

Risk Reduction for HIV-Positive African American and Latino Men with Histories of Childhood Sexual Abuse

John K. Williams · Gail E. Wyatt · Inna Rivkin ·
Hema Codathi Ramamurthi · Xiaomin Li ·
Honghu Liu

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Abstract While the HIV epidemic has disproportionately affected African American and Latino men who have sex with men (MSM), few HIV prevention interventions have focused on African American and Latino men who have sex with both men and women (MSMW). Even fewer interventions target HIV-positive African American and Latino MSM and MSMW with histories of childhood sexual abuse (CSA), a population that may be vulnerable to high-risk sexual behaviors, having multiple sexual partners, and depression. The *Men's Health Project*, a small randomized clinical trial, compared the effects of two 6-session interventions, the *Sexual Health Intervention for Men* (S-HIM), guided by social learning theory and aimed at decreasing high-risk sexual behaviors, number of sexual partners, and depressive symptoms, and a standard health promotion control (SHP). A community sample of 137 HIV-positive gay and non-gay identifying African American and Latino MSM and MSMW with histories of CSA was recruited. Results were based on an "intent to treat" analyses of baseline to post, 3 and 6 month follow-ups. The sample as a whole reported reductions in sexual risk behaviors and number of sexual partners from

baseline to post-test, and from the 3 to 6 month follow-ups, although the decrease in sexual risk behavior from baseline to post-test was significant only for S-HIM participants. No significant differences between conditions were reported for depressive symptoms, but the total sample reported a significant decrease at 6 months. These findings highlight the importance of addressing sexual decision-making and psychological adjustment for ethnic men, while being sensitive to CSA histories and sexual minority status, and suggest the need to develop additional strategies to heighten HIV risk reduction over time.

Keywords African American · Latino · Homosexuality · Bisexuality · Childhood sexual abuse · HIV

Introduction

In the United States, racial and ethnic minority groups have been the most impacted by HIV/AIDS (Center for Disease Control [CDC], 2005a). While HIV continues to spread disproportionately among African American and Latino men who have sex with men (MSM), few studies and interventions target high-risk African American and Latino men who have sex with men and women (MSMW) (CDC, 2005a, 2005b). Due to the high rates of HIV infections and to high-risk behaviors, such as unprotected sex, it has been suggested that this behaviorally bisexual population of African American and Latino MSMW may be contributing to HIV transmission to both male and female partners (CDC, 2004). Over one in three African American MSMW are HIV-positive and their overall prevalence rate is two to three times that of White or Latino MSMW (Bingham et al., 2003; CDC, 2004). The annual AIDS rate for Latino men is more than three times that of White men (CDC, 2001, 2002) and the highest rates of

J. K. Williams (✉) · G. E. Wyatt · H. C. Ramamurthi · X. Li
Department of Psychiatry and Biobehavioral Sciences, Semel
Institute of Neuroscience & Human Behavior, University of
California, Los Angeles, 760 Westwood Plaza, Suite C8-871C,
Los Angeles, CA 90024-1759, USA
e-mail: Keoniwmd@aol.com

I. Rivkin
Department of Psychology, University of Alaska Fairbanks,
705 A Gruening Building, Fairbanks, AK 99775, USA

H. Liu
Department of General Internal Medicine and Health Services
Research, University of California, Los Angeles, Los Angeles,
CA, USA

unprotected anal intercourse of any racial or ethnic group have been reported among gay and bisexual Latino men (Denning & Campsmith, 2005; Diaz, Stall, Hoff, Daihle, & Coates, 1996; Jarama, Kenamer, Poppen, Hendricks, & Bradford, 2005; Remien, Wagner, Dolezal, & Carballo-Diequez, 2001). These statistics support the need to develop risk reduction interventions specifically targeting HIV-positive African American and Latino MSM and MSMW.

It is important to understand the psychosocial and cultural issues that are pertinent to sexual decision-making for ethnic minority populations. In an effort to be culturally sensitive and to conduct culturally congruent research, investigators have examined issues such as HIV stigma and social isolation among African American and Latino MSM and MSMW, which they face as both ethnic and sexual minorities (Harawa, Williams, Ramamurthi, & Bingham, 2006; Icard, 1986; Kraft, Beeker, Stokes, & Peterson, 2000; Malebranche, 2003; Miller, Serner, & Wagner, 2005; Stokes & Peterson, 1998; Williams, Wyatt, Resell, Peterson, & Asuan O'Brien, 2004). Unfortunately, while many interventions recruit gay or bisexual men (Kanouse et al., 2005; Kegeles, Hays, & Coates, 1996; Kelly et al., 1997; Miller, 1995; Patterson, Shaw, & Semple, 2003; Wolitski, Gomez, Parsons, & The SUMIT Study Group, 2005), few of them actually address issues of race and ethnicity, and sexual identity, and more specifically, the potential disconnect between sexual identity and sexual behavior.

Nevertheless, many of these HIV prevention interventions focus on decreasing high-risk behaviors, such as unprotected sex, multiple partners, and drug use. Two interventions have been developed specifically for African American and Latino men (Carballo-Diequez et al., 2005; Peterson et al., 1996). However, others that target specific racial/ethnic MSM and MSMW populations and include representative samples with adequate sizes for generalizable results are needed.

Research that considers how ethnic minority men define their sexual identity is particularly needed given that African American MSM are more likely than White MSM to have both male and female partners but to identify with incongruent labels such as heterosexual and straight (CDC, 2003; Doll et al., 1992; Goldbaum et al., 1998; Harawa et al., 2006; Heckman, Kelly, & Bogart, 1999; Millet, Malebranche, Mason, & Spikes, 2005; Montgomery, Mokotoff, Gentry, & Blair, 2003). Recently, much attention has been given to African American men who are behaviorally bisexual, with the “down-low or DL” terminology being applied to this population (King, 2004; Millet et al., 2005). However, the issue of men having sex with both male and female partners, where the partners (usually female) are not aware of the bisexual behavior and where the men identify as heterosexual, is not new or unique to African American men. Even among recent studies of Latino MSM, there was a preference for heterosexual labels even though the men had not had any recent sexual contact with a woman and were engaging in predominantly same-sex behaviors with male partners

(Carballo-Diequez & Dolezal, 1994; Diaz, 1998; Doll et al., 1992). Subsequently, these men may not participate in HIV prevention or risk reduction interventions or listen to health messages about HIV, believing those messages apply to gay men, a group with which they do not identify.

