against the child, using force or trickery. All of these conditions suggest an unequal power relationship and violate ideas of consensuality.

Thus, crucial to the definition of CSA is the criterion of the age differential (Finkelhor, 1984). It is important to consider the age difference between the victim and his perpetrator as this usually differentiates abusive situations from mutual childhood sexual exploration with playmates or peers (Gartner, 1999). The age difference required to indicate a sexually abusive situation varies considerably in different studies. Generally, Finkelhor’s (1984) graded classification system is used in the determination of abuse, whereby the age difference varies with the age of the victim. This means that for a victim younger than 13
years, a perpetrator had to be at least 5 years older. For a victim aged 13 to 16 years, a perpetrator had to be at least 10 years older. Most researchers, however, require a 5-year age difference before operationally defining behaviour as abusive (Babiker & Herbert, 1998; Madu, 2001; Madu & Peltzer, 2001). This age criterion is particularly evident in studies focusing on male sexual abuse (Dilorio, Hartwell, & Hansen, 2002; Gore-Felton et al., 2006; Jinich et al., 1998). When the perpetrator is a peer, emphasis is on whether the sexual activities are unwanted, exploitative, or can otherwise be distinguished from normal sexual curiosity (Finkelhor, 1994).

Furthermore, the additional criterion of coercion is used by most investigators in defining child sexual abuse (Finkelhor, 1994; Paul et al., 2001). This criterion requires that, either in whole or in part, sexual experiences had to involve some element of coercion or force to be defined as abusive (Gore-Felton et al., 2006; O’Leary, Purcell, Remien, & Gomez, 2003). A modification of this was that there may not have necessarily been obvious force, but the victim may have perceived the perpetrator to be more powerful (Holmes & Slap, 1998).

In summary, research definitions of child sexual abuse thus require two elements: (1) sexual activities involving a child and (2) an abusive condition (i.e., criterion of age differential or coercion).

### 1.3.1 Types of sexual abuse

Sexual abuse includes both contact and non-contact sexual abuse (Carstens, 2002). Contact sexual abuse is touching of the sexual parts of the child’s body, or the child’s touching the sexual portions of he other person’s body (Finkelhor, 1994). Contact sexual abuse involves penetration, which includes penile, digital, and object penetration of the vagina, mouth, or anus, and non-penetration, which includes fondling, kissing, or touching of sexual parts of the child’s body (Bromberg & Johnson, 2001).
Noncontact sexual abuse typically involves exhibitionism, voyeurism, and the involvement of the child in the making of pornography or other sexually exploitative acts (Bromberg & Johnson, 2001).

1.3.2 Legal definitions

Legal definitions of child sexual abuse vary from country to country. In South Africa, the law offers specific protection for children (Spies, 2006). In this regard, reference can be made to common-law and statutory law. With reference to sexual abuse, the common-law crimes of sexual assault, rape, and incest are relevant, and will be defined below.

The South African Constitution defines a child as a person under the age of 18 years (Act No. 108 of 1996).

1.3.2.1 Rape

The definition of rape before 2007 consisted of a male having unlawful and intentional sexual intercourse with a female without her consent. Sexual intercourse was defined only as vaginal penetration. Thus, the crime of rape did not include the sexual assault of males nor sexual assault that involved anal or oral penetration or penetration with an object. According to the Sexual Offences and Related Matters Amendment Act 32 of 2007, the new definition, which is gender neutral, reads as follows:

Any person (“A”), who unlawfully and intentionally commits an act of sexual penetration with a complainant (“B”) without the consent of the complainant (“B”), is guilty of the offence of rape.

Sexual penetration includes any act which causes penetration to any extent whatsoever by:
a) the genital organs of one person into or beyond the genital organs, anus, or mouth of another person;

b) any other part of the body of one person or any object, including any part of the body of an animal, into or beyond the genital organs or anus of another person; or

c) the genital organs of an animal, into or beyond the mouth of another person.

1.3.2.2 Sexual assault

The definition for sexual assault (before December 2007 known as indecent assault) according to the Sexual Offences and Related Matters Act (2007) reads as follows:

Any person (“A”) who unlawfully and intentionally sexually violates a complainant (“B”) without the consent of (“B”) is guilty of the offence of sexual assault.

1.3.2.3 Incest

Incest consists of the unlawful and intentional sexual intercourse between a male and female person who are prohibited from marrying each other, because they are related within prohibited degrees of consanguinity, affinity, or adoptive relationship (Spies, 2006). This common-law definition of incest is gender-biased and does not apply to sexual abuse between relatives of the same sex. Spies (2006) identifies four types of incest, namely: father-daughter, sibling, mother-son incest, and incest involving extended family members.

1.4 Chapter Overview

This chapter has emphasised that definitions of child sexual abuse vary across the world and cover a wide range of acts within South Africa. The commonalities in these definitions will be identified and underlined, so as to yield a more comprehensive and all-encompassing understanding of CSA. Almost all of the definitions of CSA, whether research or legal definitions, involve the abuse of power. CSA can be defined as physical or non-
physical contact between a child and another person, where the contact is of a sexual nature, and where there is an imbalance of power between the child and the perpetrator on the basis of age, physical size, and developmental maturity. The child is unable to understand the meaning of the sexual interaction due to his or her developmental immaturity; and, although involved in the abuse, is unable to give informed consent.

Deriving from various definitions of CSA in studies focusing on male sexual abuse and the associated long-term psychological, emotional and behavioural effects (Gore-Felton et al., 2006; Jinich et al., 1998; O’Leary et al., 2003; Paul et al., 2001), this study operationalises CSA in the following way: Child sexual abuse is limited to any contact form of abuse which took place before the age of 13 years. The perpetrator must have been an adult or a person at least 5 years older than the child. Furthermore, the experience must have involved some element of force or coercion, and must thus be considered unwanted by the child.
CHAPTER 2
The Long-term Effects of Childhood Sexual Abuse

2.1 Introduction

CSA is possibly the most debilitating experience that a child can endure. It is a violation of body, boundaries, and trust. It entails a degree of stimulation that is far beyond the child’s ability to comprehend and assimilate. As a result, there is not only disturbance in the achievement of normal developmental tasks, but the child’s mastery of self, environment, and relationships with others is considerably disrupted (Spies, 2006). Thus, sexual abuse has a profound, enduring, and debilitating impact on the way children think and feel about themselves, about other people, and about the world around them (Spies, 2006). Unless identified and resolved, the psychological after-effects can stay with the survivor long after the abuse experience. The necessary defensive strategies that initially protect the survivor subsequently fix these problems into place, interfering with adult psychological and sexual functioning (Horwitz, Widom, McLaughlin, & White, 2001).

A number of published studies (Briere & Elliot, 1994, 2003; Kalichman et al., 2001; Paolucci, Genius, & Violato, 2001) indicate that sexual abuse is commonly (although not unavoidably) associated with significant psychological pain and trauma in adulthood – suffering that may continue over the years unless specifically dealt with. In one seminal review of this literature, Browne and Finkelhor (1986) describe the results of 52 studies on the impact of CSA and conclude that “empirical studies with adults confirm many of the long-term effects of CSA mentioned in the clinical literature” (p. 72). Moreover, they state that the risk of initial and later mental health impairment for CSA survivors should be taken very seriously. Regarding the impact of CSA in men, Fromuth and Burkhart (1989) found that a history of CSA was significantly related to later psychological maladjustment in a
sample of university men. Other, more recent studies on the detrimental long-term effects of CSA in males offer similar conclusions (Dilorio et al., 2002; Gore-Felton et al., 2006).

Thus, research conducted over the past three decades indicates that a wide variety of psychological problems are more prevalent among individuals with a history of sexual abuse than among those with no such experiences. Even though a clear causal relationship between such problems and sexual abuse cannot be determined using retrospective research methodologies (Dallam et al., 2001), the accumulation of consistent findings in this literature warrants the conclusion that CSA is a major risk factor for a range of difficulties and problems, both in the short term and in later adult functioning (Beichtman et al., 1992, Briere & Elliot, 2003; Paollucci et al., 2001).

The purpose of this chapter is to familiarise the reader with the types of psychological difficulties commonly linked with CSA. There are a multitude of problems reported in the abuse literature (Briere, 1996; Briere & Elliot, 2003), and, as a result, the common long-term results of CSA will be divided here into five categories. These categories are defined as (1) posttraumatic stress, (2) cognitive effects, (3) emotional effects, (4) interpersonal effects, and (5) avoidance.

2.2 Posttraumatic Stress

Several writers, including Briere (1996), have proposed that sexual abuse during childhood, particularly incest, may produce posttraumatic symptoms, both immediately after the victimisation and subsequently in life. For example, Briere and Elliot (2003) found that sexual abuse survivors are at increased risk for the subsequent development of clinically significant post-traumatic stress symptoms, as measured by the Trauma Symptom Inventory (TSI).
Increasing literature thus suggests that extremely stressful, traumatic incidents can leave a lasting imprint on victim’s psychological functioning. Posttraumatic Stress Disorder (PTSD) involves enduring psychological disturbance attributed to the experience of a major traumatic event (Briere, 1996). Most researchers and clinicians acknowledge that sexual abuse is a frightening, painful, and psychologically overwhelming event for many children (Briere, 1996; Ross & O’Garroll, 2004). CSA must therefore be considered majorly traumatic given the extreme level of intrusion and violence that can go along with such sexual victimisation in childhood.

The American Psychiatric Association (APA, 2000) lists three criteria for PTSD (see Appendix A): re-experiencing of the trauma, avoidance, and hypervigilance. As the following paragraphs show, each of the criteria for PTSD has been described in the literature as a long-term outcome of CSA.

2.2.1 Re-experiencing of the trauma

Many survivors of CSA report intrusive memories or flashbacks of the abuse, as well as frequent nightmares (Briere, & Elliot, 1994). Such reliving of the abuse through disturbing memories and sudden flashbacks may be so compelling as to produce a temporary break with the external environment. Furthermore, abuse-related memories and emotions may be triggered to such intensity that the individual dissociates or withdraws into a period of panic or depression. According to Briere (1996), common triggers of re-experiencing are sexual interactions, abuse by more powerful people, physical assault, or disclosures of the abuse. Nightmares with violent abuse-related themes are also commonly associated with sexual abuse-related PTSD symptoms (Briere & Elliot, 1994).
2.2.2 Numbing of general responsiveness

This component of PTSD refers to a constriction in feeling or emotion, so that the individual experiences diminished reactivity, detachment from others, or restricted affect (APA, 2000). Avoidance as a coping strategy is thought to develop during the abusive event, when any means of avoiding pain, fear, humiliation and helplessness is reinforced. This avoidance defense may then generalise to other stressful and anxiety-provoking experiences later in life, ultimately becoming a relatively pervasive defensive symptom (Briere, 1996). Briere (1996) states that at its most fundamental level, reduced responsiveness is a form of dissociation. As will be discussed in more detail in the next chapter, several empirical studies have noted the prevalence of dissociative symptoms among both male and female sexual abuse survivors (Briere & Elliot, 2003; Kisiel & Lyons, 2001). Dissociative symptoms are of special relevance to individuals with a history of CSA as they may represent a powerful defense against abuse-related memories or feelings. Whether such symptoms occur as components of PTSD, or operate relatively independently as a dissociative disorder, they seem to serve as a means for the individual to disrupt normal states of mental activity in order to reduce psychological distress.

2.2.3 Hypervigilance

PTSD often involves a variety of symptoms of autonomic hyperarousal, including sleep disturbance, difficulties in maintain concentration, hyper-alertness, and irritability (APA, 2000). Just as many of these symptoms are found in individuals who have experienced overwhelming trauma (Dubner & Motta, 1999), including rape victims, CSA survivors are likely to experience similar difficulties at some point in their lives (Briere, 1996).
2.3 Cognitive Effects

According to Spies (2006), CSA can change the way the victim perceives and understands themselves, others, and the future. Given the negative and adverse nature of the abuse experience in children, assumptions and perceptions about the self commonly reflect an overestimation of the amount of danger in the world and an underestimation of the individual’s self-efficacy and self-esteem. Such cognitive distortions may produce severe changes in affect, resulting in depression and anxiety disorders (Briere, 1996). The most common abuse-related cognitive distortions appear to be negative self-evaluation and guilt, perceived helplessness and hopelessness, and distrust of others (Briere, 1996). These cognitive alterations often persist into adolescence and adulthood (Briere & Elliot, 1994).

2.3.1 Negative self-evaluation and guilt

Several studies found that CSA survivors present with clinically significant levels of low self-esteem, self-blame, and guilt (Horwitz et al., 2001; Kinnear, 1995). Thus, it is not uncommon for CSA survivors to perceive themselves as bad and evil and ultimately responsible for their pain. The CSA survivor’s negative self-evaluation may result from society’s tendency to blame the victim, as well as society’s scepticism about the innocent or accidental nature of victim behaviour (Briere, 1996). Furthermore, CSA survivors tend to blame themselves for having been injured or hurt, a phenomenon that includes beliefs about a “just world” (Lerner, 1980, in Briere, 1996, p. 15). In this regard, CSA survivors may choose to believe that they got what they deserved as opposed to the possibly more terrifying thought that violence is arbitrary and unjust, and that one is unable to avoid being victimised. Thus, self-blame may be a critical defense for some victims against feelings of complete powerlessness. It must therefore be considered that the victim’s defensive belief in a fair world, as well as society’s reaction to abuse disclosure, create a degree of self-blame and
later self-derogation in survivors of CSA. However, specific aspects of the CSA event may also produce negative self-perceptions. For example, the abuser and the victim are often locked in a conspiracy to keep the abuse silent (Spies, 2006). This secrecy elicits in the victim the idea that they were guilty co-participants involved in a shameful act. Finkelhor and Browne (1985) call this process stigmatisation, whereby the abuser communicates to the child the badness, shame and guilt about the abuse experience and these negative connotations then become incorporated into the child’s self-image. Thus, stigmatisation refers to all the ways in which the abuser as well as the child’s environment that undermine the child’s positive self-image. These negative esteem effects tend to generalise over time, resulting in chronic states of self-loathing and self-destructiveness (Boudewyn & Liem, 1995).

### 2.3.2 Helplessness and hopelessness

Enduring feelings of helplessness may result from the fact that the child abuse occurred when the victim was physically and psychologically unable to resist or defend against the abuser (Briere & Elliot, 2003). Many abuse dynamics reinforce to the victim that they are relatively powerless in the face of negative events, and these aspects of the abuse experience contradict feelings of personal power or self-efficacy. For example, the child’s experience of violation and invasion by a more powerful person, as well as the often repetitive nature of the sexual abuse, may result in pervasive and persistent feelings of vulnerability and an inability to protect oneself (Finkelhor & Browne, 1985). Thus, the victim comes to assume that he or she is “without recourse or options under a widening variety of circumstances” (Briere & Elliot, 1994, p. 56). This learned helplessness may form the basis of the adult survivor’s passivity, perception of self as a victim, and vulnerability to later victimisation by others (Boudewyn & Liem, 1995). As is described in the next chapter, such
feelings of helplessness, hopelessness, and low self-esteem may be the root of negative mood states among adult CSA survivors.

### 2.4 Emotional Effects

Clinicians and researchers have long noted the emotional distress reported by many CSA survivors (Briere & Elliot, 2003). This emotional pain has primarily been documented in terms of increased depression, anxiety, and anger.

#### 2.4.1 Depression

A variety of studies have documented greater depressive symptoms among adult survivors of CSA than among adults with no history of CSA (Boudewyn & Liem, 1995; Briere & Elliot, 2003; Morril et al., 2001). For example, Horwitz et al. (2001) found that adult men who were victims of sexual abuse in childhood had more symptoms and diagnoses of dysthemia. Theories of the etiology of depression, relevant to the experience of sexual abuse victims, include enduring negative, self-blaming cognitions during childhood, and learned helplessness arising from chronic experiences of having no control over painful events (Briere, 1996). As mentioned earlier, the survivor’s negative self-perception, which refers to the message the child got from the abuser during or after victimisation, or similar messages when the abuse is discovered by others, becomes internalised by the child and so becomes part of his or her self-image (Briere, 1996). Furthermore, victims may come to devalue and blame themselves during the process of abuse so as to make sense of the intrusive and painful events they are experiencing at the hands of a more powerful adult. In this sense, the victim incorporates from others (referring to many social and abuser-related messages) the notion the he or she is essentially bad and worthy of punishment. The pervasive sense of guilt and introjected badness that victims carry with them, result in a state
of self-loathing (Coffey et al., 1996), which together with feelings of powerlessness (Kinnear, 1995) invariably produces negative affective states – most notably clinical depression.

2.4.2 Anxiety

Child abuse is, by its nature, threatening and disruptive, and may interfere with the child’s emerging sense of safety and security (Briere, 1992). Thus, it can be expected that victims of such abuse are prone to chronic feelings of anxiety or fearfulness. There is some evidence that women with a history of CSA, compared with nonabused women, suffer from generalised emotional symptoms such as fear and anxiety. For example, Briere and Elliot (2003) found a relation between CSA and increased adult anxiety symptoms among male and female survivors. According to Briere (1996), the conditioned components of adult abuse-specific anxiety revolve around the fact that CSA typically occurs in relationships where closeness and nurturance is expected, yet intrusion, humiliation, and / or pain result. Thus, a learned association may form between social stimuli and danger, so that a number of otherwise rather neutral interpersonal situations elicit fear (Spies, 2006). For example, the individual with a history of abuse may become anxious in the presence of intimate or close relationships. Furthermore, because the child learnt from an early age to be continuously aware of danger, his or her belief in a safe, just world is compromised, eventually leading to an adult who perceives the world to be a harmful place where vigilance and a continuous defensive outlook are crucial for ongoing survival (Spies, 2006).

2.4.3 Anger

Another common emotional sequel of CSA is that of anger. Chronic irritability, uncontrollable feelings of anger, and difficulties linked to the expression of anger have been reported by adult survivors of CSA (Briere & Elliot, 2003; Gartner, 1999). In adult CSA
survivors, the suppression of anger can be quite harmful, in that these feelings can become internalised as self-hatred or depression, resulting in instances of self-harm, suicide attempts, or particularly degrading acting out (Briere, 1996). Such self-devaluation in the form of acting out is especially evident in the abuse survivor repetitively seeking out sexual contacts with abusive individuals (Gartner, 1999). Intolerable anger may also be externalised by the survivor, sometimes resulting in the perpetration of abuse or other aggressive acts against others (Horwitz et al., 2001).

2.5 Interpersonal Effects

Child abuse occurs within the context of a relationship between a person in a position of power and a victim, and as a result, survivors often experience difficulties in the domain of interpersonal functioning. Furthermore, early attachment-related difficulties that arise from the violation and betrayal of boundaries in the context of intimacy produce painful effects, since they are associated with feelings of alienation, perceiving oneself to be incapable of having a satisfying relationship, and chronic states of neediness (Briere, 1996). Furthermore, the survivor’s childhood experience may cause generalised feelings of anger and rage, coupled with fearfulness – emotions that emerge in later interactions with others (Spies, 2006). These intimacy problems seem to focus principally on ambivalence and fear regarding interpersonal vulnerability. According to Briere and Runtz (1993), interpersonal problems develop from both the immediate cognitive and conditioned responses to victimisation (viz. learned patterns of behaviour) that extend into the long-term (e.g. distrust of others, anger at or fear of those with greater power, abandonment fears), as well as those responses which the survivor has adapted to in situations of ongoing abuse (e.g. passivity, sexualisation). A variety of sexual-abuse-related interpersonal difficulties have been commonly reported by
survivors and clinicians, most of which have been further noted in the empirical literature (Carey, 1997; Miller, 1999).

