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Sexual abuse and HIV-risk behaviour among black and minority ethnic men who have sex with men in the UK

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ABSTRACT

Black and minority ethnic (BME) men who have sex with men (MSM) face a major burden in relation to HIV infection. It was hypothesised that sexual abuse would predict sexual risk-taking, and that this relationship would be mediated by victimisation and maladaptive coping variables. Four hundred and thirty-two BME MSM completed the survey; 54% reported no sexual abuse and 27% reported sexual abuse. Mann–Whitney tests showed that MSM with a history of sexual abuse reported higher frequency of drug use, and of homophobia and racism than those reporting no prior sexual abuse. A structural equation model showed that the experience of sexual abuse was positively associated with sexual risk-taking and that this relationship was mediated by victimisation variables: frequency of racism and frequency of homophobia and by the maladaptive coping variable: frequency of drug use. The findings can inform the design of psycho-sexual and behavioural interventions for BME MSM.

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KEYWORDS

Sexual abuse; psychological adversity; HIV; maladaptive coping; drug use

Introduction

Both men who have sex with men (MSM) and black and minority ethnic (BME) groups experience significant sexual health inequalities. BME MSM face a double jeopardy in relation to sexual health. Black MSM are more likely to be diagnosed with a bacterial sexually transmitted infection (STI) compared to other ethnic groups (Dougan et al., 2005), and this group is 15 times more likely to be HIV-positive compared with the general population (Millet et al., 2012). According to recent Public Health England HIV surveillance data (Public Health England, 2015), there has been a more than 82% increase in new HIV diagnoses among MSM of “other” and mixed heritage. In a survey study conducted at a London sexual health clinic (Soni, Bond, Fox, Grieve, & Sethi, 2008), it was found that BME MSM were more likely to report condomless anal intercourse with casual partners in the preceding three months than White British respondents.

Most research on BME MSM has focused on Black MSM rather than British South Asians (BSA) – the largest ethnic minority group in the UK. The small number of studies of this

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population generally suggest a low HIV prevalence among BSA MSM, although there is emerging evidence of high-risk behaviours in this group (Griffiths, 2015). For instance, in survey research, it has been argued that BSA MSM are less likely to report sexual activity with a known HIV-positive partner (Hickson et al., 2004). This may actually be construed as a risky sexual behaviour given that individuals may be engaging in “sero-guessing”, that is (erroneously) guessing the HIV status of their sexual partner. There has also been some work on BSA MSM’s engagement with genito-urinary medicine (GUM) clinics. Survey research conducted at GUM clinics suggests that BSA may be more reluctant than other ethnic groups to seek care from GUM clinics due to cultural stigma (Dhar et al., 2010). Similarly, a national survey of MSM living in Britain found that BSA were more likely to express anxiety about attending a sexual health clinic due to the possibility that others in their community might find out that they had sex with men (McKeown et al., 2012). Although the prevalence of diagnosed HIV remains low among South Asians in the UK, a year on year increase in HIV incidence has been observed in this group (Desai et al., 2015). Given the scarcity of research among BSA MSM, this study explores the factors likely to be associated with sexual risk-taking in this group.

The links between HIV transmission and drug abuse have been described in the epidemiological literature (see Amaro, Raj, Vega, Mangione, & Norville Perez, 2001; Pence et al., 2008). The use of some recreational psychoactive drugs, such as mephedrone, γ -hydroxybutyrate (GHB), γ -butyrolactone (GBL), and crystallised methamphetamine, has been associated with HIV transmission. When used in sexualised settings – a practice known as “chemsex” – these drugs can lead to sexual disinhibition which in turn can pave the way for sexual risk-taking behaviours (Duesberg, Koehnlein, & Rasnick, 2003; Melendez-Torres & Bourne, 2016; Pence et al., 2008). Indeed, HIV and alcohol/drug use have been termed “twin epidemics” because of their interconnectedness (Welch, 2000).

Epidemiological research suggests that ethnic minorities in the US manifest a higher prevalence of both drug use and HIV (Amaro et al., 2001). African Americans and Latinos are particularly vulnerable to HIV acquisition and may use drugs as a maladaptive coping strategy (Amaro et al., 2001; Pence et al., 2008). Research suggests a high prevalence of recreational drug use in Asian MSM. For example, Fazio, Joe-Laidler, Moloney, and Hunt (2010) found that 54% of 250 Asian Americans reported consuming recreational drugs, such as poppers, methamphetamine and lysergic acid diethylamide (LSD). Moreover, Asian MSM reported higher rates of lifetime gammahydroxybutyrate (GHB) and ketamine use than Asian heterosexual males as well as higher rates of current methamphetamine, GHB and ketamine use.