It is critical to understand how African American and Latino MSM and MSMW define themselves racially/ethnically and sexually, and who their sex partners are. Additionally, few interventions address possible barriers to risk reduction that may be racially/ethnically or culturally embedded (e.g., the negative and/or stigmatized meaning of having sex with men or with men and women within the African American or Latino communities). Also, sensitive issues such as histories of childhood sexual abuse (CSA) may be difficult to discuss and are often neglected when considering current sexual behaviors and decision-making. Inclusion of such topics is necessary in order to develop HIV interventions addressing the most pertinent psychosocial and cultural issues for African American and Latino MSM and MSMW.

Men with histories of CSA may experience shame and not disclose its occurrence. CSA may influence current sexual decision-making and contribute to tendencies of male victims to externalize control over sexual behaviors to partners. CSA, defined as unwanted or coerced sexual body contact prior to the age of 18 with an adult or someone at least 5 years older, must be considered when developing HIV interventions for African American and Latino MSM and MSMW. CSA prevalence rates for males vary with large-scale national studies reporting 8% (Baker & Duncan, 1985), 13% (Badgley et al., 1984), 16% (Finkelhor, Hotaling, Lewis, & Smith, 1990), and others documenting rates varying between 4% and 76% (Burns-Loeb et al., 2002). These rates may differ, in part, due to difficulties inherent in assessing CSA among men and due to the diverse ways in which CSA is conceptually defined and operationalized.

CSA is not typically addressed in current HIV prevention interventions for men in general, or for MSM or MSMW specifically, even though it is an important predictor of high-risk sexual behaviors and depression (Garnefski & Arends, 1998; Holmes & Slap, 1998; Koenig, Doll, O'Leary, & Pequegnat, 2003; Paul, Catania, Pollack, & Stall, 2001; Ruggiero, McLeer, & Dixon, 2000). Specifically, male victims of CSA have reported significant problems, including hypersexual or compulsive behaviors, unprotected sex with multiple partners, and psychological distress including depression (Friedrich, Urquiza, & Beilke, 1986; Green, 1993; McCarty, Roberts, & Hendrickson, 1996; Tebbutt, Swanston, Oates, & O'Toole, 1997; Watkins & Bentovim, 1992). Many men abused as children continue to experience persistent problems revolving around sexuality, sexual activity and depression throughout adulthood (McCarty et al., 1996; Tebbutt et al., 1997). Further, victims of CSA are more likely to be sexually revictimized and less able to negotiate sexual activity as adults (Tjaden & Thoennes, 2000; Wyatt, Guthrie, & Notgrass, 1992).

HIV risk reduction interventions for African American and Latino MSM and MSMW who are HIV-positive and who have a history of CSA are needed. This highly vulnerable population of men, who are both ethnic and sexual minorities dealing with the stigma of being HIV-positive, are at risk for re-infection with HIV and for transmitting HIV to their male and female partners. Given these circumstances, the purpose of the study was to develop and test two conditions as part of a small randomized clinical trial called the *Men's Health Project*. We compared the *Sexual Health Intervention for Men* (S-HIM), aimed at decreasing high-risk sexual behaviors (i.e., unprotected anal and vaginal sex), number of sexual partners, and depressive symptoms, with a *standard health promotion attention control* (SHP) for gay and non-gay identifying HIV-positive African American and Latino MSM and MSMW who have a history of CSA.

Method

Participants

A community sample of HIV-positive African American and Latino MSM and MSMW was recruited from HIV and other service agencies in Los Angeles County using fliers, print advertisements, and face-to-face recruitment. Prospective participants were screened with seven items asking if they were (1) male, (2) 18 years of age or older, (3) English-speaking, (4) self-identified as African American/Black or Latino, (5) HIV-positive (verified through medical records or recent HIV, CD4 or viral load tests by the interviewer obtaining informed consent prior to baseline interviews), (6) had sex (oral, anal or mutual masturbation) with a male partner in the prior 6 months, and (7) prior to age 18, had an experience of unwanted or coerced sexual body contact with an adult or someone at least 5 years older. Prospective participants were asked to first listen to all seven items and then asked to indicate whether all seven items were applicable. Only those who said “yes” were eligible to participate in the study. Those who responded “no” were not asked to identify which item did not apply. Additionally, prospective participants could not have evidence of severe psychiatric, neurocognitive or other physical limitations that would prevent them from participating in the study or from providing informed consent. Interviewers were trained on how to obtain informed consent, assessing that potential participants understood the purpose, procedures, and risks and benefits of the study. Thirty-seven men were screened ineligible and were provided referrals (e.g., to other research studies, community based organizations, men's group, etc.).

Initially, we enrolled 164 men but only 137 completed the intervention due to death ($n = 5$) or lost to follow-up ($n = 22$). The sample size of the S-HIM was 62 (African Americans = 36, Latinos = 26) and the SHP was 75 (African

Americans = 53, Latinos = 22). While the original intent of the study was to develop an intervention specifically for MSM, more than half of the participants (59%) were MSMW. The reason for the inclusion of bisexual men as opposed to the target population of specifically MSM was due to the screener assessing only for sexual activity with male and not female partners in the previous 6 months. However, through baseline assessments and group discussions, we learned that the sample also included men who had sex with both male and female partners and who identified with various gay, bisexual and heterosexual labels.

The participants were a middle-aged (M age = 43.5 years, $SD = 8.0$), high school educated ($M = 12.3$ years of education, $SD = 3.4$), poor (average per capita monthly income = \$906.61, $SD = 3,065$), and underemployed (87.5% unemployed) sample. Regarding sexual partners, 41% reported having sex with only male partners, while 59% reported having sex with male and female partners. When asked what they considered their sexual identity label to be, 58% identified as homosexual or gay, 29% as bisexual, 9% as straight or heterosexual, and 4% as undecided or not defined. Of the men who identified as homosexual or gay, 23% had sex with a female partner in the previous 6 months. The relationship status of this group included predominantly single men who were not in a committed or serious relationship and living alone (81%).