### 2.5.1 Disturbed relatedness

CSA is a form of maltreatment that often combines exploitation and invasion with, in some circumstances, what might otherwise be demonstrations of love and caring (Blume, 1990; Briere, 1996). Furthermore, in the context of physical or emotional abuse or neglect, any form of attention or compassion, even if only for one’s sexual value, may be perceived as positive. Given this blend of confusing signals, many sexual abuse survivors are strongly ambivalent about intimate relationships, particularly ones that emphasise sexuality and intimacy (Spies, 2006). Briere (1996) states that “such ambivalence may express itself as mixed and sometimes contradictory motivations for relating to others” (p. 24). For example, CSA survivors may feel distrust or fear of others while also idealising individuals they see or want to perceive as “good”. An unfortunate consequence of this idolisation process may be revictimisation (Carey, 1997). The empirical literature suggests that female sexual abuse survivors are more likely to be victimised as adults (e.g., rape, abusive relationships) than are women with no history of CSA. Kalichman et al. (2001) found that MSM who were sexually coerced as adults, were more likely to report subsequent sexual revictimisation. Paul et al. (2001) investigated sexual revictimisation in relation to CSA, however, their finding was insignificant. Although multiple explanations have been offered for the phenomenon of revictimisation in individuals with a history of abuse, one possibility is that in their drive to see their partners in a positive light, some survivors may ignore or overlook cues or behaviours that nonabused individuals would see as warning signs, such as aggression. An additional explanation is that the survivor, due to his or her low self-esteem, may adopt the belief that abusive individuals are all that they deserve (Briere, 1996). Furthermore, the
learned helplessness resulting from the CSA may lead to passivity and obedience in the face of imminent victimisation (Paul et al., 2001). Finally, the CSA survivor’s impaired sense of self may account for their diminished ability to identify boundary violations or to reject the advances of the victimiser (Spies, 2006). Thus, some adults abused as children are unable to experience their own needs and internal states, independent of the reactions or demands of others, and these difficulties may result in an inability to define one’s own boundaries or rights when confronted with the demands of others in the interpersonal context. This, in turn, may be associated with a greater possibility for victimisation.

2.5.2 Sexual intimacy problems

A contradictory and ambivalent dynamic similar to that of idealisation often occurs in the CSA survivor’s sexual relationships. On the one hand, they have learned that sexual intercourse may potentially involve exploitation and trauma, and thus they appropriately fear the vulnerability and closeness that are intrinsically part of a sexual relationship. This fear not only produces in the CSA survivor intense dissociative states during the sexual act, but this fear may also lead to a general distrust of sexual partners and widespread difficulties with intimacy (Briere, 1992; 1996). On the other hand, however, these individuals may long for the nurturance and loving they had not received in childhood (Spies, 2006). Having learned as children that one of their most powerful qualities in achieving some sort of contact with others was their sexual availability, many CSA survivors report episodes of compulsive sexual behaviour. Several empirical studies have established this link in male survivors of CSA (O’Leary et al., 2003; Paul et al., 2001). The compulsive yet brief nature of these sexual encounters can thus be understood as the need to seek nurturance, love, and power in any way possible while at the same time coming to terms with fears of exploitation and rage at having been so badly hurt by similar individuals (Briere, 1996). Briere (1996) describes this vicious
cycle in the male CSA survivor: He may seek out sexual contact as a way to gain support, love, and validation, only to find such temporary contact unsatisfying after the initial excitement has passed and the sexual partner involved starts to make demands (e.g., for more intimacy or a relationship), leading to a search for new partners.

Apart from serving as an asset to gain nurturance and affirmation, the survivor may further engage in indiscriminate sexual activity to soothe painful abuse-related feelings, distract himself from disturbing thoughts or internal states, fill perceived loneliness and emptiness, and counteract his own self-devaluation by eliciting positive responses from others (Briere, 1992). Such tension-reducing behaviour, however, is only effective in the short-term, leading to an increase in compulsive sexual acting-out.

To summarise, adults with a history of CSA are especially likely to report problems with sexual intimacy, which may present as fears of vulnerability; revictimisation; a tendency to overidealise those with whom they create close relationships; and a history of multiple, superficial sexual relationships that terminate as intimacy develops.

2.5.3 Avoidance

Withdrawal from stressful or aversive events is a normal, adaptive human behaviour in that most people find ways to evade things they might experience as distressing. In the CSA survivor, however, this coping strategy may become overdeveloped as the individual increasingly develops ways to avoid, and thus survive, his or her psychological history (Gartner, 1999). Avoidant behaviour among CSA survivors may thus be understood as attempts to cope with the abuse-related chronic trauma, anxiety, and negative affects. Unfortunately, although temporarily effective in reducing distress, avoidance often interferes with the normal processing and resolution of traumatic stress and may lead to increased levels of symptomatology (Briere & Elliot, 2003).
2.5.4 Dissociation

Dissociation can be defined as a defensive, unconscious coping strategy whereby the individual psychologically limits or avoids full contact with feelings, thoughts, memories, and awareness in order to reduce the emotional pain associated with abuse-related recollections or experiences (Briere & Elliot, 1994). As a result, the CSA survivor superficially operates at higher levels of psychological functioning, however, this occurs at the expense of acquiring more adaptive opportunities for learning how to tolerate painful affect without avoidance (Briere, 1996). Thus, the necessary reliance on dissociation during early childhood at the time of the abuse provokes the continued need for dissociation and other primitive avoidance mechanisms in adulthood.

2.5.5 Tension-reducing behaviour

Because the development of self-capacities and self-functions occurs during childhood, maltreatment such as child sexual abuse forms the basis for later self-difficulties and long-standing problems in the self-domain (Briere, 1996). Thus, CSA can be severely damaging by virtue of its potential to disturb normal development and prevent the development of crucial self-functions. These self-functions include a sense of personal identity, awareness of one’s personal boundaries, and the ability to manage, or regulate, affect. The injurious nature of CSA precludes the development of these self-capacities, leading to impairments in the negotiation of interpersonal interaction and the necessity for the individual to resort to other activities in order to accommodate overwhelming trauma-related distress. For example, the boundary impaired CSA survivor may be less aware of his or her right to safety, leading to potential acceptance of being re-victimised (Briere, 1996). Furthermore, in the face of the CSA survivor’s inability to experience sustained negative affects due to his or her impaired capacity for affect tolerance, he or she may resort to
avoidance activities such as substance abuse that distract or soothe (Miller, 1999; Morril et al., 2001).

Thus, in the absence of sufficient self-functions, the survivor needs to rely on dissociation or other avoidance or external activities to deal with painful internal states, particularly when they are re-stimulated by current events (Briere, 1996). These external activities (e.g., compulsive sexual behaviour, chronic overeating, substance abuse), rather than being seen as impulsive acting out behaviours, represent for the abuse survivor problem-solving strategies in the face of considerable painful affect and diminished self-functioning (Briere, 1996).

Tension-reducing behaviours may provide momentary distraction, interrupt dysphoric experiences, numb psychological pain, re-establish a sense of control, or relieve guilt and self-loathing (Gartner, 1999). Such behaviours are often efficient in creating a brief sense of calm and relief. However, owing to their effectiveness in reducing pain and temporarily eliminating anxiety, the use of tension-reducing strategies is likely to be repeated in the presence of future pain (Briere & Elliot, 1994). To the degree that avoidance coping strategies like tension reduction succeed, the survivor continues to be stripped of the chance to develop more sophisticated modes of affect regulation.

2.6 Chapter Overview

It is evident that the long-term effects of CSA can be so pervasive that it may be hard to pinpoint exactly how the abuse affects the survivor. However, it is clear that sexual abuse has wide-ranging influences on the survivor’s life, including his or her sense of self, intimate relationships, and sexuality. This review confirms the general impression that the impact of sexual abuse is serious and can manifest itself in a variety of symptomatic and pathological behaviours and feeling states. Thus, CSA may be interpreted as a profoundly traumatising
event. Furthermore, it appears that CSA produces multifaceted effects, and that distinct mechanisms and processes may operate to account for the variety of mental health outcomes among males and females. In the following chapter, there will be a review of the long-term mental health outcomes or psychological symptoms of CSA in adult men who have sex with men (MSM). More specifically, the association between CSA and HIV sexual risk behaviour among MSM will be discussed, whereby particular attention will be paid to the residual effects of the abuse (i.e., the long-term psychological symptoms) that may account for increased HIV sexual risk behaviour.
CHAPTER 3

Mediating Factors in the Relationship between CSA and HIV Sexual Risk Behaviour

3.1 Introduction

As noted in the previous chapter, the effects of child sexual abuse have been studied in great detail over the past three decades, with research indicating that a broad range of long-term psychological difficulties are more prevalent among individuals who have been sexually abused than among those with no such experiences (Briere & Elliot, 1994, 2003). Thus, adults who report experiences of CSA report significantly elevated rates of psychopathology including depression, self-destructive behaviour, substance abuse, and anxiety (e.g., Briere & Elliot, 2003; Kendall-Tackett, Williams, & Finkelhor, 1993; Paolucci et al., 2001). Important past research has also indicated that behavioural and psychological consequences of CSA may increase the likelihood of sexual risk behaviours during adulthood, putting individuals at risk for HIV infection (Zierler et al., 1991). HIV sexual risk behaviours include unprotected sexual intercourse, sex with multiple partners, and brief sexual relationships with casual partners (O’Leary et al., 2003). Thus, evidence of connections between experiences of sexual abuse and the risk of sexual transmission of HIV and other STDs has been mounting since the early 1990s. Given that survivors of CSA do exhibit a variety of emotional and behavioural sequelae, and that a history of CSA does predict adult engagement in behaviours that carry risk for HIV transmission, an important goal of current research in this area is to determine whether the psychological consequences of CSA (as described in Chapter 2) represent pathways in their effects on HIV sexual risk behaviour. Of even greater importance is the determination of the extent to which such “symptom correlates” (Briere & Elliot, 2003) occur in understudied populations, as opposed to solely in the female populations, university contexts and clinical contexts where most studies in this area have been conducted. In other
words, given the fact that a history of CSA is a risk factor for later HIV infection in adulthood, an understanding is needed of the extent to which probable negative consequences of CSA impact HIV risk behaviour in a population that is (even in the absence of a CSA history) at increased risk of exposure to HIV infection: men who have sex with men (MSM).

According to Bacon et al. (2006), MSM populations are at a particularly increased risk for HIV-infection in that sexual risk-taking among MSM is increasing in many countries and, in fact, the HIV prevalence rate for MSM in the United States is substantially higher than that for the general population. Furthermore, it is important to note that more homosexual and bisexual men report CSA than do heterosexual men, with rates for MSM being comparable with those for women and three times that of the general male population (Bartholow et al., 1994; Jinich et al., 1998; O’Leary et al., 2003). However, although outcome studies focusing on males have increased in recent years, there is a relative lack of empirical literature regarding the long-term mental health outcomes experienced by males who survived CSA. This scarceness of data prevents an accurate understanding of the possible impact of such abuse on adult mental health and sexual behaviour in males who run an elevated risk of coming into contact with HIV. Thus, if one is to fully understand the relationship between unwanted childhood sexual activity and risky sexual behaviours, then it is important to examine the outcomes of CSA that might be associated with HIV risk behaviour among a specific population of men that shows high prevalence rates of childhood sexual abuse (Allers & Benjack, 1991; Bartholow et al., 1994; Jinich et al., 1998) and who are at particular high risk for contracting sexually transmitted diseases, including HIV. In other words, because the prevalence estimate of sexual abuse among MSM is high (Gore-Felton et al., 2006), and because this subpopulation of men are at a particularly high risk for HIV/AIDS, an examination of the psychological and behavioural factors that result from CSA and are associated with HIV risk behaviour, is warranted.
A history of CSA has been found to be linked with higher levels of HIV sexual risk behaviour among MSM in (a) a sample of self-reported homosexually active men found at STD clinics in the USA (Bartholow et al., 1994), (b) a clinical sample of predominantly African-American and Hispanic men (Dilorio et al., 2002), (c) a convenience sample of homosexually active Latin American men (Carballo-Dieguez & Dolezal, 1995), and (d) other population-based samples that reflect the broad range of MSM in major US cities (Jinich et al., 1998; O’Leary et al., 2003). Thus, an increasing number of international studies suggest that, compared to MSM who do not report a history of sexual abuse, CSA reported by MSM does predict adult engagement in HIV sexual risk behaviour, including unprotected anal intercourse (Bartholow et al., 1994; Dilorio et al., 2002). Considering the absence of studies focusing on CSA and HIV sexual risk behaviour among MSM in the South African context, an exploration of the effects of CSA on sexual risk-taking among South African MSM seems justified, if not essential.

Various studies have found that for MSM, CSA is associated with a wide range of sexual, psychological, and interpersonal difficulties in adulthood (Bartholow et al., 1994; Jinich et al., 1998; O’Leary et al., 2003). Thus, there is an empirically well-established relationship between CSA in MSM and a variety of emotional and behavioural sequelae. For MSM, these consequences include, amongst others, substance abuse (Bartholow et al., 1994), depression (Paul et al., 2001), anxiety (O’Leary et al., 2003), suicidality (O’Leary et al., 2003), and prostitution (Gore-Felton et al., 2006). A growing number of studies furthermore indicate that for MSM, CSA history predicts adult engagement in behaviours that carry risk for HIV transmission, including unprotected anal intercourse, sex with multiple partners, and brief sexual affairs with casual partners (Bartholow et al., 1994; Carballo-Dieguez & Dolezal, 1995). Thus, despite this well-established association between CSA and HIV sexual risk
behaviour among MSM, the potential mediators\(^3\) of the complex relationship between CSA and HIV risk behaviour are the focus of this study. In other words, the long-term negative outcomes (or effects) of CSA may influence the relationship between sexual abuse and subsequent risk for HIV infection (Gore-Felton et al., 2006). For example, MSM who were sexually abused as children may experience several CSA-related sequelae, such as depression, sexual promiscuity, or substance abuse that might, in turn, increase their risk of engaging in behaviours associated with HIV transmission.

A growing number of empirical studies therefore indicate that the relationship between CSA and HIV sexual risk behaviour is multidirectional; that is, survivors of CSA show a variety of emotional, behavioural, and cognitive sequelae (Arreola et al., 2008; O’Leary et al., 2003) that make up pathways accounting for the effects of CSA on sexual risk behaviour. For instance, MSM who report a history of forced sexual activity during childhood are at a greater risk of practicing behaviours (e.g. substance abuse) that increase their risk of engaging in unprotected sex (Bartholow et al., 1994; Holmes, 1997). Furthermore, MSM who have been sexually abused as children experience higher rates of depression or interpersonal difficulties (Paul et al., 2001) that may increase their risk of engaging in behaviours associated with HIV transmission (Arreola et al., 2008; Lenderking et al., 1997). These studies offer some potential mediating variables to understand and conceptualise consistent findings linking CSA to increased sexual risk behaviour among men. It is therefore suggested that the relationship between CSA and HIV sexual risk behaviour can be explained in terms of intervening variables (mediators) or long-term CSA-related mental health outcomes that are correlated with increased risks of unsafe sexual behaviours.

The current study thus seeks to expand on the established relationship between CSA and later HIV sexual risk taking among MSM, in that it proposes that a deeper understanding

\(^3\) Mediation is used to test a model in which an independent variable (X) causes an intervening variable (M), which in turn causes the dependent variable (Y). The mediator is the intervening variable in this model (Baron & Kenny, 1986).
is needed of the extent to which potential emotional, behavioural, and psychological long-term effects of CSA impact HIV risk behaviour in MSM.

3.2 Conceptual Models Linking CSA and HIV Risk Behaviour

In this section, there will be a description of multiple theoretical models that have attempted to identify mediating variables in the association between CSA and HIV risk behaviour. Thus, these models explain how the sequelae of CSA may comprise various pathways that increase the likelihood of HIV sexual risk behaviour. In other words, they offer conceptual frameworks that propose that the relationship between CSA and HIV risk is mediated by many of the long-term sequelae of sexual abuse (i.e. CSA-related mental health outcomes).

Miller (1999) presented a theoretical model for understanding the link between CSA and sexual risks in women. Her conceptual model examined the pathways between sexual abuse, psychopathology (i.e., PTSD, dissociation, depression), drug use and sexual adjustment, as predictors of HIV risk behaviour in women. More specifically, Miller (1999) hypothesised that three underlying mechanisms motivate HIV risk behaviour among women with histories of CSA: (1) the use of drugs to self-medicate, (2) participation in self-destructive behaviours, and (3) the use of psychological escape through the creation of dissociative symptoms as a means of self-protection. Thus, psychological distancing techniques such as dissociation, and behaviours such as drug use and sexual promiscuity, increase the risk of participation in behaviours associated with HIV transmission, in that the ability to accurately perceive risk and implement self-protective behaviours is endangered. Miller therefore presented a theoretical model hypothesising three probable mediators: substance abuse, sexual adjustment problems, and psychopathology. Her model thus provides
a conceptual framework for understanding the link between CSA history and sexual risks in women.

Gore-Felton et al. (2006) also reported a conceptual model exploring linkages between sexual abuse, psychopathology (i.e., borderline personality, dissociation, trauma-related anxiety), drug use, and sex trading as predictors of HIV risk behaviour in a sample of MSM. They suggested that a history of CSA has bidirectional relationships with psychopathology and substance abuse, which in turn have direct correlations with sexual and drug risks for HIV-infection. The role of substance abuse appears to be particularly crucial as a form of trauma-related self-medication, in that empirical studies show a significant association between CSA and drug and alcohol use in adulthood (Allers & Benjack, 1991; Dilorio et al., 2002; Jinich et al., 1998; Paul et al., 2001). Furthermore, psychopathological symptoms that developed as a response to the childhood trauma of sexual abuse also seem to be important risk factors for HIV risk behaviour in MSM (Kalichman et al., 2001).

The current study proposes an expanded model based on Paul et al.’s (2001) social learning model of CSA and its relationship to sexual risk. Their model combines previous research findings on the overlap between specific long-term mental health outcomes of CSA and observed correlates of HIV risk behaviour, with other empirical findings and theoretical conceptualisations from the extant CSA literature. Their mediational model, which was developed specific to MSM, proposes numerous pathways whereby important behavioural, cognitive, and emotional outcomes of CSA are related to HIV sexual risk behaviour. In particular, it hypothesises that specific CSA-related long-term sequelae directly or indirectly affect two crucial components of HIV sexual risk-taking models (Paul et al., 2001). These are (1) “the appraisal of potential risk” (p. 559), and (2) “the capacity to enact behaviours necessary to reduce risk” (p. 559). Paul et al. (2001) state that emotional factors (e.g., anger, depression, and anxiety), escape-avoidance coping strategies (e.g., substance abuse), risk
appraisal processes (e.g. inability to evaluate risky situations), and interpersonal difficulties (e.g., communication about sexual matters), act as important intervening variables that may put MSM with histories of CSA at a higher risk of engaging in sexual risk-taking behaviour (relative to MSM with no CSA history). Their model thus proposes a range of pathways whereby crucial CSA-related long-term behavioural, cognitive, and emotional patterns are associated with sexual risk behaviour.

The model is embedded within the following theoretical framework with respect to CSA. Paul et al. (2001) conceptualise CSA as a harmful, traumatic experience that compromises the welfare of the body and the mind. In terms of social learning theory, when a child is subjected to the abuse of sexuality he is exposed to a perverted example of how people relate to each other (Bolton, Morris, & MacEachron, 1989). He may learn that personal boundaries are meaningless to others, or he may learn that trust only brings pain. He may also learn that love is contingent on sex. The child does not learn normal social skills, but instead develops strategies that allow him to endure or cope with the abusive experiences. During adulthood, these survival strategies become problematic, as they preclude the development of prosocial behaviour (Bolton et al., 1989). Thus, few CSA survivors possess an understanding of the normal skills for healthy interpersonal relationships. Relationships are formed upon unmet childhood needs, mistaken beliefs about interpersonal relationships, and various other strategies developed for survival. When the CSA survivor realises that what appeared to work for a child is no longer useful for an adult, he is left without adequate resources, and his relationships tend to be unsatisfying and dysfunctional (Bolton et al., 1989).

Paul et al. (2001) further conceptualise CSA as a painful experience that may arouse fight or flight reactions under conditions that prevent physical escape or avoidance and that punish any attempts by the child to change or escape the situation. These feelings, in turn,
may lead to depressive and self-sabotaging tendencies that indirectly deter the adoption or performance of health-promoting sexual behaviours. Thus, depressive and self-destructive tendencies may influence the survivor’s core belief systems, such as the belief in their ability to perceive risk, so that they eventually feel unconcerned about sexual health risks. This ultimately results in an inability to communicate effectively and self-regulate in interpersonal situations, resulting in poor enactment of sexual health practices and a potential increased risk for HIV infection.

CSA differs significantly from other forms of traumatisation in that such early experiences may directly mould the abused child’s subsequent sexuality and sexual relationships (Briere, 1996; Paul et al., 2001). Traumatic sexualisation refers to the process in which a child’s sexual feelings and attitudes are “shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse” (Finkelhor & Browne, 1985, p. 532). The effects that such traumatised children may experience include disgust of anything sexual or, more importantly, a consuming interest in sex. Thus, children may cope by becoming promiscuous or developing an aversion to sex; and each response represents a failure to develop healthy sexual relationships. In adulthood, traumatic sexualisation may lead to poor impulse control. Moreover, subjective positive aspects of these childhood sexual experiences, such as affection and nurturance, may strengthen the use of sexual behaviour as a mechanism of soothing (Paul et al., 2001). Furthermore, compulsive sexual behaviour may represent a mechanism of relief from abuse-related anxiety and emotional pain. Overall, compulsive sexual behaviour patterns provide a key explanation why MSM with a history of CSA report higher numbers of sexual partners than MSM with no such history (Jinich et al., 1998). These elevated numbers of sexual partners may increase risk for HIV infection.