Substance use among BME MSM can be explained through the lens of the stress-coping model (Wills & Cleary, 1995). Research guided by the stress-coping model examines the association between exposure to stressors in one’s life and various adverse physical and mental health consequences, including substance use behaviours. The likelihood of experiencing adverse health outcomes as a result of cumulative stress exposure, however, may be conditioned by the presence (or absence) of a number of personal and social resources that can enable the individual to cope effectively (Jaspal, 2018). Coping strategies – the array of cognitive and behavioural strategies that people use to manage stress – have been associated with various adverse health behaviours, including substance use (Hasking & Oei, 2004; Lazarus & Folkman, 1984). Maladaptive coping strategies include emotion-focused strategies, such as behaviours that promote temporary

positive affective experiences (e.g., euphoria, self-confidence, hedonistic pleasure) such as drug use (Carver, 1997).

BME MSM are at particularly high risk of experiencing stressors related to the stigmatisation of one of more group memberships, such as racism and homophobia (Diaz, Ayala, & Bein, 2004). In several empirical studies, stressors such as racism and homophobia have been linked to engagement in sexual risk-taking behaviours. In a sample of Latino gay men, social exclusion was associated with participation in sexually “difficult” situations, that is, “sexual situations that compromise strong personal intentions and motivations to practice safer sex” (Diaz et al., 2004, p. 257). In another study of Black and Latino MSM, it was found that racism and homophobia were associated with unprotected anal intercourse with a sero-discordant or sero-unknown partner (Ayala, Bingham, Kim, Wheeler, & Millett, 2012). In a survey of Latino MSM in the US, respondents who had faced homophobia were more likely to engage in condomless receptive anal intercourse than those who faced no homophobia (Mizuno et al., 2012). Homophobia from within one’s ethnic in-group can decrease a sense of connection with one’s ethnic in-group, which in turn can increase sexual risk-taking behaviours. Crucially, BME MSM may face homophobia from both their ethnic ingroup *and* the general population (Jaspal, Fish, Williamson, & Papaloukas, 2016). Indeed, there is now a body of research that demonstrates the multiple social stressors associated with racism, religious prejudice and homophobia faced by BSA MSM (Jaspal & Cinnirella, 2010, 2012; Jaspal & Siraj, 2011). Perceived exclusion from multiple social groups can lead to feelings of marginalisation, leaving individuals with few sources of social support and sexual health information.

The experience of sexual abuse has also been identified as a significant predictor of sexual risk-taking behaviours (Rosario, Schrimshaw, & Hunter, 2006). Indeed, MSM who have faced experiences of childhood sexual abuse tend to report more sexual partners and higher levels of unprotected anal sex than those MSM who have no history of childhood sexual abuse (O’Leary, Purcell, Remien, & Gomez, 2003). In one study of adult survivors of sexual abuse (Zierler et al., 1991), there was a twofold increase in HIV prevalence among sexually abused men versus those who had not been abused. Various mediating factors, such as drug use and other traumatic experiences such as victimisation by racism, have been described in previous research into the relationship between sexual abuse and sexual risk-taking behaviours (Pence et al., 2008; Sikkema et al., 2007).

There is some evidence of a higher prevalence of sexual abuse experiences among BME individuals due partly to the silencing of such issues and consequential perception that perpetrators will not be apprehended (Durham, 2003). The experience of sexual abuse can induce the emotional experiences of guilt and shame, which in turn can increase susceptibility to other forms of victimisation, such as engagement in impulsive and reckless behaviours (e.g., drug use, chemsex), as a coping strategy (Reich & Zanarini, 2008). Moreover, the feelings of frustration and betrayal provoked by experiences of sexual abuse are not dissimilar to the feelings of victimisation associated with racism and homophobia. The distress that these feelings provoke can lead to short-term coping strategies, such as drug use and sexual risk-taking behaviours, which may provide pleasure and euphoria in the short term, while also perpetuating a vulnerable and unstable sense of self in the individual.

