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Sexual victimization and health-related indicators among sexual minority men

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Abstract

This study reports rates of childhood and adult sexual victimization among a community sample of 634 gay and bisexual-identified men, and examines how men with differing sexual victimization histories compare on a number of health-related outcomes. Results indicate that men with histories of childhood and adult sexual victimization are more likely to report substance use, more lifetime STIs, higher sexual compulsivity scores, and greater gay-related stigma scores than men with no histories of sexual victimization. Few differences are found in comparisons of health outcomes based on age at first sexual victimization (childhood vs. adulthood). Furthermore, men with histories of sexual victimization report healthier coping skills than men with no histories of sexual victimization, but no significant group differences are found in social support or stress-related growth. Findings underscore the importance of assessing lifetime sexual victimization among sexual minority men during counseling, with special attention given to the enhancement of protective factors among those at risk for harmful behaviors and subsequent poor health outcomes.

Keywords

gay/bisexual men; sexual victimization; substance use; adult sexual assault; childhood sexual abuse

Sexual victimization can occur in childhood or adulthood and may include a range of non-consensual sexual experiences, such as unwanted sexual contact, coercion, attempted rape, or rape. The exact age criterion used to differentiate “childhood” from “adulthood” varies across studies, with researchers differentiating childhood sexual victimization from adult victimization by the age when adolescence generally occurs, between 14 to 18 years of age. Consequently, the selected age criterion has impacted the reported prevalence and incidence rates of sexual victimization in previous studies (Goldman & Padayachi, 2000; Wyatt & Peters, 1986). Using under age 18 to indicate “childhood,” Finkelhor, Hotaling, Lewis, and Smith (1990) found that 16% of men in the general population were sexually victimized as children. Prevalence rates for adult sexual victimization have been purportedly lower than rates of childhood sexual abuse (CSA), with 4% of men reporting adult sexual assault (ASA; Elliot, Mock, & Briere, 2004). Regardless of the age criterion used across studies to differentiate CSA from ASA, evidence has strongly indicated a variety of short-term and long-term negative consequences related to experiences of sexual victimization (for reviews, see Beitchman et al., 1992; Classen, Palesh, & Aggerwal, 2005; Leonard & Follette, 2002).

Knowledge about the negative consequences of sexual victimization in the general population has compelled a growing number of researchers to seek a better understanding of sexual victimization prevalence among sexual minority men.

Prevalence rates of CSA among gay/bisexual men has ranged from 14 to 39%, depending upon the definition used and the population studied (Arreola, Neilands, Pollack, Paul, & Catania, 2008; Doll et al., 1992; Paul, Catania, Pollack, & Stall, 2001; Ratner et al., 2003; Relf, 2001). In general, CSA rates have appeared to be higher among gay and bisexual men than among heterosexual men (Davies, 2002), but similar to rates found among heterosexual women (Doll et al., 1992; Finkelhor et al., 1990; Hughes, 2005). Furthermore, Balsam, Rothblum and Beauchaine's (2005) findings suggested that CSA rates may differ by sexual identity, with bisexual men more likely than gay-identified men to report histories of sexual victimization experienced in childhood. Prevalence rates for adult sexual victimization among sexual minority men are difficult to find and current statistics likely reflect under-reporting due to cultural (mis)perceptions of sexual assaults as only male-to-female events and stigma associated with male non-consensual sexual experiences. Findings have indicated, in general, that rates of sexual assault in adulthood vary from 14 to 20% among sexual minority men (Kalichman et al., 2001; Krahe, Schutze, Fritzsche, & Waizenhofer, 2000; Ratner et al., 2003), which is higher than reported rates of 4% among men in the general population (Elliot, Mock, & Briere, 2004).