Procedure

The University of California, Los Angeles (UCLA) Men's Health Project was a 3-year study conducted from 2003 to 2006 to develop and test an HIV risk reduction intervention. Participants were administered a baseline assessment by a trained interviewer in English and then randomly assigned to one of two conditions: The S-HIM focused on decreasing high-risk sexual behaviors, such as unprotected anal and vaginal sex, number of sexual partners, and psychological distress, specifically depressive symptoms. The attention-control *Standard Health Promotion* (SHP) comparison condition focused on health issues unrelated to sexual behavior, including diet, exercise, adequate rest, and medication adherence. Both interventions included six weekly 2-h group sessions led by a trained ethnically matched male facilitator with each group comprised of 5–7 African-American or Latino men. If participants missed a session, they were given an abbreviated 30-min one-on-one session with the facilitator prior to the next session. After completing the intervention, participants were post-tested immediately and at 3 and 6 months. All attempts were made to administer follow-up assessments as close to their due dates as possible with all assessments being administered face-to-face by trained, racial/ethnically matched male interviewers to reduce possible culturally mediated obstacles to effective communication. All participants were paid \$10 per session and \$15 per assessment for a total of \$120 per person.

Sexual Health Intervention for Men (S-HIM)

The S-HIM was adapted from the evidence-based *Women's Enhanced Sexual Health Intervention* (ESHI), an 11-session intervention for HIV-positive women with histories of child sexual abuse (Wyatt et al., 2004), guided by cognitive-behavioral approaches (Bandura, 1986) to risk reduction using cultural- and gender-specific concepts commonly promoted within families and religious teaching of ethnic minority populations. Additionally, the S-HIM was guided by formative data from four ethnic- and gay/non-gay-identifying specific focus groups (i.e., African American gay versus non-gay identifying, Latino gay versus non-gay identifying) (Williams et al., 2004), discussing issues faced by ethnic minority MSM and MSMW. These issues included dealing with stigma and social isolation, and importantly, the triple minority status of being HIV-positive, an ethnic minority, and a sexual minority in society at large but, more specifically, within the African American and Latino community.

The S-HIM curriculum highlighted sexual ownership that included personal responsibility for self-care and protection of health and well-being (Chin, Wyatt, Carmona, Loeb, & Myers, 2004). HIV skills were taught within the context of personal, family, and community values so that participants could acknowledge the cultural and religious messages that possibly contradict HIV prevention efforts. For example, the concept that condom use may not be possible for Latino men to use with their wives was identified. However, discussions of the importance of protecting self, partners, and family encouraged the use of condoms with secondary partners. The S-HIM curriculum included discussion of sexual behaviors with both primary and secondary male and female partners, which made it applicable to both MSM and MSMW.

Choices regarding sexual behaviors and consequences were discussed within a culturally congruent social context, specifically for HIV-positive ethnic men. General topics included (1) the influence of gender and ethnicity (i.e., the meaning of being an African American or Latino man); (2) early socialization regarding gender and culture, as well as adult experiences (i.e., being gay/bisexual versus heterosexual within the African American and Latino communities, having male and/or female partners; having early and/or unwanted sexual experiences); (3) the stigma of HIV, particularly within African American and Latino communities; (4) the Keeping Males in a Healthy Place (KMNHP) concept to problem solving (i.e., Know about the problem, eMotions-identify how you feel, Need to deal with the problem, Holding you back from changing, and Plan); (5) the ability and skills to improve psychological well-being and self acceptance/esteem by addressing personal experiences of depression; and (6) strategies for recognizing triggers and for coping with these problems.

The issue of consensual and non-consensual childhood sexual experiences was discussed, as well as how these experiences affect current sexual decision-making. Participants learned how to identify triggers to risk behaviors, especially feelings that were connected to such previous sexual experiences. Participants were also taught skills to improve their communication with their sex partners concentrating on negotiation and assertiveness training.

Because CSA may diminish self-worth and interest in self-preservation, the S-HIM included treatment of cognitive distortions or negative thoughts and emotions such as all-or-none thinking, overgeneralization, jumping to conclusions, and making “should” statements, and addressed affective dysregulation that can limit successful risk reduction (De Arellano et al., 2005). Aspects of the *Treatment Engagement Model* (Cole & Barney, 1987), including cultural values such as the importance and survival of family and community as motivators for behavior change, were utilized as well. While we did not require the men to disclose their abuse history or with whom they have sex, the focus of the intervention was on the sexual histories of participants and their link to current cognitive, affective, and behavioral patterns. The impact of CSA on personal decision-making was emphasized throughout the sessions as an important link between past traumatic experiences, HIV infection, and current functioning. Emphasis was placed on problem-solving strategies and communication skills training.

Standard Health Promotion Intervention (SHP)

The SHP intervention was designed to control for the Hawthorne effect and reduce the likelihood that effects of the S-HIM could be attributed to special attention and group interaction. From an ethical standpoint, participants in both conditions received a valuable intervention that extended beyond “usual care”. The SHP intervention addressed health issues, including certain cancers, hypertension, diabetes, and heart disease, all of which are common among ethnic minority men, but did not specifically focus on sexual behavior. Participants were taught that these diseases could be prevented by changing personal behaviors (e.g., increasing physical activity and healthy dietary practices, ceasing cigarette smoking and alcohol and drug abuse), or managed with early detection and screening behaviors (e.g., testicular self-examination). Participants were also taught information and skills to increase their adherence to medical regimes, including HIV medication adherence. The SHP intervention was structurally similar to the S-HIM, consisting of six 2-h psychoeducational sessions that included discussions, interactive exercises, role-playing, and games (e.g., using the relaxation and feelings thermometer, identifying and rating your health risks, negotiating self-exercise regimes, planning diets and the food pyramid matching game, etc.).