It can be hypothesised that BME MSM will be particularly vulnerable to various stressors (social, economic, racial, etc.) provoked by experiences of abuse, discrimination and

exclusion, which in turn will give rise to maladaptive coping strategies (e.g., drug use). These maladaptive coping strategies may predispose individuals to engage in sexual risk-taking behaviours, resulting in additional stress due, for instance, to HIV infection. The stress provoked by previous traumatic experiences and current health issues can lead to further dependence on substances as a means of coping (Bourne, Reid, Hickson, Torres Rueda, & Weatherburn, 2014). This can result in a circular perpetuation of maladaptive health behaviours.

Despite the sexual health inequalities faced by BME MSM and the high incidence of HIV in this population, there has been limited empirical research into the possible HIV-risk factors in BME MSM (Fish, Papaloukas, Jaspal, & Williamson, 2016). Accordingly, a cross-sectional correlational survey study was conducted to address this lacuna in research into BME MSM.

Hypotheses

Given the observed higher prevalence of sexual abuse in BME MSM than the general population and the possible link to sexual risk-taking observed in other groups (Rosario et al., 2006), it is predicted that in our BME MSM sample, sexual abuse will be associated with sexual risk-taking. Moreover, in view of evidence of an association between sexual abuse and racism, homophobia and drug use (Pence et al., 2008), it is predicted that the relationship between sexual abuse in BME MSM and sexual risk-taking behaviour will be mediated by victimisation variables, namely homophobia and racism, and the maladaptive coping strategy of drug use.

Methods

Participants

Recruitment 432 BME MSM were recruited over an 18-month period through the following sexual health charities: NAZ: Sexual Health for Everyone (London), Trade Sexual Health (Leicester) and Yorkshire MESMAC (Yorkshire). The criteria for participation included self-identification as MSM and BME. Table 1 provides an overview of the socio-demographic characteristics of the sample. BSA MSM constitute the majority of the sample.

Measures

A questionnaire was devised to identify some of the sexual health issues and needs in BME MSM communities. The following scales were included:

Sexual abuse was measured with the following single item: "Have you ever experienced sexual abuse?" and respondents had to respond either yes or no. Before responding to the question, respondents were given the following definition of sexual abuse "Sexual abuse is any sort of non-consensual sexual contact. Sexual abuse can happen to men or women of any age".

Frequency of homophobia was measured using the following single five-point scale item: "How often do you experience homophobia?". This item was scored on a five-point Likert scale (1 = "never" to 5 = "daily").

Table 1. Socio-demographic characteristics.

	Sexual abuse (N = 143)	No sexual abuse (N = 289)
Ethnicity		
South Asian	N = 103 (72%)	N = 185 (64%)
Black	N = 13 (9%)	N = 42 (14.5%)
Latino	N = 21 (25%)	N = 45 (15.6%)
Mixed	N = 1 (0.7%)	N = 9 (3.1%)
Other	N = 5 (4%)	N = 8 (2.8%)
Sexual orientation		
Gay	N = 128 (90%)	N = 245 (86.6%)
Bisexual	N = 7 (4.9%)	N = 30 (10.6%)
MSM	N = 6 (4%)	N = 5 (1.8%)
Not sure	N = 1 (0.7%)	N = 2 (0.7%)
Other	N = 0	N = 1 (0.4%)
Age group		
Under 25	N = 32 (22.4%)	N = 71 (24.8%)
26–35	N = 81 (57%)	N = 140 (49%)
36–50	N = 26 (18.2%)	N = 70 (24.5%)
Over 50	N = 3 (2%)	N = 5 (1.7%)
Education level		
Did not complete high school	N = 5 (3.5%)	N = 9 (3.1%)
Complete high school	N = 78 (55%)	N = 133 (46%)
University degree	N = 80 (40.2%)	N = 147 (50.9%)
HIV status		
HIV negative	N = 89 (73%)	N = 184 (77.3%)
HIV positive	N = 33 (27%)	N = 54 (22.7%)

Frequency of racism was measured using the following single five-point scale item: “How often do you experience racism?”. This item was scored on a five-point Likert scale (1 = “never” to 5 = “daily”).

The questionnaire also tapped into drug use behaviour focusing particularly on the use of “poppers” (alkyl nitrites).

