Self-Reported Sexual Behavioral Similarities and Differences Among Young Men Who Have Sex With Men With Childhood Sexual Abuse Histories: A Qualitative Exploratory Study

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Abstract

Young men who have sex with men (YMSM) have the highest burden of sexually transmitted infections (STIs), including HIV. Childhood sexual abuse (CSA) is a risk factor for high-risk sexual behavior and STI acquisition. Studies that have explored sexual behavior based on the type of reported sexual abuse are limited. This study aimed to further understand current sexual behaviors and perceptions among YMSM that have experienced different types of CSA. Sixteen YMSM who were survivors of CSA were interviewed utilizing a phenomenological conceptual framework and methodology. Thematic findings were divided into two parts. Part I gave an overview of the entire sample, and themes were as follows: unprotected oral sex used to evaluate penile abnormalities, trust promoting unprotected sex, and alcohol and other drugs not cited as the reason for casual sex. Part II demonstrated the differences among those with a history of CSA involving non-penile–anal intercourse and those with a history of CSA involving penile–anal intercourse. The major themes in Part II were that victims of CSA involving penile–anal intercourse reported the following: a hypersexual self-definition, an STI diagnosis and noncondom use history, and a third sexual partner during sexual activity. Based on the findings, early life experiences such as CSA should be considered when developing preventative sexual health strategies and individuals who experienced penetrative sexual abuse may have different needs which should be further explored.

Keywords

men who have sex with men, sexual behavior, sexually transmitted infections, HIV/AIDS, childhood sexual abuse

Men who have sex with men (MSM) are a subpopulation that is among those most impacted by HIV and other sexually transmitted infections (STIs), and rates continue to be prevalent among this group (Centers for Disease Control and Prevention, 2019a). Their younger counterparts, young men who have sex with men (YMSM), in the ages of 13–24, accounted for 64% of all new HIV infections among all MSM, accounting for 67% of HIV diagnoses in the United States (Centers for Disease Control and Prevention, 2019b). Men with a previous history of childhood sexual abuse (CSA) are at increased risk for HIV and other STI acquisition (Batchelder et al.,

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2017; Boroughs et al., 2015; Mimiaga et al., 2009; Paul et al., 2001). Studies that sampled gay and bisexual men have reported CSA prevalence that is five times higher than men within the general population (Mimiaga et al., 2009, 2015; O'Cleirigh et al., 2019; Paul et al., 2001).

Abundant research has suggested an association between CSA and high-risk sexual behavior (Abajobir et al., 2017; Arriola et al., 2005; Kalichman et al., 2004; Levine et al., 2018; Merrill et al., 2003; Mimiaga et al., 2009; Paul et al., 2001). Several studies have reported a greater likelihood of HIV infection among YMSM CSA survivors (Boroughs et al., 2015; Kalichman et al., 2004; Mimiaga et al., 2009; Paul et al., 2001), which suggests that the experiences of CSA among YMSM correlate with high-risk sexual behavior (Mimiaga et al., 2009; Paul et al., 2001). Within the HIV and STI prevention discussion, childhood trauma is oftentimes left out, even though male CSA survivors report a higher frequency of high-risk sexual behavior such as transactional sexual activity (Brennan et al., 2007), less frequency of condom use (Phillips et al., 2014), unprotected anal intercourse (Mimiaga et al., 2009; Wu, 2018), sexual activity under the influence of alcohol and other drugs (Hailes et al., 2019; Levine et al., 2018), and more lifetime sexual partners (Wu, 2018).

High-risk sexual behaviors are associated with STI acquisition, which are highest and oftentimes lead to adverse outcomes among the MSM population (Centers for Disease Control and Prevention, 2019a). For instance, the human papillomavirus (HPV), the most common sexually transmitted virus, has been the dominant cause of the majority of penile and anal cancers (Wang et al., 2020). Compared with heterosexual men, MSM have the highest burden of sexually acquired hepatitis C and skin lesions, such as genital herpes (Lockart et al., 2019; Stewart & Wallace, 2019). Bacterial STIs such as syphilis, chlamydia, and gonorrhea continue to disproportionately affect YMSM (Unemo et al., 2017). MSM accounted for 58% of primary and secondary syphilis, as well as a significant amount of chlamydia and gonorrhea cases (Centers for Disease Control and Prevention, 2019c). Often, chlamydia and gonorrhea are diagnosed concurrently. Co-infection remains a risk factor for transmitting and contracting HIV among YMSM (Jones et al., 2019). CSA survivors are significantly more likely to contract STIs than those without CSA histories (Brennan et al., 2007; Phillips et al., 2014).