Measures

A comprehensive structured interview taking approximately 90 min to complete was administered to participants. This interview included demographic variables such as age, race/ethnicity, education, total monthly income, employment, and relationship status. *History of childhood sexual abuse* was measured with a series of nine questions that assessed incidents of fondling, frottage, attempted or completed intercourse, oral sex, and type of penetration prior to the age of 18. Severity of CSA was operationally defined in terms of two characteristics of CSA experiences (Wyatt, 1985): (1) type of physical contact, ranging from fondling and frottage to digital penetration and attempted or completed oral or anal sex against their will with an adult or someone 5 years older than them; and (2) the relationship of the alleged perpetrator to the participant, from a stranger to trusted adult or family member. This approach is more comprehensive than the usual approach that simply assesses whether or not a history of CSA is reported (Wyatt, 1985; Wyatt et al., 2004).

The vast majority of participants (87.6%) reported CSA that included performing and/or receiving oral or anal sex, digital penetration or penetration with objects. Of those participants, 53% reported anal penetration, 37% reported performing or receiving oral sex against their will and 10% reported both. The remaining 12.4% reported CSA that included touching, fondling, or frottage. Among the sample, 52% reported one incident of CSA, 48% reported two or more incidents and the mean number of incidents for the total sample was 1.7. *Incident* refers to an individual episode of abuse with each episode being counted as one. If, for example, the same perpetrator victimized a child multiple times, each was counted as an incident. The mean age of first incident was 10.6 years. Intrafamilial CSA where the perpetrator of the abuse was a family member was reported by 27%, while extrafamilial CSA where the perpetrator of the abuse was not a family member was reported by 73%. None of the participants reported both intrafamilial and extrafamilial abuse. The majority of intrafamilial CSA was perpetrated by distant relatives (i.e., second or third degree male relatives), such as uncles, cousins, or second cousins (74%), while father and brother comprised 26% of the remaining perpetrators. Extrafamilial CSA was perpetrated by total strangers in 15.3% of the cases and by semi-strangers (i.e., people frequently seen by the victim but not known to them, such as the grocery store clerk or the school custodian) in 84.7% of the cases.

Sexual risk behavior, number of sexual partners, and depressive symptoms were the outcome variables of interest.

Sexual Risk Behavior

Sexual risk behaviors with male and female partners, including high-risk unprotected behaviors where the transmission of HIV is more likely to occur, were measured with

11 items from the Revised Wyatt Sex History Questionnaire (Wyatt, 1984). These included questions about performing and/or receiving oral sex, oral–anal sex, unprotected anal sex, and anal penetration with fingers, fists, or objects. It also assessed for unprotected vaginal and oral–vaginal sex. Eight of these items assessed for sexual activity between men and three items between men and women (i.e., unprotected anal/vaginal sex, oral–vaginal sex and digital/fisting–vaginal penetration). “Yes” responses were coded as “1” and “no” responses were coded as “0.” A weighted summation of the 11 variables was calculated using the fixed effect coefficients of a mixed effect model as weights. The weights assigned a relative importance to each of the 11 items used in the scale. If a participant had only low risk behavior (e.g., oral sex), then he would have a lower risk score, but if a participant had a higher-risk behavior (e.g., unprotected anal intercourse and unprotected vaginal intercourse), then his risk score would be higher. Thus, possible scores ranged from 0 to 6.65, with higher values representing greater risk.

Number of Sexual Partners

The number of sexual partners in the previous 6 months was assessed with one item that included the total number of male and female sexual partners.

Depressive Symptoms

The 20-item Center for Epidemiological Studies-Depression Scale (CES-D) was utilized to assess for depressive symptoms (Radloff, 1977). Participants were asked to rate the occurrence of various feelings on a four-point scale ranging from *rarely* (1) to *most of the time* (4). The CES-D yields an overall depression score with higher scores signifying more depressive symptomatology.

Statistical Analyses

In order to evaluate the effectiveness of the S-HIM intervention, covariate-adjusted repeated measures analyses of variance were conducted to examine changes from baseline to post-test and 3 and 6 month follow-ups in the outcome measures (i.e., sexual risk behaviors, number of sexual partners, and depressive symptoms), and to test the differences between intervention and control participants in changes from baseline to follow-ups. We conducted model-based imputation using generalized longitudinal mixed effects models with coefficients of fixed effects, which in the context of analysis of variance is used to denote factors with levels that are deliberately arranged rather than randomly sampled. Our coefficients of fixed effects included participants’ age, income, education, employment status, and severity of CSA experience (i.e., type of physical contact), and random effects containing time to

impute the partial missing data (less than 10%) on sexual risk behaviors, number of sexual partners, and depressive symptoms. The predicted values from the mixed effects models at each time point (baseline, post, 3 month and 6 month) were used as the imputed values. The comparisons between intervention and control were conducted using the outcome measures with imputed values. SAS statistical software was used for the analysis and the macro procedure %glimmix was used to fit the generalized linear repeated measures models.

Results

The mean number of group sessions attended by participants was 4.1 with 93% receiving their post, 3 and 6 month follow-up assessments on their due dates. Seven percent had a mean of 1.1 months delay due primarily to the transient character of this population (i.e., change in living accommodations). There were no significant differences at baseline between S-HIM and SHP intervention participants in demographic variables such as age, education, employment and income, in severity of CSA, or in the outcome variables (sexual risk behaviors, number of sexual partners, and depressive symptoms).

Sexual Risk Behavior

The covariate adjusted 2 (condition: S-HIM and SHP) by 4 (time: baseline, post, 3 month, and 6 month) repeated measures analysis of variance (ANOVA) revealed a significant main effect of time on sexual risk behavior, $F(3, 130) = 8.94$, $p < .0001$. The sample as a whole reported reductions in level of sexual risk behavior from baseline ($M = 3.69$, $SE = .14$) to post-test ($M = 3.13$, $SE = .15$), $t = 2.96$, $p = .004$, and from the 3 month ($M = 3.21$, $SE = .15$) to the 6 month ($M = 2.77$, $SE = .14$) follow-up, $t = 2.44$, $p = .016$. Further simple effects tests revealed that the reduction in level of sexual risk behavior from baseline to post-test was significant for S-HIM participants (M reduction = .90, $SE = .28$), $t = 3.21$, $p = .002$, but not significant for SHP comparison participants, (M reduction = .22, $SE = .26$), $t < 1$. However, there was no significant main effect of condition on level of sexual risk behavior, $F(1, 130) < 1$, and no significant condition by time interaction, $F(3, 130) = 1.15$, $p = .33$. Mean scores for sexual risk behavior, number of partners and depression over time are presented in Table 1.