According to Paul et al. (2001), CSA experiences may not only influence the number of sexual partners, but sexual partner selection as well. Adult CSA survivors may be attracted
to high-risk partners who resemble the perpetrator and who possess certain psychological traits that are familiar to the victim. These may fulfil buried needs that were rooted in the original victim-perpetrator dyad. According to Finkelhor and Browne’s (1985) abuse dynamic of betrayal, betrayal occurs when children recognise that they are being harmed by trusted individuals on whom they are also vitally dependent. In the CSA survivor, the consequence is an impaired ability to trust other people in many subsequent situations, especially those involving interpersonal relationships. However, owing to the abused child’s thwarted need to feel safe, secure, loved, and protected, he or she never really gives up on his or her basic need and desire to trust others (Kinnear, 1995). In adulthood, this emotional need to perceive a given relationship as trustworthy may impair the CSA survivor’s accurate appraisal of later relationships (Paul et al., 2001). For example, individuals with a history of CSA are more likely to attract dominating, controlling partners who have less concern about the well-being of others. In some cases, this may extend to physical violence and, as noted in Chapter 2, adult sexual revictimisation. Furthermore, because the abused child’s basic need for love and security is not fulfilled, they may as adults try to please everyone else at the expense of their health and sexual well-being, without realising that they are important and have their own needs and desires. In the face of such victimisation and powerlessness, the individual is unable to enact sexual health practices which, in turn, pose a risk for HIV infection.

Another long-standing effect of CSA on the survivor’s adult sexual relationships that may promote sexual risk-taking is poor anger control (Paul et al., 2001). CSA perpetrators often model sexually aggressive behaviour, and the child may learn and later enact similar patterns of aggressive affect and anti-social behaviour in his adult sexual relationships. Aggressive sexual responses may also result in reaction to the dynamic of powerlessness that may characterise the male’s response to the childhood abuse (Finkelhor & Browne, 1985).
Long-term patterns of sexual aggression may promote sexual risk-taking, in that the individual’s ability to care about the health of others may be compromised. Alternatively, a permanent sense of powerlessness in the victim, particularly as a result of repeated childhood sexual assaults, may lead to an inability to avoid further victimisation due to reinforced passive, compliant, and powerless responses in the face of aggression (Paul et al., 2001).

As part of cognitive and behavioural strategies that affect the CSA survivor’s ability to appraise potential risk and enact health-promoting sexual practices, Paul et al. (2001) further state that escape-avoidance coping strategies such as substance abuse and dissociation may result from their learned usefulness in regulating the emotional pain of CSA experiences (Chu & Dill, 1990; Miller, 1999), as well as managing the distress of long-term negative outcomes such as anxiety and depression. As stated above, the psychological or emotional distance that coping strategies provides, promote the potential for sexually risky behaviour in that the CSA survivor’s awareness of risk is reduced.

The current study proposes that dissociation, substance abuse in sexual contexts, depression, one-night stands, impaired interpersonal skills, and submissive sexual scripts, will serve as critical CSA-related mental health outcome measures that impact on the sexual risk behaviour of MSM who were sexually abused as children. Thus, these variables are believed to reflect underlying motivational, cognitive, and interpersonal factors that are hypothesised to mediate the link between CSA and sexual risk-taking. These mediators, and their individual correlations with CSA and HIV risk behaviour, will be discussed in more detail in the following sections. The discussion will be specific to MSM.
3.3 CSA-related Mental Health Outcome Measures and their Association with HIV Sexual Risk Behaviour

3.3.1 Dissociation

Explanations for the association between CSA and adult sexual risk behaviour have emphasised the role of psychopathological symptoms such as dissociation. A number of studies have determined a relationship between CSA and dissociation among adult survivors, and dissociation has widely been considered a mediator of psychopathology and risk-taking behaviour (Kalichman et al., 2001; Kisiel & Lyons, 2001; Paul et al., 2001). Thus, recent literature on CSA has increasingly emphasised the role of dissociation as a protective defense against the terrifying and disorganising feelings that accompany childhood sexual trauma.

According to Briere (1992), dissociation is defined as “a defensive disruption in the normally occurring connections among feelings, thoughts, behaviour, and memories, consciously or unconsciously invoked in order to reduce psychological distress” (p. 36). The literature suggests that dissociation involves a trade-off where the victim sacrifices fully integrated functioning in order to soothe the occasionally overwhelming anxiety associated with complete awareness of traumatic experiences (Putnam, Helmers, Horowitz, & Trickett, 1995). According to Gartner (1999), dissociation is accomplished through self-induced hypnoid states that protect the individual from “psychic disorientation and pain” (p. 154). In dissociated mental states, the separated mental contents exist side by side without reference to one another. These separate states of consciousness then become discontinuous, disparate, and unrelated. In this way, the individual can be conscious of the fact of a traumatic incident in his past while dissociating and thus not getting in touch with the overpowering feelings about it that would otherwise disorient him. According to Bromberg (1998), the goal of
dissociation as a reaction to trauma is to maintain personal continuity, coherence, and integrity of the sense of self and to avoid the traumatic disintegration of the self.

Thus, dissociation can become an automatic response to stress that can impair functioning and increase vulnerability to serious psychopathology and risk-taking behaviour (Kisiel & Lyons, 2001). An over-dependence of cognitive escape-avoidance coping strategies such as dissociation may later impair the CSA victim’s ability to appraise potentially risky situations and enact behaviours needed to reduce risk (Paul et al., 2001). Further, the dependence on such coping mechanisms may be a result of their learned usefulness in managing abuse-related long-term emotional distress and negative affective states (Chu & Dill, 1990).

Given that dissociation has been under-studied in relation to sexual risk behaviour in MSM populations, and its importance as a coping strategy providing emotional distance from pain associated with trauma, dissociation will be considered as one of many psychopathological outcomes of CSA. Dissociation reduces attention to danger cues and inhibits self-regulatory processes necessary for negotiating and enacting safer sexual practices. This, in turn, increases the risk of participation in HIV sexual risk behaviour.

### 3.3.2 Substance abuse

A number of studies of MSM have focused on substance use as a mediator between CSA and unprotected anal intercourse. In other words, substance abuse is an important CSA-related outcome variable that has been found to be significantly related to HIV sexual risk behaviour among MSM with histories of CSA (Allers & Benjack, 1991; Dilorio et al., 2002; Jinich et al., 1998; Paul et al., 2001). For instance, Paul et al. (2001) found that those with a history of CSA also reported higher levels of substance use in sexual contexts which, in turn, was associated with greater sexual risk-taking. Furthermore, although Gore-Felton et al.
(2006) did not find a significant relationship between CSA and substance use, their major finding that substance use has a significant role in the risks for HIV-infection among MSM is in line with the broader HIV risk behaviour literature (Bacon et al., 2006; Deiss et al., 2008; Parsons & Halkitis, 2002; Rotheram-Borus et al., 1994).

According to Briere and Elliot (1994), it seems that substance abuse represents a self-destructive method of coping with child abuse experiences in that it allows the abuse survivor to separate psychologically from disturbing memories, painful internal states, negative cognitions and the environment. Substance abuse therefore represents a behavioural, rather than a cognitive, escape-avoidance coping strategy (Paul et al., 2001) which survivors may resort to in order to cope with the pain linked to the traumatic experience. Furthermore, substance abuse can help the CSA survivor experience highs that prove to him that he is still alive when he begins to feel depersonalised, numb, and empty. Substance abuse in sexual contexts may reduce awareness of dangerous situations (Kalichman et al., 2001) and impair interpersonal regulatory skills that are necessary for contemplating and performing safer sexual behaviours.

### 3.3.3 Depression

Clinicians, as well as extant empirical studies, have long considered the emotional distress reported by adult survivors of sexual abuse (Briere & Elliot, 2003). As far back as the 1980s, the clinical as well as in the research literature on CSA has emphasised that “depression is the symptom most commonly reported among adults molested as children” (Browne & Finkelhor, 1986, p. 152). Moreover, existing studies involving MSM have considered a relationship between depression and HIV risk behaviour (Arreola et al., 2008; O’Leary et al., 2003; Paul et al., 2001), and negative emotional states have been reported as a correlate of sexual risk-taking among gay men (Marks, Bingman, & Duval, 1998).
In an attempt to understand the negative consequences of CSA, Finkelhor and Browne (1985) conceptualised children’s emotional and cognitive reactions to the impact of CSA in terms of several trauma-causing dynamics. According to the dynamic of powerlessness, the child’s sense of ability to control his or her life becomes distorted, in that the child’s will, as well as his or her body, is repeatedly invaded and rendered powerless. This loss of self-efficacy is strengthened when the child sees their attempt to stop the abuse thwarted. The child’s sense of impotence may become associated with despair, depression, and suicidality in adulthood (Finkelhor & Browne, 1985). Furthermore, the child’s loss of control felt during the traumatic incident may generalise into learned helplessness and further powerlessness which, in turn, may lead to depressive states and self-destructive behaviours (Miller, 1999; Morrill et al., 2001). Besides precipitating self-destructive tendencies that can lead to sexual risk behaviour, depression and the resulting sense of low self-efficacy may also affect the survivor’s ability to self-regulate in dangerous sexual situations and screen for sexually risky partners (Paul et al., 2001). Essentially, depressive symptoms indirectly prevent the individual from performing healthy sexual behaviours by influencing risk perceptions and concerns about health risks.

### 3.3.4 Sexual compulsivity

Difficulties in adult sexual adjustment are common in victims of abuse, in that CSA may directly shape victims’ later sexuality and sexual relationships. For instance, several empirical studies have reported heightened and indiscriminate sexual activity among adult males who were abused as children (Allers & Benjack, 1991; Briere & Elliot, 2003; Jinich et al., 198; Zierler et al., 1991). A possible explanation is that particular positive aspects of these early sexual experiences (such as getting attention and nurturance) may reinforce the use of sexual behaviour as a way of self-soothing in the face of distress. In this way, adult CSA
survivors may learn to use compulsive sexual behaviour as a tool to meet non-sexual interpersonal needs. For example, Briere (1992) states that compulsive sexual activity is a problem behaviour that is associated with avoidance of abuse-specific memories and affects, in that it represents a choice to become involved in self-destructive behaviours rather than experiencing the pain, anxiety and distress of complete awareness of the abuse. The compulsive sexual behaviour is reinforced by the orgasm-related tension reduction which the sexual act produces. Thus, sexual compulsivity soothes anxiety by producing a tranquilising effect that results when analgesic chemical opioids are released to regulate distress during and after trauma (Van Der Kolk, McFarlane, & Weisaeth, 1996). Owing to this chemically seductive and powerfully reinforcing experience, the individual is moved to experience it again and again. A man is therefore driven to repeat the sexual behaviour that first induced these self-soothing chemicals to be released (Gartner, 1999). Thus, since the secretion of the opioids was a reaction to traumatic sexual activity, the victim may later become compulsively sexual as a way of reliving those tranquilising effects. Engaging in compulsive sex thus allows the male CSA survivor to recapture directly the biochemical means his body used to calm his anxiety when the abuse first happened (Gartner, 1999).

Besides providing physical discharge, the compulsive sexual act itself becomes the main focus of the survivor’s attention. This is because the compulsive sex act resembles the original traumatising event, and thus offers the adult survivor the opportunity to engage in a self-hypnotic dissociative trance to take over his consciousness and block off abuse-related memories (Gartner, 1999; Pincu, 1989).

The releasing of the opioids and the hypnotic focusing on the sexual behaviour thus serve to help the individual soothe unbearable affect that is triggered by reminders of his abuse (Briere, 1996). However, when anxiety is triggered in unpredictable situations, the individual may experience unmanageably high levels of sexual arousal that necessitates a
greater need to dissociate (Gartner, 1999). This, in turn, leads to an inability to monitor the safety of his sexual behaviour, in that he has a reduced capacity to judge the danger or harm of sexual activities like unprotected sex.

To summarise, many CSA survivors resort to dissociation as a commonplace method of warding off anxiety in almost any uncomfortable situation. The adult male CSA survivor may develop compulsive sexual behaviour as a means to hypnotise himself and return to a dissociated state. Thus, while behaving compulsively, the survivor may enter self-induced trance states that replicate important elements of his original dissociative reaction to trauma (Gartner, 1999). In this way, the individual may re-enter the protected dissociated state he had created while being abused. The danger occurs when such defensive dissociation becomes chronic and generalises to all anxiety-provoking situations and all aspects of the individual’s life, thereby distorting his perceptions, confusing his interpersonal relatedness, and compromising his sexuality (Bartholow et al., 1994; Paul et al., 2001). The CSA survivor’s resultant failure to monitor his enactment of health-promoting sexual practices puts him at risk for harm and a greater risk of HIV infection.

The literature also mentions that sexual compulsivity as a form of risk behaviour relates to acting out and lack of impulse control (Paul et al., 2001), whereby CSA survivors may externalise their conflicts and suffer from specific inabilitys to inhibit behavioural responses to needs, frustrations, or emotional states that others successfully control. Essentially, the immediate effectiveness of such a tension-reducing coping strategy reduces the need to learn more sophisticated affect regulation skills, which, in turn, leaves the survivor with few alternatives but more tension-reduction behaviours when faced with more psychological pain. Compulsive sexual behaviour, or increased numbers of sexual partners, as reported among MSM with histories of CSA (Jinich et al., 1998, Paul et al., 2001), therefore relates to sexual risk behaviour in that the urge for the CSA survivor to lessen or
prevent abuse-related distress precipitates repetitive engagements with multiple sexual partners. This consequently increases risk for HIV infection.

Paul et al. (2001) further add that the number of sexual partners in male CSA survivors may be elevated due to some specific negative consequences of CSA that may disturb the development of long-term relationships, leading to a string of temporary sexual encounters (“one-night stands”). For example, impairments in interpersonal trust and difficulties in forming secure attachments may prevent CSA survivors from developing secure long-term relationships, leaving them no option but to engage in frequent, tension reducing sexual activity with a number of different sexual partners. Furthermore, having learned that his sexuality is valuable to others, he may make it the basis for his self-esteem, whereby sexuality pervades all his interpersonal encounters (Gartner, 1999). Moreover, intimacy, or interpersonal closeness becomes eroticised because sex represents the only way for the man to feel (seemingly) intimate. Desiring interpersonal closeness yet fearful about it, and believing that sexual contact is his only chance to feel loved but at the same time experiencing love as abuse, the male CSA survivor who allows himself to be sexual at all, often solves his problem by engaging in frequent, random, and dissociated sexual experiences (Briere, 1996). Compulsively pursuing sex, he nonetheless gains very little intimacy. Rather, his anxiety is temporarily soothed by impersonal encounters of sexuality, however, these incidents leave him feeling empty and lonely and ready to restart this behavioural circuit. Furthermore, compulsive sexual behaviour allows the male CSA survivor to dislocate abuse-related emotions which he may as “non-masculine” (Gartner, 1999, p. 72). Instead, he adopts hyper-masculinised or sexualised behaviours that defend against threatening emotional experiences.

Such one-night stand situations involve particular dangers for HIV risk behaviour in that there is often a failure to accurately evaluate risk, individuals are unable to effectively
negotiate sexual interactions, and sexual health is given up at the expense of pleasure. All this interrupts the males’ ability to perform sexual activities that pose a low risk for HIV transmission.

3.3.5. Impaired interpersonal regulation

CSA is possibly the most painful experience a child can endure because it is a violation of body, boundaries, and trust (Spies, 2006). The child may not know how to make choices because they never were entitled to have choices. This sense of powerlessness, along with feelings of betrayal, can result in serious alienation, impaired self-efficacy, and lack of interpersonal assertiveness in the adult CSA survivor. Thus, poor adult interpersonal regulation skills in individuals with a CSA history, stem from feelings of low self efficacy that developed as a result of specific control techniques that sustained the victim-perpetrator relationship. It is hypothesised that poor interpersonal skills impair appropriate assertiveness and communication in adult sexual relationships of CSA survivors (Paul et al., 2001). In the absence of such crucial sexual communication and assertiveness (e.g. inquiring about sexual history and HIV serostatus, revealing one’s own sexual history, or requesting condom use), the ability to negotiate safer sex and enact risk reduction practices diminishes greatly (Van Der Straten, Catania, & Pollack, 1998). Catania et al. (1992) found people with high levels of health protective sexual communication are more likely to use condoms. Health protective sexual communication includes, amongst others, assertiveness and sufficient communication about sexual matters. A lack of communication and assertiveness reflect deficits in interpersonal regulation (Paul et al., 2001), which may be associated with unprotected anal intercourse (i.e. HIV sexual risk behaviour). Greater health protective sexual communication is associated with “a belief in one’s ability to regulate sexual situations generally and with respect to safer sex practices, and a belief in one’s ability to assertively avoid unwanted
sexual contacts” (Van Der Straten et al., 1998, p. 214). These beliefs and practices, as mentioned above, may be poorly developed or even impaired in individuals with a history of CSA.

Gartner (1999) states that sexually abused men may not understand what involvement with others entails and what they risk or, alternately, do not have to risk when they are intimate with others. Distortions about intimacy are an extension of having had flawed, corrupt early relationships with abusers and often with other adults as well. Their understanding of interpersonal relating, which served a purpose in those early destructive relationships, interferes with their ability to create healthy intimate relationships in adulthood. Thus, situations involving trust, sexuality, intimacy, power and authority may pose specific problems to the male CSA survivor (Spies, 2006). For example, the power differential between child and abuser can impact on the boy later in life and create a flawed or distorted self-concept that determines disturbances in relating to other people. For instance, vulnerability often becomes associated with powerlessness to an abused boy. In adult relationships, when feeling vulnerable he may anxiously react as if he were still powerless and needed to pacify authorities (Gartner, 1999). An obscured self-concept, along with enduring feelings of powerlessness and vulnerability, impact on the individual’s self-efficacy and on his ability to effectively negotiate interpersonal relationships. In the absence of health protective behaviours such as assertiveness, communication, and the ability to negotiate control and power, the risk for dangerous sexual activity increases.

3.3.6. Submissive sexual scripts

Research suggests that CSA does have long-term effects on victim’s adult sexual relationships. As mentioned above, the survivor’s sexuality bears the brunt of the damage of CSA (Blume, 1990; Lenderking et al., 1997; O’Leary et al., 2003; Parsons & Halkitis, 2002).
For instance, sex is equated with an attitude of dominance or submission for many CSA survivors. According to social learning theory, perpetrators may reward passivity and obedience in the face of their aggression and control, which reinforces more submissive and compliant responses (e.g., receptive anal sex) in the victim’s later sexual situations. Also, the sexually abused individual who is comfortable only taking on the passive position may derive a sense of safety in not having to take initiative in sexual encounters with others. For the victim, taking on the active sexual role may stimulate feelings of discomfort or even guilt, especially if the victim’s abuse represented having to touch or satisfy someone else (Blume, 1990). Furthermore, it is common for men who have been sexually abused to consider themselves feminised because they have been victimised (Finkelhor & Browne, 1985). Gartner (1999) elaborates on this dynamic of disempowerment and states that by being victimised, the man has lost his sense of agency, which refers to his ability to feel that he is in charge of his actions, feelings, and interpersonal relationships. Gartner (1999) further states that for men not to feel such agency worsens any doubts they may have about their masculinity. This can also be understood in terms of Finkelhor and Browne’s (1985) concept of traumatic sexualisation, which refers to the process in which a child’s sexuality (including sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion. In the adult CSA survivor, traumatic sexualisation is associated with confusion about sexual identity as well as sexual norms and standards (Finkelhor & Browne, 1985; Spies, 2006). Furthermore, the abused child may associate sexual contact with a sense of powerlessness, which may contaminate his sense of efficacy, his perceived locus of control, and his later sexual experiences (Carey, 1997). Thus, men who have been sexually abused, particularly when the abuse has been chronic, are less likely to feel empowered in their life, less able to be in charge of the forces that impinge on them, and more likely to feel at the will of others (Carey, 1997; Gartner, 1999). As a result of this lost sense of agency,
they are more likely to enact submissive sexual response patterns. An over-reliance on such submissive sexual responses means that the individual has a diminished capacity to effectively monitor and control his sexual life. Thus, the sense of impotence related to the traumatic dynamics of powerlessness and dysfunctional sexualisation may be associated with the adult survivor’s helplessness, passivity, and, most importantly, expectations of revictimisation (Carey, 1997).

