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Evaluating a Novel Intervention to Reduce Trauma Symptoms and Sexual Risk Taking: Qualitative Exit Interviews with Sexual Minority Men with Childhood Sexual Abuse

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Abstract

Childhood sexual abuse (CSA) continues to affect sexual minority men (SMM) at disproportionate levels and contributes to multiple negative health outcomes, including sexual-risk taking and HIV acquisition. This paper presents qualitative evaluative feedback from SMM (N=9) who participated in a 10-session Cognitive Behavioral Therapy-Trauma and Sexual Health (CBT-TSH) intervention to reduce CSA-related posttraumatic stress reaction and distress. The treatment was designed to increase accurate sexual risk appraisals and to improve self-care health behaviors related to HIV/STI acquisition. The researchers identified four emerging themes: (1) motivation to participate, (2) response to cognitive therapy, (3) process of change, and (4) considerations for intervention improvement. These qualitative findings provide useful feedback on the acceptability of an innovative program that integrates CBT for trauma related to CSA with sexual risk-reduction counseling.

Keywords

Sexually Minority Men; MSM; Childhood Sexual Abuse; HIV Prevention

Introduction

Childhood sexual abuse (CSA) continues to affect sexual minority men (SMM) at disproportionate levels. It is estimated that 27.3 to 47% of SMM have histories of CSA (Lloyd & Operario, 2012; Sweet & Welles, 2012; Lenderking et al., 1997; Mimiaga et al., 2009; Arreola, et al., 2008), compared to 2 to 15% of the general male population (Aosved,

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Long, & Voller, 2011). HIV also disproportionately affects SMM, with approximately 83% of all new HIV cases occurring annually in this subgroup (CDC, 2016). SMM with CSA have higher rates of HIV, other sexually transmitted infections (STIs) and higher rates of sexual risk-taking compared to those with no CSA experience (Jinich et al., 1998; Mimiaga et al., 2009; O’Leary et al., 2003; Stall et al., 2008; Borroughs et al., 2015).

CSA in SMM contributes to multiple negative outcomes, which include confusion about sexual identity (Relf, 2001), mental health concerns (Carballo-Diequez & Dolezal, 1995; Jinich et al., 1998), and substance and alcohol abuse (Kalichman et al., 2011; Miller 1999; O’Leary et al., 2003). Stall et al. (2008) found CSA in urban SMM often co-occurs with other reinforcing epidemics (i.e., depression, substance use, partner violence), resulting in a powerful syndemic that decreases overall health and leads to HIV acquisition. Among SMM, CSA severity has been related to mental health and substance use disorders in adulthood, increased risk for STIs and condomless sex with serodiscordant partners (Borroughs et al., 2015). Also, among SMM CSA is associated with current and lifetime Post-Traumatic Stress Disorder (PTSD), and other behavioral and health issues in adulthood (Borroughs et al., 2015; Batchelder et al., 2017). Purcell et al. (2004) found that men with CSA histories reported negative mental health outcomes (e.g., avoidance-related behaviors and/or emotional regulation problems). SMM with CSA experience long-term psychosocial distress, unhealthy substance use problems, and sexual risk taking (Arreola et al, 2008; Holmes, 1997; Brennan et al., 2007). There is a need to design effective integrated psychotherapies to address the behavioral and sexual health consequences of developmental trauma, particularly for CSA (Cloitre, 2009), and the importance of implementing these treatments in community settings has been stressed (O’Cleirigh, Safren & Mayer, 2012).

Cognitive Behavioral Therapy (CBT) is an evidence-based treatment strategy to address PTSD symptoms. Harvey, Bryant, and Tarrier (2003) describe the general principles of CBT for PTSD (i.e., psychoeducation, exposure, cognitive restructuring, and anxiety management) and the empirical evidence that supports its efficacy in the treatment of PTSD. Furthermore, in a recent literature review Kaminer & Eagle (2017) identified considerable empirical evidence that supports trauma-focused CBT approaches and multimodal, phased-based interventions to address PTSD and its complex symptomatology.

