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Sometimes you just have to have a lot of bitter to make it sweet: **Substance abuse and partner abuse in the lives of HIV+ men** **who have sex with men**

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Abstract

Although links between partner abuse (PA) and substance abuse (SA) are well-documented in the literature, we know less about these relations among HIV-positive men who have sex with men (MSM). We conducted a qualitative study with this group (N = 28). Participants reported (1) social modeling of SA in childhood and in adult social networks, (2) initial use of substance to cope with child abuse and neglect, and (3) the reinforcement of problematic SA by experiences of PA, whereby SA led to PA, resulting in increased SA. Recommendations for clinicians working with HIV+ MSM are discussed.

Keywords

HIV positive; men who have sex with men; substance abuse; partner abuse

Despite the existing literature suggesting that men who have sex with men (MSM) are at greater risk of interpersonal violence across the lifespan (Braitstein et al. 2006; Paul, Catania, Pollack, & Stall, 2001), few studies have examined the lived experience of HIV-positive MSM related to their interpersonal abuse histories. As a group, lesbian, gay, and bisexual adults (LGB or “sexual minority” individuals) report more childhood psychological and physical abuse by parents and caretakers than their heterosexual siblings of the same sex, and more childhood sexual abuse (Balsam, Rothblum, & Beauchaine, 2005). In a study of young MSM (age 15–22), 68% of the sample reported experiencing verbal and physical violence victimization from family members (Koblin et al., 2006). These early experiences of victimization put MSM at increased risk for subsequent experiences of violence and abuse in adulthood (Balsam, Lehavot, & Beadnell, 2011; Lalor & McElvaney, 2010). For instance, adult MSM with a history of child physical or sexual abuse are more likely to experience victimization in their romantic relationships (Balsam et al., 2005; Koblin et al., 2006; Williams et al., 2004).

Partner Abuse and HIV

Interpersonal victimization in the context of a romantic relationship, often termed partner abuse (PA), is characterized by a pattern of coercive behaviors that can include verbal threats, physical abuse, psychological abuse, sexual assault, that can result in physical or emotional injury (e.g., Burke, 1998). Much work has been done looking at PA in women and even in HIV-positive women, documenting higher rates of abuse among infected vs. non-infected women drawn from the same underlying population (Gielen et al., 2007). The few studies that have quantitatively explored PA in male same-sex partnerships suggest that MSM experience abuse rates similar to, or higher than, those reported by women in heterosexual relationships (Greenwood et al, 2002; Pantalone et al., 2012; Seelau, Seelau, & Poorman, 2003), and that having HIV may place an MSM at even greater risk. A review of PA among MSM living with HIV indicated a lifetime frequency of physical (15–39%), sexual (8–33%), and psychological abuse (22–73%; in press author citation omitted) across studies. These rates are three times higher than those reported by men involved in heterosexual relationships (Tjaden & Thoennes, 2000), based on data from a representative sample of the U.S. population.

The experience of PA has been consistently associated with unprotected sex as well as HIV acquisition among MSM (Merrill & Wolfe, 2000; Nieves-Rosa, Carballo-Diequez, & Dolezal, 2000; Relf et al., 2004). In one study of sexual risk among lesbian, gay, bisexual, and transgender individuals with PA histories, participants reported feeling forced by their partners to have sex, feeling unsafe requesting that their abusive partners use barrier protection (Heintz & Melendez, 2006). In one study of HIV-positive MSM, 23.5% reported forcing their intimate partners to have sex without using a condom and 27.5% reported being forced to have sex without a condom (Craft & Serovich, 2005).