Alternatively, some men consciously enact behaviours and develop traits that resemble a lack of agency. For example, some men wish to define themselves as everything they believe their abusers were not. Thus, they avoid behaviours and interests commonly thought of as masculine, and develop qualities typically defined as unmasculine (Gartner, 1999). On the negative side, these qualities may include non-assertiveness, over-compliance, and fearfulness which, in turn, may put them at a greater risk for sexual exploitation and revictimisation.

Enduring patterns of such sexual passivity often lead to the creation of fixed, rigid sexual scripts. Such dynamics may protect the individual against replaying the abuse and against unresolved negative feelings that accompany certain sexual roles. Some abuse survivors, however, may need to replay the abuse as adults rather than protect themselves from its negative effects, and their rigid devotion to a particular sexual role replicates the experience (Carey, 1997; Davies & Frawley, 1994). For instance, if the survivor’s sense of belonging, esteem and importance came at the cost of satisfying someone more powerful, then he or she would need to repeat this, whether servicing is being active or passive (e.g., allowing oneself to be controlled). As mentioned before, such fixed roles result in rigid sexual scripts which, in turn, increase the risk of HIV sexual risk behaviour through an inability to either insist on safe sex or an inability to refuse sexually aggressive partners (Paul et al., 2001).
3.4 Chapter Overview

Prior research indicates high prevalence levels of CSA among the general population, and particularly among MSM. Mounting research also indicates that CSA of MSM is associated with adult sexual behaviours that are known to place individuals at greater risk for HIV infection. However, these two events, sexual abuse in childhood and sexual transmission risk behaviour, are generally separated by years. Thus, the search for mediation by intervening events or conditions remains a pivotal one for all populations at risk for HIV infection and transmission (O’Leary et al., 2003). The literature reviewed in this treatise suggests that sexual abuse has a great impact on one’s formative sexual development and experiences. It may affect one’s perception of power in sexual relationships and one’s ability to negotiate sexual safety, one’s choice of sexual partners, and the personal meanings that one attaches to sexual activity. In general, CSA appears to have sustained effects on psychological functioning. This study works towards producing a theoretical understanding and framework which can explain the association between CSA and HIV risk by exploring the mechanisms of potential mediating variables, or CSA-related mental health outcomes, which will include: dissociation, substance abuse, depression, sexual compulsivity, impaired interpersonal communication, and submissive sexual scripts. In other words, this study attempts to specify probable pathways through which childhood sexual victimisation elevates the risk of engagement in destructive sexual behaviours.

3.5 Research Aims

There is a growing consensus that CSA may manifest various types and degrees of impairment in adult MSM, and that these can have longstanding consequences. This study will explore the prevalence of CSA among a sample of adult South African MSM and investigate the relationship between CSA and high-risk sexual behaviour in adulthood.
Crucial CSA-related effects (or mental health outcomes) include emotional and sexual consequences, cognitive and behavioural coping strategies, and interpersonal difficulties; all of which are associated with an increased risk of engaging in HIV sexual risk behaviour. More specifically, dissociation, sex-related substance abuse, depression, sexual compulsivity, impaired interpersonal regulation and submissive sexual scripts, will be treated as outcome measures mediating the association between CSA and HIV risk behaviour. Furthermore, an important factor that occurred before the abuse experience (adverse family experiences) will be considered as a potential covariate.

In particular, this study will aim to:

1a. Describe demographic characteristics of the sample and determine the prevalence of CSA and HIV sexual risk behaviour among a South African sample of MSM.

1b. Explore comparisons between the CSA group and the non-CSA group on demographic variables.

2a. Explore whether there are differences between the CSA group and the non-CSA group on CSA-related mental health outcome measures.

2b. Explore whether there are differences between the CSA group and the non-CSA group on measures of HIV sexual risk behaviour.

3a. Explore whether CSA-related outcome measures are related to the HIV sexual risk behaviour dependent variable “Number of male sexual partners”.

3b. Explore whether CSA-related outcome measures are related to the HIV sexual risk behaviour dependent variable “Unprotected Anal Intercourse”.

4a. Explore whether CSA and the outcome measures of CSA predict number of male sexual partners.

4b. Explore whether CSA and the outcome measures of CSA predict unprotected anal intercourse.
5. Explore whether the CSA-related outcome measures mediate the relationship between CSA and number of male sexual partners; and explore whether the CSA-related outcome measures mediate the relationship between CSA and unprotected anal intercourse.
CHAPTER 4
Methodology

4.1 Research Design and Setting

This is a quantitative study with an exploratory descriptive methodological approach. The main focus of the study is to explore whether long-term psychological effects (i.e. mental health outcomes) of CSA predict as well as mediate HIV sexual risk behaviour among MSM. Thus, a correlational approach within this exploratory descriptive framework is used. Correlational research involves detecting a relationship between variables which allows for an estimation of the type and the strength of the non-causal relationship (Babbie & Mouton, 2001).

4.2 Participants

Many studies focusing on CSA have used samples made up of clinical or psychiatric and university populations. The problem is, however, that samples consisting of individuals in psychiatric clinics presenting with CSA-related symptoms and receiving intervention cannot be considered representative of the general population nor of non-clinical persons suffering from the same presenting symptoms (Rind & Tromovitch, 1997). University samples are also unrepresentative of the general CSA population because they consist of individuals who, by their acceptance into an academic environment, show a higher degree of functioning and coping. This study did not recruit individuals from clinical or university populations. Rather, in order to obtain a sample that can be considered representative of the broader population of MSM in South Africa, a convenience sample of MSM was recruited. Participants were recruited online. Emails were randomly sent to MSM frequenting a gay South African internet dating site. This email contained a link that included the information
letter, the survey, and the debriefing form. Furthermore, emails containing the link were sent out to LGBT (Lesbian-Gay-Bisexual-Transgendered) non-governmental organisations. In a similar study with the same sample, this online recruitment method proved to be effective and successful (Heusser, 2008). This is because participants were able to voluntarily complete the survey in their own home and time, ensuring complete anonymity.

The advantage of having used a convenience sample of MSM recruited in this manner is that it resulted in a population-based sample that represents the diversity of MSM living in South Africa. In this sense, convenience samples can be considered more generalisable to the larger CSA population, as opposed to clinical and university samples (Rind & Tromovitch, 1997). Thus, convenience sampling allows the researcher to accurately generalise findings to minority populations such as MSM, thereby increasing the credibility of research findings (Babbie & Mouton, 2001). However, a disadvantage of this randomised sampling method lies in the data collection procedure, in that there may have been a systematic tendency to exclude one kind of sample unit or another from the sample. This method of selection, in which inadvertently some types of sample units or items or favoured before others, is known as sampling bias. Judgement also occurs when the criterion used to select samples is related to the variables of interest (Babbie & Mouton, 2001). For example, the criterion of using a convenience sample of men frequenting a gay internet dating site may have led to a bias in the reporting of sexually risky behaviours, which constitute variables of interest in this study. A disadvantage of the online recruitment method is that it may have limited participation of MSM of lower socio-economic standard, owing to factors such as inaccessibility to and lack of online resources. On the other hand, this online sampling strategy proved to be a feasible way to access a minority population that would otherwise be difficult and challenging to locate.
To be included in the final analysis of the study data, men had to be at least 18 years of age. Upon accessing this particular gay internet dating site, web users have to accept an agreement which states and confirms that they are adults of at least 18 years of age. This agreement provided surety that participants recruited online were indeed 18 years or older. There was no cut-off rate for age, in that anecdotal evidence suggests that HIV sexual risk behaviour among MSM does not decrease with age.

The study was approved by the NMMU FRTI and Human Research Ethics Committee. Participants were greeted with the information letter upon opening the survey link (see Appendix B). There were no serious risks of the participants sustaining physical, psychological, or social harm. The main minimising factors in this regard were that anonymity was ensured; information collected was used for research purposes only; participants were informed about the nature of the research; research participation was voluntary and all participants received the same questionnaire.

A possible risk is that memories of CSA might have resurfaced. However, any potential for distress was dealt with through the provision of referral sources in the debriefing form (see Appendix D). These referral sources included counselling, therapy, and VCT testing services. Upon completion of the computerised survey, the debriefing form appeared on participants’ computer screens.

4.3 Measures

Two hundred and thirty seven participants completed the computerised survey (see Appendix C). The questionnaire consisted of four sections. In the first section, participants answered questions relating to demographic information. In the second section, participants answered questions relating to childhood sexual and adverse family experiences, as well as current substance abuse. In the third section, participants completed a standardised measure
of dissociation and depression. The fourth section investigated participants’ current and past sexual practices, and consisted of a standardised measure of sexual and interpersonal communication. This questionnaire, apart from the measures determining depression, interpersonal difficulties, and submissive sexual scripts, has been used and tested successfully (Heusser, 2008). The questions relating to CSA, substance abuse, and sexual practices were adapted from seminal studies in the field of CSA and its effects on MSM, and were formulated in consultation with the specialist literature and experts in the field (Finkelhor, 1984, 1994; Briere, 1992, 1996; Briere & Elliot, 2003; Gore-Felton et al., 2006; Jinich et al., 1998). In order to complete the survey, participants’ needed to be first or second language English speakers and achieved a Grade 10 literacy level. The approximate time to complete the survey is 20 minutes. The following sections describe all measures of the survey more accurately, and the complete survey, consent form and debriefing form are presented in the Appendix.

4.3.1 Demographic information

In the first section of the survey, participants were asked to complete basic biographic and demographic questions. Variables included age, ethnicity (Black; Coloured; Indian; White; or other), self-defined sexual orientation (gay/homosexual; bisexual; heterosexual; or other), marital status (single; partner, closed relationship; partner, open relationship; married, opposite sex; married, same sex; or divorced), occupation (unemployed; self-employed; business employed; or student), years of education, and self-reported HIV status (yes; no; or status unknown).
4.3.2 Alcohol abuse

The study assessed alcohol use problems with the CAGE, a 4-item screening instrument (Mayfield, McLeod, & Hall, 1974). Respondents answered “yes”, “no”, or “not applicable” to each of the four questions.

4.3.3 Substance abuse

A drug use question determined whether, during the past 3 months, participants had used any other addictive substances besides alcohol and tobacco. Participants were also asked whether they had used any drugs and/or alcohol in a sexual context in the past 6 months. Responses were “yes” and “no”. Participants reporting “yes” to any of these items were classified as using drugs.

4.3.4 Childhood sexual abuse

A screening question opened the survey’s section on CSA (“Before you were 13, did you ever have unwanted or forced sexual activity with anyone who was 5 or more years older than you? These situations may have involved sexual fondling, oral sex, or penetration”). This question was constructed using Finkelhor’s (1984) developmental classification of male sexual abuse. According to Finkelhor’s (1984) criteria, an experience is classified as abusive contingent upon the age of the child, the age difference between partners, and whether force was involved.

Respondents who answered in the negative to CSA were asked again with a more general question relating to childhood sexual experiences (Sometimes people’s views about their experiences change over time. Did you ever have an experience before the age of 13 when you felt at the time that you were forced or frightened into doing something sexually that you did not want to do?”). It was believed that a second query might minimise
respondent’s avoidance of self-disclosure on this sensitive topic. A seminal review of research findings by Peters, Wyatt, and Finkelhor (1986) found that multiple enquiries to determine potential sexual abuse led to greater disclosure of such victimisation in otherwise comparable studies. Furthermore, Purcell, Malow, Dolezal and Carballo-Dieguez (2002) found that some adult male CSA survivors initially perceived the sexual abuse experience as coercive and harmful, but that their perceptions of the event became more favourable over time. It is thus clear that the CSA survivor’s current perception of the event versus his perception of the event at the time that it occurred influences the disclosure or reporting of such victimisation. It is for this reason that a second enquiry into participants’ potential childhood sexual experiences was made, with specific emphasis on how the CSA survivor felt at the time of the abusive event.

4.3.5 Adverse family experiences

Due to the importance of separating the effects of CSA from the independent effects of dysfunctional family relations (Collings, 1995; Paul et al., 2001), the survey included items relating to adverse family experiences. Three questions assessed parental substance abuse, inter-parental violence, and childhood physical abuse. Respondents received a composite score of such adverse family experiences, ranging from 0 (for none) to 3 (for co-occurrence of all three problems). Inter-parental violence and childhood physical abuse each added a point to this composite score if reported to occur two or more times (versus never or once only).

4.3.6 Dissociation

The Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986), a widely used 28-item questionnaire with established validity and test re-test reliability (r = .84) was
used to measure the current prevalence of dissociative symptomatology. Respondents are asked to indicate on a scale of 0-100 the percentage of the time they experience dissociative symptoms, which include disturbances in identity, memory, awareness, and cognition, as well as feelings of depersonalisation and derealisation. The DES has been used in a South African context with reported reliability and validity (Lochner et al., 2004, 2007). Furthermore, the DES was used in a previous study on a convenience sample of South African MSM (Heusser, 2008). Moreover, the DES has been used internationally in studies investigating childhood sexual experiences and adult health sequelae (e.g., Gore-Felton et al., 2006; Lipschitz, Kaplan, Sorkenn, Chorney, & Asnis, 1996). Ross, Joshi, and Currie (1991) found that neither gender, socio-economic status, ethnicity, nor religion accounted for differences in dissociative scores on the DES.

4.3.7 Depression

Depressive symptoms were measured using the Beck Depression Inventory Second Edition (BDI-II) (Beck, Steer & Brown, 1996), a widely administered 21-item self-report measure that assesses the existence and severity of symptoms of depression. The test has been shown to have high test-retest reliability ($r = .93$) as well as high internal consistency ($\alpha = .91$) regardless of the population measured. The BDI-II is regularly used in South African research studies (Somhlaba & Wait, 2008; Ward, Flisher, Zissis, Muller, & Lombard, 2001). For example, Somhlaba and Wait (2008) used the BDI-II to measure depression among Xhosa-speaking participants. Furthermore, Fisha (2001) found the BDI-II to be a reliable and valid instrument for the diagnosis of depression among black South African clinical populations.
4.3.8 Sexual practices

Two different HIV sexual risk behaviours were measured. For both sexual risk behaviour measures, open response formats were used so as to minimise response bias. Firstly, participants were asked to report the number of times they had engaged in anal intercourse, as the insertive or receptive partner, as well as the number of times they used or did not use condoms during anal intercourse over the previous 3 months. Participants who reported one or more incidents of either insertive or receptive anal intercourse in the absence of condom use were coded as having had unprotected anal intercourse. Thus, data on the frequency of unprotected insertive and receptive anal intercourse was combined, so as to devise an overall measure of sexual risk-taking. Particular interest was given to anal intercourse because of the high transmission-risk that it poses (O’Leary et al., 2003). Secondly, participants were asked to record the number of male partners with whom they had engaged in sexual activity over a 3 month, 6 month, 9 month, and 12 month period. Responses were weighted and then totalled in order to yield an aggregate score of male sexual partners over a 12 month period. The two sexual risk behaviour variables (“unprotected anal intercourse” and “number of male sexual partners”) were classified as dependent variables. Measures similar to these have been found reliable (Gore-Felton et al., 2006; Jinich et al., 1998).

4.3.9 Sexual compulsivity

To measure episodes of compulsive, short-term sexual activity, participants were asked how many of the men with whom they had had sexual relations in the previous year were someone they had sex with only once (commonly referred to as “one-night stands”). This measure was dichotomised as none vs. one or more.
4.3.10 Submissive sexual scripts

Having an abusive partner in adulthood may reflect submissive roles or scripts in sexual and interpersonal relations, which may, in turn, lead to a failure to avoid sexually risky situations or even revictimisation (Paul et al., 2001). The following question, adapted from the literature in the field of adult revictimisation, determined abusive relationships: “Have you been in one or more intimate relationships over the previous 5 years that have involved two or more experiences of physical or emotional abuse? Situations may have involved being hit, shoved, beaten, verbally threatened, or degraded by your partner”. Respondents answered “yes” or “no” to this question.

Limited literature also suggests that sadomasochistic / bondage and discipline sexual practices may be indicative of learned sexual scripts that highlight submissive or aggressive sexual roles (Bolton, Morris, & MacEachron, 1989; Paul et al., 2001). The following question determined this: “In the past 12 months, have you engaged in any sexual practices that included elements of either dominance and submission, bondage and discipline, physical or psychological pain, or master-slave role-playing?” Responses were dichotomous, “yes”-“no”.

4.3.11 Impaired interpersonal regulation

To determine deficits in interpersonal regulation, participants were asked to complete the Health Protective Sexual Communication (HPSC) Scale (Catania et al., 1992). This 10-item scale assesses how often respondents discuss health protective topics with a new, first-time sexual partner. Items address health protective concerns related to safer sex, sexual histories, and condom use. Higher scores on the HPSC Scale are related to increased condom use, greater sexual and condom relations skills and communication, and greater sexual assertiveness. Two items were excluded as they are not specific to gay men. The HPSC Scale has not been used in South Africa. It has, however, been administered to varied populations.
in North America, including adolescents and urban probability samples that adequately represent White, Black, and Hispanic ethnic groups, as well as high HIV-risk groups (Catania, Coates, & Kegeles, 1994). Internal consistency of the measure for Catania et al.’s study was good ($\alpha = .67$).

4.4 Procedure

As stated above, participants were recruited online. A website service called Zoomerang, which is an online survey software tool, was used to create the electronic survey for the current study. Emails containing the survey link were randomly sent to members of a gay South African internet dating site. Furthermore, LGBT (Lesbian-Gay-Bisexual-Transgendered) non-governmental organisations were contacted and asked to forward the email on their mailing lists. Upon opening the link, the information letter appeared on screen, outlining the nature of the study and highlighted potential risks and benefits resulting from their involvement in the research. It also stated that participation was completely voluntary, and that termination as a research participant was possible at any time. Informed consent was obtained through the online participant’s choice and agreement to take part in the study. In other words, participants consented to the study by, after having read the information letter, proceeding to complete the electronic survey. Upon completion of the survey, participants were automatically met with the debriefing form, which contained further information on the study, as well as referral sources.

Anonymity was ensured in that participants’ names were not collected for the study at any time, and participants were fully informed about the measures taken to preserve their confidentiality.
4.5 Data Analysis

Data analysis proceeded in ten stages, in accordance with the ten research aims:

In line with research aim 1a, descriptive statistics were conducted in order to describe demographic characteristics of the sample, and to determine the sample prevalence rates of CSA and sexual risk behaviours.

In line with research aim 1b, Chi-square contingency tests were conducted to determine comparisons on demographic variables across the CSA and non-CSA groups. Phi statistics ($\phi$) and odds ratios ($OR$) were reported as indices of effect size, which measures practical significance. Practical significance looks at whether a statistically significant result is large enough to be of value in a practical, real-world sense.

In keeping with aims 2a and 2b, t-tests were conducted to compare the CSA group and the group reporting no CSA history on mean scores for CSA-related mental health outcome measures, and measures of HIV sexual risk behaviour. Cohen’s $d$ statistics were reported as measures of effect size for statistically significant t-tests. Group comparisons involving categorical variables were carried out with Chi-square contingency tests. For statistically significant results, Phi statistics ($\phi$) and odds ratio were reported as measures of effect size.

Corresponding to aims 3a and 3b, correlations, biserial correlations, and Chi-square contingency tests were conducted to explore the associations between CSA-related outcome variables with the two sexual risk behaviour dependent variables. Pearson’s correlations ($r$) were used where both variables were continuous (i.e. measured on a ratio scale), and point-biserial correlations were used where one variable was continuous and the other dichotomous (i.e. categorical with only two categories). Point-biserial correlations were then converted into the biserial correlation coefficient ($r_b$) using an equation (Field, 2005). According to Field (2005), the point-biserial correlation is used when one variable is a discrete dichotomy.
(e.g. pregnancy), whereas the biserial correlation coefficient is used when one variable is a continuous dichotomy. When a dichotomy is continuous, there is an underlying continuum between the categories, which are still measured as two values. An example in this case is drug abuse or no drug abuse: some participants may use drugs only seldom whilst others will use drugs more regularly, perhaps even daily. So although participants fall into only two categories (drugs or no drugs) there is an underlying continuum along which they lie. For this reason, point-biserial correlations were converted into biserial correlations. The coefficient of determination ($r^2$) was reported as a measure of the strength of association. Comparisons involving two categorical variables were carried out with Chi-square contingency tests.