Although researchers have lacked consensus on the exact prevalence of lifetime sexual victimization by sexual minority men, a growing body of research has reported a variety of long-term negative health behaviors associated with sexual victimization among gay and bisexual men. Researchers have found a link between CSA and adulthood psychological distress (e.g., depression, suicidal thoughts or behaviors, mental health counseling and hospitalization; Arreola et al., 2008; Bartholow et al., 1994; Ratner et al., 2003), risky sexual behaviors (e.g., greater numbers of sexual partners, inconsistent condom use, history of exchanging sex for money or drugs, behaviors that place individual at risk for contracting HIV and other STIs; Arreola et al., 2008; Bartholow et al., 1994; Brennan, Hellerstedt, Ross, & Welles, 2007; Dilorio, Hartwell & Hansen, 2002; Gore-Felton et al., 2006; Kalichman, Gore-Felton, Benotsch, Cage, & Rompa, 2004; Lenderking et al., 1997; Paul et al., 2001; Rosario, Schrimshaw, & Hunter, 2006), and substance-related problems (Bartholow et al., 1994; Brennan et al., 2007; Dilorio et al., 2002; Holmes, 1997; Neisen & Sandall, 1990; Paul et al., 2001; Ratner et al., 2003; Rosario et al., 2006). Some research also has suggested that CSA may be a risk factor for sexual revictimization in adulthood among sexual minority men (Krahe, Scheinberger-Olwig, & Schütze, 2001; Coxell, 1999), although this area of investigation remains underdeveloped. Less is known about the health consequences of ASA among sexual minority men, but findings have shown that ASA is associated with substance misuse (Kalichman et al., 2001) and poor self-esteem (Ratner et al., 2003). Despite growing awareness among researchers about the risks associated with sexual victimization histories among sexual minority men, less is known about how gay and bisexual men with histories of CSA compare to men who first experience sexual victimization in adulthood. One known exception is Kalichman et al.'s (2001) findings, which identified similar risky behaviors among men with CSA and ASA histories. Kalichman et al. found that ASA survivors were most likely to have multiple unprotected partners, but CSA histories did not predict this risky behavior "demonstrating the independent effects of unwanted sexual contact in adulthood on sexual risk behavior" (p. 6). Overall, Kalichman et al. concluded that CSA alone was not associated with substance abuse or sexual risk behaviors, but their research clearly indicated the importance of examining the multi-dimensional nature of sexual victimization across the lifespan to better understand how sexual victimization experiences may play differential roles in health-related outcomes in adulthood. Overall, knowledge about the relationship between sexual victimization history and adult health outcomes has

improved, but there are still many gaps in our knowledge, particularly as it relates to differential outcomes based on type of victimization experience.

The goal of this study was to report the prevalence of childhood and adult sexual victimization and examine health-related outcomes among a community sample of 634 gay and bisexual-identified men. Specifically, we hypothesized that men with histories of sexual victimization would be more likely to report substance use, more lifetime sexually transmitted infections (STIs), higher sexual compulsivity scores, and greater stigma than men with no histories of sexual victimization. Additionally, we wanted to explore the possibility that differences may occur in reported risk and protective factors among men based on the timing of their first sexual victimization experience (childhood vs. adulthood).

Method

Participants

Male participants (N = 634) ranged in age from 18 to 77 years old, with a mean age of 37.7 years (Table 1). The majority of the sample was White, employed full-time, had post-secondary education, and reported an annual income level over \$40,000. Participants reported their sexual identity as gay or bisexual and their gender as male.

Procedures

Data came from the 2003 Sex & Love Study, which was a cross-sectional, street-intercept study conducted with 634 men attending two large LGBT community events in New York City. Street-intercept survey methods (Miller, Wilder, Stillman, & Becker, 1997) have been used in other studies (e.g., Carey, Braaten, Jaworski, Durant, & Forsyth, 1999; Kalichman & Simbaya, 2004) and have been shown to produce rigorous results (Halkitis & Parsons, 2002). Participants were approached by the research team and offered the opportunity to participate as part of a booth display erected for the purposes of conducting the study at the 2-day long community events. Eligible individuals were required to be at least age 18 and self-identify as gay, lesbian, or bisexual in order to participate (only data from male participants are presented in the current study). Each participant was provided with a clipboard, upon which the survey was affixed, and given the opportunity to step away from others to anonymously complete the self-administered survey. After completing the 15 to 20 minute long survey, participants were asked to deposit their completed surveys into a dropbox that was secured by the research staff. Participants were offered a movie pass as an incentive for completing the assessment. Data were entered into SPSS and verified by project staff for accuracy. All procedures were approved by Hunter College's Institutional Review Board.