HIV serostatus may also be a factor in maintaining one's abusive relationship. Once they are diagnosed as HIV-positive, MSM may be less likely to leave an abusive relationship for a number of reasons, including poor health (Merrill & Wolfe, 2000), lack of financial resources (Letellier, 1994), fear of losing a caregiver (West, 1998), or fear of becoming sick and dying alone (Merrill & Wolfe, 2000). Further, it is plausible that, regardless of serostatus, dating in the context of the epidemic may weigh heavily in decisions to stay in an unhealthy or abusive relationship (Merrill & Wolfe, 2000). For HIV-negative MSM with HIV-positive partners, the decision to stay may be influenced by not wanting to "abandon" an HIV-positive partner (Merrill & Wolfe, 2000). In sum, HIV may be an antecedent or consequence of abuse experiences, and may also serve to heighten a man's willingness to remain in an abusive relationship.

Relations of Interpersonal Abuse and Substance Abuse

In the broader literature on interpersonal abuse, there is overwhelming evidence to support the notion that substance abuse (SA) is a significant risk factor for both victimization and perpetration of PA (Craft & Serovich, 2005; Houston & McKirnan, 2007). Further, MSM are especially vulnerable to SA, given the high rates of alcohol and SA in survivors of child abuse established in the literature and the high rates of childhood abuse experiences among MSM (for reviews, see Lloyd & Operario, 2012; Ouimette & Brown, 2003). These associations are also well established for HIV-positive MSM in particular, as SA is a common problem among MSM living with HIV (Pantalone et al., 2010; Beckett, Burnam, Collins, Kanouse, & Beckman, 2003). Multiple studies have established associations between PA and SA among MSM living with HIV (Houston & McKirnan, 2007; Nieves-Rosa et al., 2000; Zierler et al., 2000). In a study of male same-sex battering, 46% of victims reported alcohol use and 18% reported drug use immediately prior to the violent episode

(Stermac, Sheridan, Davidson, & Dunn, 1996). Elevated use of alcohol and drugs by both partners has been implicated in the evolution of aggression and the increased probability of PA (Stuart et al., 2008). Further, the use of illegal drugs before or during sex increases the probability of engagement in unprotected sex, and is linked to the acquisition and transmission of HIV (Houston & McKirran, 2007; Nieves-Rosa et al., 2000; Zierler et al., 2000).

The Current Study

Although HIV-positive MSM experience relatively high rates of PA, this phenomenon continues to be understudied. More information, especially about the phenomenological experience of these men, is needed. Several researchers have posited that alcohol and drug use may function as a form of anesthesia, or self-medication, used as a coping strategy to temporarily escape painful traumatic memories (Briere, 1989; Khantzian, 1997). In HIV-positive men, SA may be a form of HIV-related thought avoidance (Nemeroff, Hoyt, Huebner, & Proescholdbell, 2008). From the alcohol literature, we know that drinkers who strongly endorse coping motivations for drinking (i.e., to escape, avoid or minimize unpleasant or aversive emotional experiences) have poorer long-term outcomes (Cooper, Frone, Russel, & Mudar, 1995; Cooper, Russell, & George, 1988). Although little is known about how the dysfunctional use of substances to cope may impact MSM with a history of abuse, there is evidence that survivors of child abuse often engage in avoidance coping responses to abuse-related distress (Briere & Rickards, 2007; Briere & Scott, 2006; van der Kolk et al., 1996). Indeed, there is evidence that some MSM report the use of substances to enhance sexual experiences, increase sexual arousal, facilitate sexual encounters, and increase the capacity for sexual behaviors (Myers et al., 2004).

The literature has focused almost exclusively on PA and SA as two distinct influences on HIV risk (transmission and health), rather than considering a synergistic effect. Thus, we aim to use qualitative methods to gain insight into the combined impact of SA and PA on the lives of MSM living with HIV, hearing about their experiences in their own words. Additionally, we aim to identify contextual issues surrounding abuse that may be specific to this population.