To explore research aim 4a, a hierarchical multiple regression analysis was used with number of male sexual partners as the dependent variable. This was done in order to examine the association between CSA and sexual risk behaviour over and above adverse family experiences and CSA-related mental health outcome measures.

To explore research aim 4b, a hierarchical logistic regression model was tested with unprotected anal intercourse as the dependent variable, and CSA, adverse family experiences, and CSA-related psychological outcome measures as predictor variables.

Finally, to explore aim 5, mediation analysis was performed to determine the effect of CSA on the two sexual risk behaviour dependent variables through the proposed mediators / CSA-related outcome measures (i.e. dissociation, depression, substance abuse, one night stands, interpersonal regulatory deficits, and submissive sexual scripts). The advantage of using mediation analysis is that it offers a more complex account of the relationship between two variables, in that it investigates the impact of a crucial third intervening variable on the dependent and independent variable (Baron & Kenny, 1986). For example, mediators explain how and why individuals with a history of CSA are more likely to engage in sexual risk behaviour. The relationship between CSA and HIV sexual risk is not unidirectional, rather,
critical mental health outcomes such as depression account for the effects on sexual risk behaviour. A disadvantage, however, is that large sample sizes are needed to detect significance and achieve statistical power (Fritz & MacKinnon, 2007).

4.6 Chapter Overview

To summarise, this study used online participants drawn from MSM-frequented internet dating sites. Participants were randomly selected, and opening the survey link, were greeted with the consent form. Research participation was voluntary, and all participants received the same questionnaire. The questionnaire was divided into four sections, consisting of questions relating to demographic information, early sexual history, psychological outcomes measures, and current sexual practices. Upon completion of the survey, participants were met with the debriefing form, which contained referral sources. Data analysis proceeded in five stages, and the results thereof will be provided in the following chapter.
CHAPTER 5

Results and Discussion

In this chapter, the results of the current study will be presented according to each of the research aims. There will also be a discussion following the presentation of each of the findings.

5.1 Aim 1a: Descriptive Statistics

One of the first aims of the study was to conduct descriptive statistics in order to describe the demographic characteristics of the sample, as well as to determine prevalence rates for CSA, drug abuse, and HIV sexual risk behaviours.

The survey returned 237 questionnaires. Seven questionnaires were excluded from the analysis because individuals were below the age of 18. The study population thus amounted to 230 participants. Missing data cases were excluded listwise (or casewise), meaning that if a participant had a missing value for any variable, then they were excluded from the whole analysis. The following paragraph states the results for the demographic information. A complete demographic description of the sample is presented in Table 1.

The mean age of persons in the sample was 34.96 years \( (SD = 10.11) \), with a median age of 34 years. Overall, 81.74% of the male participants were White, 6.52% Indian, 4.35% Coloured, 4.35% Black, and 3.04% other ethnic group. Of the male respondents, 89.13% self-identified as gay, 55.22% reported being single, and 69.23% had completed or were completing a degree from a tertiary education facility. The majority of the sample (80.79%) reported their HIV status to be negative, while 12.66% reported a positive HIV status and 6.55% did not know their status.
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* p < .05.
The following paragraph states the sample prevalence rates for CSA, substance abuse, history of one-night stands, and unprotected anal sex. A more complete description is presented in Table 2.

Of the respondents, 54 (23.48%) reported a history of CSA and 176 (76.52%) reported no such history. Participants that answered positively to the question determining sexual abuse before the age of 13 were placed into the CSA group, and those that responded negatively formed the non-CSA group. Around 37.72% of the sample reported recreational drug abuse, and 35.22% reported using drugs in sexual contexts. Furthermore, 40.72% of the participants reported having engaged in unprotected anal intercourse (either insertive or receptive) in the past three months. In addition, 69.27% of the sample reported having had one or more one-night stands (either oral and / or anal sex) in the past 12 months.

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</table>
This study confirms prior international research indicating high prevalence levels of CSA among MSM, and extends this research into the South African context. In this sample, roughly 1 in 4 participants (23.48%) reported a history of CSA. Previous reports of the prevalence of CSA among gay and bisexual men range from 11% to 37% (Brennan, Hellerstedt, Ross, & Welles, 2007). This study’s prevalence is consistent with American studies reporting a prevalence range from 15% to 28% (Jinich et al., 1998; O’Leary et al., 2003; Paul et al., 2001), and this prevalence range is considered to be more representative of the MSM community because these studies used non-clinical convenience samples, as did this study. It must however be noted that the current study’s prevalence rate would have been much higher if there had been a wider spread of data across the different ethnic groups. Research indicates that the prevalence of CSA is often higher in poorer, under-resourced communities. This may be especially true in the South African context. Given that this study’s sample is predominantly White and well-educated, the prevalence estimate of CSA among a more general South African MSM population is thus likely to be even higher. Nonetheless, the current finding suggests that a substantial segment of the MSM population in South Africa has been subjected to potentially severe CSA experiences.

This study also found extraordinarily high rates of recreational drug abuse, as well as sex-related drug abuse, in the sample. These findings suggest that drug abuse, whether recreational or sex-related, is widespread in the South African MSM population. Furthermore, this finding provides empirical confirmation of anecdotal information on the high rate of drug abuse among gay and bisexual men in South Africa (Parry et al., 2008). This should be considered a serious public health problem, particularly in this population, given that approximately 37% of the participants were classified as drug users.

Of even more concern, however, is the level of unprotected anal intercourse found in this sample. Just under half of the participants reported engaging in unprotected anal
intercourse in the past three months. This finding suggests that the sexual risk for HIV transmission in this population is alarmingly high. It also seems that one-night stands are common practice among MSM, given that over two-thirds of the participants engaged in sexually compulsive behaviour in the past year. Thus, the propensity for MSM to engage in high-risk behaviours cannot be underestimated, and this may account for the increasing rates of HIV infection among MSM in this country. In this sample alone, roughly 1 in 10 men reported an HIV positive serostatus. However, this number is unlikely to be representative of the broader population of South African MSM; rather, it is estimated to be even higher owing to the possibility that participants from poorer socio-economic and different ethnic backgrounds may have been excluded from the sample. For instance, recent same-sex research conducted by Lane, McIntyre, and Morin (2006a) revealed that Black South African MSM are highly vulnerable to HIV infection.

5.2 Aim 1b: Between-Group Comparisons on Demographic Variables

Aim 1b sought to explore comparisons between the CSA group and the non-CSA group on demographic variables. Chi-square contingency tests were conducted in order to determine differences between the two groups on demographic characteristics. Table 1 shows comparisons on demographic characteristics across the CSA and non-CSA group.

There were no significant relationships between abused and non-abused men with respect to age, ethnicity, sexual orientation, marital / partner status, occupation, and HIV status. Level of education, however, was found to be statistically significantly associated with CSA ($\chi^2(2) = 6.90, p = .032$). However, this result cannot be interpreted in that the Phi statistic and the odds ratio indicate that the strength of association between CSA and education does not meet the recommended minimum effect size for practical significance. In
other words, the strength of association is too small for this result to be translated into recommendations for the general MSM and CSA population.

5.3 Aim 2a: Between-Group Comparisons on CSA-related Mental Health Outcome Measures

Aim 2a explored whether there are differences between the CSA group and the non-CSA group on CSA-related mental health outcome measures. Independent sample t-tests as well as Chi-square contingency tests were conducted in order to determine differences between the two groups on CSA-related mental health outcome measures. The following six variables were constituted as CSA-related mental health outcome measures: dissociation, substance abuse, depression, sexual compulsivity (as measured by one-night stands), impaired interpersonal regulation (as measured by health protective sexual communication), and submissive sexual scripts (as measured by sadomasochism and adult revictimisation). As mentioned in Chapter 4, dissociation was measured with the Dissociative Experiences Scale (DES); depression was assessed with the Beck Depression Inventory (BDI-II); and health protective sexual communication was measured using the Health Protective Sexual Communication Scale (HPSC). Cronbach’s alpha indicated that the internal consistency for each of the scales was good (Cronbach’s $\alpha$ for DES = .94; Cronbach’s $\alpha$ for BDI-II = .92; Cronbach’s $\alpha$ for HPSC = .85). Table 3 shows comparisons on CSA-related mental health outcome variables across the CSA and non-CSA group.
Table 3
*Comparison of CSA and non-CSA group on CSA-related Mental Health Outcomes (Mediators) and the Two Sexual Risk Behaviour Variables*

<table>
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<tr>
<th></th>
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<th>t</th>
<th>df</th>
<th>p</th>
<th>d</th>
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<td>227</td>
<td>.265</td>
<td></td>
</tr>
<tr>
<td>Dissociation</td>
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<tr>
<td>Depression</td>
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<td>1.94</td>
<td>195</td>
<td>.053*</td>
<td>-0.31</td>
</tr>
<tr>
<td>Health Protective Sexual Communication</td>
<td>14.27 5.54</td>
<td>15.12 6.06</td>
<td>-0.87</td>
<td>194</td>
<td>.384</td>
<td></td>
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</table>

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<thead>
<tr>
<th></th>
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<th>%</th>
<th>N</th>
<th>%</th>
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<th>$df$</th>
<th>p</th>
<th>OR</th>
<th>$\phi$</th>
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<td>60</td>
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<td>1.85</td>
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<td>25</td>
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<td>.17</td>
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<td>121</td>
<td>82.88</td>
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Measures of sexual risk behaviour

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
<th>OR</th>
<th>$\phi$</th>
</tr>
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<tbody>
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<td>Number of male sexual partners</td>
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<td>38.71</td>
<td>49.56</td>
<td>1.75</td>
<td>187</td>
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<th></th>
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<th>%</th>
<th>N</th>
<th>%</th>
<th>$\chi^2$</th>
<th>$df$</th>
<th>p</th>
<th>OR</th>
<th>$\phi$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprotected anal sex</td>
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<td></td>
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<td></td>
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<td>44.00</td>
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<td>64.58</td>
<td></td>
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</table>

* $p < .05$. ** $p < .001$. 


A statistically significant difference was observed on scores of dissociation between men reporting a history of CSA and those reporting no such history. Men who were sexually abused as children scored higher on dissociation on average than men who reported no sexual abuse. However, Cohen’s $d$ indicates a small effect size, suggesting that the difference between the two groups on scores of dissociation is not large enough to be of value or importance in a practical sense. Thus, this result cannot be interpreted further.

There was also a statistically significant between-group difference on scores of depression. Men who were sexually abused as children scored higher on the BDI-II on average than men who reported no sexual abuse. Cohen’s $d$ indicates a small effect size. Thus, despite its statistical significance, this result offers limited practical significance, and therefore cannot be explored further.

The between-group difference on the measure of alcohol abuse was found to be statistically non-significant. However, there was a statistically significant difference on measures of drug abuse as well as drug abuse in sexual contexts between abused and non-abused men. Men who were abused as children were 1.85 times more likely to engage in drug abuse than those who reported no sexual abuse. Furthermore, abused men were 3.06 times more likely to use drugs in sexual contexts than non-abused men. The Phi statistic for the strength of association between CSA and drug abuse is .13, and .24 between CSA and sex-related drug abuse. Ferguson (2009) states that strength of association above .2 meets the recommended minimum effect size representing a “practically” significant effect. The strength of association between CSA and sex-related drug abuse meets this requirement.

This finding is consistent with the extant literature linking CSA to substance abuse in MSM (Arreola et al., 2008; Bartholow et al., 1994; Carballo-Diuguez & Dolezal, 1995; Dilorio et al., 2002). This confirms that some CSA survivors may show an over-reliance on behavioural escape-avoidance coping strategies such as substance abuse. Substance abuse
may represent an opportunity for psychological and emotional distance by dulling dysphoric or distressing states that may be linked to memories of the abuse or that may be associated with long-term abuse-related negative affects such as anxiety or depression (Briere, 1996; Gartner, 1999). The necessity for such escape-avoidance behaviour may become particularly evident in sexual situations, whereby the CSA survivor is reminded both physiologically and psychologically of the original sexual abuse experience. Thus, substance abuse provides for the CSA survivor a necessary problem-solving strategy in the face of intolerable painful affect and reduced self-functioning (Briere, 1996). To the extent that such external avoidance behavior is effective in reducing tension and providing cohesion to a structurally damaged self (Kohut), it may develop into a chronic and unsophisticated mode of affect regulation (Miller, 1999), particularly in contexts (sexual) that resemble the abuse experience.

Comparisons on sexual compulsivity indicated a significant difference between men reporting a history of CSA and those reporting no such history. Men who were sexually abused as children were 2.74 times more likely to report one or more one-night stands in the past year than men who reported no sexual abuse. Ferguson (2009) states that an odds ratio above 2.0 meets the recommended minimum effect size for a “practically” significant effect, and an odds ratio of 3.0 represents a moderate effect.

This finding confirms that MSM who were sexually abused as children, compared to MSM with no CSA history, are at a higher risk of engaging in compulsive sexual behaviour, and thus reporting higher numbers of male sexual partners (Jinich et al., 1998). CSA differs from other forms of traumatisation in that such early experiences may shape the victim’s subsequent sexuality and sexual relationships. Finkelhor and Browne (1985) termed this “traumatic sexualisation”, which describes the shaping of a child’s sexual feelings and attitudes in a developmentally inappropriate and interpersonally dysfunctional manner. An example of such a failure to develop a healthy sexual relationship would be the CSA
survivor’s preoccupation with sex, or poor sexual impulse control. For instance, aspects of the childhood sexual experience which the child may have subjectively perceived as positive (e.g., obtaining attention or nurturance) may reinforce the use of sexual behaviour as a means of soothing, or a tool to meet interpersonal needs that relate to the reception of nurturance and affection (Paul et al., 2001). Furthermore, the CSA survivor’s compulsive sexual behaviour may be motivated by a need to reduce or dull negative affective states such as anxiety and depression that are triggered by memories of the abuse, and this compulsive act is reinforced by the orgasm-related tension reduction (Briere, 1996). Compulsive sexual acts may also represent a return to a defensive dissociative state in which relief is sought through the warding off of unbearable affect. The immediate soothing effect of such tension-reducing coping strategies lessens the need to adopt more sophisticated methods of affect regulation, which, in turn, increases engagement in tension reduction behaviours when faced with more psychological pain (Briere, 1996; Gartner, 1999).

Submissive sexual scripts were measured in terms of participation in sadomasochistic sexual activity, as well as a history of abusive relationships in adulthood. There was no significant between-group difference on the measure of sadomasochism. In contrast, however, there was a statistically significant between-group difference on the measure of adult revictimisation. More specifically, men who were abused as children were 2.42 times more likely to have been in a recent abusive relationship than those who were not abused as children. The risk estimate, or odds ratio, is above 2.0 and thus satisfies the recommended minimum effect size for practical significance.

In accordance with previous research (Kalichman et al., 2001), this finding confirms that MSM who were sexually abused as children are 2.42 times more at risk than those who were not abused to be revictimised in adulthood (Kalichman et al., 2001). One explanation for this is that adult CSA survivors may be more likely to attract dominating, overly
controlling partners, as these characteristics were familiar to the victim and satisfied certain needs that arose from the victim-perpetrator relationship (Paul et al., 2001). Such partners may have less concern about the well-being of others, which in extreme situations may lead to physical abuse, rape, or any other form of revictimisation. Another explanation is that many CSA survivors tend to idealise their partners, and in their drive to see their partners in a positive light, they may fail to notice cues or behaviours that signal danger (Briere, 1996). Furthermore, the CSA survivor’s impaired sense of self may account for their reduced capacity to identify boundary violations or define their boundaries in the context of a more powerful other (Spies, 2006).

Having an abusive partner in adulthood may also reflect the enactment of a submissive role in sexual relationships, which may be associated with a greater risk of revictimisation (Gartner, 1999; Paul et al. 2001). This is because the sexual abuse, especially prolonged abuse, may lead to a permanent sense of powerlessness and thwarted sense of self-efficacy in the victim, which results in an inability to avoid further victimisation in adulthood. As a result of this powerlessness and diminished sense of agency, MSM in particular, may be more likely to enact submissive sexual scripts, which, together with a sense of learned helplessness and passivity, reduces their ability to effectively control and monitor their sexual lives (Carey, 1997). Furthermore, MSM may adopt characteristics of non-assertiveness and over-compliance as a reaction formation against identifying with the more powerful and threatening abuser (Muehlenhard, Highby, Lee, Bryan, & Dodrill, 1998). Alternatively, some CSA survivors may feel the need to replay the abuse as adults by devoting themselves to the particular sexual role (e.g., one of helplessness and fear) that is reminiscent of the original experience. The (re)enactments of such rigid sexual scripts and the associated feelings of disempowerment, passivity, and low self-efficacy thus increase the risk of sexual revictimisation in adulthood (Muehlenhard et al., 1998).
Finally, there was no significant difference between the CSA and the non-CSA group in their scores on the HPSC Scale, which was used as a measure to determine interpersonal regulation and communication.

### 5.4 Aim 2b: Between-Group Comparisons on Sexual Risk Behaviour

Aim 2b explored whether there are differences between the CSA and the non-CSA group on both measures of HIV sexual risk behaviour, namely number of male sexual partners and unprotected anal intercourse. Results for this analysis are also shown in Table 3.

There was no statistically significant difference between the CSA group and the non-CSA group in terms of self-reported number of male sexual partners. However, a statistically significant association was found between CSA and unprotected anal intercourse. The odds ratio, which meets the recommended minimum effect size for practical significance, indicates that those who reported CSA were 2.32 times more likely to engage in unprotected anal intercourse than those with no CSA history.

Despite its small effect size, this finding is consistent with the extant international literature linking CSA to unprotected anal intercourse in MSM (Bartholow et al., 1994; Carballo-Dieuguez & Dolezal, 1995; Jinich et al., 1998; O’Leary et al., 2003). One explanation for this increased risk is that CSA experiences may lead to impairments in the victim’s ability to trust people or situations and to form intimate attachments (Briere & Elliot, 1994). This, in turn, disrupts the development of long-term relationships, leading to a pattern of short-term sexual relationships (Paul et al., 2001). In the absence of regular condom use, these short-term sexual encounters may increase the risk for HIV infection. As mentioned above, people with a history of CSA are also more likely to attract dominating partners that have little concern about the safety of others. In extreme cases, this may lead to adult sexual
revictimisation which, in turn, has a high likelihood of involving unsafe sex (Paul et al., 2001).

Many abusers model sexually aggressive behaviour and poor impulse control, so that their victims may learn and later exhibit similar hostile emotional and behavioural reactions in their adult sexual relationships. Such aggressive sexual behaviour impedes the development of mutual sexual regulation and healthy sexual communication which, in turn, results in an increased likelihood of risk behaviour. On the other hand, perpetrators may reward passivity and obedience in the face of control, which reinforces more submissive responses (e.g., receptive anal sex) of CSA victims in later sexual situations. Enduring patterns of sexual aggression or sexual passivity often lead to the creation of fixed sexual scripts that increase the risk of unprotected anal intercourse through an inability to either insist on safe sex, an inability to refuse sexually aggressive partners, or an inability to care about the well-being or safety of others (Paul et al., 2001).

5.5 Aim 3a: Relationships between CSA-related Mental Health Outcome Variables and Number of Male Sexual Partners

Aim 3a looked at exploring associations between CSA-related mental health outcome measures and the dependent sexual risk behaviour variable “Number of male sexual partners”. Pearson’s correlations, as well as biserial correlations, were used to test this aim. Results are presented in Table 4.
**Table 4**  
**Associations Between CSA-related Mental Health Outcomes and Two Dependent Variables of Sexual Risk**

<table>
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<th>Variable</th>
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<th>Number of male sexual partners</th>
</tr>
</thead>
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<td></td>
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<td>Health Protective Sexual Communication</td>
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<td>.044*</td>
</tr>
</tbody>
</table>

* $p < .05$. ** $p < .01$. *** $p < .001$. 

Pearson's $r$ and $P$ values are calculated as follows:

$rb$ and $p$ values are calculated as follows:

- Alcohol abuse: $rb = .03$, $p = .73$
- Dissociation: $rb = -.02$, $p = .837$
- Depression: $rb = -.03$, $p = .664$
- Communication: $rb = -.15$, $p = .044*$
Alcohol abuse, dissociation, depression, and a history of adult abusive relationships were not significantly associated with number of male sexual partners. However, drug abuse was statistically significantly positively related to number of male sexual partners, indicating that those men who reported drug abuse also reported increased numbers of male sexual partners. This finding also achieved practical significance, as biserial correlation coefficient indicates a moderate strength of association between the two variables (Ferguson, 2009). The coefficient of determination indicates that drug abuse accounts for 11.56% of the variation in numbers of sexual partners. There was also a statistical positive relation between drug abuse in sexual contexts and number of male sexual partners, indicating that those who used drugs in sexual contexts tended to report higher numbers of male sexual partners than those who did not use drugs in sexual contexts. This result achieved a moderate effect size (Ferguson, 2009), whereby 24.01% of the variation in numbers of sexual partners can be accounted for by sex-related drug abuse.