Measures

The Sex & Love Study is conducted annually, although survey questions are modified each year to accommodate emergent issues related to sexual health among men who have sex with men (MSMs). Given the brief, intercept method utilized in the study-- which required rapid assessments to expediently reach the sizeable target population attending the LGBT events—some pre-existing measures were modified and shortened for ease of administration (as indicated where applicable below). As part of the 2003 version of the survey data utilized in the current study, participants were asked a wide range of questions about sexual behaviors, coming out milestones, and psychological status. Findings presented in this paper represent a secondary analysis of those data. Several other studies have emerged from the larger Sex & Love Studies database (e.g., Bimbi, Palmadessa, & Parsons, 2008; Frost, Parsons, & Nanin, 2007; Grov, Parsons, & Bimbi, 2010; Grov, Parsons, & Bimbi, 2008; Grov et al., 2007; Grov, Bimbi, Nanin, & Parsons, 2006), but the current study is novel in

that none of these previous publications have examined sexual victimization histories among the study participants.

Sexual victimization histories—History of sexual victimization was assessed by asking each participant if he “had ever been forced or frightened by someone into doing something sexually that you did not want to do?” (Paul et al., 2001). If a participant responded affirmatively, he was asked at what age the incident first occurred. Responses were coded as “never,” “age 14 or before” to indicate CSA, and “age 15 to present” to indicate ASA. Selection of this age criterion was based on a definition employed in the *Sexual Experiences Survey*, a widely utilized and well-validated sexual aggression measurement instrument (Koss & Oros, 1982; Koss et al., 2007), and other studies concerning sexual victimization risk (e.g., Arata, 2000; Livingston, Hequembourg, Testa, & VanZile-Tamsen, 2007; Miller, Downs & Testa, 1993; Parks, Hequembourg, & Dearing, 2008; Testa & Livingston, 1999). Literature reviews pertaining to sexual victimization risk (Livingston, Hequembourg, & Testa, in press; Rich, Combs-Lane, Resnick, & Kilpatrick, 2004; Roodman & Clum, 2001) also have reported the use of this age criterion across a wide range of studies.

Substance use—Substance use was assessed by asking participants if they had ever used (yes/no) alcohol or nine other non-prescription, recreational drugs (i.e., crystal methamphetamine, powdered cocaine, crack cocaine, ecstasy, GHB, Special K, marijuana, poppers, and intravenous drugs). Participants also were asked (yes/no) if they had combined alcohol or any of the recreational drugs with sex in the past 3 months.

Current relationship satisfaction and sexual health—Participants were asked their relationship status (“single-not dating,” “single-casually dating,” “partnered but not monogamous,” “partnered and monogamous”). If a participant indicated he was in a partnered relationship, he was asked to report his satisfaction (1) with the quality of his current relationship, (2) with his partner as a person, and (3) with the sex he has with his partner. Possible answers were on a 4-point response range from “extremely dissatisfied” to “extremely satisfied.”

Participants were asked (yes/no) if they had ever been diagnosed with nine distinct sexually transmitted infections (STIs), including human papillomavirus (“HPV”), herpes, warts, pubic lice (“crabs”), urinary tract infections, Hepatitis B, Hepatitis C, syphilis, and HIV. A summary score was calculated to indicate (yes/no) if the respondent had been diagnosed with any of the assessed STIs in his lifetime. HIV was not included in the summary scores for the comparative analyses unless otherwise specified, with separate results for HIV reported where indicated.

A 10-item sexual compulsivity assessment (Kalichman et al., 1994; Kalichman & Rompa, 2001) was conducted, in which participants were asked how well certain statements (e.g., “My desires to have sex have disrupted my daily life.”) described their feelings on a 4-point response range from “not at all like me” to “very much like me.” Possible summary scores ranged from 10 to 40. Formal diagnostic criteria for sexual compulsivity have yet to be outlined (Groß, Parsons, & Bimbi, 2010); therefore, ranges to indicate severity were generated for this study based on previous studies indicating that values ≥ 24 may indicate problematic sexual compulsivity behaviors (Parsons, Bimbi, & Halkitis, 2001). Scores less than 24 were classified as a low range of sexual compulsivity, scores ranging from 21 to 30 were classified as moderate sexual compulsivity, and scores ranging from 31 to 40 were classified as falling within the highest range of sexual compulsivity. Internal reliability for this measure was excellent ($\alpha = .90$).