Number of Sexual Partners

The covariate adjusted repeated measures (condition by time) analysis of variance (ANOVA) revealed a main effect of time on number of sexual partners, $F(3, 129) = 12.66$, $p < .0001$. The sample as a whole reported reductions in the number of sexual partners from baseline ($M = 6.09$, $SE = .97$) to

Table 1 Sexual risk behavior, number of partners, and depression over time as a function of condition

Variables	S-HIM (<i>n</i> = 75)		SHP (<i>n</i> = 62)		Full sample (<i>n</i> = 137)	
	<i>M</i>	<i>SE</i>	<i>M</i>	<i>SE</i>	<i>M</i>	<i>SE</i>
Sexual risk behavior						
Baseline	3.78	.21	3.60	.19	3.69	.14
Post-test	2.89	.23	3.37	.21	3.13	.15
3-months	3.09	.23	3.33	.21	3.21	.15
6-months	2.81	.21	2.72	.19	2.77	.14
Number of partners						
Baseline	6.69	1.43	5.49	1.32	6.09	.97
Post-test	3.46	.51	3.49	.47	3.47	.34
3-months	2.34	.47	3.12	.43	2.73	.32
6-months	1.69	.19	1.71	.17	1.70	.13
Depression						
Baseline	22.81	1.35	23.32	1.23	23.03	.92
Post-test	22.85	1.16	23.05	1.06	22.95	.77
3-months	22.23	1.04	22.77	.95	22.42	.72
6-months	20.19	.89	21.25	.82	20.66	.61

post-test ($M = 3.47$, $SE = .34$), $t = 3.30$, $p = .001$. This reduction was significant for S-HIM participants, $t = 2.77$, $p = .007$, and marginally significant for SHP participants, $t = 1.86$, $p = .065$. There was a marginally significant reduction in number of sexual partners from post-test to the 3 month follow-up, $t = 1.80$, $p = .073$, and a significant reduction from the 3 month to the 6 month follow-up, $t = 3.42$, $p = .0008$. There was no main effect of condition on number of sexual partners, $F(1, 129) < 1$, and no condition by time interaction, $F(3, 129) < 1$.

Depression

This sample evidenced high levels of depression at baseline, $M = 23$ ($SD = 11$). The clinical cutoff score for the CES-D is 16 for mild depressive symptoms and 21 for moderate to severe symptoms. Covariate adjusted repeated measures (condition by time) analysis of variance (ANOVA) revealed a main effect of time on depression, $F(3, 135) = 2.89$, $p = .038$. Simple effects tests indicated a significant decrease in depressive symptoms from the 3 month to the 6 month follow-up assessment for the sample as a whole ($M = 22.42$, $SE = .72$ for 3 months depression and $M = 20.66$, $SE = .66$ for 6 months depression), $t = 2.40$, $p = .018$. However, there were no significant changes in depressive symptoms from baseline to post-test, $t < 1$, or from post-test to the 3 month follow-up, $t < 1$. There was no main effect of condition on depression, $F(1, 135) < 1$, and no condition by time interaction, $F(3, 135) < 1$, indicating

that the reduction in depression was not significantly different for S-HIM and SHP participants.

Discussion

The purpose of this study was to conduct a small randomized clinical trial whose aims were to reduce sexual risk behaviors, number of sexual partners, and depressive symptoms for gay and non-gay identifying HIV-positive African American and Latino MSM and MSMW with histories of CSA. The most effective strategies for reducing risk for HIV infection/re-infection and transmission require an understanding and appreciation of the host of factors implicated in the etiology of sexual risk behavior. There is increasing evidence that a history of CSA is associated with a greater likelihood of developing depression and self-destructive behaviors, including patterns of sexual risks such as unprotected anal and vaginal sex (Agonick et al., 2004; Carballo-Diequez, Dolezal, Nieves-Rosa, & Diaz, 2000; Friedrich et al., 1986; Green, 1993; Tebbutt et al., 1997; Watkins & Bentovim, 1992; Wyatt et al., 2004).

The results of this small study suggest that participants in both the S-HIM condition, which focused on sexual health, and the SHP condition, which focused on general health, experienced decreased sexual risk behavior and depression over time. However, only S-HIM participants reported reductions in sexual risk behavior from baseline to post-test. Both S-HIM and SHP participants reported reductions in number of sexual partners from baseline to post-test. However, this effect was greater for S-HIM participants. Although reductions in sexual risk behavior were immediate, reductions in depressive symptoms were not found until the 6-month follow-up and were for the sample as a whole.

Whereas the decreases in sexual risk behavior and sexual partners were most striking at post-test, further decreases were also found from the 3 to 6 month follow-ups. The sexual decision-making skills provided in the S-HIM may have helped the men to reduce sexual risk behaviors and number of sexual partners immediately. However, the use of these skills may fluctuate over time, and participants may benefit from ongoing support for change. This may include booster sessions to maintain effects over time (Chesney, Chambers, Taylor, Johnson, & Folkman, 2003). While the S-HIM curriculum more directly addressed sexual risk and depression and provided participants with skills to examine cognitive, affective, and behavioral patterns than the SHP, both interventions may have produced benefits. Both conditions showed a decrease in number of sexual partners from baseline to post-test and in depressive symptoms at the 6-month follow-up.