Frequency of drug use was measured using the following single five-point scale item: “How often do you use drugs?”. This item was scored on a five-point Likert scale (1 = “never” to 5 = “daily”).

The questionnaire then focused on risky and unsafe sexual lifestyle and behaviour. Respondents were asked about attending sex parties and saunas and engagement in unprotected anal intercourse and about their reasons for not using condoms during sexual intercourse to prime them to think about different kinds of sexually risky behaviours.

Sexual risk was measured using the following five-point scale item: “I would consider the type of sex I’ve had in the last 12 months to be [all safe/ mostly safe etc]”. This item was scored on a five-point Likert scale (1 = “I haven’t had any sexual contact” to 5 = “all safe”). A higher score indicates more risky sexual behaviour.

HIV knowledge was measured using an adapted version of the 18-item HIV knowledge questionnaire (Carey & Schroder, 2002).

Results

Normal distribution checks

All statistical analyses were conducted using SPSS and AMOS version 21. Kolmogorov–Smirnov tests were performed to ascertain the normality of distribution. All of the major

variables were not normally distributed. Hence, non-parametric tests were used. Non-parametric tests were conducted to examine whether there were statistically significant differences between the BME groups and age groups on the dependent variables of interest, namely sexual risk.

Ethnic group differences

Results showed that there were no statistically significant differences between South Asians (Mdn = 3, SD = .726) and Black individuals (Mdn = 3, SD = 1.16) and Latinos (Mdn = 3, SD = .83) on sexual risk ($Z = -1.36, p = .17$ and $Z = -.26, p = .79$). Moreover, Black individuals did not manifest more sexual risk-taking than Latinos ($Z = .53, p = .94$). These results are consistent with existing evidence that Asians (including South Asians) engage in as much sexual risk-taking (e.g., unprotected anal sex) as other ethnic groups (Maung Maung et al., 2013). Conversely, South Asians did show statistically significant less knowledge of HIV (Mdn = 3, SD = 1.86) than Black individuals (Mdn = 5, SD = 2.08) and Latinos (Mdn = 5, SD = 2.01) ($Z = -4.85, p < .001$ and $Z = 3.04, p < .001$). There was no statistically significant difference between Black individuals and Latinos on the knowledge score ($Z = .57, p = .90$) This seems to suggest that South Asians do seem to be less informed about HIV than the other ethnic groups in the sample. It is noteworthy that, as expected, Black individuals experienced significantly more homophobia (Mdn = 3, SD = 1.25) and racism (Mdn = 3, SD = 1.16) than both South Asians (Mdn = 2, SD = 1.29 and Mdn = 2, SD = 1.11) ($Z = 2.18, p = .029$ and $Z = 4.94, p < .001$) and Latinos (Mdn = 2, SD = 1.18 and Mdn = 2, SD = .97) ($Z = 1.52, p = .020$ and $Z = 2.57, p < .001$). In contrast, Latinos reported more frequent drug use (Mdn = 2, SD = .99 than South Asians (Mdn = 1, SD = .74) and Black individuals (Mdn = 1, SD = .78) ($Z = 2.62, p < .001$ and $Z = 2.01, p < .001$).

Age group differences

Younger respondents (under 25) exhibited less knowledge of HIV (Mdn = 3, SD = 1.85) than older respondents: 26–35 (Mdn = 4, SD = 1.86) ($Z = 1.59, p = .012$); 36–50 (Mdn = 6, SD = 1.84) ($Z = 3.23, p < .001$); over 50 (Mdn = 6.50, SD = 1.95) ($Z = 7.11, p < .001$).

Differences between sexual abuse vs. no abuse groups

In a sample of 432 individuals, 54% reported no sexual abuse, whereas 27% reported having experienced sexual abuse. A non-parametric Mann–Whitney test was conducted to examine statistically significant differences between those who reported prior sexual abuse ($n = 143$) and those who did not ($n = 289$) in relation to the frequency of homophobia, racism and drug use and sexual risk (Table 2). Mann–Whitney tests showed that victims of sexual abuse reported higher frequency of drug use ($M = 1.49, Z = 2.10, p = .036$) and higher frequency of both homophobia ($M = 2.80$) and racism ($M = 2.77$), ($Z = -3.15, p = .002$ and $Z = -3.52, p < .001$) than those who reported no prior sexual abuse ($M = 1.34$ for frequency of drug use and $M = 2.39, M = 2.32$ for frequency of homophobia and racism, respectively). There was no statistically significant difference between these two groups in relation to sexual risk ($Z = 0.85, p = .40$). The results suggest that victims of sexual abuse were more vulnerable to engaging in drug use and to other forms of victimisation, such as homophobia and racism.