The evolution of HIV prevention has progressed to include biomedical approaches such as treatment as prevention, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP) (Wood, 2020; Wu et al., 2017). With the utilization of PrEP or PEP, the recommendation is to use condoms during sexual activity, since biomedical approaches do not protect against other STIs (Devarajan et al., 2019; Wu et al., 2017). Yet, YMSM with CSA histories are more likely to engage in condomless sex and use condoms inconsistently (Boroughs et al., 2015; Kalichman et al., 2004; Mimiaga et al., 2009; Paul et al., 2001). Given the pronounced disparity of STI and HIV rates among YMSM with CSA histories in comparison to those without, little is known about the sexual behavioral differences among those who have experienced different forms of CSA such as penetrable versus nonpenetrable CSA (Latzman et al., 2017).

Previous studies have concluded that generally CSA survivors engage in risker sexual behaviors (Abajobir et al., 2017) and experience further episodes of sexual victimization (Krahé & Berger, 2017; Ports et al., 2016)—another risk factor for HIV and STIs (Latimer et al., 2017). Research on female CSA survivors has reported that the experience of being abused can lead to long patterns of oversexualization and undersexualization (Slavin et al., 2020), information which is limited among men, MSM, and YMSM. Predominantly, research on CSA and sexual behavior is correlational, over-represents female populations, and provides limited information on the outcomes of varying types of CSA (Alaggia et al., 2019).

Additional research is needed to advance the understanding between types of CSA and sexual health behaviors, which is exacerbated by underreporting and varied definitions of CSA (Emetu, 2019; Mathews & Collin-Vézina, 2019). Studies have conveyed variability among different types of experienced sexual abuse and health outcomes; however, results are not consistent (Maniglio, 2013; Mellins et al., 2017; Turner et al., 2017). Differences in CSA parameters, such as nonpenetrable versus penetrable episodes could elicit varied outcomes (Mathews & Collin-Vézina, 2019; Lemieux & Byers, 2008). Exploratory research is needed to elucidate variability in experienced CSA and health outcomes among YMSM. Therefore, the purpose of this study is to further understand the sexual behaviors of YMSM who have experienced penetrable CSA versus nonpenetrable CSA.

Methods

Participants and Study Settings

This study is part of a larger project that comprehensively explored sexual health among YMSM CSA survivors. Phenomenology is a narrative study approach where individuals with the same lived experience or phenomena share their perspective or insight (Creswell & Creswell, 2017). The present study used a phenomenological conceptual framework, which was appropriate to document a shared viewpoint of sexual health among men who have experienced CSA. Sixteen ($N = 16$) men between the ages of 18 to 27 participated in this study, with a mean

age of 22.5 (*SD* = 2.7). Twelve (75%) men self-identified as gay, and four (25%) identified as bisexual. Twelve (75%) participants were White, three (19%) were Black, and one (6%) was Asian. Ten (62%) individuals were both students and employed. Nine (*N* = 9) participants reported a previous history of CSA involving non-penile–anal intercourse (CSA-NPAI), and seven (*N* = 7) participants reported CSA involving penile–anal intercourse (CSA-PAI).

CSA is defined as sexual contact, sexual activity, sexual interaction, or sexual coercion that involves touching, kissing, oral sex, and penetration. CSA can include nonsexual contact, such as exhibitionism, showing sexually explicit material, or sexual requests during childhood, preadolescence, or adolescence by an adult or individual who is at least five years older than an underage victim (Kalichman et al., 2004; Lind et al., 2016). For this study, CSA-PAI was defined as coercive or noncoercive anal penetration during childhood, preadolescence, or adolescence by an adult or individual who is at least five years older than an underage victim. CSA-NPAI was defined as any other sexual contact, sexual activity, sexual interaction, sexual coercion (including touching, kissing, and oral sex), or nonsexual contact that excludes anal penetration during childhood, preadolescence, or adolescence by an adult or individual who is at least five years older than an underage victim.