Method

Participants and Procedures

Study participants consisted of HIV-positive MSM ($N = 24$) receiving medical care at an urban outpatient HIV clinic. Potential participants were referred to the study by providers and a research nurse recruiter if they had reported a history of PA. Men who reported PA experiences in the past year were excluded due to potential safety concerns. After an initial screening, participants completed a short demographics questionnaire. To determine sexual orientation, participants rated their sexual behaviors with and sexual attractions to men versus women on a scale of 0 (*women only*) to 6 (*men only*). During audio-recorded interviews, participants were asked questions about the role of HIV in their lives and romantic relationships. The context and dynamics of one relationship in which PA occurred were explored in depth. Audio recordings were transcribed by one research assistant, reviewed for accuracy by a second research assistant who noted discrepancies, and the discrepancies were reconciled by a third research assistant.

Data Analysis

Analysis was conducted using a team-based approach and guided by the theory and methods of content analysis (Hsieh & Shannon, 2005). The team began the analytic process by

reading through the transcripts to gain a general sense of emergent topics in the data. To develop an initial template of categories, team members read three initial transcripts of interviews to determine what content emerged as interesting or important. Each team member generated a preliminary list of codes by highlighting relevant text from the transcript that captured key elements and giving the code a descriptive label (Krippendorff, 2003). No codes, categories, or themes were specified *a priori*. Then, the process of reading, coding, categorizing, discussing, and refining ideas began. The coding team met and reviewed each of the three transcripts line by line, discussing codes and potential categories. This process was repeated with two additional sets of three transcripts until a total of nine transcripts had been reviewed, and coding team members agreed that saturation of codes had been reached. At this point, the team had agreed on a coding scheme comprised of the codes and categories generated from consensus.

For the final coding stage, each transcript was independently reviewed and coded by two members of the coding team. The coded transcripts were then compared across team members; discrepancies were discussed and resolved through consensus (Hill, Thompson, & Williams, 1997). Over the course of data analysis, research team meetings shifted focus from a discussion of potential codes and categories to a discussion of how the data addressed empirical questions about the experiences of HIV-positive MSM who have experienced PV (Morse & Field, 1995). The use of various forms of triangulation—multiple sources of data (i.e., participants), multiple readings, multiple coders, and the iterative process of consensual agreement—enhances the verification (validity) of the analysis (Patton, 2002). Robust themes were identified and organized conceptually. Final codes, categories, and themes were entered into the computerized qualitative data analytic program Atlas.ti (Muhr, 2004) to assist with data organization. Exemplars from the text were identified to capture the meaning of each theme.

Results

Sample Characteristics

The mean age of the 24 participants was 42 years. The sample was very diverse in terms of racial identity: with men identifying as: White ($n = 11$), Black/African American ($n = 7$), Biracial/Multiracial ($n = 3$), or American Indian/Native American ($n = 3$). Two participants identified their ethnicity as Latino. Most men identified their sexual orientation as gay ($n = 21$). Remaining participants self-identified as bisexual, two-spirit, or wrote in a unique self-identification. In terms of sexual behavior in the past year, the majority of the sample reported sex mostly or exclusively with men ($n = 19$). Almost half of the participants were in a relationship at the time of the interview ($n = 11$). Despite 92% of the sample having a high school degree or more education (and 54% reported having at least some college), mean income was very low overall, with 63% living on \$10,000 or less a year and 71% noting state or federal assistance as their major source of income.

Qualitative Analyses

Overview—Three overarching themes arose from the data that provide important contextual information regarding the dual impact of PA and SA on HIV-positive MSM: (1) social modeling of SA in early environments and social reinforcement of SA in adulthood; (2) the use of alcohol and drugs (beginning in adolescence) as short term coping strategies to numb or escape the emotional and physical effects of abuse; and (3) observations of the relations between SA and violence in romantic relationships whereby SA increases PA, then PA increases SA, and the pattern continues.