These findings corroborate previous research linking drug abuse to sexual-risk taking in MSM (Dolezal, Carballo-Dieguez, Nieves-Rosa, & Diaz, 2000; Gore-Felton et al., 2006). This relationship between drug abuse and HIV sexual risk has also been established in the South African context (Parry et al., 2008). In Parry et al.’s (2008) study, which used an integrative qualitative methodology, MSM subjectively reported that drugs such as crack cocaine, crystal methamphetamine, methcathinone, and cannabis lead to high-risk sexual activities such as not using condoms, having sex with strangers, participating in group sex, and having sex with multiple partners. Although there does not appear to be a simple causal relationship between substances and sexual risk (Dolezal et al., 2000), attempts can be made to explain this link. For example, drugs may inhibit interpersonal regulatory abilities (Paul et al., 2001) that permit safe sex by decreasing perceptions of risk or concerns about safety, or by encouraging sexual sensation seeking. Drugs may also boost self-esteem, increase self-
confidence, and enhance arousal. Furthermore, HIV-positive MSM may want to escape from thoughts of safer sexual behaviours, and so actively choose to use recreational drugs to enable escape and look for sex partners in commercial sex environments (such as bath houses or sex clubs) where anonymous sex acts with multiple partners are more normative (Parsons & Halkitis, 2002). This study’s finding therefore empirically validates that drug abuse plays a significant role in the maintenance of high-risk sexual practices among MSM in South Africa, regardless of CSA history.

As expected, sexual compulsivity was also positively related to number of sexual partners. In other words, men who engaged in one or more one-night stands in the past year tended to report higher numbers of male sexual partners. This result was also practically significant with a moderate effect size (Ferguson, 2009), and the coefficient of determination implies that 25% of the variability in numbers of male sexual partners can be explained by sexual compulsivity.

As stated in Chapter 3, sexual compulsivity often represents a method to ward off anxiety in uncomfortable situations and an attempt to return to a temporary dissociated state of calmness (Gartner, 1999). As this defensive acting out becomes chronic and generalises to all anxiety-provoking situations of the individual’s life, his perceptions, sexuality, and interpersonal relatedness become distorted. Furthermore, the effectiveness of the immediate tension-reduction following the compulsive sexual act reduces the need to adopt more sophisticated methods for coping and affect regulation. This, in turn, increases reliance on avoidance learning behaviour when faced with distress, pain, or anxiety (Briere & Elliot, 1994; Paul et al., 2001). Sexual compulsivity thus relates to HIV risk in that the individual’s need to numb distress and avoid internal conflict reinforces repetitive engagement with multiple sexual partners; thus explaining the current study’s finding that sexual compulsivity is associated with increased number of partners.
Although there was no correlation between adult revictimisation and number of sexual partners, engagement in sadomasochism was significantly positively related to number of male sexual partners. The biserial correlation coefficient is above 2.0 and thus satisfies the recommended minimum effect size for practical significance (Ferguson, 2009). Men who participated in sadomasochistic sexual activity in the previous year reported more male sexual partners than those who did not engage in sadomasochism. Moreover, 5.76% of the variation in the number of reported male sexual partners is accounted for by engagement in sadomasochistic sexual activity.

Although the literature on sadomasochism and its relation to sexual risk behaviour in MSM is sparse, speculations can still be made to explain this finding. For example, engagement in sadomasochistic sexual activity involves particular dangers for HIV sexual risk behaviour in that there is often a failure to accurately evaluate risk, individuals are unable to effectively negotiate sexual interactions, and sexual health is given up at the expense of pleasure and pain. All this interrupts the males’ ability to perform sexual activities that pose a low risk for HIV transmission. Furthermore, just as sexual compulsivity becomes a chronic mechanism for tension reduction and dissociation, so sadomasochistic sexual acts may serve to reduce tension from negative affect and enable entry into self-hypnotic states that soothe and dull psychological pain.

Finally, there was a statistically significant negative correlation between health protective sexual communication and number of sexual partners. The finding also achieved practical significance. Men who scored lower on the HPSC Scale reported more male sexual partners. In other words, as health protective sexual communication decreased, the number of male sexual partners increased. More specifically, health protective sexual communication accounts for 4% of the variation in number of male sexual partners.
Health protective sexual communication refers to the ability to be assertive in sexual situations and to communicate sufficiently about sexual matters (Catania et al., 1992). Van Der Straten et al. (1998) state that greater health protective sexual communication is associated with confidence in one’s ability to regulate and control sexual situations and safer sex practices, and a belief in one’s capacity to assertively avoid unwanted sexual contacts. Thus, interpersonal impression management, assertiveness skills, self-regulation specific to condom use, and self-regulation with respect to sexual interactions are some factors that have direct influences on health protective sexual communication (Van Der Straten et al., 1998). It makes intuitive sense then that a lack of communication and assertiveness is associated with increases in sexual partners, in that the individual’s ability to refuse unwanted sexual partners, and to negotiate control and power, is impaired. As the individual’s HPSC decreases, so does his ability to assertively avoid unwanted sexual contacts. In other words, there is a deficit in the individual’s ability to regulate and negotiate interpersonal situations, which in turn is associated with an increased number of male sexual partners.

5.6 Aim 3b: Relationships between CSA-related Mental Health Outcome Variables and Unprotected Anal Intercourse

Aim 3b looked at exploring associations between CSA-related mental health outcome measures and the dependent sexual risk behaviour variable “Unprotected Anal Intercourse”. Biserial correlations were used where only one variable was categorical, and Chi-square contingency tests were used where both variables were categorical. Results for this analysis are also presented in Table 4.

There were no significant associations between unprotected anal intercourse and alcohol abuse, dissociation, depression, a history of one-night stands, sadomasochism, and adult revictimisation. However, there was a significant association between drug abuse and
unprotected anal intercourse. Drug abuse in sexual contexts was also significantly associated with unprotected anal intercourse. Both of these findings achieved practical significance, as an odds ratio above 2 represents a recommended minimum effect size (Ferguson, 2009). Men who abused drugs recreationally in the past 3 months were 2.4 times more likely to engage in unprotected anal intercourse than those who did not abuse drugs. Men who abused drugs in contexts in which they sought out sexual activity and/or engaged in sexual activity were 2 times more at risk to engage in unprotected anal intercourse than those who did not abuse drugs.

These findings confirm a well-established link between drug abuse and engagement in high-risk sexual behaviours among MSM, such as unprotected anal intercourse (Dolezal et al., 2000; Gore-Felton et al., 2006). As mentioned before, drug abuse, particularly drug abuse in sexual contexts, may impair the individual’s ability to evaluate risk and negotiate sexual safety behaviours, such as wearing a condom or refusing an aggressive partner that insists on “barebacking”. Furthermore, certain substances can increase sexual sensation seeking and arousal, decrease inhibitions, and reduce concern about sexual risk behaviour. Also, MSM who ordinarily feel relatively powerless against other males’ sexual advance may become even more so when under the influence of drugs (Morojele, Brook, & Kachienga, 2006). To summarise, drugs may inhibit the individual’s internal locus of control that permits the negotiation and enactment of safer sex (Paul et al., 2001).

There was also a statistically significant negative correlation between health protective sexual communication and unprotected anal intercourse. This finding, however, failed to achieve practical significance and therefore cannot be interpreted further.
5.7 Aim 4a: Creating a Model to Predict Number of Sexual Partners

Aim 4a explored whether CSA and the outcome measures of CSA predict number of male sexual partners. Thus, a hierarchical multiple regression analysis was carried out in order to predict the effects of CSA on number of sexual partners in adulthood after controlling for other contextual factors of the childhood abuse experience (e.g., adverse family experiences) and CSA-related mental health outcome measures. Participant’s self-reported number of male sexual partners in the previous 12 months was therefore used as an index of HIV sexual risk behaviour (dependent variable) in this multiple regression analysis. Five blocks of predictor variables were entered in the following sequence: (1) CSA; (2) adverse family experiences; (3) current drug and alcohol abuse, as well as drug abuse in sexual contexts; (4) scores on the dissociation and depression indices; and (5) history of one-night stands, history of adult abusive relationships, sadomasochism, and health protective sexual communication. Results for this analysis are presented in Table 5.

Pre-diagnostic testing indicated no intercorrelations between the independent variables. As indicated in Table 5, CSA did not contribute significantly to the number of partners when entered into the model alone. Furthermore, the addition of adverse family experiences did not lead to a significant change in the amount of variance explained in the number of sexual partners. Substance abuse as a block, however, contributed significantly to the prediction of the number of sexual partners ($F(3, 179) = 9.59, p < .001$) over and above CSA and adverse family experiences. More specifically, drug abuse in sexual contexts was significantly associated with number of partners ($t(179) = 3.91, p < .001$), indicating that for every one unit change in substance abuse, the scores on the number of male sexual partners increased by 34.89 units. Drug abuse in sexual contexts remained a significant predictor of number of sexual partners when scores on dissociation and depression were added to the model. The addition of dissociation and depression did not lead to a significant change in the
amount of variance in the number of sexual partners. However, when the variables measuring a history of one-night stands, adult revictimisation, sadomasochism, and health protective sexual communication were entered as a block into the model, a significant change in the amount of variance on the dependent variable was noted ($F(4, 173) = 7.53, p < .001$). Drug abuse in sexual contexts remained a significant predictor of number of sexual partners. Also, even after controlling for this drug abuse relation, number of one-night stands also turned out to be significantly associated with number of partners ($t(173) = 4.42, p < .001$). This indicates that as the amount of one-night stands increased by one unit, the number of sexual partners increased by 33.97 units. Sadomasochism was also significantly associated with number of partners ($t(173) = 1.99, p = .05$) over and above drug use and number of one-night stands, indicating that for every unit of participation in sadomasochistic sexual activity, the scores on the number of sexual partners increased by 16.65 units.

The results indicate that a model for predicting (or understanding) number of male sexual partners among MSM is constituted by the variables drug abuse in sexual contexts, number of one-stands, and engagement in sadomasochism. The overall regression model is statistically significant ($F(11, 173) = 6.19, p < .001$), with a total explained variance ($R^2$) of .28. Of the three variables in the final model, the Beta values suggest that a history of one-night stands has the most impact in predicting number of sexual partners, relative to drug abuse in sexual contexts and participation in sadomasochistic sexual activity.
Table 5
Results of Hierarchical Linear Regression on Number of Male Sexual Partners

<table>
<thead>
<tr>
<th>Step</th>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Constant</td>
<td>38.95</td>
<td>4.34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CSA</td>
<td>14.09</td>
<td>8.52</td>
<td>.12</td>
</tr>
<tr>
<td>2</td>
<td>Constant</td>
<td>38.91</td>
<td>5.16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CSA</td>
<td>14.08</td>
<td>8.58</td>
<td>.12</td>
</tr>
<tr>
<td></td>
<td>Adverse family experiences</td>
<td>0.03</td>
<td>2.21</td>
<td>.00</td>
</tr>
<tr>
<td>3</td>
<td>Constant</td>
<td>27.38</td>
<td>5.72</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CSA</td>
<td>4.99</td>
<td>8.22</td>
<td>.04</td>
</tr>
<tr>
<td></td>
<td>Adverse family experiences</td>
<td>-1.12</td>
<td>2.09</td>
<td>-.04</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
<td>-2.22</td>
<td>14.89</td>
<td>-.01</td>
</tr>
<tr>
<td></td>
<td>Drug abuse</td>
<td>9.45</td>
<td>8.49</td>
<td>.09</td>
</tr>
<tr>
<td></td>
<td>Drug abuse sexual contexts</td>
<td>34.89</td>
<td>8.93</td>
<td>.33***</td>
</tr>
<tr>
<td>4</td>
<td>Constant</td>
<td>30.02</td>
<td>8.55</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CSA</td>
<td>5.71</td>
<td>8.35</td>
<td>.05</td>
</tr>
<tr>
<td></td>
<td>Adverse family experiences</td>
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<td>2.15</td>
<td>-.03</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
<td>0.21</td>
<td>15.09</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>Drug abuse</td>
<td>7.67</td>
<td>8.65</td>
<td>.07</td>
</tr>
<tr>
<td></td>
<td>Drug abuse sexual contexts</td>
<td>35.75</td>
<td>9.04</td>
<td>.33***</td>
</tr>
<tr>
<td></td>
<td>Dissociation</td>
<td>0.10</td>
<td>0.34</td>
<td>.02</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>-0.45</td>
<td>0.39</td>
<td>-.09</td>
</tr>
<tr>
<td>5</td>
<td>Constant</td>
<td>25.22</td>
<td>13.07</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CSA</td>
<td>1.66</td>
<td>7.93</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td>Adverse family experiences</td>
<td>-0.36</td>
<td>2.02</td>
<td>-.01</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
<td>-3.30</td>
<td>14.15</td>
<td>-.02</td>
</tr>
<tr>
<td></td>
<td>Drug abuse</td>
<td>9.50</td>
<td>8.13</td>
<td>.09</td>
</tr>
<tr>
<td></td>
<td>Drug abuse sexual contexts</td>
<td>19.96</td>
<td>8.97</td>
<td>.19*</td>
</tr>
<tr>
<td></td>
<td>Dissociation</td>
<td>0.21</td>
<td>0.32</td>
<td>.05</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>-0.62</td>
<td>0.38</td>
<td>-.12</td>
</tr>
<tr>
<td></td>
<td>One-night stands</td>
<td>33.97</td>
<td>7.68</td>
<td>.31***</td>
</tr>
<tr>
<td></td>
<td>Sadomasochism</td>
<td>16.65</td>
<td>8.33</td>
<td>.13*</td>
</tr>
<tr>
<td></td>
<td>Adult revictimisation</td>
<td>-3.98</td>
<td>8.54</td>
<td>-.03</td>
</tr>
<tr>
<td></td>
<td>HPSC</td>
<td>-1.03</td>
<td>0.58</td>
<td>-.12</td>
</tr>
</tbody>
</table>

Note. $R^2 = .02$ for Step 1; $\Delta R^2 = .00$ for Step 2; $\Delta R^2 = .14$ for Step 3 (ps < .001); $\Delta R^2 = .01$ for Step 4; $\Delta R^2 = .13$ for Step 5 (ps < .001).

* $p < .05$. ** $p < .01$. *** $p < .001$. 
The results presented in the previous paragraphs will be discussed in the following section.

The finding that MSM who reported sex-related drug abuse reported significantly more sexual partners than those reporting no drug abuse is consistent with the broader HIV sexual risk behaviour literature (Bacon et al., 2006; Deiss et al., 2008; Gore-Felton et al., 2006; Stall & Purcell, 2000). When used in sexual contexts, substance abuse may impair the individual’s ability to evaluate potential risk and may reduce his capacity to perform behaviours necessary to reduce risk (Paul et al., 2001). For instance, MSM who use drugs while frequenting commercial sex environments such as bath houses, cinemas, or dance clubs with public “dark rooms” may be unlikely to refuse a stranger’s sexual initiation or advances owing to the sensation-seeking, increased arousal, increased self-esteem, and enhancement of sexual pleasure that are related to drug use (Parry et al., 2008). Sensation-seeking is a complex construct that encompasses thrill and adventure seeking, experience seeking, disinhibition, and susceptibility to boredom (Kalichman & Rompa, 1995). The association between drug use and greater sensation-seeking implies that those MSM who use drugs in sexual contexts have a predilection to seek and enjoy sexual experiences with greater variety of partners than low sensation seekers (Kalichman & Rompa, 1995). Drug-related sensation-seeking therefore offers a crucial motivational explanation for maintained high-risk sexual behaviour among MSM despite the threat of HIV infection. It must also be mentioned that unwanted sex with a stranger may occur due to the poor judgement of the substance user, and the associated lack of control or communicative skill to effectively reject the stranger (Purcell, Parsons, Halkitis, Mizuno, & Woods, 2001).

Among the three variables in the model, number of one-night stands contributed the most to the predication of number of sexual partners. This finding makes intuitive sense, in that MSM reporting more one-night stands will also report a greater number of sexual
partners in the past 12 months. Chronic engagement in brief, temporary sexual encounters reflects a compulsive sexual behaviour pattern, which can be defined as an “insistent, repetitive, intrusive, and unwanted urge to perform specific acts often in ritualised or routinised fashions” (Kalichman & Rompa, 1995, p. 587). The individual’s intense and focused necessity to meet sexual needs is crucial to sexual compulsivity, as well as the impulsivity and poor impulse control. However, at the core of this compulsion are also obsessive thought processes, preoccupations, and rigid behaviour patterns (Pincu, 1989) that drive the individual to seek out new partners, over and over again, without consideration of the risk for HIV infection. For sexually compulsive MSM, every sexual encounter brings with it anxiety reduction (anxiety often having to do with abandonment fears, low self-esteem, loneliness and isolation) and a flight from intimacy. The number of sexual partners increases as the sexual exploits become reinforced through the calming “fix” that comes with the anxiety reduction, the high that comes with the excitement of the chase or “cruising”, and the tolerance and withdrawal cycles that mimic chemical addiction (Pincu, 1989). The addictive agent (i.e., the one-night stand) is needed more and more just to maintain equilibrium and function. Sexual activities become the primary focus of life, and the individual experiences a progressive loss of control. The eroded self-esteem produces anxiety, which in turn becomes sexualised, leading to a partial reduction in the anxiety by further compulsive sexual acts. This produces lowering of self-esteem, and so on (Pincu, 1989). Thus, MSM who engage in one-night stands regularly report an overall greater number of male sexual partners because they are caught in a vicious cycle in which repetitive sexual exploits are necessary in order to temporarily alleviate dysphoric affect states such as anxiety and lowered self-esteem (Briere, 1996).

Over and above drug use and sexual compulsivity, engagement in sadomasochistic sexual activity also contributed to the prediction of number of sexual partners. A possible
explanation for this is that sadomasochism represents a sexual practice that emphasises the reliance on learned sexual scripts in which one partner enacts the submissive sexual role. This submissiveness may generate into other contexts in which the individual is unable to refuse sexual partners or negotiate effective boundaries. Furthermore, as mentioned above, it can be hypothesised that sadomasochistic sexual acts may represent an attempt to reduce tension as well as an attempt to sexualise anxiety or other negative feelings. This affect regulation or mood alteration component serves as a strong reinforcer for the potential addiction to and obsessive preoccupation with the sadomasochistic sexual behaviour. Furthermore, if the individual is plagued by a pressing need for continuous sadomasochistic sexual activity at the expense of other sexual activities, then he will be more likely to repetitively seek out an increasing number of sexual partners that will satisfy his need.