The focus on health promotion in the SHP intervention may have encouraged men to consider areas of health not

directly addressed in the SHP intervention, including sexual health. Emotion regulation was addressed in the SHP intervention in the context of relaxation, which may have resulted in decreased depression and risk behavior, and reduced differences between the two conditions. The weekly group format of both interventions may have provided social support that helped to alleviate social isolation contributing to symptoms of depression. Social support may be an important variable to incorporate in interventions for participants who endure a triple stigma of being HIV-positive and an ethnic and sexual minority. Research has only begun to explore the effects of being a triple minority within communities that may not necessarily be accepting of this type of diversity (Malebranche, 2003; Mays, Cochran, & Zamudio, 2004; Williams et al., 2004). Fear of persecution, especially from their respective African American and Latino communities and consequential social isolation, may have resulted in secrecy and shame revolving around their sexuality, their HIV status, and their history of CSA. The support of other group members who were facing similar issues may have served as a buffer against rejection and racial and health stigma for these men.

It is possible that more time may be necessary to process and absorb the benefit from the intervention to demonstrate further improvements in depression for S-HIM participants. This idea is supported by the ESHI findings of greater improvements in psychological distress first appearing at the 6-month follow-up (Wyatt et al., 2004, 2006). Wyatt et al. (2006) suggest that longer-term interventions may be indicated in order to process, incorporate, and appropriately apply all the information and acquired skills especially when addressing mental health issues such as CSA and depressive symptoms, and sexual behavior. Also, it is possible that the treatment dosage was simply inadequate for such a high-risk, marginalized sample.

The participants in this study were middle-aged men who were poor, undereducated, and predominantly single, lacking both primary or long-term partners and family support. These factors, along with their abuse histories, are important to consider when developing sexual risk reduction interventions. Additionally, discomfort with specific sexual labels and possibly their sexual identity, may contribute to stigma, social isolation and further marginalization within their ethnic communities. These psychosocial factors may have contributed to the moderately high symptoms of depression identified in both the S-HIM and the SHP participants.

Also, the effects of CSA on high-risk sexual behaviors and psychosocial dysfunction are complicated by the fact that many victims of sexual abuse are revictimized (West, Williams, & Siegel, 2000). While the S-HIM focused on sexual ownership and linking past CSA experiences with current sexual decision-making, future interventions may need to also focus on adult sexual relations, including sexual abuse.

Learning from past experiences and applying them to current adult relationships may be complicated, requiring longer interventions.

Interventions that address sexual abuse among ethnic minority men need to be developed as they may have never previously disclosed their abuse histories or explored the impact of this experience in their current lives, especially as it relates to sexual decision making. Understanding the meaning of CSA in cultures where being sexually abused would preclude positive images of strength and prowess need to be considered when working with ethnically and racially diverse men. Broad and diverse health programs, as well as interventions that target specifically MSM and MSMW, must address sexual abuse within the auspices of sexual and general health. The S-HIM is among the first to attempt to reduce sexual risk behaviors, number of sexual partners, and depressive symptoms among gay and non-gay identifying HIV-positive African American and Latino MSM and MSMW with histories of CSA.

Limitations

More research is needed to further understand how African American and Latino men define and apply sexual labels and how these definitions coincide with their actual sexual behaviors. Different reasons for the disconnect between sexual identity and behavior may apply to gay-identifying and heterosexual-identifying men who have sex with both men and women. Interventions targeting specifically African American and Latino men who have sex with only men and interventions targeting those who are currently having sex with both men and women may need to be developed separately (Williams et al., 2004). It is possible that psychosocial issues for MSM and MSMW are significantly different and that our intervention did not target issues most pertinent to the MSMW subculture. For example, more recent research is beginning to explore identity development, the influence of race/ethnicity and culture, stigma, and biphobia among bisexual men (Bieschke, Perez, Ruperto, & DeBord, 2007). Bisexual men may be particularly vulnerable to mental health problems due to biphobia (Dodge & Sandfort, 2007).

It has also been suggested that, for many men, factors such as race, culture, religion, family history, and HIV serostatus all influence their sexual lives, including their partner selection (Gomez, Mason, & Alvarado, 2005). Interventions for African Americans and Latinos may also need to be developed separately. The S-HIM addressed common cultural issues. However, more specific culture-based HIV-related information may need to be linked to risk reduction for each ethnic/racial group.

Another potential area that may need further exploration is whether there is a difference in the appraisal of the abuse when the perpetrator is male versus female. Because of the open-ended manner in which we assessed for who the perpetrator

was, we were not always able to determine perpetrator gender. For example, when participants identified their perpetrators as school custodian or store clerk, it was not known whether these were men or women. Future studies may need to explore the meaning of being abused by a male versus female perpetrator. This may be especially important within African American and Latino communities where gender roles and images of masculinity may influence behavior.

Despite these limitations, this small study was one of the first to address factors influencing sexual risk and decision making for ethnic minority MSM and MSMW, including CSA and sexual minority status. Not only do risk reduction interventions need to specifically target MSM and MSMW populations, they need to consider ethnicity and culture and the importance of social support from family, friends, and community within a sociocultural context. Group interventions targeting vulnerable populations, such as gay and non-gay identifying HIV-positive African American and Latino MSM and MSMW, are an important addition to prevention efforts. Such programs would provide social support for these men who are facing considerable rejection and social isolation. Indeed, a focus on the stigma of being HIV-positive, a sexual and ethnic minority, and having a history of CSA may require more intense emphasis over time. Only by addressing these pertinent psychosocial issues, will interventions such as the S-HIM be better able to effect change in sexual decision-making and psychological adjustment.