HIV prevention strategies in SMM should address psychosocial factors that predict and increase sexual risk for HIV, as these factors might impede the effectiveness of traditional HIV prevention interventions in this particularly vulnerable group (O’Cleirigh, Mayer, & Safren, 2012; Lenderking et al. 1997; Kolbin et al. 2004). Based on CBT best practices and Cloitre’s (2009) charge to address comorbid conditions within a community-based setting, we developed a CBT-Trauma and Sexual Health (CBT-TSH) program that includes elements of cognitive processing therapy (CPT) to treat both CSA-related trauma symptoms and to reduce risky sexual behaviors, and then pilot-tested it in a mini randomized control trial.

Grounded in information processing theory, CPT includes elements of psychoeducation, imaginal exposure, and cognitive reprocessing around core issues related to traumatic experiences. Originally developed to treat PTSD symptoms in rape victims (Resick & Schnicke, 1992; Monson et al., 2006), CPT is also used to reduce symptoms of PTSD

related to sexual abuse (Chard, 2005; Owens, Pike & Chard, 2001), co-morbid depression (Nishith, Resick & Griffin, 2002) and co-morbid panic disorder (Falsetti, Resnick & Lawyer, 2006; Falsetti, Resnick & Davis, 2005), with significant pre-post reductions in severity of cognitive thinking errors that were maintained through one year of follow-up (Owens, Pike & Chard, 2001). Integrating sexual trauma treatment with sexual risk reduction strategies has the potential to improve acceptability and feasibility of HIV prevention.

Our 10-session CBT-TSH intervention incorporated four novel risk-reduction education modules: (1) psychoeducation/resource building, (2) cognitive restructuring, (3) behavioral rehearsals, and (4) intimacy/relationship issues. The goals of the intervention were to directly reduce CSA-related PTSD symptom severity/distress (i.e. decrease hyper-arousal, negative emotions, and intrusive thoughts); provide participants with skills to make more accurate sexual risk appraisals; and improve self-care behaviors through more adaptive management of sexual risk for HIV/STI acquisition. In the current paper, we present participants' feedback on intervention acceptability and utility, their experiences in the program, suggestions for program strengthening, and areas of improvement for future iterations.

Method

The qualitative data discussed in this paper were collected during optional exit interview sessions in the CBT-TSH intervention. Exit interviews were part of a larger battery of measures to evaluate the intervention. For the parent CBT-TSH study, participants were recruited at Fenway Health, a non-profit community health center that specializes in LGBT health care and HIV/AIDS research. Recruitment strategies included venue (i.e., bars, clubs, and cruising areas) and community outreach, advertisements within the Fenway Health center, and distribution of study flyers at medical provider meetings. To ensure that the experimental and control groups were relatively equal on the presence of PTSD symptoms, we utilized stratified-randomization based on PTSD diagnosis using the Mini-International Neuropsychiatric Interview (Sheehan et al., 1998).

Criteria for participation in the parent study included: identifies as MSM; reports history of CSA; reports at least one episode of unprotected anal or vaginal intercourse within the past three months; and reports HIV-negative status confirmed by a rapid HIV test. Participants were excluded if: 1) all episodes of unprotected intercourse occurred only with a single, primary HIV-negative partner; 2) there was a diagnosis of significant mental health burden requiring immediate treatment (e.g. bipolar disorder; any psychotic disorder); 3) they were unable to complete the informed consent process (e.g., substantial cognitive impairment, inadequate English language skills); and/or 4) they received CBT for PTSD within the past 12 months. All study procedures were approved by the Fenway Health Institutional Review Board.