Social Modeling of SA—More than one third of the participants ($n = 10$, 42%) characterized their childhood homes as places in which it was not safe to be a child, and described the need to take on adult roles and responsibilities to survive. The men described many instances of neglect. This neglect led to an early, heightened awareness of the need to fend for oneself, as well as early exposure to SA. As one participant described, “She [my mother] was crossing the street and she got hit by a car... She was an alcoholic and everything. And she used to drink with me, and she used to drink with my sister, and stuff.” Other men drew parallels between their own use of drugs and alcohol and the presence of SA in their early environments. One man stated,

I’ve been mentally abused all my life. Coming from a single mother that was a drug addict, an alcoholic, uh, livin’ in a milk wagon—I battled myself out of that and I started climbing the ladder of any job... to the point where, once I got to that stage where I was the best at whatever I did, there was nothing else to prove. And that’s what happened with the job that I quit, to live with him [abusive partner].

This participant was reflecting specifically on how the desire to leave one abusive environment led him into another one. Another man revealed his own feelings of shock and disappointment in developing alcohol dependence, a trait that he associated with his childhood abuser. He stated,

I always said, you know, “I’ll never grow up to be like you, [abuser’s name].” [laughs] That’s what I said. And I grew up to be exactly like him! When it came to the alcoholism, it was—I became a full-fledged alcoholic.

Men not only reflected on the co-occurrence of SA and abuse and neglect in their own early environments, but also described these same dynamics in the early environments of their abusive partners. When reflecting on his partner, one man explained,

It’s hard for him [abusive partner] to admit but, uh, alcohol, alcoholism played a very big part, and not only in our relationship and [his] life, and I didn’t know how to break the pattern.

This line of thinking led to several ways in which the men attempted to normalize, minimize, or dismiss violence perpetrated by their partners. In a sense, some men suggested that SA was causing the violence. For example, one man noted, “You know, I still believe in my heart that he’s a good person, it’s just the alcohol turned him into someone else.” Other men recounted how their early experiences of abuse, contributed to a lower sense of self-worth, which created vulnerability for SA and partner abuse in their adult lives. One man described SA as self-inflicted abuse; he also characterized his choice to stay in an abusive relationship as self-inflicted abuse, he said,

Literally, if you’re abusing yourself with drugs and alcohol, or you’re abusing yourself in an abusive relationship, you’re not caring or loving for yourself, you know. And maybe it’s because you don’t know how. Or maybe you don’t feel worthy? Maybe you don’t feel like you deserve it. And those, those kinda lessons, all take time...

Some men described how the normalization of SA (and interpersonal abuse) within their families, social networks, and relationships made it difficult to recognize and discern problematic patterns. For example, one man described how SA often served as the context in which he met potential romantic partners; he stated,

That’s how I met ‘em [partners]. Through alcohol. That’s how I met ‘em. I didn’t meet ‘em sober. I met ‘em when we were drinking. Yeah, at a bar. And then it’s been that way ever since, for years, you know. It’s like, I guess every bar you go to, that’s how people meet other guys and that’s how women meet other women, but

then, you really don't know who that person is until maybe, sometimes it takes years for you to figure out who somebody really is.

Here, it is clear that many of the men and their partners used drugs or alcohol during the initiation of the relationship; they also described drinking at bars as an activity they did with their partners. Some men described how the bar scene was often a place where conflicts emerged. As one man described,

Well, he was drinking every day, to me he was emotionally abusive and then, when he'd get drinking, you know—I mean, he'd start mouthing off. And he didn't realize how much his words hurt... And I was just, like I said, blinded by, blinded by love and the alcohol and, like, when we went out, I thought we were going out to socialize and then, as the patterns developed, I seen he wanted to go out so he could drink. He needed to drink.

This man noted how meeting partners in the context of drinking might have made it difficult to recognize his own, or his partner's, problematic alcohol use. Other men reported that it was difficult to identify their own problematic use, when SA appeared to be the social norm. He stated,

Alcohol snuck up on me. I didn't realize it was a problem until it was a freaking big-ass problem. And then, that even destroys more of your self-esteem, to come to feel like you're an alcoholic or something... But I think [the] drugs and alcohol [were] just so much during our social, gay social life... it's like, everyone has to have their own life experience...you know what I mean?