Table 2. Sexual abuse groups' descriptives.

	Sexual abuse		No sexual abuse	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Frequency of drug use	1.49	.881	1.34	.775
Frequency of racism	2.77	1.11	2.32	1.13
Frequency of homophobia	2.80	1.28	2.39	1.24
Sexual risk	2.68	.859	2.62	.806
HIV knowledge score	3.75	2.09	3.96	2.11

Correlations

Since the data were not normally distributed, Spearman Rho tests were conducted to examine relationships between the variables. The categorical variable Sexual Abuse (yes vs. no) was dummy coded to facilitate correlation analyses. Spearman rho correlations showed, as expected, that the victimisation variables were all significantly correlated with each other. More specifically, being a victim of sexual abuse was positively correlated with frequency of homophobia ($r = .15, p = .002$), frequency of racism ($r = .17, p < .001$) and frequency of drug use ($r = .10, p = .025$). Moreover frequency of racism was strongly and positively correlated with frequency of homophobia ($r = .52, p < .001$). This suggested that BME MSM who had faced sexual abuse were more likely to experience victimisation on the basis of race and sexual orientation (that is, racism and homophobia), and more likely to engage in drug use. HIV-positive status was positively correlated with drug use ($r = 2.74, p = .001$). Moreover, drug use was positively correlated with sexual risk ($r = .17, p < .001$). Thus, HIV-positive status and increased sexual risk are associated with more frequent drug use. Finally, frequency of racism had a weak positive correlation with sexual risk ($r = .09, p = .042$), suggesting that the more frequent one's experience of victimisation by racism, the more risky one's sexual behaviour is.

Binary logistic regression model predicting HIV status

A binary logistic regression was performed by inserting blocks of predictors, starting with the victimisation variables, namely frequency of homophobia, frequency of racism, followed by HIV knowledge; and finally, frequency of drug use. HIV-positive status was inserted in the model as the dependent variable. The model with the first two victimisation variables showed a Chi square of .79, $df = 2, p = .65$ which suggested that the first two predictors did not have a statistically significant effect. Indeed, the first two variables of victimisation did not contribute to the model ($\beta = .020$, Wald = .032, $p = .85$ for frequency of homophobia, and $\beta = -.101$, Wald = .074, $p = .40$ for frequency of racism). When the variable of HIV knowledge was added, the model showed a statistically significant Chi Square of 28.02, $df = 1, p < .001$, suggesting that this variable added significant predictive value to the model. Here the model predicts .06% of the dependent variable. The HIV knowledge score showed a $\beta = .31$, Wald = 25.46, $p < .001$ and added .06% of predictive value. Finally, when frequency of drug use was added to the model, the Chi Square was 21.96, $df = 1, p < .001$ and the model predicted 11.7% of the variance of the dependent variable. The frequency of drug use had a $\beta = .61$, Wald = 21.34, $p < .001$, predicting an added 12% of the dependent variable.

Structural equation model predicting sexual risk

Sexual abuse was associated with increased drug use, experiences of homophobia and racism, which in turn are associated with increased sexual risk behaviour. Thus, a structural equation model was constructed to examine the direct and indirect effects of sexual abuse and frequency of racism, frequency of homophobia and frequency of drug use on sexual risk (Figure 1). The mediation analyses used Baron and Kenny's approach (1986). Sexual risk was inserted as the dependent variable in this model as a continuous variable. The higher the score, the more unsafe and risky the sexual behaviour. The sexual abuse variable was inserted in the model as the predictor and frequency of homophobia, frequency of racism and frequency of drug use were inserted in the model as mediators of the impact of sexual abuse on sexual risk. The model showed a good fit with a Comparative Fit Index (CFI) of 1 and an RMSEA of .05 (see MacCallum, Browne, & Sugawara, 1996, for more on goodness of fit). The model was statistically significant with a $\chi^2 = 146.89$, $n = 432$, $df = 3$, $p < .001$. The model suggested that sexual abuse by itself did not have a statistically significant effect on sexual risk ($\beta = .02$, $p = .76$). However, there were statistically significant indirect pathways suggesting that sexual abuse had statistically significant direct effects on both the frequency of homophobia and frequency of racism ($\beta = .17$, $p < .001$ and $\beta = .18$, $p < .001$, respectively). Frequency of racism emerged as a statistically significant mediator of the impact of sexual abuse on sexual risk ($\beta = .10$, $p = .010$). Frequency of drug use also mediated the relationship between sexual abuse and sexual risk.