Inclusion Survey and Interview Guide

Institutional review board approval (IRB# 1311789791) was received before the study was conducted. The inclusion criteria were as follows: participants needed to be men who (a) have engaged in same-sex sexual behavior, (b) reported a previous history of CSA, and (c) are between the ages of 18 and 29. According to Centers for Disease Control and Prevention (2018), men between the ages of 13 and 29 who engage in same-sex behaviors are considered YMSM. In order for participants to consent for themselves those over the age of 18 were recruited. Participants were recruited in the Midwest through announcements on mobile applications (e.g., Grindr), list serves (e.g., university LGBT services), and fliers distributed at targeted LGBT-friendly venues (e.g., local bars). Interested men who viewed the announcement either clicked or typed out a valid URL that routed them to an online inclusion survey. The first portion of this inclusion survey asked questions about age, gender, and sexual behavior. The second set of questions inquired about CSA history. If both requirements were met, participants were asked to provide an email address, which could be an alias for confidentiality, to schedule an interview.

Interviews were conducted at a private location in either the researcher's office or in a private room at a library. Semistructured interviews, a method that is commonly used in phenomenological studies, were selected to leave room for elaboration, ensure consistency, and encourage flexibility (Creswell & Creswell, 2017). Most phenomenological studies have a sample size of 5–25 participants (Alaggia & Millington, 2008; Collins et al., 2017). As such, this study aimed to recruit 15–20 men. Data saturation was achieved by the 12th interview, and the remaining scheduled interviews were conducted afterward. In total, 16 interviews were conducted by the end of data collection. Interviews lasted 25–70 min, and participants were compensated with a $25 gift card code via email. The interview questions were comprised of a combination of questions devised in collaboration with other sex researchers, the Safe Sex Behavior Questionnaire (SSBQ), and the Multidimensional Sexual Self-Concept Questionnaire (MSSCQ; DiIorio, 2011; Snell, 2011). SSBQ and MSSCQ were validated quantitative instruments that were expanded into qualitative open-ended questions. The interview questions could not inquire about the experienced sexual abuse, duration, or frequency of the abuse due to IRB restrictions. Participants were informed that if they discussed the abuse or their perpetrator, then the researcher was liable by law to report the incident. Consequently, the interview questions only inquired about sexual behavior.

Thematic Analysis

Interviews were tape-recorded to ensure accuracy for later transcription. Using a semiotic phenomenological procedure, data analysis included the three levels of description, reduction, and interpretation (Merriam, 2002). After completion of the interviews, data were transcribed accurately and verbatim to fully describe the participants' responses. Narrative data were then reduced to adequate categories and themes. Finally, the reduced elements were translated and interpreted into substantive points (Merriam, 2002). In addition, NVivo 12, a qualitative software, was used to assist with content and discourse analysis. To ensure agreement in thematic analysis, an additional coder was utilized. Following the development of the reduced themes and categories, two qualitative researchers with expertise in sexual health and thematic analyses assisted as peer debriefers by reviewing codes, themes, and finalized results. These debriefers contributed significantly to the reliability and validity of the study's findings, which increased the transferability, confirmability, and credibility of the results (Creswell & Creswell, 2017).

Results

YMSM with CSA histories were interviewed to further understand their current sexual behaviors. There were similarities (Part I) and differences (Part II) reported by those who experienced penetrative CSA versus those who reported nonpenetrative CSA. Among the entire sample, participants engaged in unprotected penile–anal sex. Among those partnered, being in a committed relationship made condom use even more difficult. For Part I, three themes emerged: unprotected oral sex used to evaluate penile abnormalities, trust promoting unprotected sex, and alcohol and other drugs not rationalized as the reason for unprotected sexual activity. These results are based on descriptions about the participants' sexual behavior and do not imply any causation or association to the experienced sexual abuse. Additional corresponding quotes for each theme can be found in Table 1 (reported similarities) and Table 2 (reported differences). The expansive list of quotes provide further evidence of the themes found in this study.

Part I: Self-Reported Similarities

Theme I: Unprotected Oral Sex Used to Evaluate Partner's Penile Abnormities. All participants stated that flavored condoms either were rarely used or never used during oral sex. Thirteen (81%) participants discussed not finding any value in using condoms for oral sex. One participant stated that he contracted HIV through oral sex, and two others stated that they contracted other STIs through oral sex. Interestingly, participants stated that they participated in unprotected oral sex as a method for checking partners for cuts, abrasions, and lesions in the penile and genital areas. One participant stated, "You gotta look at it. . .doing stuff. But it's not like 'let me make sure you aint got no bruises before we do it.' You can't have oral sex without looking" (R.V., age 22).