Stigma—Stigma related to having a gay or bisexual identity was assessed using a 10-item version of the HIV stigma scale (Berger, Ferrans, & Lashley, 2001) with language modified to assess gay-related stigma (Frost, Parsons, & Nanin, 2007). Participants were asked to indicate on a 4-point response range from “strongly disagree” to “strongly agree” whether they had experienced certain reactions from others, such as “I regret having told some people that I’m gay or bisexual.” Total scores for the stigma measure were computed. Low scores represented strong disagreement with the questions, indicated lower levels of experienced stigma. Internal reliability was excellent for this measure ($\alpha = .90$).

Protective factors—Stress-related growth was assessed by asking participants “how much your life has changed by coming to terms with your sexual identity” in 15 domains of life (e.g., “I learned to be nicer to others,” “I feel freer to make my own decisions;” modified from Park, Cohen, & Murch, 1996). Stress-related growth refers to the idea that positive outcomes can result from stressful experiences; in other words, a stressful experience, which may oftentimes result in personal crises, can also lead to personal growth and development that may not have been possible without the instigating stressful experience. A total score was computed, with higher scores indicating a stronger stress-related growth response (i.e., participant made positive changes as a result of coming to terms with their sexual identity). The measure had excellent internal reliability for the current study ($\alpha = .92$).

An 18-item shortened version of the *Brief COPE* was used to assess a broad range of functional and dysfunctional coping responses to various stressors in the participants' lives (Carver, 1997). Participants were asked how often they had been doing things like “getting comfort and understanding from someone” to cope with stress. Possible responses were chosen from a 4-scale ranging from “not at all” to “a lot.” Six items in the measure were reversed coded before a summary measure was computed, whereby higher scores indicated more functional coping styles. The internal reliability for this measure also was excellent ($\alpha = .90$).

Participants were asked to consider their current relationships with friends and family. A 12-item shortened version of the *Social Provisions Scale* (Cutrona & Russell, 1987) asked them to indicate the extent to which a series of statements described their current relationships with other people. Statements included: “There are other people who enjoy the same social activities I do.” and “There is someone I could talk to about important decisions in my life.” Participants were asked to answer on a 4-point range from “strongly disagree” to “strongly agree.” Six items were reverse coded and a summary measure was computed with higher scores indicating greater social support than lower scores. Internal reliability was acceptable ($\alpha = .78$).

Analyses

Descriptive results were first conducted, followed by a series of comparative analyses to investigate possible sexual victimization differences in substance use, sex and relationships, current partner satisfaction, lifetime STIs, sexual compulsivity, stress-related growth, coping, and social support. Specifically, we were interested in outcome differences among men with no histories of sexual victimization, men with histories of CSA, and men with histories of adult sexual victimization. ANOVAs were conducted to examine group differences in the continuous outcome variables: lifetime STIs, sexual compulsivity, stress-related growth, social support, and coping. Post-hoc Tukey HSD results were reported for statistical comparisons among the three sexual victimization groups. Chi-square analyses were conducted to examine group differences in the substance-related variables (expressed as categorical outcome variables).

Results

Sexual Victimization

Nearly three-quarters of the sample (70.5%) reported no sexual victimization experiences in their lifetime, while 15.3% reported unwanted sexual experiences at age 14 or younger, and 14.2% reported unwanted sexual experiences after age 14.

Health-related Correlates

Substance use—Over three-quarters of the sample (84.2%) reported using alcohol in their lifetime. Nearly half (46.8%) reported that they combined alcohol and sex during the 3 months prior to the survey. Based on the semi-partial correlations, we found a significant positive association between ever using alcohol and at least one lifetime STI (not including HIV; $r = .16$, $n = 602$, $p < .01$), social support ($r = .14$, $n = 603$, $p < .01$), and coping ($r = .14$, $n = 616$, $p < .01$). We found a significant negative correlation between ever using alcohol and experiences of stigma ($r = -.12$, $n = 620$, $p < .01$) and stress related growth ($r = -.08$, $n = 621$, $p < .05$). Chi-square results indicated a significant association between sexual victimization history and ever using alcohol, with a greater proportion of men with histories of CSA (86.3%) and adult sexual victimization (93.1%) reporting ever using alcohol than men with no victimization histories (82.0%; see Table 2). The association between sexual victimization history and combining alcohol and sex was not significant.