Further, one man noted the toll that SA, violence, and the HIV epidemic had taken on his immediate social circle over the years,

I've lost thirty-five friends. Thirty-five people, since I've moved to [the Northwest] in '82. And none of my friends lived to be fifty. And not all of 'em died of AIDS, only, only four of 'em died of AIDS. A lot of 'em died from overdoses. A lot of 'em died from alcoholism. And maybe, out of all of 'em, about eight of 'em were murdered.

Some men described the prevalence of SA in their current social circles. As one man stated, "Most of the people who I feel associated with now is nothing but crackheads and alcoholics. And it seems I can't get rid of them, I'm like a magnet to them." Of the men who reported ongoing SA in their current social environments, many conveyed feelings of hopelessness about being able to have a supportive network of sober friends. Much like many of the men reported pessimism about being able to have romantic relationships that do not involve SA or violence. Many of these men believe that violence and SA are part of every relationship, and they could not see it being any other way.

Drug and alcohol use as short-term coping—The majority of participants ($n = 18$, 64%) described the use of drugs and alcohol as short-term coping strategies to escape distress related to the abuse they endured as children. The men frequently described their use of drugs and alcohol beginning in early adolescence. The men described discovering the effectiveness of SA in 'numbing themselves' from the abuse-related distress and their chaotic home environment. One participant described the onset of his SA as such: "I think a lot of the problem was the abuse that was going on, plus I had started drinking alcohol and all that crap. You know, to medicate myself."

In addition, many of the men identified their use of drugs as a means to improve their mood, or to distract from their feelings of self-worth. The men related that this was true during times of abuse, as well as post-abuse, in reflecting on their pasts. Remaining drunk or high

was often noted as the best way to survive the realities of the abuse in their lives, and escape the negative affect that is present when sober. One participant stated: “I basically stay stoned. I smoke a lot of marijuana, because, if I don’t, I want to walk off in front of that bus. You know, it’s just so easy, just so easy...”

Although participants noted the dangers of SA and often described these behaviors critically, as “bad” or “unhealthy,” many men also reported believing that the drugs helped them survive the violence in their lives. Many men described their SA as a subsistence strategy that helped them through especially difficult times, until they could bring themselves to work through some of the abuse they had experienced in their lives, or to remove themselves from abuse that they were experiencing in the present. As one man reflected on the use of substance to cope with fear and intrusive thoughts,

Sometimes there’s subconscious that takes over and you don’t even know why you do the things you do. You know, ‘cause I, I know alcohol is obviously not, like, real good for me. And I, yet I don’t know why I do that. And, uh, I don’t know. I, I think what I do is—‘cause when I get a good buzz, I forget about all that stuff [abuse], at least temporarily... Probably at least twice a week, where I remember [the abuse] and start worrying about when he’s gonna get out [of prison], is, is he gonna try to kill me? Is he gonna try to beat me up when he sees me? And so, you know, like, I’ll drink and then I’d listen to music and it’s, it’s just like a temporary vacation.

Other men noted the way that alcohol provided a cognitive escape from distressing thoughts. For example, one man reported that, “[Alcohol] got me out of my mind. Got me out of where I was, you know, but took me into blackouts.” Similarly, many men described the use of alcohol as an immediate coping response to the experience of partner abuse, especially psychological abuse. As one man described, “He was just degrading me, you know, and swearing and... just like I, I, he wished me illness and all that stuff and... I drank a lot at that...” On the other hand, some men noted how the using alcohol would increase their abuse-related distress, rather than numb it. As one man described: “Well, I still drink occasionally. It all [memories of abuse] surfaces if I get too high on alcohol. I get emotionally wrapped up in yesterday, and I shouldn’t do that.”