5.8 Aim 4b: Creating a Model to Predict Unprotected Anal Intercourse

The second part of aim 4 was to create a model to predict the second measure of sexual risk behaviour, namely, unprotected anal intercourse. A hierarchical logistic regression analysis was therefore conducted using self-reported unprotected anal sex as the dependent variable and five blocks of independent variables: (1) CSA; (2) adverse family experiences; (3) alcohol abuse, drug abuse, and drug abuse in sexual contexts; (4) dissociation and depression; and (5) history of one-night stands, adult revictimisation, sadomasochism, and health protective sexual communication. Table 6 shows odds ratios ($\exp b$) and their associated 95% confidence intervals ($CI$) for this analysis.
### Table 6

**Results of Hierarchical Logistic Regression on Unprotected Anal Intercourse**

<table>
<thead>
<tr>
<th>Step</th>
<th>Variable</th>
<th>$B$ ($SE$)</th>
<th>Lower</th>
<th>Odds ratio (exp $b$)</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CSA</td>
<td>.95 (.34)**</td>
<td>1.33</td>
<td>2.58</td>
<td>5.02</td>
</tr>
<tr>
<td>2</td>
<td>CSA</td>
<td>.92 (.34)**</td>
<td>1.29</td>
<td>2.51</td>
<td>4.89</td>
</tr>
<tr>
<td></td>
<td>Adverse family experiences</td>
<td>.09 (.09)</td>
<td>0.92</td>
<td>1.09</td>
<td>1.30</td>
</tr>
<tr>
<td>3</td>
<td>CSA</td>
<td>.82 (.35)*</td>
<td>1.13</td>
<td>2.26</td>
<td>4.52</td>
</tr>
<tr>
<td></td>
<td>Adverse family experiences</td>
<td>.06 (.09)</td>
<td>0.89</td>
<td>1.06</td>
<td>1.28</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
<td>.08 (.66)</td>
<td>0.25</td>
<td>0.93</td>
<td>3.37</td>
</tr>
<tr>
<td></td>
<td>Drug abuse</td>
<td>.68 (.36)</td>
<td>0.97</td>
<td>1.98</td>
<td>4.06</td>
</tr>
<tr>
<td></td>
<td>Drug abuse sexual contexts</td>
<td>.2 (.38)</td>
<td>0.57</td>
<td>1.21</td>
<td>2.58</td>
</tr>
<tr>
<td>4</td>
<td>CSA</td>
<td>.86 (.36)*</td>
<td>1.17</td>
<td>2.37</td>
<td>4.81</td>
</tr>
<tr>
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<td>Adverse family experiences</td>
<td>.08 (.09)</td>
<td>0.90</td>
<td>1.08</td>
<td>1.30</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
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<td>0.27</td>
<td>0.99</td>
<td>3.69</td>
</tr>
<tr>
<td></td>
<td>Drug abuse</td>
<td>.67 (.37)</td>
<td>0.94</td>
<td>1.95</td>
<td>4.03</td>
</tr>
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<td></td>
<td>Drug abuse sexual contexts</td>
<td>.19 (.39)</td>
<td>0.56</td>
<td>1.20</td>
<td>2.58</td>
</tr>
<tr>
<td></td>
<td>Dissociation</td>
<td>.01 (.01)</td>
<td>0.96</td>
<td>0.99</td>
<td>1.02</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>.01 (.02)</td>
<td>0.96</td>
<td>0.99</td>
<td>1.03</td>
</tr>
<tr>
<td>5</td>
<td>CSA</td>
<td>.81 (.37)*</td>
<td>1.09</td>
<td>2.25</td>
<td>4.63</td>
</tr>
<tr>
<td></td>
<td>Adverse family experiences</td>
<td>.08 (.10)</td>
<td>0.90</td>
<td>1.09</td>
<td>1.31</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
<td>.14 (.69)</td>
<td>0.22</td>
<td>0.87</td>
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<tr>
<td></td>
<td>Drug abuse</td>
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<td>0.89</td>
<td>1.86</td>
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<td>Drug abuse sexual contexts</td>
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<td>0.46</td>
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</tr>
<tr>
<td></td>
<td>Dissociation</td>
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<td>0.97</td>
<td>0.10</td>
<td>1.03</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>.01 (.02)</td>
<td>0.95</td>
<td>0.99</td>
<td>1.02</td>
</tr>
<tr>
<td></td>
<td>One-night stands</td>
<td>.24 (.37)</td>
<td>0.61</td>
<td>1.27</td>
<td>2.65</td>
</tr>
<tr>
<td></td>
<td>Sadomasochism</td>
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<td>0.41</td>
<td>0.90</td>
<td>1.95</td>
</tr>
<tr>
<td></td>
<td>Adult revictimisation</td>
<td>.30 (.40)</td>
<td>0.62</td>
<td>1.35</td>
<td>2.95</td>
</tr>
<tr>
<td></td>
<td>HPSC</td>
<td>.05 (.03)</td>
<td>0.90</td>
<td>0.95</td>
<td>1.01</td>
</tr>
</tbody>
</table>

*Note. $R^2 = .10$ (Cox & Snell); .13 (Nagelkerke). Model $\chi^2(11) = 19.81, p = .05$.  
* $p < .05$. ** $p = .01$. 

Results indicate that CSA significantly predicts unprotected anal intercourse when entered into the model alone. The classification table indicated that 63.7% of cases were correctly classified when CSA was entered into the model. This association remained significant when the variable measuring adverse family experiences was added into the model. Including adverse family experiences in the model did not significantly improve the
ability to predict unprotected anal intercourse. Furthermore, adding the substance use variables (third block) to the model did not make a significant contribution to the prediction of unprotected anal intercourse. Moreover, the effect of adding variables measuring dissociation and depression in Step 4, as well as the addition of the variables in Step 5, did not lead to a significant improvement in the prediction of unprotected anal intercourse. The association between CSA and unprotected anal intercourse remained significant in the final model. In other words, CSA remained the sole predictor of unprotected anal intercourse even after controlling for the other variables in the model. The value of \( \exp b \) indicates that the odds of engaging in unprotected anal intercourse are 2.25 times greater for men who were abused as children than for men with no CSA history. In other words, CSA increases the odds of adult men engaging in risky sexual behaviour. Furthermore, because both values of the confidence interval are greater than 1, the relationship between CSA and unprotected anal intercourse found in this sample is likely to be true of the whole population of CSA survivors. An examination of \( R^2 \) suggests that the final model can account for 13% of the variance in unprotected anal intercourse, and roughly 87% of what explains participation in unprotected anal sex is still unknown.

Possible hypotheses and interpretations explaining the link between CSA and unprotected anal intercourse were given in a previous section (see Aim 2b). In this section, history of CSA was found to predict engagement in unprotected anal sex in adulthood. In summary, it can be hypothesised that people with a history of CSA are likely to replay sexual situations that mimic the original victim-perpetrator relationship (Davies & Frawley, 1994). Thus, CSA survivors may attract aggressive or dominating partners that show little concern for the safety or the well-being of others (Paul et al., 2001). This may result in adult sexual revictimisation (Kalichman et al., 2001), which has a high likelihood of involving unsafe sex. Furthermore, CSA survivors may learn to adopt patterns of sexual aggression or sexual
passivity that were modelled by the perpetrator. Such patterns may become fixed into rigid sexual scripts that increase the risk of unprotected anal intercourse through the individual’s learned helplessness or powerless, their failure to be assertive about safer sex issues such as condom use, or their inability to reject sexually aggressive partners. Alternatively, through identification with the aggressor (Davies & Frawley, 1994; Gartner, 1999), the CSA survivor is less likely to care about the safety or protection of their sexual partner, resulting in sexual coercion or an inability of the partner to insist on condom use.

It must be noted, however, that the significant association between CSA and unprotected anal intercourse can only be explained indirectly. While CSA is an important predictor of unprotected anal intercourse, the influence of CSA on sexual risk behaviour is often mediated by diverse psychological variables, or mental health outcomes. For instance, compulsive sexual acts, recent experiences with an abusive partner, dissociation, and substance use during sex, may mediate the link between CSA and engagement in sexual risk behaviour. For this reason, explanations regarding the direct relationship between CSA and unprotected anal intercourse can only be made indirectly and under consideration of the various mediators or psychological pathways that account for this link (Fergusson, Horwood, & Lynskey, 1997; O’Leary et al., 2003; Paul et al., 2001). In other words, the increased risk of engaging in sexual risk behaviour of those reporting CSA arises from a range of psychological factors, or CSA-related mental health outcomes, which may be associated with sexual risk-taking in adulthood. Results of this study’s mediation analysis will be presented in the following section.
5.9 Aim 5: Testing for Mediation

Corresponding to aim 5, mediation analysis was performed in order to identify possible mediators in the link between CSA and the two sexual risk behaviour dependent variables. Two steps are required to address the question of mediation (Baron & Kenny, 1986): (1) determine whether the independent variable (in this case, CSA) is related to each of the proposed mediators (in this case, drug abuse, drug abuse in sexual contexts, dissociation, depression indices, history of one-night stands, history of adult abusive relationships, sadomasochism, and health protective sexual communication); and (2) examine whether the relationship between the independent variable and the dependent variable (in this case, the two sexual risk behaviour dependent variables) is reduced when the proposed mediators are included in the model.

5.9.1 Number of male sexual partners as the dependent variable

To complete the first test of mediation, each of the mediators had to be regressed onto CSA. Simple regressions were performed for continuous mediator variables, and logistic regressions were conducted for dichotomous variables. Statistically significant results were obtained for drug abuse, drug abuse in sexual contexts, one-night stands, history of abusive relationships, dissociation, and depression. Thus, these six potential mediators passed the first stage of mediation analysis and became candidates for the second stage.

The second step of mediation was performed by comparing the model regressing number of sexual partners on CSA, with models including the mediator as well as CSA. In other words, a simple regression analysis was conducted with CSA predicting number of sexual partners. In a subsequent step, multiple regression analyses were conducted with CSA and each of the proposed mediators predicting number of sexual partners. Results indicate that only drug abuse, drug abuse in sexual contexts, and history of one-night stands remained
significant after controlling for CSA (i.e., these mediators affected the dependent variable). The CSA beta values of the two models were compared in order to determine whether controlling for the mediators attenuated the association between CSA and sexual risk behaviour. As indicated in Figure 1, adding drug abuse to the model predicting number of sexual partners, reduced the CSA beta value from .13 to .09. This reduction achieved statistical significance as indicated by the Sobel test (Sobel $t = 1.68; p = .046$).

**Figure 1.** Mediation Model for Drug Abuse

<table>
<thead>
<tr>
<th>X = Independent Variable (Predictor)</th>
<th>a = Path from X to M</th>
</tr>
</thead>
<tbody>
<tr>
<td>M = Mediator Variable</td>
<td>b = Path from M to Y (controlling for X)</td>
</tr>
<tr>
<td>Y = Dependent Variable (Outcome Variable)</td>
<td>c = Direct path from X to Y</td>
</tr>
<tr>
<td></td>
<td>c' = Path from X to Y (controlling for M)</td>
</tr>
</tbody>
</table>

**Figure 1.** Standardised regression coefficients for the relationship between childhood sexual abuse and number of sexual partners as mediated by drug abuse. The standardized regression coefficient between childhood sexual abuse and number of sexual partners controlling for drug abuse is in parenthesis.
As shown in Figure 2, the addition of drug use in sexual contexts also resulted in a reduction of the CSA beta value from .13 to .04, resulting in statistical significance (Sobel $t = 2.93; p = .002$).

**Figure 2. Mediation Model for Drug Abuse in Sexual Contexts**

![Mediation Model](image)

*Figure 2. Standardised regression coefficients for the relationship between childhood sexual abuse and number of sexual partners as mediated by drug abuse in sexual contexts. The standardized regression coefficient between childhood sexual abuse and number of sexual partners controlling for sex-related drug abuse is in parenthesis.*

Finally, when one-night stands was added to the model, the CSA beta value reduced from .13 to .06. This reduction also achieved statistical significance (Sobel $t = 2.04; p = .021$).

**Figure 3. Mediation Model for One-night Stands**

![Mediation Model](image)

*Figure 3. Standardised regression coefficients for the relationship between childhood sexual abuse and number of sexual partners as mediated by drug abuse in sexual contexts. The standardized regression coefficient between childhood sexual abuse and number of sexual partners controlling for sex-related drug abuse is in parenthesis.*
Thus, when these three mediators were entered into models, the effect of CSA on number of sexual partners was rendered insignificant as a result of the inclusion of the mediator, indicating mediation. Thus, these findings support complete mediation, in that the effect of CSA on number of sexual partners was zero when the three proposed mediators were controlled. In other words, the relationship between CSA and number of sexual partners was non-significant when drug abuse, drug abuse in sexual contexts, and history of one-night stands were controlled for.

To summarise, the regression coefficient between CSA and number of sexual partners decreased substantially when controlling for each of the three mediators, namely drug abuse, drug abuse in sexual contexts, and one-night stands. Furthermore, the three mediators were significant predictors of number of sexual partners while controlling for CSA. The presence of these conditions indicates that the indirect effect of CSA on number of sexual partners through substance abuse and sexual compulsivity is significant.

These findings are the most important findings of the current study, and are consistent with other findings that have established that long-term negative sequelae of CSA mediate HIV sexual risk behaviour. This study found that substance abuse in adulthood, as an outcome or consequence of CSA, mediates the relationship between being sexually abused as a child and reporting more male sexual partners in adulthood. In other words, CSA leads to higher numbers of male sexual partners because of drug abuse. More specifically, this result indicates that MSM who are survivors of sexual abuse are particularly susceptible to drug abuse and drug abuse in sexual contexts, and as a result of these drug use problems, they report more male sexual partners. Thus, CSA increases the likelihood of engaging in drug abuse, and drug abuse, in turn, increases HIV sexual risk. One possible explanation for this, which is consistent with the broader literature as reviewed in Chapter 2 and 3, is that high levels of drug use before or during sex may serve as a coping tool to manage or dull negative
affect and thoughts associated with the memory of the CSA experience (Paul et al., 2001). The use of drugs, in turn, may disrupt or preclude logical consideration of the future consequences of one’s actions (Marks, Bingman, & Duval, 1998). MSM with a history of CSA may thus use drugs as a means to self medicate and to soothe painful affect. This reliance on drugs as an escape-avoidance strategy usually occurs in the context of a sexual situation, as the sexual situation itself reminds the CSA survivor of the original abuse experience and the associated split-off painful affect (Briere, 1996). However, besides providing psychological distance from dysphoric internal states, the drugs may also dull awareness and contemplation of one’s sexual actions, which may lead to increased sexual activity and promiscuity. Furthermore, each new sexual partner may represent a triumph over lingering memories and feelings that have not been dampened by the drugs.

Alternatively, drugs such as cocaine may enhance self-esteem or alleviate psychological despair (Miller, 1999), and may lead to disinhibited sexual activity and sensation-seeking. Disinhibition in sexual situations and sexual sensation-seeking in turn are associated with increased numbers of male sexual partners. Furthermore, the blend of drug use and sexual activity usually occurs in commercial sex environments where anonymous sex with multiple partners is standard practice (Parsons & Halkitis, 2002). In the absence of effective interpersonal regulatory skills, which are impaired by the drug use, the individual is less likely to refuse a new sexual partner. These are just some hypotheses that explain the link between CSA and drug use, and drug use and sexual risk as measured by number of sexual partners.

The mediation analysis also demonstrated that engaging in frequent one-night stands mediates the link between CSA and sexual risk. In other words, sexual compulsivity is a significant mediator in the relationship between CSA and reported number of sexual partners. As mentioned in Chapter 3, sexual compulsivity is one of the most commonly noted
psychological sequelae of CSA in MSM and in the general population (Briere & Elliot, 2003; Jinich et al., 198; Zierler et al., 1991). The current study not only confirms that MSM with a history of CSA are more likely to engage in compulsive sexual behaviour patterns than those with no such history, it also demonstrates that the route from CSA to increased numbers of sexual partners in adulthood is not direct. Rather, it occurs through an indirect pathway in which CSA predicts sexually compulsive behaviour in adult MSM, and this sexual compulsivity in turn predicts higher reported numbers of male sexual partners. The following paragraph offers an explanation for this finding.

MSM who were sexually abused as children may seek out sexual contact as a way to gain support, love, validation, and power (Briere, 1996). At the same time, they are coming to terms with fears of exploitation and rage at having been so badly hurt by similar individuals in the past. After the initial excitement of such temporary sexual contact wears off, and the sexual partner involved starts making demands for more intimacy or closeness, the CSA survivor leaves, feeling unsatisfied and in search of new partners that promise temporary relief and excitement (Gartner, 1999). Thus, difficulties in interpersonal trust and impairments in forming secure attachments may prevent CSA survivors from developing stable long-term relationships, leaving them no alternative but to engage in compulsive, tension reducing sexual activity. The paradox is that the male CSA survivor desires interpersonal closeness yet is fearful about it. Thinking that sexual contact is his only option to feel loved but simultaneously experiencing love as abusive and hurtful, he often solves his dilemma by compulsively pursuing sex and gaining very little intimacy (Paul et al., 2001). Instead, his anxiety and loneliness are temporarily soothed by impersonal encounters of sexuality, however, these incidents leave him feeling even emptier and lonelier and ready to restart this vicious cycle. Furthermore, to the extent that compulsive sexual encounters are used to dissociate from psychological pain, the continued use and success of such tension
reduction strips the CSA survivor of the opportunity to develop more sophisticated ways of regulating affect.

To summarise, sexual compulsivity thus relates to HIV risk in that the individual’s need to soothe distress and dissociate from internal conflict reinforces and precipitates repetitive engagement with multiple sexual partners. Furthermore, intimacy becomes eroticised because sex provides the illusion of intimacy and closeness. Once the sexual act is completed, however, and sexuality no longer serves as the basis for his self-esteem, he feels unsatisfied and sexualises the next relationship in the hope of feeling (seemingly) intimate (Paul et al., 2001).

5.9.2 Unprotected anal intercourse as the dependent variable

Using unprotected anal intercourse as the second dependent variable as a measure of sexual risk behaviour, a logistic regression analysis was conducted with CSA predicting unprotected anal intercourse. Next, hierarchical logistic regression analyses were conducted with CSA and each of the proposed mediators predicting unprotected anal intercourse. Results indicate that only two of the proposed mediators, namely drug abuse and drug abuse in sexual contexts, significantly affected the dependent variable after controlling for CSA. Adding drug abuse to the model for unprotected anal sex reduced the CSA coefficient from .19 to .18; and adding drug abuse in sexual contexts reduced it to 0.16. Coefficients from this model with a dichotomous dependent variable had to be standardised in order to make the coefficients comparable across equations (MacKinnon & Dwyer, 1993). These reductions, however, failed to achieve statistical significance (Sobel \( t = 1.55; \ p = .062 \) and Sobel \( t = 1.51; \ p = .064 \)), indicating an absence of mediation. The results thus indicate that neither drug abuse in general nor drug abuse in sexual situations accounted for indirect effects of CSA on unprotected anal intercourse.
These non-significant results are inconsistent with other findings that have established that drug abuse, as an outcome of CSA, does mediate HIV sexual risk behaviour as measured by unprotected anal intercourse (Paul et al., 2001). The fact that these variables failed to account for this association suggests that additional mediators which were not measured in the study are operative (O’Leary et al., 2003). For example, this study did not examine mediators such as anxiety, hostility, and suicidality. Furthermore, it is possible that unmeasured pathways exist that account for the connection of drug abuse with unprotected anal sex.
CHAPTER 6
Conclusion, Limitations, and Implications

6.1 Conclusion

Studies focusing on the link between CSA and HIV sexual risk behaviour among MSM are numerous, however, CSA and HIV research with this specific population has not been conducted in South Africa to date. The current study examined the prevalence of CSA among South African MSM. It also examined the long-term effects of CSA on mental health, as well as the effects of CSA on sexual risk behaviour in adulthood. It also explored the influence of CSA on sexual behaviour through various mediating variables, or correlates of CSA.

The current study’s findings have a general fit with the broader theoretical framework described in Chapters 2 and 3. Thus, in line with expectations, it was found that CSA is a widespread problem among MSM in South Africa. Furthermore, strong support was found for the independent effects of CSA on indices of psychopathology (i.e. mental health outcomes), including sexual compulsivity, substance abuse, and adult revictimisation experiences. CSA was also associated with unprotected anal intercourse, however, this relationship was not mediated by any of the mental health outcome variables. Instead, the effect of CSA on number of sexual partners, which was also operationalised as a measure constituting HIV sexual risk behaviour, was mediated by current recreational drug use, drug use in conjunction with sexual activity, and sexually compulsive behaviour. In the regression model, the only predictor of unprotected anal intercourse was CSA. In creating a model to predict number of male sexual partners in adulthood, drug use in sexual contexts, sexual compulsivity, and engagement in sadomasochism were the strongest predictors.
Thus, consistent with the wider CSA literature, this study authenticates that CSA does indeed have deleterious effects on the adjustment and mental health of adult MSM. Given the fact that most CSA studies conducted in South Africa focus on female and heterosexual male samples, the current study thus extends the understanding of childhood sexual abuse as a predictor of later psychopathology to a population that evidences very high prevalence rates of CSA. This study also empirically corroborates anecdotal evidence that suggests that MSM in South Africa are at an increased risk for HIV infection. Furthermore, consistent with the broader HIV risk behaviour literature, this study confirms that high levels of substance use in sexual situations may serve as a coping tool to manage intrusive negative feelings and thoughts associated with a CSA history. Also, the presence of one-night stands as a mediator may be indicative of sexual preoccupation, poor risk appraisal, and impairments in attachment and trust, thereby increasing the risk for HIV infection.