Fifteen percent of participants reported ever using crystal methamphetamine, 29% reported ever using powdered cocaine, 51% reported ever using marijuana, 43% reported ever using poppers, and 3% reported ever using intravenous drugs. A series of individual chi-square analyses indicated statistically significant associations between sexual victimization histories and the use of crystal methamphetamine, powdered cocaine, marijuana, poppers, and intravenous drugs (Table 2). A greater portion of those participants with histories of ASA, compared to the other two groups of men, reported ever using crystal methamphetamine, powdered cocaine, marijuana, poppers, and intravenous drugs. No association was found between sexual victimization histories and the use of crack cocaine, ecstasy, GHB, or ketamine.

The incidence of combining sex with the use of illegal drugs in the past 3 months was low for crystal methamphetamine (4.9%), powdered cocaine (5.2%), crack cocaine (1.6%), ecstasy (8.2%), GHB (1.6%), ketamine (2.1%), and intravenous drugs (0.5%). The most commonly reported drugs used in combination with sex in the past 3 months were marijuana (15.2%) and poppers (19.6%). No statistically significant associations were found between sexual victimization histories and the combination of sex and any of the illegal drugs used in the past 3 months.

Sex and Relationships

Current partner satisfaction—Nearly half (43.5%) of the participants were currently partnered. Among currently partnered participants, 19.4% were extremely satisfied with the quality of their relationship, 25.1% were extremely satisfied with their partner as a person, and 18.2% were extremely satisfied with the sex they were having with their current partner. Chi-square analysis indicated no significant association between sexual victimization histories and current relationship statuses, $\chi^2 (6, n = 616) = 1.96$, $p = ns$, or relationship satisfaction, $\chi^2 (6, n = 262) = 2.54$, $p = ns$. Bivariate correlations indicated that those with greater relationship satisfaction reported better social support, but less positive coping skills, $r = .25$, $n = 251$, $p < .01$.

Lifetime sexually transmitted infections—Half (50.3%) of the sample reported having at least one STI (not including HIV) in their lifetime, with the mean number of reported STIs equaling one (.97 out of 9 possible). Among the STIs measured, pubic lice (37.7%) was the most commonly reported diagnosis. Eleven percent reported HIV positive status. Significant differences were found in the mean number of lifetime STIs (not including HIV) by sexual victimization histories, $F(2, 609) = 10.5, p < .001$, although the effect size was small ($\eta^2 = .03$). Post-hoc (Tukey HSD) analysis indicated that those with ASA experiences ($M = 1.7, SD = 1.8$) reported significantly higher lifetime STIs compared to those with CSA experiences ($M = 1.0, SD = 1.3$) and those with no sexual victimization experiences ($M = .9, SD = 1.3$). Chi-square analysis indicated a significant association between HIV status and sexual victimization history, with a higher percentage of men with ASA histories reporting positive HIV status (20.2%) compared to men with histories of CSA (9.6%) or no histories of sexual victimization (9.8%; $\chi^2 [2, n = 623] = 8.42, p < .05$).

Sexual compulsivity—The mean score for the sexual compulsivity measure was 17.2 ($SD = 6.4$). Scores falling in the lowest range were reported by the majority of the sample (80.6%), with 12.5% of participants reporting moderate scores, and 6.9% reporting scores that fell in the highest range. Bivariate correlation analyses showed a significant positive relationship between sexual compulsivity and coping, and a significant negative relationship with social support (Table 3). Post-hoc (Tukey HSD) analysis indicated that those participants with CSA experiences ($M = 19.5, SD = 8.0$) reported significantly higher sexual compulsivity scores than men with no histories of sexual victimization ($M = 16.5, SD = 5.9$) or those with histories of adult sexual victimization ($M = 17.9, SD = 6.6; F[2, 621] = 9.5, p < .001$), although the effect size was small ($\eta^2 = .03$).

Stigma

We found significant differences in reported stigma among the three groups, $F(2, 632) = 10.2, p < .001$, although the effect size was small ($\eta^2 = .03$). Post-hoc (Tukey HSD) comparisons indicated that stigma scores were significantly lower among those with no sexual victimization histories ($M = 17.7, SD = 6.5$) compared to those who experienced victimization in childhood ($M = 20.6, SD = 7.7$) or adulthood ($M = 20.2, SD = 6.3$).