Some men described the intricate relations between HIV and SA, noting that SA was both a precursor and consequence of their HIV diagnosis. As one man stated, “When you drink, and you don’t think about what people got [if they have HIV], you’re just there to have a good time, and alcohol takes away all those [negative] feelings and those [negative] emotions and those thoughts.” Another man explained the use of substances to cognitively escape the reality of having recently received an HIV diagnosis,

At the time I caught [HIV], um, I wasn’t getting no medication for it right off the bat because I was living on the street. I was hustling. ‘Cause I used to be a hustler on the street. Okay, and so, at the time, I was trying to block it out—I didn’t take it too serious. I just blocked it out and was using drugs and alcohol to make it, [and] you know, not remind myself of it... I mean, I used to alcohol to block it out. For, you know—to erase the pain of it—and I was so mad because I didn’t know how I got it.

When reflecting on early experiences of SA, many men reported initial positive effects of SA, such as its utility in reducing anxiety and tension, and improving sexual satisfaction. One man stated, describing his SA experiences,

“[That time] was all crazy and fun and exciting... I mean, [I was] just really tightly wound. I mean, people were like, “You need to like loosen up every now and then.”

Um, little did they know, once drugs came in, I, I, you know, it was very exciting to like, to be... [pause] irresponsible, because I was never irresponsible.”

Another man recalled the sexual benefits of SA,

I never ever enjoyed sex until I did crystal meth, ever. And I wasn't even all, all that sexual in [my hometown]. And, um, I would have sex maybe once every six months. I just, poor, [had] such poor self-esteem. I didn't work out. You know, and, plus, plus the years of prior abuse growing up...

These men described how some of the sequelae of early abuse resulted in low self-esteem and social anxiety, which could be temporarily ameliorated with SA.

Patterns of PA and SA in relationships—The majority of participants (n = 16, 67%) described a cyclical pattern existing between SA and violence in their romantic relationships. These relationships were characterized by the use of substances, which would inevitably lead to increased conflict and, at times, result in PA. As one participant explained, about his past partners, “They made you get pissed, so you went out and got high. Now you go back home and they're already calmed down, and now they're going to get mad because you went out and got all blasted.”

Several participants described situations where the violence began with one partner's disapproval of the other's use of substances or alcohol, even when both partners engaged in SA. As one participant explained, “He hated my drinking, I hated him shooting speed. He'd come down off those drugs and get smartass, and I'd get smartass coming down off my alcohol. You know, we tore the house up.” Another man recalled an episode of violence where both he and his partner had been drinking; he stated,

Um, I beat the crap out of him... And I, I feel sorry that I did that to him, but it was the alcohol, I know, I know it was. Because I don't, he would not have done that, if not. 'Cause we had a wonderful relationship, you know. And with just me catching him with my best friend, you know, and there he's drunk too. Huh, you know. And having sex on the day bed.

This man seemed to use alcohol use to explain away his perpetration of violence as well as his partner's infidelity. This participant used alcohol to cope with his own distress, and used alcohol as a way to rationalize his partner's behaviors—and, thus, to remain in that relationship. Another man described his partner's jealousy and violent behavior toward others when they were at bars. He described how his partner,

Would fight, I mean he, somebody look at me wrong and he'd beat, I mean, literally—fight 'em. Beat them. I mean literally, I was like, “Damn! What are you doing?” You know, I kept trying, he was a, he was one that I could say was a true alcoholic.

Interestingly, this man seemed surprised but not outwardly alarmed by his partner's violence toward other men. Later in the interview, he denied that this partner had been violent toward him in their relationship. It might be that witnessing violence toward others did not register as a red flag for this man, as violence was likely an expected behavior. Still, other men describe a similar scenario, which resulted in physical partner abuse once the couple had left the bar. One man describes an abuse episode,

We'd go to the bar, and he'd play pool. And I'd go to the bar, and there'd be guys I'd been with before, but they weren't boyfriends, they were just guys I've dated before him. Okay? He'd get all jealous, and tell the guys to get away from me. So the bartender would kick him [out], would cut him off alcohol. He'd wait outside

for me to leave the bar. Next thing you know, we'd start fighting outside, in front of the bar. He'd follow me down the street... It got physical after that.