All participants in the CBT-TSH group (n=23) were asked to participate in the qualitative exit interview. The research team reviewed best practices to develop a qualitative semi-structured interview guide (Denzin & Lincoln, 2005). Nine men volunteered for the 30-minute interview, which was conducted by an expert in qualitative research methods. We

approached the data using a qualitative descriptive design (Sandelowski, 2010; Sandelowski & Corson Jones, 1996; Sullivan-Bolyai, Bova, & Harper, 2005), requiring us to engage in low interpretation and inference. Two researchers independently coded each transcript (within-case analysis) line-by-line, and then compared (across-case analysis) codes of each transcript (Ayres, Kavanaugh, & Knafl, 2003). Next, the researchers discussed commonalities and differences within and across cases and organized across-case findings into emerging themes.

Results

Table 1 provides socio-demographic data for the participants. Average ages of the exit interview sample and the entire sample were 38.2 and 39.2 years respectively. Table 2 provides four emerging themes with significant statements to support those themes.

Theme I: Motivation to participate.

Participants generally described that they were highly motivated to participate in a research study that might help them better understand their experience of sexual abuse as a child or adolescent. Two subthemes for motivation were identified: *understanding of perceived guilt* and *the desire to explore positive coping skills*. A few participants felt guilty for having endured unwanted sexual contact as a child (quote 1). Other participants shared they wanted to understand how to better cope with potential symptoms having been traumatized by the sexual abuse (quote 2).

Theme II: Response to Cognitive Processing.

Seven of the nine participants expressed that it was helpful they could process and release their emotions about the sexual abuse (quote 3). In similar statements resembling catharsis, other participants recognized how not talking about the abuse perpetuated negative emotions that needed to be released (quotes 4, 5).

Theme III: Perceived Process of Change.

When asked how the novel CBT-TSH curriculum specifically affected their lives during and/or after the intervention, responses could be categorized into three subthemes. In subtheme one (*recognizing avoidance behavior*), some participants expressed that they could identify how the sexual abuse affected their interactions with others. Specifically, one participant described how through the intervention he could process his avoidance-coping behavior in detail (quote 6). Some participants identified they would engage in potentially risky activities as a way of avoiding the emotional pain of their sexual abuse, highlighting the use of alcohol and sexual encounters to avoid the residual pain of CSA (quote 7).

In subtheme two (*increased adaptive coping skills*) participants shared how they learned through the intervention to incorporate adaptive coping skills to improve social functioning (quote 8). Other participants noted how those adaptive coping strategies helped them be more honest with themselves and not blame others for their sexual abuse experience, as demonstrated in quotes 9 and 10.

Most participants discussed how their sexual decision-making had changed throughout their participation, subtheme three (*decreased sexual-risk taking*). Six of the nine participants provided examples of how they decreased their sexual risk taking because of the intervention. Some felt more sexually safe after participating in the study (quote 11). One noted he became more assertive about using condoms instead of responding with avoidant coping strategies (quote 12) and another asserted safer-sex strategies in open, long-term relationships (quote 13).

Theme IV: Considerations for Intervention Improvement.

We were specifically interested in soliciting feedback about how to improve the CBT-TSH intervention. Three specific areas of improvement were identified: clarify goals of the intervention (quote 14); increase the number of sessions (quote 15); and improve the referral process for additional behavioral health services (quote 16).

Discussion

These qualitative data provide insight on the acceptability of an innovative program for SMM that integrates CBT with sexual risk-reduction counseling. Four emerging themes were identified. First, participants generally had multiple motivations to participate. Many participants were highly motivated to discuss CSA and address trauma symptoms related to the experience, especially while feeling “a lot of anger” or that they “don’t deserve to be happy.” However, only nine out of 23 participants volunteered for the exit interview. The Transtheoretical Model for Behavior Change (Prochaska & Velicer, 1997) provides a framework for understanding this motivation as part of the contemplation and preparation continuum. Accordingly, motivational interviewing (Miller & Rollnick, 2013) could facilitate motivation throughout the remaining stages and thereafter.

Participants shared the experience that sexual abuse was, and continues to be emotionally, cognitively, and behaviorally complex. For several participants, the abuse occurred against a broader background of physical abuse, neglect, and impoverishment. For others, the abuse was in the context of a conflicted relationship in childhood or adolescence; and many still feel conflicted as adults. For others, the abuse represented a significant disturbance in an otherwise nurturing and supportive upbringing. The heterogeneity of the contexts in which the CSA occurred underscores the varied motivations brought to the therapeutic process.