> It was actually that I got out of that relationship where I was very sexually frustrated, and immediately hooked up with two different people, and then didn't have sex [penile-anal intercourse] again for several weeks, and then I got into the relationship that I'm in now. One of those two people gave me HIV, and I was able to figure out which one because he wasn't diagnosed, so he's diagnosed now. But I was in that relationship for several weeks before I got diagnosed. And I'd always practiced a level of safe sex. Any sort of penetrative sex, I would use condoms. I actually contracted HIV from oral sex without a condom. I just got a lucky draw of having someone with an insanely high count. (W.S., age 21)

Theme II: Trust as a Supporting Reason for Unprotected Sex. Trust was discussed with regard to honesty about one's HIV status, which was established through the process of being tested or receiving an HIV test with one's partner. During new sexual encounters, 12 (75%) participants voiced distrust in other men if they physically did not see their HIV test results to support their HIV negative status. Thirteen (81%) men expressed a preference in getting tested together with their sexual partner prior to engaging in unprotected sex.

> I'm going to say, like, the whole dominance thing with the guys. I've done some research on how AIDS and other STDs are contracted. Basically, I was seeing him for a bit, and he was like "you can trust me" and I told him, "I don't trust you." I'm not going to lie; I was kind of was high, that day. I made a bad decision. . .Now since I'm trying to take more responsibility, or just trying to find someone I can be monogamous with, and not having to worry about having to get tested every month. (T.I., age 18)

An indirect element of trust was demonstrating a level of sexual responsibility. Over half (68%) of participants mentioned how having discussions of sexual and testing history made them feel more sexually responsible and helped them trust their partners more.

> I moved to [current town], so about four years ago, two of my really good friends became HIV positive. So, at the time I wasn't in a relationship with anybody, so I had a lot of anxiety about meeting new people. . .and being sexually active with them I was like really nervous. . .Actually, these were questions that I never asked. And then whenever my first friend became HIV positive, I got in the habit of always asking, 'What's your status?' (N.B., age 23)

Theme III: Alcohol and Drugs Not Cited as the Reason for Casual Sex. The majority (87%) of the sample reported using alcohol and other illicit drugs such as marijuana, cocaine, MDMA (ecstasy), and methamphetamine. They reported using these substances prior to sex, but made it clear that these substances were not needed in order to engage in sexual activity. All participants who reported drug and alcohol use prior to sexual activity disclosed that these substances were not the reason why they engaged in unprotected sex.

> I met the guy who owns [company name] ironically in [a city name]. And we got along great; we started drinking at the bars. And he kept buying my drinks. . .I had like six beers, three then maybe seven. All kinds of things I probably shouldn't have drank like gummy bear shots. . . It's just like marinated in vodka for days. And then he took me into the bathroom and then we snorted cocaine off of a car key. . . And then to add to it and then we went back to his hotel room and had unprotected sex, four times. It wasn't necessary the drugs, it was about the person. (C.L., age 25)

Table 1. Self-Reported Similarities Extended Quotes.

Theme I: Unprotected Oral Sex Used to Evaluate Penile Abnormalities

C.L., Age 25: "There's several ways to do that if you wanted to, like giving head you can check it out pretty quickly, like oh what is that. If there's something weird on it's much easier to do, you want to be sly about it or just feeling around. . . Anytime I've ever received It [oral sex]. That's honestly never crossed my mind to do it. But for somebody else. . .somebody had made a suggestion one time about using a condom during oral sex. And I'm like stupid [inaudible] why would you want to do that. . ..No, we did. Just without a condom."

M.V., Age 20: "When I'm going to town, I'm definitely taking like inventory of the house, I guess I would say? Like, I would notice, and I know that I would notice, if something were either out of place or out of the norm. So I'd say yes, but I'm definitely not, let me see your junk up front. It's more of a discrete kind of thing."

R.V., Age 22: "Ah, no. I had a scare. . . I had an HIV scare once. I did the swab test and it came back positive, and then they did a Western Blot and that came back negative. At that time I was dating someone who was positive so that made it overly scary. I mean we did use condoms but we didn't in the mouth and with oral sex and things like that."