Similarly, another man noted an increase in paranoia and jealousy in his partner during SA. He recalled saying to his partner, "Okay, you know what, you're a little bit too possessive, something else is going on here other than you just doing drugs, you know. I realize that the drugs is making you paranoid, but there's something more." This man was recognizing that, perhaps, all of his partner's behavior could not be explained away by SA.

Many men described similar realizations, although, sadly, many of them reported also that they suffered long periods of abuse before recognizing the need to leave to maintain their own safety. Another man explained why he stayed in an abuse relationship,

For his alcoholism. You know, I always told him, "Well, maybe you should try treatment." Which he never did, he always talked about doing it, but he was pretty much convinced that he couldn't, wouldn't, couldn't stop and you know, that's when I decided well... it's time for me to go. Before you kill me. You're gonna end up killing me. Well, you know, there was... a lot of times I would leave, but then I got nervous about leaving him alone, because I was afraid that he was gonna do something to hurt himself... I thought well, maybe, for his best interest, even though I was afraid to be around, it got to the point where I was afraid to be around him because I didn't know what he gonna do...

This participant describe how challenging it was to put his own need for safety first, and how at that time he was more concerned about the health and safety of his abusive partner. Another factor commonly mentioned by the men was a feeling that they somehow deserved to be mistreated in their relationships, and this expectation made it difficult for men to leave. As one man put it,

I wanted someone to be there in case I passed away [from HIV]. Um, I, I'd lost, uh, three really good friends within a year and a half and, after they were gone, it was like, I felt, in my world, [he] was all that was left. You know, and I didn't have, he had depleted me so much, of myself, that I didn't, I couldn't even stand up for myself or be there for myself, and I relied on his abusiveness and alcoholic asinine shit. That that was all I deserved. That was all there was.

In sum, the men described a perceived inability to control many of the negative factors in their lives, and a tendency to either control or be controlled by their partner. For many, years of abuse and neglect led to neglect of their own physical and mental health and opened them up to the abuse of others as adults. As a result, these men attribute the cycle of drug use and violence continues largely due to lack of self-esteem and feelings of worthlessness.

Discussion

The men in our sample described a range of experiences with SA and PA. Without being questioned specifically about childhood abuse, the majority of participants spontaneously reported experiencing neglect and abuse in childhood, often at the hands of substance abusing parents (author citation omitted). Our findings are consistent with social learning and coping models of addiction, which assert that early social observation of SA can serve as modeled behavior, whereby one develops expectancies of the effect of SA (e.g., Bandura, 1977; Brown, Tate, Vik, Haas, & Aarons, 1999). This common theme arose from these men's narratives, where men described how early exposure to SA facilitated initial use.

Also consistent with learning theory (Bandura, 1999), SA was reinforced in a variety of ways. For many of the men, SA facilitated communication and increased sexual pleasure with their partner—thus substances were useful in increasing "intimacy" with partners (i.e.,

positive reinforcement) as well as reducing negative affect or improving mood (i.e., negative reinforcement). Regarding the latter point, the men's reports of using substances to "numb" abuse-related negative emotions are congruent with the literature that discusses SA as a coping strategy employed by men who have experienced sexual victimization (e.g., Arreola et al., 2008). In relation to PA, some men participants viewed SA as a catalyst for many of the violent episodes in their relationships. From their accounts, alcohol and drug use would often escalate verbal disagreements into violence; this relation is also suggested in the empirical literature (e.g., Bjork & Dougherty, 1998). Some of the men in our sample described the way in which using substances together had the potential to promote reconciliation following an episode of abuse; this was even reported by some men who had also posited SA as antecedent to violence.