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References

- Agonick, G., O'Donnell, L., Stueve, A., San Doval, A., Durna, R., & Vargo, S. (2004). Sexual behaviors and risks among bisexually- and gay-identified young Latino Men. *AIDS and Behavior*, 8, 185–197.
- Badgley, R., Allard, H., McCormick, N., Proudfoot, P., Fortin, D., Ogilvie, D., et al. (1984). *Sexual offenses against children* (Vol. 1). Ottawa: Canadian Government Publishing Center.
- Baker, A. W., & Duncan, S. P. (1985). Child sexual abuse: A study of prevalence in Great Britain. *Child Abuse and Neglect*, 9, 457–467.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Upper Saddle River, NJ: Prentice-Hall.
- Bieschke, K. J., Perez, R. M., & DeBord, K. A. (Eds.). (2007). *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 119–145). Washington, DC: American Psychological Association.
- Bingham, T. A., Harawa, N. T., Johnson, D. F., Secura, G. M., MacKellar, D. A., & Valleroy, L. A. (2003). The effect of partner characteristics on HIV infection among African American men who

- have sex with men in the Young Men's Survey, Los Angeles, 1999–2000. *AIDS Education and Prevention*, 15(1 Suppl A), 39–52.
- Burns-Loeb, T., Williams, J. K., Rivkin, I., Vargas Carmona, J., Wyatt, G., Chin, D., et al. (2002). The effects of child sexual abuse on adolescent and adult sexual functioning. *Annual Review of Sex Research*, 13, 307–345.
- Carballo-Diequez, A., & Dolezal, C. (1994). Contrasting types of Puerto Rican men who have sex with men (MSM). *Journal of Psychology and Human Sexuality*, 6, 41–67.
- Carballo-Diequez, A., Dolezal, C., Leu, C. S., Nieves, L., Diaz, F., Decena, F., et al. (2005). A randomized control trial to test an HIV prevention intervention for Latino gay and bisexual men: Lessons learned. *AIDS Care*, 17, 314–328.
- Carballo-Diequez, A., Dolezal, C., Nieves-Rosa, L., & Diaz, F. (2000). Similarities in the sexual behavior and HIV risk factors of Colombian, Dominican, Mexican, and Puerto Rican MSM residing in New York City. *Journal of Psychology and Human Sexuality*, 12(4), 49–67.
- Centers for Disease Control and Prevention (CDC). (2001). *HIV/AIDS surveillance report (year end edition No. 13, 2)*. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention (CDC). (2002). *HIV/AIDS among Hispanics in the United States [Factsheet]*. CDC: Author.
- Centers for Disease Control and Prevention. (2003). *HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation, six US cities, 1994–2000*. (Morbidity and Mortality Weekly Report No. 52). Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention. (2004). *HIV/AIDS surveillance report, 2003* (Vol. 15). Atlanta: US Department of Health and Human Services, Center for Disease Control and Prevention.
- Centers for Disease Control and Prevention. (2005a). *HIV/AIDS surveillance report, 2004* (Vol. 16). Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention. (2005b). *HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—Five US Cities, June 2004–April 2005*. (Morbidity and Mortality Weekly Report No. 54). Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention.
- Chesney, M. A., Chambers, D. B., Taylor, J. M., Johnson, L. M., & Folkman, S. (2003). Coping effectiveness training for men living with HIV: Results from a randomized clinical trial testing a group-based intervention. *Psychosomatic Medicine*, 65, 1038–1046.
- Chin, D., Wyatt, G., Carmona, J., Loeb, T., & Myers, H. (2004). Child sexual abuse and HIV: An integrative risk-reduction approach. In L. J. Koenig & L. S. Doll (Eds.), *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention* (pp. 233–250). Washington, DC: American Psychological Association.
- Cole, C. H., & Barney, E. E. (1987). Safeguards and the therapeutic window: A group treatment strategy for adult incest survivors. *American Journal of Orthopsychiatry*, 57, 601–609.
- De Arellano, M. A., Waldrop, A. E., Deblinger, E., Cohen, J. A., Danielson, C. K., & Mannarino, A. R. (2005). Community outreach program for child victims of traumatic events: A community-based project for underserved populations. *Behavior Modification*, 29, 130–155.
- Denning, P. H., & Campsmith, M. L. (2005). Unprotected anal intercourse among HIV-positive men who have a steady male sex partner with negative or unknown HIV serostatus. *American Journal of Public Health*, 95, 152–158.
- Diaz, R. M. (1998). *Latino gay men and HIV: Culture, sexuality and risk behavior*. New York: Routledge.
- Diaz, R. M., Stall, R. D., Hoff, C., Daihle, D., & Coates, T. J. (1996). HIV risks among Latino gay men in the southwestern United States. *AIDS Education and Prevention*, 8, 415–429.
- Dodge, B., & Sandfort, T. G. M. (2007). A review of mental health research on bisexual individuals when compared to homosexual and heterosexual individuals. In B. A. Firestein (Ed.), *Becoming visible: Counseling bisexuals across the lifespan* (pp. 28–51). New York: Columbia University Press.
- Doll, L. S., Petersen, L. R., White, C. R., Johnson, E. S., Ward, J. W., & The Blood Study Donor Group. (1992). Homosexually and nonhomosexually identified men who have sex with men: A behavioral comparison. *Journal of Sex Research*, 29, 1–14.
- Finkelhor, D., Hotelling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics and risk factors. *Child Abuse & Neglect*, 14, 19–28.
- Friedrich, W. N., Urquiza, A. J., & Beilke, R. (1986). Behavior problems in sexually abused young children. *Journal of Pediatric Psychology*, 11, 47–57.
- Garnefski, N., & Arends, E. (1998). Sexual abuse and adolescent maladjustment: Differences between male and female victims. *Journal of Adolescence*, 21, 99–107.
- Goldbaum, G., Perdue, T., Wolitski, R., Reitmeijer, C., Hedrich, A., Wood, R., et al. (1998). Differences in risk behavior and sources of AIDS information among gay, bisexual, and straight-identified men who have sex with men. *AIDS and Behavior*, 2, 13–21.
- Gomez, C. A., Mason, B., & Alvarado N. J. (2005). Culture matters: The role of race and ethnicity in the sexual lives of HIV-positive gay, bisexual men. In P. Halkitis, C. Gomez, & R. J. Wolitski (Eds.), *HIV+ sex: The psychological and interpersonal dynamics of HIV-seropositive gay and bisexual men's relationships* (pp. 87–100). Washington, DC: American Psychological Association.
- Green, A. H. (1993). Child sexual abuse: Immediate and long-term effects and intervention. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 890–902.
- Harawa, N. T., Williams, J. K., Ramamurthi, H. C., & Bingham, T. A. (2006). Perceptions towards condom use, sexual activity, and HIV disclosure among HIV-positive African American men who have sex with men: Implications for heterosexual transmission. *Journal of Urban Health*, 83, 682–694.
- Heckman, T. G., Kelly, J. A., & Bogart, L. M. (1999). HIV risk differences between African American and white men who have sex with men. *Journal of National Medical Association*, 91, 92–100.
- Holmes, W. C., & Slap, G. B. (1998). Sexual abuse of boys: Definition, prevalence, correlates, sequelae, and management. *Journal of the American Medical Association*, 280, 1855–1862.
- Icard, L. (1986). Black gay men and conflicting social identities: Sexual orientation versus racial identity. In J. Gipton & M. Valentich (Eds.), *Social work practice in sexual problems* (pp. 83–93). New York: Haworth Press.
- Jarama, S. L., Kennamer, J. D., Poppen, P. J., Hendricks, M., & Bradford, J. (2005). Psychosocial, behavioral and cultural predictors of sexual risk for HIV infection among Latino men who have sex with men. *AIDS and Behavior*, 9, 513–523.
- Kanouse, D. E., Bluthenthal, R. N., Bogart, L., Iguchi, M. Y., Perry, S., Sand, K., et al. (2005). Recruiting drug-using men who have sex with men into behavioral interventions: A two-stage approach. *Journal of Urban Health*, 82, i109–i119.
- Kegeles, S. M., Hays, R. B., & Coates, T. J. (1996). M-powerment Project: A community-level HIV prevention intervention for young gay men. *American Journal of Public Health*, 86, 1129–1136.
- Kelly, J. A., Murphy, D. A., Sikkema, K. J., McAuliffe, T. L., Roffman, R. A., Solomon, L. J., et al. (1997). Randomized, controlled, community-level HIV-prevention for sexual-risk behavior among homosexual men in US cities. *Lancet*, 350, 1500–1505.
- King, J. L. (2004). *On the down low: A journey into the lives of 'straight' Black men who sleep with men*. New York: Random House.