Protective Factors

ANOVA results indicated no significant differences among the comparison groups in reports of stress-related growth, $F(2, 633) = 1.3, p = ns$, or in levels of social support/sense of belonging, $F(2, 611) = 2.3, p = ns$. However, they differed significantly in coping behaviors, $F(2, 627) = 11.1, p < .001$, with a small effect size ($\eta^2 = .03$). Post-hoc (Tukey HSD) comparisons indicated that men with no histories of sexual victimization reported significantly lower coping scores ($M = 40.3, SD = 10.4$) compared to men with histories of childhood ($M = 44.8, SD = 10.8$) or adult sexual victimization ($M = 44.1, SD = 9.1$).

Discussion

Findings from this study indicate that rates of sexual victimization among participants are comparable or higher than those found among men and women in the general population (Elliot, Mok, & Briere, 2004; Finkelhor et al., 1990) and within the lower range of reports found among gay and bisexual men in previous studies (Arreola et al., 2008; Doll et al., 1992; Paul et al., 2001; Kalichman et al., 2001; Krahe et al. 2000; Ratner et al., 2003). Results support our hypothesis that men with histories of sexual victimization report riskier behaviors than men with no histories of sexual victimization. Given the caveat of our small effect sizes, results indicate that men with histories of CSA or ASA reported more lifetime STIs, higher sexual compulsivity scores, and greater stigma than those men with no sexual

victimization histories. Men with histories of CSA or ASA also are more likely to indicate that they had ever used alcohol; however, these findings are tempered by measurement limitations imposed by the alcohol survey question. More specifically, because the focus of the original study was not risky alcohol use, measurement limitations allowed only for the examination of lifetime alcohol use as affirmative or not (i.e., yes or no responses). Given that this study was a secondary analysis of existing data, our analyses and results are shaped by the researchers' choices of measures during the original survey design process. Despite limitations posed by the brevity of some of the chosen measures, current study findings serve as an important and necessary step toward exploring comparisons in the potential impact of CSA and ASA among gay/bisexual men. The results should be considered exploratory as it is not possible to know if the participants are representative of all gay/bisexual men in New York City or even gay/bisexual men who have been sexually victimized. However, given that the sample was drawn from large-scale community-based GLBT events, we believe that these findings may be particularly useful for counselors who are providing services-- or trying to extend the provision of services-- to visible and accessible members of the GLBT community. Unfortunately, this means that the representativeness of study findings to less visible portions of the gay community cannot be assumed without further studies that include a more diverse sample of gay/bisexual men at varying stages of disclosure.

Contrary to the hypothesis regarding healthier coping styles among men with no sexual victimization histories, the results indicate no differences among men in stress-related growth scores. Furthermore, men with no sexual victimization histories report fewer coping skills and social supports than men with sexual victimization histories. These data support prior study findings that have indicated important differences in a variety of health-related risk factors among gay and bisexual men with histories of sexual victimization, but our findings also provide additional insights into these differences based on the age at first sexual victimization (i.e., CSA or ASA). While prior literature has focused on CSA as a risk factor for a variety of poor health outcomes in adulthood, our results indicate the importance of assessing sexual victimization experiences over a person's lifetime in order to differentiate between the effects of sexual victimization experienced in childhood and adulthood. Overall, this study suggests that gay and bisexual participants with different experiences of sexual victimization may be at differential health-related risks in adulthood. The association between sexual victimization and illicit drug use and risky sex is strongest for men with histories of adult sexual victimization. This association, combined with higher reports of lifetime STIs among this group, suggests the importance of considering connections among sexual victimization histories, substance use, and risky sex during targeted interventions for MSM. Because it is not possible to determine the direction of causality from the current study, it is unclear whether the use of illicit drugs and risky sexual behaviors preceded or followed adult sexual victimization experiences.

Prior studies (Kalichman et al., 1994; Kalichman & Rompa, 1995) have identified associations between sexual sensation seeking and health-averse sexual risk behaviors, such as unprotected anal receptive sex, among gay and bisexual men. These findings, combined with those linking CSA to high risk sexual behaviors among gay and bisexual men (see Paul et al., 2001), underscore the importance of sensitizing counselors and public health workers to the complex relationship between sexual victimization histories and current risks for adverse health outcomes. Our findings pertaining to differences among men with sexual victimization histories further highlight the importance of assessing the type of sexual victimization experienced. Furthermore, other research about the sexual abuse of boys (Holmes & Slap, 1998) suggests the importance of not only assessing the type of sexual victimization, but also the characteristics of the sexual victimization (e.g., severity, age, presence of revictimization, relationship to perpetrator) as important health-relevant

information that may moderate the relationship between sexual victimization histories and negative health outcomes.