Theme II: Trust Promoting Unprotected Sex

C.L., Age 25: "I know several people in the gay community that don't disclose their HIV status and go around and have unprotected sex and it's scary. And there's new things that pop up all the time like that killer strains of gonorrhea, that. . .while it's not here it's still scary, and people lie about the last time they were checked for things. . .it's just a constant. . .There is just too much stigma involved, STDs in general. The there's that scare, some rumors going around about people poking holes in condoms. Then you have the bug chasers. . . People who purposely try to contract STDs. There's quite a few of them actually. I don't know, attention. At that time I was dating someone who was positive so that made it overly scary. . .he didn't disclose it at first. Well, someone else told me about his status. And he told me that he wasn't going to tell me until he was ready. And I'm like I don't think that's the way that works, but okay. I'm like if I'm gonna trust somebody I need to think about it. I don't have the problem asking the questions; it's whether or not the other person answers the question because being truthful is you know part of it."

S.F., Age 27: "If we've been tested together, that I've sort of underlying together in that sense that like. . .then you have confirmation from somebody. You don't have somebody just saying, "Oh, I've been tested." At that point you can like. . . If you go on in together and you hear the confirmation together, then you know for a fact. [Laughing]"

K.L., Age 21: [STI talk] "I don't know. . .I guess it's like I don't want to offend them. But it's for my health and I guess their health. It's something that I want to ask. While it may be awkward it's the responsible thing to do. I guess. . .like STDs, stuff like that, HIV. That's the only thing that really makes me go out of my way. I make sure to try to be responsible."

Theme III: Alcohol and Drugs Not Cited as a Reason for Casual Sex

N.B., Age 23: "Well, we're not 100% sure what happened. But, I just don't remember a huge chunk of my night at the bar. So, I woke up at a hotel and I didn't have any clothes on. So, not really sure if something sexual happened but I just went to the doctor to make sure. I didn't contract any diseases or anything. In the past, I used to use meth, and I would use meth before sex and things of that nature. But that's about it, I never did anything else drug wise. But I don't have to like get high before sex or drink before sex."

S.F., Age 27: "I enjoy going out and having drinks and dinner. If we're staying in, we hang out and have a couple of drinks and make things and enjoy, you know, taste and flavors and discussions of that. So I would say it's far more culinary in a way for myself rather than just that feeling of, "Oh, I need to go drink." Now, I guess the offset of that. . .that might cloud that is oftentimes when I am drinking I don't get off as easily, so that sort of mitigates that. So there is, in a sense, a benefit to doing it. But I don't necessarily feel like I have to go drink to go have sex. And I don't think if I were to try and like. . .it's far more occasional that I would be drinking and having sex than like drinking and then going in and having sex."

Part II: Self-Reported Differences

There were notable differences among participants with a previous history of CSA involving non-penile–anal intercourse (CSA-NPAI; *N* = 9) and CSA involving penile–anal intercourse (CSA-PAI; *N* = 7). For Part II, the themes are as follows for those with a CSA-PAI history: hypersexual self-description; STI diagnosis and noncondom use; and references to "the third."

Theme IV: Hypersexual Self-Description. With the exception of one participant, all participants who reported a

history of CSA-PAI described themselves as hypersexual or experiencing feelings of sexual frustration either previously or currently. The sexual frustration was related to (a) not feeling satisfied after orgasm or ejaculation or (b) not having the opportunity to share their desire to engage in kinks such as bondage and domination with their previous or current partners.

> Oh man, I was actually having that conversation today and I was saying that I'm almost addicted to sex. I feel like I'm not ever satisfied with the sexual component. .like I could have sex multiple times a day and not feel like my libido is

Table 2. Self-Reported Differences Extended Quotes.

Theme IV: Hypersexual Self-Description

N.B., Age 23: "I'm really sexually active. I'm really more sexually active than my partner is. . . I just become more aroused more frequently. It's more of a thing more than it is his. I'm more of the aggressor, even though that's not the word that I'm looking for. . .maybe pursuer. When we were like a new couple it caused some friction."

J.P., Age 20: "I feel like . . . the term I would use is I am sexually liberated. I see sex as a fun game so I tend to have it a lot. A lot of people see sex as something very serious and it leads to some problems due to conflicting views. But I like it, so I do it a lot."