The second emerging theme was the positive response to processing the CSA experience. One therapy procedure involves writing and re-writing an impact statement (Resick & Schnicke, 1992), setting the stage for an examination of cognitive distortions around the CSA and negative self-cognitions. The process of developing a coherent narrative about the CSA and its meaning, with the therapist teaching specific cognitive restructuring skills, requires one to move toward more realistic self-appraisal. This process allowed the participant to discard trauma-associated guilt, self-blame, and shame. Achieving some success in confronting painful aspects of the trauma allows one to discard intense feelings of guilt and self-blame (illustrated in quotes 3 and 5). As one moves beyond these negative emotions, he can minimize the hyperarousal used to protect against the distress of intrusive feelings, thoughts and other painful associations of the CSA (quotes 4 and 5).

Perceived process of change was another theme that emerged from the data. Increased insight into avoidant behavior patterns might describe this process of change. One participant (quote 6) became more aware of shutting down and withdrawing in social situations lest others realize that he has suffered CSA and is broken or damaged. This is a common trauma-related, cognitive self-distortion, that the trauma has caused irreversible damage, that the person is now necessarily cutoff from other people; this is a prominent symptom of PTSD (SAMHSA, 2015). L-28 identified the avoidant pattern and the cognitive distortion that drives it. Identifying cognitive self-distortions and recognizing avoidance patterns are central mechanisms by which the intervention is designed to resolve CSA-related distress and reduce maladaptive avoidance.

Several younger participants (quotes 6–8, 12) expressed insight concerning their using sex to avoid distress in their lives. Two participants describe avoidant processes during sex either through alcohol use (quote 7) or increasing withdrawal and passivity during sex (quote 12). This latter case suggests that SMM who were sexually traumatized in childhood may not be fully present during adult sexual experiences. This withdrawal or avoidance could interfere with accurate risk/safety appraisals and compromise the ability to engage in approach-oriented, self-protecting adaptive coping (e.g., discussing HIV risk, condom use, and asking about HIV status).

These reports are broadly consistent with several clinical epidemiology studies that examine the impact of CSA on subsequent health and mental health development in SMM. Mimiaga et al. (2015) reported CSA combined with other psychosocial problems increases risky sexual behavior among SMM as reflected in significantly higher rates of HIV infection. Boroughs et al. (2015) reported that many contextual aspects of the CSA experience (CSA severity) significantly predicted mental health, substance use, and sexual health problems in adulthood. Most recently, we found that avoidant coping significantly mediated the relationship between CSA severity and sexual risk behavior in a large cohort of SMM with CSA histories (O’Cleirigh, et al., 2016).

The ego-insult associated with CSA can interfere with a positive self-image, worthiness of happiness, self-protection and safety. Quote 6 illustrates an insight around a more positive self-view of and a struggle for assertiveness. The development of a more realistic positive self-appraisal is a key feature of the therapeutic resolution of CSA-related trauma, and in our conceptual model, is a prerequisite for achieving assertiveness and self-protection in sexual situations. Overall, the participants’ insights support their understanding of the treatment model logic. Moreover, they identify with the treatment rationale that underlies the importance of acquiring realistic appraisals of the trauma and of self. These include identifying individual avoidant strategies and adopting alternative approach-oriented coping strategies, particularly in adult sexual situations that require assertiveness and allow communication of needs and wants to protect sexual health.

Soliciting feedback for improvement is an important component of intervention development. This step serves as a feedback loop for evidence-based improvement in public health interventions (Linnan and Steckler, 2002). Although participants demonstrated a sophisticated understanding of the treatment rationale, they did suggest clarifying treatment

goals and providing more treatment sessions to address other health concerns. Participants often have comorbid conditions (e.g., mood disorders, anxiety disorders, alcohol and substance use issues) that co-occur with CSA (e.g., Mimiaga et al., 2015); these comorbidities were apparent in our sample. As the participant addresses CSA-related distress in therapy, the therapist could be more aware of distress management pathways that lead to risky sex or to increased alcohol or substance use, and could better understand participant's full ranges of adaptive coping skills.