6.2 Limitations

A major problem with all research in this area is the use of self-report measures that require participants to remember events from their childhood. Retrospective recall of information is highly dependent on memory, which is not always accurate (Schacter, 1999). However, all of the literature in the CSA area suffers from this measurement problem (O’Leary et al., 2003). Furthermore, self-report measures of sensitive childhood experiences and adult behaviours may lead to socially desirable responses (Gore-Felton et al., 2006). In this study, the potential for social desirability influences was minimized by an anonymous survey procedure, and the high rates of substance use, multiple sexual partners, and unprotected anal intercourse reported by this sample suggests that participants were primarily honest in their responses.
Another limitation of this study is that it did not take into account other factors besides CSA-related long-term mental health outcomes that are pertinent to explaining the association between CSA and HIV sexual risk behaviour among MSM. For instance, previous research indicates that crucial variables specific to the abusive event itself have a bearing on later maladjustment (Finkelhor, 1986; Dolezal & Carballo-Dieguez, 2002). Such variables include the victim’s relationship to the abuser, the duration of the abuse, and the parent’s reaction upon disclosure. Variations in the adult survivor’s symptomatology or psychopathology may be accounted for by such characteristics of the abuse experience. However, consideration of such abuse-specific moderator variables would have been beyond the scope of this study.

This study is further limited by its generalisability of findings. This study was conducted using a convenience sample of gay and bisexual men frequenting, amongst others, a sex-related internet dating site. This may have led to an over-reporting of behaviours constituting sexual risk behaviour. This sample is thus unique because it consisted, although not exclusively, of a high-risk population in a study of high-risk behaviours. Furthermore, the online recruitment method may have excluded MSM of lower socio-economic standard to participate in the study. This sample consisted predominantly of White, highly educated homosexual men. Thus, the men who completed this study’s survey may differ from the general population of gay and bisexual men in this country along such dimensions as ethnicity, socio-economic status, sexual orientation, and education. Therefore, this sample cannot necessarily be considered as representative of the broader population of South African MSM. It is thus unclear how relevant this study’s findings are to a less urban and less high-risk sample of South African MSM.
6.3 Directions for Future Research

Future studies should focus on clearly defining CSA, as well as assessing multiple aspects of the experience (Purcell et al., 2002). Consistent operationalisations of CSA can help determine which aspects of the abuse are related to negative mental health outcomes. Another methodological issue that needs to be addressed is that population-based sampling strategies are necessary in order to achieve larger samples that are more reflective of South African MSM populations. Furthermore, future studies should consider socio-cultural aspects of sexual behaviour and drug abuse among MSM. Resiliency factors should also be considered in order to determine the factors that protect MSM with histories of abuse from developing negative mental health outcomes in adulthood. Finally, sexual scripts should be considered as pathways from CSA to adult sexual risk-taking. The fact that fixed sexual scripts may impair interpersonal regulatory abilities and determine unsafe sex cannot be underestimated (Paul et al., 2001).

6.4 Clinical and Policy Implications

Despite some limitations, this study has yielded important findings that may have implications for future research and HIV prevention or risk reduction programs. The current data suggest that unwanted sexual experiences in childhood represent a prevalent and pervasive public health problem for MSM in South Africa. It is thus suggested that an increased recognition of sexual abuse among MSM is vital for the optimal development of prevention programs targeting HIV sexual risk behaviour. This is because the choices that MSM make regarding their sexual behaviours are partly influenced by their own sexual development and experiences (Jinich et al., 1998). CSA, which is a critical factor associated with sexual development, may have a crucial impact on a person’s likelihood of sticking to risk reduction practices. In reducing sexual risk taking among such men, it might be useful to
identify men who have experienced unwanted sexual activity during childhood and to provide opportunities for counseling around these issues. Because the proportion of men in this sample reporting CSA was relatively high (23.48%), screening for unwanted sexual activity during childhood among MSM seeking care or treatment in STD clinics or NGOs could be the first step in identifying men with abuse histories and should be included as part of the sexual history interview (Dilorio et al., 2002).

The current data also indicate that MSM with histories of CSA are vulnerable to experiencing psychological symptoms in adulthood, many of which predict engagement in HIV sexual risk behaviors. Current intervention studies and projects focusing on HIV risk reduction among MSM target sex-related substance use and risky sexual activity as avenues geared towards decreasing sexual risk behaviour (Halkitis, Shrem, & Martin, 2005; Parry & Pithy, 2006; Parry et al., 2008; Wechsberg, Luseno, Lam, Parry, & Morojele, 2006). Indeed, the current study’s findings do suggest the need for prevention programmes to focus on issues of substance abuse as it relates to sexual risk behaviour. Because the proportion of men in this sample reporting drug abuse is quite high (37%), it makes sense for public health programs targeting MSM to provide opportunities for counseling around issues of substance abuse. However, the current data also suggest that factors that determine the high risk for HIV infection among MSM cannot only be accounted for by sex-related substance use and risky sexual practices. Instead, as mentioned above, CSA, and the pathways it represents towards increasing HIV sexual risk, should be recognised and understood. For instance, this study empirically confirms that a CSA history has a direct influence on the use of drugs in conjunction with sexual activity. It also confirms the influence of a CSA history on later psychopathology (i.e., depression and dissociation), and the propensity for survivors to seek out intimate relationships that are abusive and marked by distorted power dynamics. All of this may be exacerbated by multiple casual sexual encounters (Gartner, 1999), which are
directly linked to CSA history. These findings thus provide potentially fruitful grounds for interventions targeting risk behaviour among MSM in South Africa. What emerges from these findings is that most of these CSA-related mental health outcomes, particularly the drug abuse during sexual encounters and the compulsive sexual behaviour, represent escape-avoidance coping strategies (Paul et al., 2001) which the CSA increasingly relies on to manage negative affect. Thus, substance use risk reduction messages that direct individuals to stop all use, and prevention recommendations to avoid sexual activity while intoxicated, are likely to be ineffectual and unsuccessful if individuals with CSA histories are not given alternative ways of coping with potentially troubling and intrusive CSA-related memories and feelings (Paul et al., 2001). In other words, intervention strategies focusing on substance use or sexual health promotion should recognize that sex-related drug use, one night stands, and cognitive escape mechanisms are coping functions which, in many cases, coat and mask the enduring impact of childhood sexual victimisation.

In conclusion, these findings confirm the importance of considering the relevance of CSA frequency and its effect on the delivery of services, prevention interventions, and health care services to gay and bisexual men (Brennan et al., 2007). Given the prevalence of a history of CSA among MSM in South Africa, it appears that there is a dire need for specialized interventions that target the long-term consequences or sequelae of such unwanted childhood sexual experiences. Early identification and treatment for sexual abuse of males could make an important contribution to preventing HIV and other STDs, and should be incorporated into prevention programs for male substance abusers. Furthermore, increased recognition and understanding of male CSA is vital for adequate clinical assessment (Bartholow et al., 1994). It is recommended that health care providers screen MSM for unwanted childhood sexual experiences and be prepared to counsel and refer them if a CSA history is reported (Brennan et al., 2007). A final implication of this study suggests
the importance of making families as well as clinicians aware that sexual abuse may lead to serious negative effects in the later cognitive and emotional development of MSM.
References


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Sexual Offences and Related Matters Amendment Act, 32 (2007).


Appendix A

DSM-IV Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following have been present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated).

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma.

(3) inability to recall an important aspect of the trauma.

(4) markedly diminished interest or participation in significant activities.

(5) feeling of detachment or estrangement from others.

(6) restricted range of affect (e.g., unable to have loving feelings).

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Appendix B

Information Letter

Dear Potential Participant

I am currently completing my treatise in fulfillment of my master's degree in clinical psychology at Nelson Mandela Metropolitan University. This research aims to explore the psychological, emotional and behavioural factors that may predict risky sexual behaviour in South African men who have sex with men (MSM). Identifying the factors (including early sexual experiences) that might predict risk behaviour can have a positive impact on both prevention and intervention strategies and, as a result, is of importance for researchers and clinicians.

You are being asked to participate in a research study. You will be provided with the necessary information to assist you to understand the study and explain what would be expected of you (participant).

In this study, you will be administered a series of questions and measures. Three psychometric measures will assess mental health related factors and sexual communication strategies. You will also be asked to complete a short biographical questionnaire, as well as questions relating to sexual practices before the age of 13 and questions relating to current sexual practices. In no way are you required to give your name, ID number, or address.

Some of the questions might be unpleasant to answer. If you wish to discuss any of the information contained in the questionnaire or any discomforts you may have experienced, you may call or email the Principal Investigator listed on this form. You have the right to refuse any question you deem inappropriate or too personal.
All volunteering participants in the study will thus remain anonymous, and information collected will remain confidential and will be used for research purposes only. Completion of the questionnaire package should not last longer than 20 minutes. Participants may refuse to answer any question and may withdraw at any point that they wish. Non-participation or withdrawal in the study will not have any negative consequences for you in any way.

Feedback regarding the study's outcomes will be made available to all those interested. The findings of this research will be published in a thesis.

You are in no way required to participate in this study. You may withdraw from the study at any stage in the process. If you have any queries do not hesitate to contact me.

Thank you for taking the time to read this information. Your support is greatly appreciated.

Yours sincerely,

Shelley Heusser
Principal Investigator

Dr. Diane Elkonin
Supervisor

Contact no: 041 504 2330

Email: s209091743@nmmu.ac.za

Prof. Mark Watson
Head of Department
Appendix C
Questionnaire Package

Part 1: Biographical Information

1. Age: __________
2. What is your ethnicity? (circle one)
   Black/African   Coloured   Indian   White   Other
3. Do you identify yourself as (circle one):
   Gay   Bisexual   Heterosexual   Other   Don’t use labels
4. Marital Status? (circle one)
   (a) Single
   (b) Partner, closed relationship
   (c) Partner, open relationship
   (d) Married, opposite sex
   (e) Married, same sex
   (f) Divorced / Separated
5. Occupation (circle appropriate letter):
   (a) Unemployed
   (b) Self-employed
   (c) Business employed
   (d) Student/pupil
   (e) Other (Specify) _______________
6. Highest degree or grade completed: _____________________
7. Have you been diagnosed with HIV? (circle one)
   Yes   No   Status unknown
Part 2: Substance Abuse, CSA, and Adverse Family Experiences

Please circle the appropriate answer. Note that N/A = “not applicable.”

1. Have you ever felt that you should cut down on your drinking?
   YES             NO             N/A

2. Have people annoyed you by criticizing your drinking?
   YES             NO             N/A

3. Have you ever felt bad or guilty about your drinking?
   YES            NO             N/A

4. Have you ever had a drink first thing in the morning (an eye-opener) to steady your nerves or get rid of a hangover?
   YES             NO            N/A

5. During the past 3 months, have you used any other addictive substances besides alcohol and tobacco (e.g. dagga, “poppers”, Ecstasy, mandrax, “tik”, heroine, crack or cocaine)?
   YES             NO             N/A

6. In the past 6 months, have you used alcohol or any other addictive substances (e.g. dagga, cocaine, “tik” or Ecstasy) in situations or contexts where you did or intended to have sex with another man?
   YES             NO             N/A

7. Before you were 13, did you ever have unwanted or forced sexual activity with anyone who was 5 or more years older than you? These situations may have involved sexual fondling, oral sex, or penetration.
   YES                                               NO
8. Sometimes people’s views about their experiences change over time. Did you ever have an experience before the age of 13 when you felt at the time that you were forced or frightened into doing something sexually that you did not want to do?

YES

NO

9. Did a parent, step-parent, or foster-parent have problems with drugs or alcohol?

YES

NO

10. Did you see one of your parents hit or beat up your other parent?

Never

Once

Two or three times

Four or more times

11. Did a parent, or some other adult in charge of you ever physically hurt or beat you up?

Never

Once

Two or three times

Four or more times
Part 3: Dissociative Experiences Scale; The Beck Depression Inventory II

The following scale consists of 28 questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and indicate the percentage of the time you have the experience:

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip.

   (Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said.

   (Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

3. Some people have the experience of finding themselves in a place and having no idea how they got there.

   (Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on.

   (Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

5. Some people have the experience of finding new things among their belongings that they do not remember buying.

   (Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)
6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

8. Some people are told that they sometimes do not recognize friends or family members.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation).

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

10. Some people have the experience of being accused of lying when they do not think that they have lied.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

11. Some people have the experience of looking in a mirror and not recognizing themselves.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

12. Some people have the experience of feeling that other people, objects, and the world around them are not real.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

13. Some people have the experience of feeling that their body does not seem to belong to them.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)
14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

19. Some people find that they sometimes are able to ignore pain.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

20. Some people find that that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

21. Some people sometimes find that when they are alone they talk out loud to themselves.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)
22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.).

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that this (for example, not knowing whether they have just mailed a letter or have just thought about mailing it).

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

25. Some people find evidence that they have done things that they do not remember doing.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear.

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)
Please read each group of statements very carefully. Just tick the answer that you think is the most descriptive for your case. Choose only one for each title. If none of them is really adequate, choose the nearest one.

1. Sadness
   (feeling or showing sorrow; unhappy; causing or characterized by sorrow or regret; unfortunate and regrettable)
   - I do not feel sad.
   - I feel sad much of the time.
   - I'm sad all the time.
   - I'm so sad and unhappy that I can't stand it.

2. Pessimism
   - I'm not discouraged about my future.
   - I feel more discouraged about my future than I used to be.
   - I do not expect things to work out for me.
   - I feel my future is hopeless and will only get worse.

3. Past failure
   - I do not feel like a failure
   - I have failed more than I should have.
   - As I look back, I see a lot of failures.
   - I feel I am a total failure as a person.

4. Loss of pleasure
   - I get as much pleasure as I ever did from the things I enjoy.
   - I don’t enjoy things as much as I used to.
   - I get very little pleasure from the things I used to enjoy it.
   - I can't get any pleasure from the things I used to enjoy.
5. Guilty feelings
   - I don't feel particularly guilty
   - I feel guilty over many things I have done or should have done.
   - I feel quite guilty most of the time.
   - I feel quite guilty most of the time.

6. Punishment feelings
   - I don't feel I am being punished.
   - I feel I may be punished.
   - I expect to be punished.
   - I feel I am being punished.

7. Self-dislike
   - I feel the same about myself as ever.
   - I have lost confidence in myself.
   - I am disappointed in myself.
   - I dislike myself.

8. Self-criticalness
   - I don't criticize or blame myself more than usual.
   - I am more critical of myself than I used to be.
   - I criticize myself for all of my faults.
   - I blame myself for everything bad that happens.

9. Suicidal thoughts or wishes
   - I don't have any thoughts of killing myself.
   - I have thoughts of killing myself, but I would not carry them out.
   - I would like to kill myself.
   - I would kill myself if I had the chance.

10. Crying
    - I don't cry anymore than I used to.
I cry more than I used to.
I cry over every little things.
I feel like crying, but I can't.

11. Agitation
(a stirring up or arousing; disturbance of tranquility; disturbance of mind which shows itself by physical excitement)
I am no more restless or wound up than usual.
I feel more restless or wound up than usual.
I am so restless or agitated that it's hard to stay still.
I am so restless or agitated that I have to keep moving or doing something.

12. Loss of interest
I have not lost interest in other people or activities.
I am less interested in other people or things than before.
I have lost most of my interest in other people or things.
It's hard to get interested in anything.

13. Indecisiveness
(not having or showing the ability to make decisions quickly and effectively)
I make decisions about as well as ever.
I find it more difficult to make decisions than usual.
I have much greater difficulty making decisions than I used to.
I have trouble making any decisions.

14. Worthlessness
(having no real value or use; having no good qualities; deserving contempt)
I do not feel I am worthless.
I don't consider myself as worthwhile and useful as I used to.
I feel more worthless as compared to other people.
I feel utterly worthless.

15. Loss of energy
I have as much energy as ever.
☐ I have less energy than I used to have.
☐ I don't have enough energy to do very much.
☐ I don't have enough energy to do anything.

16. Changes in sleeping pattern

(Changes in either direction are important. Thus tick the appropriate answer either less or more do you sleep.)

☐ I have not experienced any change in my sleeping pattern.
☐ I sleep somewhat more OR less than usual.
☐ I sleep a lot more OR less than usual.
☐ I sleep most the day OR I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

(having or showing a tendency to be easily annoyed or made angry)

☐ I am no more irritable than usual.
☐ I am more irritable than usual.
☐ I am much more irritable than usual.
☐ I am irritable all the time.

18. Changes in appetite

(Changes in either direction are important. Thus tick the appropriate answer either less or more do you eat.)

☐ I have not experienced any change in my appetite.
☐ My appetite is somewhat less than usual OR My appetite is somewhat greater than usual.
☐ My appetite is much less than usual OR My appetite is much greater than usual.
☐ I have no appetite at all OR I crave food all the time.

19. Concentration difficulty

(the action or power of focusing one's attention or mental effort)

☐ I can concentrate as well as ever.
☐ I can't concentrate as well as usual.
☐ It's hard to keep my mind on anything for long.
☐ I find I can't concentrate on anything.

20. Tiredness or fatigue
☐ I am no more tired or fatigued than usual.
☐ I am more tired or fatigued more easily than usual.
☐ I am too tired or fatigued to do a lot of things I used to do.
☐ I am too tired or fatigued to do most of the things I used to do.

21. Loss of interest in sex
☐ I have not noticed any recent change in my interest in sex.
☐ I am less interested in sex than I used to be.
☐ I am much less interested in sex now.
☐ I have lost interest in sex completely.
Part 4: Current Sexual Behaviour and Health Protective Sexual Communication

The following questions refer to your sexual behavior.

1. During the past 3 months, how many times have you engaged in insertive anal sex (“top”)?
   ______________

2. During the past 3 months, how many times have you engaged in receptive anal sex (“bottom”)?
   ______________

3. How many times did you use a condom during insertive anal intercourse in the past 3 months?
   ______________

4. How many times did you use a condom during receptive anal intercourse in the past 3 months?
   ______________

5. How many male sexual partners have you had in the:
   - past 3 months ______
   - past 6 months ______
   - past 9 months ______
   - past 12 months ______

6. How many men with whom you had sex in the past 12 months were “one-night stands” (someone you had sex with only once)? This may have included oral or anal sex.
   ______________
7. In the past 12 months, have you engaged in any sexual practices that included elements of either dominance and submission, bondage and discipline, physical or psychological pain, or master-slave role-playing?

   YES                                                   NO

8. Have you been in one or more intimate relationships in the previous 5 years that have involved **TWO or MORE** experiences of physical or emotional abuse? Situations may have involved being hit, shoved, beaten, verbally threatened, or degraded by your partner.

   YES                                                   NO

*What follows is a list of things that people talk about before they have sex with each other for the **FIRST** time. How often in the past 12 months have you …*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Sometimes</th>
<th>Almost Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Asked a new sex partner how he felt about using condoms before you had intercourse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Asked a new sex partner about the number of past sex partners he had.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Told a new sex partner about the number of sex partners you have had.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Told a new sex partner that you won’t have sex unless a condom is used.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Discussed with a new sex partner the need for both of you to get tested for AIDS before having sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Talked with a new sex partner about not having sex until you have known each other longer.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Asked a new sex partner if he has ever had some type of STD (Sexually Transmitted</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Disease), like herpes, syphilis, gonorrhea.

8. Asked a new sex partner if he ever shot drugs like heroin, cocaine, or speed.
Appendix D

Debriefing Form

Sexual risk behaviour is a problem amongst adults in men who have sex with men. You were selected as a participant in this study because you are a member of a small population of men who have sex with men. The proportion of men who engage in sexual risk taking in this population is on the rise, as well as the rate of HIV infections. Identifying the factors that might predict risk behaviour can have a positive impact on both prevention and intervention strategies and, as a result, is of importance for researchers and clinicians. The questionnaires you answered included three psychometric measures: The Dissociative Experiences Scale, The Beck Depression Inventory, and The Health Protective Sexual Communication Scale. You were also asked to complete a short demographic questionnaire, as well as questions relating to sexual experiences before the age of 13 and questions relating to current sexual practices.

The purpose of this study was to determine whether factors such as early abuse and resulting long-term mental health consequences are associated with later sexual risk-taking.

Your generosity and willingness to participate in this study are greatly appreciated. Sometimes people find the subject matter of these questionnaires disturbing or uncomfortable. If answering any of these questions led you to feel distressed and you would like to speak to someone about thoughts or feelings that might have emerged, please contact one of the following for counseling or psychological services:

<table>
<thead>
<tr>
<th>The Triangle Project</th>
<th>021 448 3812</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triangle Helpline</td>
<td>021 422 2500</td>
</tr>
</tbody>
</table>
As stated in the information, your responses to all of the questionnaires are anonymous, and only people who are associated with this research will see responses to the questionnaires.

If you have any complaints, concerns, or questions about this research, please feel free to contact me: Shelley Heusser, 041 504 2330, s209091743@nmmu.ac.za, or the NMMU Psychology Clinic.

If you would be interested in obtaining a copy of the results once the study is complete, please do not hesitate to contact me.

Thank you very much for your participation!