C.C., Age 22: "I'm a . . . like in a way, I want to say repressed, but in a way repressed because there are lots of fantasies, so I just had not shared with past boyfriends. And I don't know why, because they've asked me about them and I'll tell them some of them but I won't tell them all of them. And like there are things I want to try that I've just never been able to voice to somebody before. In a way, I guess like I have always wanted to try bondage."

Theme V: STI Diagnosis and Noncondom Use

A.S., Age 27: "Oh, yes, negative feelings [about sex]. Like you don't care about it or why have it, you know? Just certain situations in life will get you thinking that way. I mean, to go more in detail, I'll be honest, because I know it's confidential. So, I'm HIV positive, so ever since I found out I was HIV positive."

J.P., Age 20: "It didn't really become a huge fear until about almost two years ago, when someone very close to me, contracted HIV. I felt very scared, because I was the last person they slept with. I thought that either I gave it to him or he could have given it to me. It turned out neither was the case; he got it from someone two days prior to meeting me. . .condom use not really normative, more like if I can't reach a condom at the moment . . . come to think of it, most of the time I don't use a condom during anal sex. It's out of pure laziness. I don't want to disengage, even for that two seconds."

L.C., Age 25: I don't particularly care for condoms. I guess that's it too. It's restrictive and it kind of hurts a little bit more. Especially, with anal intercourse you gotta be incredibly lubed up. No. Very rare [using condoms], the only expectation was that HIV positive guy. We did the kind of fool around things. I know it's harder to contract. . .having an uncle who's contracted it, my family was incredibly educated on it. . .like how is it contracted and things like that. So, you know that chances of me contracting it orally is very slim, especially since he was on medication and. . .you're undetectable right now, and so I'm like okay there are things to wait and so. . .Yeah, it depends on what kind of condoms. I'm not. . .unsure if I have a latex allergy or something because my hands break out when I wear a latex glove so I'm not sure if that is part of the problem. . .Yes, prime example is one time I did, we used a non-latex condoms and they broke three times. And then that was excessive and then by the end of it I was like just take it off anyway, just get it done because it's not even worth it.

Theme VI: The Third Sexual Partner

N.B., Age 23: "But now if were gonna have or sometimes occasionally a third, we always use protection with that. Just cause we don't really know, just can't trust the third. You know we trust each other, we know that we're not lying. But we don't know if they're fibbing or don't even know or. . . And now if I'm. . .if me and [partner's name] if we're gonna have a third or something. . .mostly one guy that we do it with now, but when we first met him we asked him if he. . .what his status was and eventually got to know him a little bit and hung out with him as a friend. And once we got to know we asked him if he would go to the health unit with us and get tested. So we went to [clinic name] together, all three of us. We did that. I feel like me and [partner's name] are going to be together probably for the rest of our lives. So, I wouldn't want to do something that would make one of us sick or both of us sick."

J.P., Age 20: "I tend to look at it for a little bit I guess [look at penis for cuts or abrasions], so I guess I would notice. I've never really noticed a cut. I think I've noticed one person; one male had a cut on his penis. This was maybe three or four years ago, I was pretty wary then. I kind of just didn't touch him for the rest of the interaction. There was another person there, so I focused my attention on the third person. He was actually very afraid, so this poor guy just kind of sat there."

satisfied. It's crazy, like I could have sex right after I have sex, and having an orgasm, I go again. Like I have to jack off again. (L.C., age 25)

On the contrary, seven out of nine participants with a previous history of CSA-NPAI described themselves to be sexually conservative. They expressed the importance of knowing their partner, dating their partners before sexual intercourse, and pursuing HIV testing together before engaging in sexual activity.

I would think that I'm less well active in general, well comfortable in doing those things then most probably 25-year olds who have had that college experience. Well, I'm not too promiscuous, so anytime I've had a partner in which any sort of intercourse was encountered it was someone that I've known for a while so those things have already been discussed. So even if it were hypothetically, it were a stranger or someone I didn't know again, I think if protection wasn't used it would be the first thing on my mind. (M.L., age 25)

Theme V: STI Diagnosis and Noncondom Use. With the exception of two participants in the CSA-NPAI group and one participant in the CSA-PAI group who refused to get tested and had never been tested for STIs, all participants with a history of CSA-PAI had been diagnosed with an STI, including two that were HIV positive. Several participants that were HIV negative provided recounts of HIV scares.