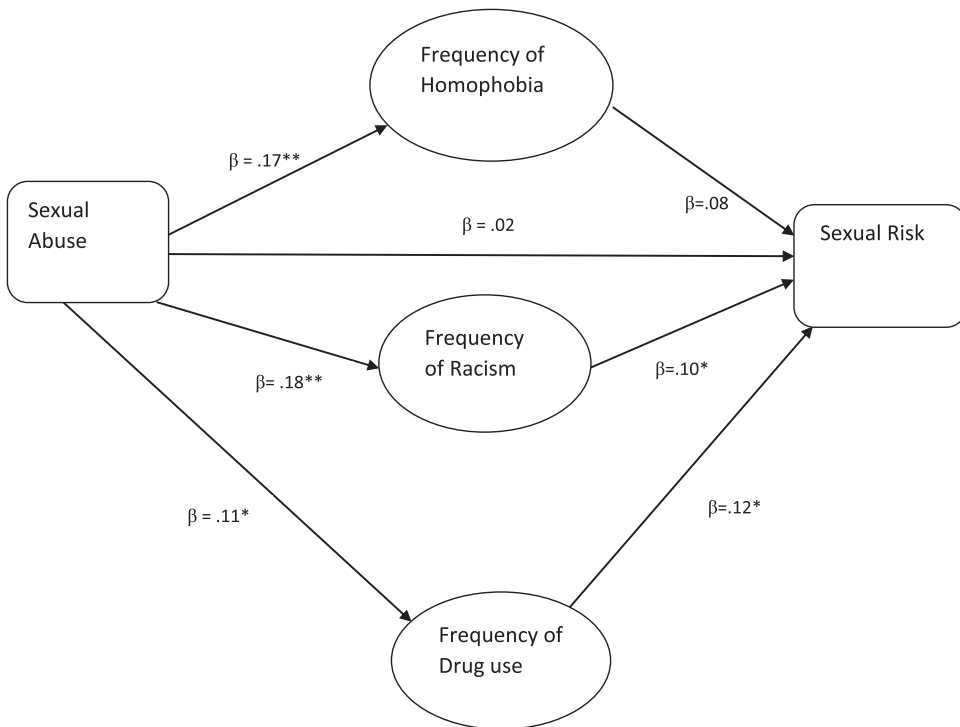


Figure 1. Pathway analysis with sexual abuse and frequency of homophobia, racism and drug use impacting sexual risk. * $p < .05$; ** $p < .005$.

Indeed, sexual abuse had a statistically significant direct effect ($\beta = .11, p = .010$) on frequency of drug use that then added ($\beta = .12, p = .009$) to the predictive value of sexual risk. The model thus suggested that the impact of sexual abuse on sexual risk is mediated by the victimisation variables: frequency of racism and frequency of homophobia, and by the frequency of drug use.

Discussion

The results of this study suggest that the experience of sexual abuse can predispose an individual to subsequent victimisation on the basis of their race and sexual orientation. Racism and sexual orientation were the only forms of victimisation measured in this study but it is possible that other forms of victimisation, such as sexual violence, may also arise following the experience of earlier sexual abuse in BME MSM. This phenomenon has been described as “revictimisation” (Classen, Paresh, & Aggarwal, 2005). However, our study suggests that revictimisation is not necessarily sexual in nature. The individual may not only develop a hypervigilant disposition and (mis-)interpret encounters and experiences as racist and/or homophobic (see Kramer, 1994 for more on the sinister attribution error), but they may actually also become susceptible to these other forms of victimisation.