A major clinical consideration from our participants' CSA is that memories, interpretations and appraisals of CSA are highly individualized. As such, the disturbance, distressing emotions, interfering cognition, and negative and distressing self-views are highly idiosyncratic. This underscores the importance for the therapist to eschew pre-conceived ideas about the source of distress, where the impairment lies, and what the CSA means to the participant. The therapeutic skill of active listening pairs well with restatement and confirmation of interpretations and should ensure that participant trauma appraisals are accurately understood.

Many of our participants agreed the therapy (10 sessions) was too brief and that more sessions could have been used to address CSA and other mental health issues. As a skills-based therapeutic system, CBT is designed to teach a set of core skills to be applied across a variety of situations. One such skill is the ability to schedule and prepare for follow-up referral appointments, which are salient for retention in care. The application of these skills should increase adaptive functioning and reduce distress. These priorities for short-term, skills-based, symptom-focused CBT should form part of the treatment rationale and be communicated to the participant at the outset.

Limitations

Although qualitative exit interviews provide evidence for the acceptability and efficacy of the intervention, this methodology has its limitations. As only nine of the 23 participants in the experimental group completed the qualitative exit interview, the emerging themes may not represent all participants. However, the intervention was found feasible and acceptable. Negative feedback about the intervention was limited, suggesting that participants may have censored their comments when interviewed by study staff. Also, the sample may be skewed towards individuals who are highly motivated to engage in treatment for their trauma symptoms, limiting the number of respondents likely to view the treatment as overwhelming or ineffectual. Despite these limitations, the data collected from these qualitative exit interviews were used to improve the intervention and inform the basis of a larger subsequent RCT currently being implemented.

Conclusion

In the US, SMM are most severely affected by HIV, and CSA contributes to negative health outcomes including HIV acquisition. There is ongoing need to create novel CBT-based interventions for SMM to reduce CSA-associated distress/trauma symptoms, while focusing on sexual health. The current report provides qualitative exit interview feedback on the

acceptability of a novel program for SMM that integrates CBT for trauma related to CSA with sexual risk-reduction counseling. Clinical researchers and practitioners who create or augment psychosocial interventions might incorporate this evaluative model to improve acceptability and effectiveness.

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Table 1**Participant Background and Demographic Characteristics**

	Mean (SD) or Number (%)	
	Exit interview sample (n=9)	Entire sample in RCT (n=43)
Age	38.2 (SD=13.77)	39.2 (SD=11.07)
Race/Ethnicity		
White	41.7	62.8
Black/African American	16.7	25.6
Latino/Hispanic	16.7	7.0
Other	0	4.6
Education		
Less than high school	8.3	9.3
HS/GED	33.3	27.9
Some College	8.3	20.9
College Degree	0	18.6
Graduate Degree	25.0	23.2
Annual income		
Less than \$10,000	25.0	30.2
\$10,001 – \$20,000	16.7	23.3
\$20,001 – \$40,000	0	14.0
\$40,001 – \$60,000	16.7	14.0
\$60,001 – \$80,000	8.3	2.3
Greater than \$80,000	8.3	16.3
Relationship status		
Single/Never married	41.7	53.5
Committed – not living with partner	0	11.6
Domestic partner	8.3	11.6
Married	8.3	7.0
Separated	0	2.3
Divorced	0	9.3
Sexual orientation		
Gay/Homosexual	58.3	62.8
Bisexual	0	27.9
Unsure	16.7	9.3

Note. Participants were able to “check all that apply” or “refuse to answer” thus percentages may not equal 100%.