Men with no sexual victimization experiences in the current study report significantly lower levels of stigma related to their sexual minority identity compared to those men with sexual victimization histories. However, those who experienced childhood or adult sexual victimization report better coping skills than men with no sexual victimization experiences. The mechanisms underlying these findings are not entirely clear from our available data, although it may suggest that sexual victimization histories are associated with simultaneous sensitivity to gay-related stigma and the development of protective factors that ameliorate the negative effects of gay-related stigma. Our data indicate that functional coping and self-growth associated with coming to terms with one's sexual identity are significantly and positively correlated with one another, supporting the possibility that these protective factors may work in conjunction with other factors (e.g., help-seeking) to moderate the relationship between sexual victimization history and negative health outcomes. Our finding might be better understood if we were able to assess the moderating role of help-seeking in this relationship between sexual victimization history and functional coping. Perhaps those men with sexual victimization histories were more likely to have sought counseling than men with no sexual victimization histories, and consequently, were more educated about ways to develop healthy coping strategies to manage adversity. This is speculative and warrants further investigation in future studies.

Given substantial evidence to indicate higher risk for revictimization among heterosexual women who report CSA (Roodman & Clum, 2001), future research is needed to investigate whether gay and bisexual men with histories of CSA also are at heightened vulnerability for sexual revictimization as adults. For the current study, sexual victimization histories were assessed when men indicated their youngest age at first sexual victimization experience, which allowed us to determine that those men who reported adult sexual assault did not have histories of CSA. However, given limitations in the design of the original survey questions, we were unable to assess whether or not those men who experienced CSA also were re-victimized as adults (i.e., CSA + adult sexual assault = revictimization). We also were unable to determine if men experienced more than one sexual victimization experience in adulthood. To better assess the relationship between CSA and subsequent revictimization among gay and bisexual men, researchers must agree upon the use of standardized conceptualizations of CSA (see Holmes & Slap, 1998; Paul et al., 2001) and utilize well-established measurement tools for adult sexual aggression, such as the *Sexual Experiences Survey*, which has been recently adapted for use among men and women, regardless of sexual orientation (Koss et al., 2007). The use of more sophisticated measurement instruments, which were not possible for this brief street-intercept study, can provide insights not only into links between victimization experiences, but also lend insights into multiple dimensions of victimization (e.g., unwanted contact, coercion, attempted rape, rape). Researchers have consistently identified evidence linking heavy episodic drinking to sexual victimization among heterosexual women (Testa & Livingston, 2009), while other researchers have found higher rates of alcohol-related problems among GLBs compared to heterosexuals (see Hughes, 2005). Findings from previous studies-- combined with results from the current study-- call for further investigation into links between substance use and sexual victimization among gay and bisexual men in future studies.

Future studies also would benefit from including a wider variety of sexual behaviors and self-identified sexual identities in their samples. Given the limitations of the current data set, we were unable to ascertain the role that sexual identity plays as a moderator in these relationships. In other words, how are these associations and outcomes different for gay men and bisexual men? Similarly, self-identification is not the only factor that should be assessed

as a moderator; sexual behaviors also may be vitally important. For example, one might ask how men who only have sexual intercourse with men differ from men who have sexual intercourse with both men and women (but don't necessarily identify as bisexual) in reports of sexual victimization risk and related negative health outcomes.

Given variations in risk and protective factors associated with sexual victimization histories, our findings underscore the importance of assessing lifetime sexual victimization among sexual minorities for the purposes of prevention and intervention, with special attention given to the enhancement of protective factors among those at risk for harmful behaviors and subsequent poor health outcomes. It is vital for mental health practitioners and other health professionals to remain aware of the possibility of higher risks for poor health outcomes among their sexual minority male clients. Counselors must be supportive of their clients' health decisions while also assisting them to make healthy choices and avoid or minimize behaviors that place their health at risk. As part of risk assessments, counselors should inquire about men's sexual victimization histories. Counselors should consciously avoid making culturally-driven assumptions that fail to identify men as possible victims of sexual abuse or aggression. Cultural assumptions regarding men's low risks for sexual victimization in adulthood can be particularly damaging if they prevent counselors from recognizing and addressing these experiences and associated health risks among sexual minority men. Although little is known about the proximal relationship between sexual victimization and substance use in adulthood among sexual minority men, research regarding the link between alcohol use and sexual victimization risk among heterosexual women suggests that sexual minority men who engage in risky sexual or substance use behaviors also may be at heightened risk for being sexually victimized. Therefore, counselors should advise their clients about strategies to help them avoid high-risk situations that may result in sexual victimization (e.g., drinking to incapacitation).