> Chlamydia. I am pretty sure that I got from having sex with a stranger. Because, like, I got tested after my relationship ended. . .I really just wanted to go out and have some fun. He gave me his number at a bar, we ended up texting, and which led to that one time. And the way I found out is I had to pee like every five seconds. And after three weeks of that, I was like, "Okay, I think I have something." (C.C., age 22)

Of the entire sample, 13 (81%) discussed that they knew about the benefits of using condoms. Some participants shared their retrospective experiences about friends or family members who either were living with HIV or had died from AIDS. However, participants with a previous history of CSA-PAI disclosed difficulty using condoms more than the CSA-NPAI group. CSA-PAI participants reported not using condoms due to either not enjoying the feeling that were associated with condoms, possible latex allergy, or condoms hindering the moment by actually having to stop foreplay, find a condom, and go through application.

> It's just in the moment right then. We were horny, we were ready right then. So, insteada trying to wait, find one, 'do you have one.' You just get caught up in the moment. 'You clean,' 'yep.' Let's do it. It's more unprotected than protected, about like 70/30. I would say there would be some people I would meet and you meet them on a Monday. And we would plan for Friday, so you had time to plan. And I left it pretty much up to them. And sometimes I felt like I didn't want to be the stick in the mud if they wanted to be unprotected. (R.V., age 22)

Theme VI: The Third Sexual Partner. With the exception of one participant in a polyfidelitous relationship in the CSA-NPAI group, participants with a history of CSA-PAI made references to "the third" or having a third sexual partner present during sexual activity. Some discussed negative feelings related to incorporating a third in the sexual act. Some discussed integration of the third safely in their relationship by seeking HIV testing together. On the other hand, some participants voiced cautious feelings such as "never trust the third," so if a third sexual partner was brought into the relationship, it would be important to use a condom in order to prevent any potential sexual infections. Participants in the CSA-PAI group that were single also made references of "the third" or

having a third sexual partner. One participant mentioned that this was a typical sexual encounter for him.

> I think the only time I've ever had a negative feeing or anxiety towards sex was in a three way, and I was with boyfriend. . .and it was a combination of jealously, and I felt really anxious and there was all kind of different components to it. (C.L., age 25)

Discussion

The findings of this phenomenological study have potential implications for health-care providers, health educators, and researchers. Thematic findings were divided into two parts. The major themes of Part I gave an overview of the entire sample, which were: unprotected oral sex used to evaluate penile abnormalities, trust promoting unprotected sex, and alcohol and other drugs not cited as the reason for casual sex. The themes in Part II demonstrated the differences among those with a history of CSA involving non-penile–anal intercourse (CSA-NPAI) and those with a history of CSA involving penile–anal intercourse (CSA-PAI). The major themes in Part II were that the CSA-PAI victims were more likely to report: a hypersexual self-definition, an STI diagnosis and noncondom use history, and a third sexual partner during sexual activity.

Part I: Self-Reported Similarities

Consistent with previous research on YMSM with CSA histories (Abajobir et al., 2017; Mimiaga et al., 2009; Paul et al., 2001), participants in this study engaged in various risky behaviors, such as multiple sexual partners, engaging in unprotected oral and penile–anal sex, and reported alcohol and drug use—even though substance use was not rationalized to contribute to unprotected sexual activity. Participants used unprotected oral sex as a strategic mechanism for checking their partner's penis for cuts, lesions, and abrasions, to reduce the risk for acquiring HIV and/or STIs. These behaviors could signify discrepancy in understanding how STIs are transmitted, and perhaps misinformation due to limitations in sexuality education at home, in school, or through other community-based organizations. Since participants were recruited from a conservative region in the United States, it is possible that they received minimal sexuality education (Hall et al., 2016).

Trust promoted both protected and unprotected penile–anal intercourse. Participants voiced their concerns about other men who might lie about their testing and sexual history, which promoted condom use. To corroborate, one study reported that MSM concealed their positive status at times out of fear of being vilified (Haas et al., 2019;

Mitchell et al., 2018). Richter et al. (2014) observed that men with a history of CSA were less likely to disclose their HIV status to partners. Even though limitations on trust promoted protected sex, getting tested with a current or potential partner produced comfortability engaging in unprotected penile–anal intercourse.