Further, these findings appear consistent with studies that have found that victims of interpersonal violence are more likely to perceive more benefits than costs of risk behavior (i.e., SA, sexual risk) relative to individuals without such histories (e.g., Smith, Davis, & Fricker-Elhai, 2004). Surprisingly, the men did not describe a relation between their past abuse experiences and their past or current risky sexual behaviors. The general lack of insight into the influence of past life experiences on sexual behavior observed in this sample is, however, consistent with the literature (Williams et al., 2004). It appears that, while men could relate their SA to coping with abuse experiences, few drew connections between PA or SA and sexual risk behavior.

Also consistent with social learning theory, it appears that these men developed expectations of both SA and violence in their lives (Bjork & Dougherty, 1998; Breslin, Riggs, O'Leary, & Arias, 1990). These men described a long-standing history of violence and abuse dating back to childhood. Overall, participants experienced abuse as normative, suggesting that these men may hold a script for relationships that involves violence and SA. Consistent with the revictimization literature, the men described how early experiences of abuse shaped relationship expectations in a way that impaired their ability to detect risk of violence in their partners (e.g., Zayfert, 2011), these men similarly described difficulty in recognizing SA problems in their partners as well as their own problematic use. Further, many men highlighted the prevalence of SA in their adult social networks. Consistent with existing data which links childhood abuse to violent relationships in adulthood (Craft & Serovich, 2005), it appears that the normalization of violence and SA described by these men may serve as a risk factor for PA (Wall & McKee, 2002).

Limitations

The findings in this study should be viewed in light of its limitations. First, the interview did not expressly ask about childhood experiences, nor did the interview questions ask participants to explicitly reflect on relations between abuse and SA. Also, inherently problematic in asking participants to reflect on experiences that may have occurred decades prior to the interview, these men are more likely to recall singular abusive events that are extreme, rather than provide an account of the day-to-day experience of living with HIV and being in an abusive relationship. Our sample may differ from HIV-positive MSM who decline participation or were excluded based on recent PA. While we excluded men who reported experiencing PA in the past year, we did not exclude men who could potentially still be with a partner who was abusive in the past. Thus, the report of previous abuse experience with a current partner may not accurately be reflected. It is also possible that due to concerns about social desirability, the men may not have accurately represented their own SA history. We also did not select or exclude participants with current substance dependence, thus some reflections on the role of substance in modulating emotions or increasing intimacy may be biased by current patterns of use.

Clinical Implications

This study described many significant issues for HIV-positive MSM experiencing PA, and highlighted the need for mental health services (i.e., individual or group therapy) that addresses the co-occurring health problems of PA and SA. To ensure effective mental health services for HIV-positive MSM, thorough (and repeated) assessments of PA and SA are warranted. Assessments of HIV-positive MSM should serve to elucidate the thoughts, behaviors, and emotions associated with SA that may make men particularly vulnerable to PA, and vice versa. In the likely event of a comorbid presentation, clinicians will need to address both simultaneously. A complete behavioral assessment (i.e., a behavioral or chain analysis) may allow clinicians to identify SA reduction strategies in the context of coping with abuse-related distress. In doing so, treatment may reduce behavioral (SA) and cognitive (i.e., helplessness, worthlessness) risk factors of revictimization (Zayfert, 2011). When working in clinical settings with HIV-positive MSM, it is imperative to screen for behavioral indicators of abuse rather than to rely on perceptual questions (e.g., “Were you abused by your partner?”; author citation omitted) and intervene upon abuse-related distress in terms of decision-making about sexual behavior, relationships, or PTSD.

With a continued lack of awareness and ineffective coping strategies among MSM, there is an increased likelihood of a continuation of patterns of violence, SA, and HIV risk behavior. Given the dearth of insight between past abuse experience and current health behaviors (and partner selection behaviors) observed in this study, clinicians should provide psychoeducation about these interrelations. For example, clinicians should validate the use of short-term coping strategy (SA) as an effective means of addressing abuse-related distress, while pushing for longer-term coping strategies. Future research should focus quantitatively on exploring the underlying mechanisms of the relations between child abuse, SA, and PA, as there are likely shared risk factors across these co-occurring health problems among HIV-positive MSM.

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