Because gay and bisexual men experience unique stressors associated with their sexual minority status, counselors should avoid making assumptions about their clients based on prior knowledge about heterosexual men and larger cultural scripts about masculinity. Counselors should respectfully inquire about same-sex sexual behaviors and sexual identity self-identification among all their clients. Findings from the current study suggest that all sexual minority clients can benefit from enhancement of their coping skills, regardless of their sexual victimization histories, and that men with histories of sexual victimization may be particularly vulnerable to sexual minority stress and related stigma. Counselors should be respectful and sensitive to the possibility that their sexual minority male clients may have painful personal stories to share that have implications for the risks they take in their everyday lives. Respect and sensitivity can help counselors overcome ignorance or misunderstandings if counselors work closely with their sexual minority clients to better understand the unique and individual situations of these clients. In summary, clinicians' awareness of their own comfort level working with sexual minority clients and personal comfort when assessing sensitive issues, such as sexual victimization among their male clients, must be supplemented by specialized knowledge related to sexual minority men in order to most effectively address the needs of diverse client populations.

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Continuing Education Credit

1. How do gay/bisexual men with histories of sexual victimization compare to men with no histories of sexual victimization in the current study?
2. Why should counselors assess the sexual victimization histories of their male sexual minority clients?

Table 1
Selected Demographic Characteristics of Study Participants by Sexual Victimization History

	No SV n = 447	CSA n = 97	ASA n = 90	Total Sample N = 634
Age (<i>SD</i>)	37.6 (11.3)	36.6 (11.4)	39.4 (10.7)	37.7 (11.2)
Level of Education (%)				
Some High School	1.6	3.1	3.3	2.1
High School	4.9	9.3	3.3	5.4
Post-Secondary	65.2	68.0	72.2	66.6
Graduate Degree	27.7	18.6	21.1	25.4
Race/Ethnicity (%)				
African-American	7.4	17.7	8.9	9.2
Asian/Pacific Is.	5.8	4.2	8.9	6.0
White	66.2	47.9	66.7	63.5
Hispanic	14.5	16.7	11.1	14.4
Other	6.1	13.5	4.4	6.9
Employment Status (%)				
Full-time/Self-Employed	72.7	57.7	81.1	71.6
Part-time	7.8	18.6	4.4	9.0
Not Employed/Other	19.5	23.7	14.5	19.4
Annual household income (%)				
None	2.5	7.2	3.3	3.3
\$1-20,000	13.0	15.4	8.9	12.8
\$20,001-40,000	20.8	28.9	30.0	23.3
\$40,001-60,000	25.3	17.5	31.1	24.9
\$61,000 or greater	36.9	28.9	25.6	34.1

Note: Some totals do not equal 100% due to missing data on the variable of interest.

Table 2
Substance Use by Sexual Victimization History

	No Sexual Victimization %	CSA %	Adult Sexual Victimization %	
Ever used Alcohol	82.0	86.3	93.1	$\chi^2 (2, n = 621) = 7.10, p < .05, V = .11$
Ever used Alcohol w/sex	45.8	53.6	45.0	$\chi^2 (2, n = 577) = 1.83, p = ns$
Ever used Meth	13.1	10.9	26.4	$\chi^2 (2, n = 613) = 11.50, p < .01, V = .14$
Ever used Cocaine	26.1	31.2	38.4	$\chi^2 (2, n = 615) = 5.61, p = .06, V = .10$
Ever used Marijuana	48.3	49.5	69.3	$\chi^2 (2, n = 622) = 13.15, p < .05, V = .15$
Ever used Poppers	39.2	44.1	58.6	$\chi^2 (2, n = 616) = 11.24, p < .05, V = .14$
Ever used IV Drugs	1.4	3.3	7.0	$\chi^2 (2, n = 606) = 9.53, p < .01, V = .13$

Note: *V* represents Cramer's *V* indicating effect size for tables larger than 2×2. A small effect size = .07, a medium effect size = .21, and a large effect size = .35 (Gravetter & Wallnau, 2004).