Thiede et al. (2003) identified that 66% of YMSM CSA survivors reported using illicit drugs. In the present study, 69% participants reported using illicit drugs, and alcohol use was even higher. Participants discussed instances where alcohol and other drug use led to unprotected penile–anal intercourse or sexual activity. However, participants did not perceive alcohol or drug usage to promote unprotected sex. Eighty-seven percent of participants said that they did not need to use alcohol and other drugs to have sex. Previous research has corroborated that alcohol and drug use is prominent among male CSA victims (Arreola et al., 2008; Brennan et al., 2007; Hudson et al., 2017; Kalichman et al., 2004; Paul et al., 2001; Walsh et al., 2014). Further attention is needed concerning substance use and sexual risk decision-making for YMSM CSA victims.

Part II: Self-Reported Differences

There were definitive differences among participants who experienced CSA-NPAI versus CSA-PAI. Consistent with previous research conducted on women (Lemieux & Byers, 2008; Najman et al., 2005) and on both women and men (Martin & Silverstone, 2013), CSA-PAI survivors in this study reported higher rates of onset consensual sexual activity, multiple sexual partners, unprotected intercourse, and STIs. Other studies on MSM CSA survivors identified that CSA was correlated with unprotected penile–anal intercourse and higher HIV rates, even though results were not stratified by CSA-NPAI and CSA-PAI experience seroprevalence (Arreola et al., 2008; Brennan et al., 2007; Kalichman et al., 2004; Mimiaga et al., 2009; Paul et al., 2001; Williams et al., 2015).

Participants who experienced CSA-PAI defined themselves as hypersexual, which was attributed to an inability to feel satisfied after ejaculation or orgasm. Conversely, participants who experienced CSA-NPAI considered themselves to be sexually conservative. Most CSA-PAI survivors discussed engaging in sexual acts with the presence of a third person. This group was more likely to report noncondom use for penile–anal intercourse. The findings that CSA-PAI participants defined themselves as hypersexual and engaged in riskier sexual behavior is supported by prior research that suggests that CSA victims tend to "oversexualize" themselves and their intimate relationships (Lacelle et al., 2012; Lemieux & Byers, 2008). CSA may influence sexual decision-making and

contribute to tendencies of YMSM survivors to externalize control over sexual behaviors.

All CSA-PAI participants had been diagnosed with an STI except for one CSA-PAI victim who had never been tested for an STI. Previous research has made the connection between CSA history and HIV/STI acquisition among YMSM (Arreola et al., 2008; Boroughs et al., 2015; Brennan et al., 2007; Kalichman et al., 2004; Mimiaga et al., 2009; Paul et al., 2001). However, none of these studies have specifically examined the differences between CSA-PAI and CSA-NPAI victims. Dissimilarities among the two groups are concerning, especially regarding intervention development that aggregate CSA victims due to the broad definition of CSA. Victims of CSA should be differentiated based on severity of sexual abuse, such as penetrable and nonpenetrable episodes and the experience of force. Therefore, counseling and interventions for CSA-NPAI and CSA-PAI may require different approaches.

Limitations

The adequate sample size for phenomenological studies are between 5 and 25 individuals (Collins et al., 2017; Creswell, 2015). Sixteen men participated in this study; once further divided by the type of CSA experienced, there were nine in the CSA-NPAI group and seven in the CSA-PAI group. Results for Part II were only presented when all participants (in some cases with the exception of one) corroborated the reported information. Direct association based on the reported similarities and differences, as well as CSA history and the themes highlighted in this study cannot be made through qualitative findings. Instead, this study provides direction for future research and intervention development. Given the narrow inclusion criteria, participants were recruited using a purposeful sampling approach, so generalizability to a larger sample of YMSM is limited. Despite these limitations, these findings provide insight into the experiences of YMSM who were sexually abused as children and adolescents.

Conclusion

Early life experiences such as CSA should be considered when designing preventative HIV/STI strategies. Participants in this study had incorrect information and misconceptions about sexual health. Considering the sensitivity of CSA, health outlets should provide adequate and appropriate sexuality information about the benefits of condoms, correct condom application, PrEP and PEP resources, and the risks involved in unprotected oral sex. Future research should focus on CSA-PAI survivors when developing sexual risk reduction interventions that

could assist with better decision-making, substance-use, impulsive sexual encounters, and other risky behaviors.

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