Table 2

Significant statements from interviews

Emerging Theme	Significant statements	Age/Ethnicity
1. <u>Motivation to participate</u>	1. "I wanted to see if I could find some answers to why this happened - just why, you know? I can't even explain these feelings. I mean, a lot of anger, but I wanted to find out, you know, somebody to tell me it wasn't my fault."	W, 45 y/o
	2. "I came into it (the study) because I wanted to learn ways that I could cope with the sexual abuse...when you've had sexual abuse in the past, you always feel like you don't deserve to be happy. You're not normal. You're not able to experience loving thoughts. It's very hard to trust people. So, I just wanted to learn how to deal with it and how to cope and I didn't want to feel alone."	L, 24 y/o
2. <u>Response to Cognitive Processing</u>	3. "It (the intervention) was necessary, because I was going through it - thinking about it, so it was best to get it off my chest."	B, 37 y/o
	4. "I really hadn't talked to anybody about it (the sexual abuse) in 35 years...it felt so refreshing because I realized that there was a lot of frustration and anger going on in my head that had been there for a long time."	W, 51 y/o
	5. "To let go of a lot of the feelings that sort of bottled up over the years, to express really what I was feeling, and not be so angry about it, and not to express them angrily or not to keep them bottled up, there were things that I had never talked about to anybody, so just being able to release those things, to let those things go."	W, 47 y/o
	6. "I was with a group of friends and as soon as more guys walked into the room, I kind of quieted down and wasn't participating as much. And so in general I felt that sometimes frustrates me. I felt like I held back sometimes in certain groups. It's like me kind of shoving down, kind of closing myself off, as a way to not let people know that the sexual abuse had happened. That this is a way of me protecting myself, and that somehow, if I participated, or if I engaged with this group or with someone else, you know, these walls would start coming down and someone would see that there was something wrong."	L, 28 y/o
3. <u>Perceived Process of Change</u>	7. "I would basically go out to the club and have a few drinks and then hook up with somebody because I felt like I needed to just take my mind off of the pain that I was going through. I used sex in place of the pain. It took the pain away."	B, 23 y/o
	8. "I've been able to seek out different methods of coping with situations better. I've been talking to my friends more often. I am able to seek out different methods of coping during situations better."	B, 23 y/o
	9. "just to let them (family) know that in spite of it all, I'm OK, I'm doing well. And that there's no need to feel guilty, and I certainly don't blame them."	W, 47 y/o
	10. "empowering me more to be honest with myself and about what I want and need from things, and be better prepared to stand up for those things if I'm in a situation where I have to do that."	W, 27 y/o
	11. "I was using sex to deal with whatever was really going on with my life...I probably wasn't coping with as well as I should have been. And then so I was turning to sex for those things. So in that respect, it's (the therapy) made things a lot safer...I feel like I'm less at risk now, cause it was a lot of risky behavior that I was getting involved with there for a while."	W, 47 y/o
	12. "More issues came out in terms of my sex life...some of the things we talked about was in group settings when I became a little bit withdrawn or a little bit passive. It was leaking over into my sex life that kind of prevents me from speaking up about using a condom, now I'm a bit more assertive...not letting somebody make the decision for me about using a condom...so it's like knowing I have this confidence and just learning how to apply it to this situation."	L, 26 y/o
	13. "When I was with my boyfriend a couple of months ago, we ran out, he's like -- I said no. And he got all pissed off. I'm like, I'm not doing it, you know, because he's -- I don't know what he's doing."	W, 45 y/o
	14. "The project could clarify a little bit more what they are focusing on exactly because I know that according to the flyer and just according to the initial description... maybe during the first session, there could be a little more explanation about how these results are going to be used."	L, 24 y/o
4. <u>Considerations for Intervention Improvements</u>	15. "I think that there should be more of them [therapy sessions]. I would say I would increase it just by maybe two or three."	B, 23 y/o
	16. "I thought that I had made some really significant progress from the time that I started to the time I finished. But I really wanted to continue on. And they did give me a referral to see somebody else...But I never followed up with him."	W, 47 y/o

w = white, B = Black, L = Latino