Exposure to and experiences of homophobia have been implicated in substance abuse, sexual risk behaviours, negative body image, suicide attempts, increased stress and limited social support among MSM (Halkitis, Fischgrund, & Parsons, 2005; Mayer et al., 2008; Wolitski, Stall, & Valdiserri, 2008). Moreover, experiences with homophobia have been shown to interfere with the ability of MSM to establish and maintain long-term relationships, which protect against HIV acquisition (Diaz, Ayala, Bein, Henne, & Marin, 2001). The experiences of homophobia may exert their effects on sexual risk-taking indirectly by exacerbating the mental health burden (Johnson, Carrico, Chesney, & Morin, 2008). Experiences of oppression and homophobia, which tend to pervade family, school and community settings, are especially relevant for young MSM, who are in the process of establishing their personal identities. Unlike other marginalised groups (e.g., immigrants) who grow up with people like themselves and who receive the support of their families, young MSM frequently have more complicated and, in some cases, abusive family dynamics (D’Augelli, Hershberger, & Pilkington, 1998; Pilkington & D’Augelli, 1995).

The effects of discrimination are likely moderated by numerous factors, including the intensity of the discriminatory experience, the duration over which these experiences occur, as well as the relationship between the victim and the perpetrator(s) (Raymond, Chen, Stall, & McFarland, 2011). For example, the life-long health risks may be even greater if family victimisation takes the form of sexual abuse; Mimiaga et al. (2009) demonstrated that MSM with a history of childhood sexual abuse were more likely to report both unprotected anal intercourse, to derive fewer benefits from participation in prevention programmes and to be at an overall greater risk of HIV infection.

The experience of sexual abuse may lead an individual to develop personality traits, such as Borderline Personality, which render them vulnerable to subsequent forms of victimisation, such as racism and homophobia (Reich & Zanarini, 2008). Clinical psychology research has highlighted that sexual abuse in MSM may predispose them to poor mental health by engendering schemas of internalised homophobia and self-hatred coupled with an unstable self-concept and negative emotions, such as guilt and shame. These negative

cognitions can result in sexual risk-taking behaviour and vulnerability to further abuse (Reich & Zanarini, 2008). Indeed, existing research suggests that experiences of child sexual abuse may cause the individual to experience a range of feelings which are not dissimilar to the experience of racism: guilt, anger, frustration and betrayal. Behaviourally, these individuals may become withdrawn, aggressive and moody and, consequently, engage in sexual risk-taking behaviours. The concurrent experience of sexual abuse and racism reinforces a negative and unstable view of the self and relationships that may lead to vulnerability to mental health problems, drug use and, ultimately, HIV infection (Durham, 2003). Furthermore, the model suggests that the experience of sexual abuse is positively associated with the maladaptive coping strategy of drug use. Indeed, several empirical studies have identified drug use as a form of escapism for sufferers of psychological trauma (e.g., Bourne et al., 2014), including sexual abuse (Sikkema et al., 2007), which would appear to fit this line of thinking. Crucially, there was a significant pathway between the three mediators – the victimisation and maladaptive coping strategy variables – with the dependent variable of type of sexual risk. Indeed, racism, homophobia and drug use have been associated with sexual risk-taking behaviours among MSM, including HIV infection (Mizuno et al., 2012).

The findings strongly support the need for psycho-sexual and behavioural interventions among BME MSM that consider the possibility of sexual abuse and its impact for susceptibility to subsequent forms of victimisation and to drug use (Jaspal, 2018). Successful interventions must look beyond sexual health concerns and understand the social and psychological aspects of BME MSM's lived experiences in more integrated and sophisticated ways. This will include assessing and addressing possible victimisation (e.g., racism and homophobia) and maladaptive coping strategies (e.g., drug use). Interventions must be led by appropriately trained and culturally competent staff for BME MSM (Jaspal & Williamson, 2017; Scott, Fuqua, & Raymond, 2014). This recommendation has been echoed in a recent systematic review of interventions for BME MSM (Fish, Papaloukas, Jaspal, & Williamson, 2016). Addressing the enduring effects of sexual abuse on sexual risk-taking could be beneficial in preventing HIV infection among BME MSM – a group at high risk of HIV acquisition. In the UK, at the time of writing, there is a current prioritisation of BME MSM's health and well-being (see Jaspal et al., 2016). Our knowledge of which interventions are efficacious for BME MSM generally, and MSM from particular ethno-cultural groups is only in its infancy – especially in relation to HIV prevention. These data clearly suggest that possible experiences of prior sexual abuse should be considered in the delivery of interventions for preventing HIV among BME MSM.

Disclosure statement

No potential conflict of interest was reported by the authors.

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