- Koenig, L. J., Doll, L. S., O'Leary, A., & Pequegnat, W. (Eds.). (2003). *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention*. Washington, DC: American Psychological Association Press.
- Kraft, J. M., Beeker, C., Stokes, J. P., & Peterson, J. L. (2000). Finding the "community" in community-level HIV/AIDS interventions: Formative research with young African American men who have sex with men. *Health Education and Behavior, 27*, 430–441.
- Malebranche, D. (2003). Black men who have sex with men and the HIV epidemic: Next steps for public health. *American Journal of Public Health, 93*, 862–865.
- Mays, V. M., Cochran, S. D., & Zamudio, A. (2004). HIV prevention research: Are we meeting the needs of African American men who have sex with men? *Journal of Black Psychology, 30*, 78–105.
- McCarty, T., Roberts, L. W., & Hendrickson, K. (1996). Urologic sequelae of childhood genitourinary trauma and abuse in men: Principles of recognition with fifteen case illustrations. *Urology, 47*, 617–621.
- Miller, R. L. (1995). Assisting gay men to maintain safer sex: An evaluation of an AIDS service organization's safer sex maintenance program. *AIDS Education & Prevention, 7*, 48–63.
- Miller, M., Serner, M., & Wagner, M. (2005). Sexual diversity among Black men who have sex with men in an inner-city community. *Journal of Urban Health, 82*(1 Suppl 1), i26–34.
- Millett, G., Malebranche, D., Mason, B., & Spikes, P. (2005). Focusing "down low": Bisexual Black men, HIV risk and heterosexual transmission. *Journal of the National Medical Association, 97*, 52S–59S.
- Montgomery, J. P., Mokotoff, E. D., Gentry, A. C., & Blair, J. M. (2003). The extent of bisexual behaviour in HIV-infected men and implications for transmission to their female sex partners. *AIDS Care, 15*, 829–837.
- Patterson, T. L., Shaw, W. S., & Semple, S. J. (2003). Reducing the sexual risk behaviors of HIV positive individuals: Outcome of a randomized controlled trial. *Annals of Behavioral Medicine, 25*, 137–145.
- Paul, J. P., Catania, J., Pollack, L., & Stall, R. (2001). Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: The Urban Men's Health Study. *Child Abuse & Neglect, 25*, 557–584.
- Peterson, J. L., Coates, T. J., Catania, J., Hauck, W. W., Acree, M., Daigle, D., et al. (1996). Evaluation of an HIV risk reduction intervention among African-American homosexual and bisexual men. *AIDS, 10*, 319–325.
- Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385–401.
- Remien, R. H., Wagner, G., Dolezal, C., & Carballo-Diequez, A. (2001). Factors associated with HIV sexual risk behavior in male couples of mixed HIV status. *Journal of Psychology & Human Sexuality, 13*, 31–48.
- Ruggiero, K. J., McLeer, S. V., & Dixon, J. F. (2000). Sexual abuse characteristics associated with survivor psychopathology. *Child Abuse & Neglect, 24*, 951–964.
- Stokes, J. P., & Peterson, J. L. (1998). Homophobia, self-esteem, and risk for HIV among African American men who have sex with men. *AIDS Education and Prevention, 10*, 278–292.
- Tebbutt, J., Swanston, H., Oates, R. K., & O'Toole, B. I. (1997). Five years after child sexual abuse: Persisting dysfunction and problems of prediction. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 330–339.
- Tjaden, P., & Thoennes, N. (2000). Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey. *Violence Against Women, 6*, 142–161.
- Watkins, B., & Bentovim, A. (1992). The sexual abuse of male children and adolescents: A review of current research. *Journal of Child Psychology and Psychiatry, 33*, 197–248.
- West, C. M., Williams, L. M., & Siegel, J. A. (2000). Adult sexual revictimization among Black women sexually abused in childhood: A prospective examination of serious consequences of abuse. *Child Maltreatment, 5*, 49–57.
- Williams, J. K., Wyatt, G. E., Resell, J., Peterson, J., & Asuan O'Brien, A. (2004). Psychosocial influences on HIV risks among HIV-positive African American and Latino MSM with a history of CSA. *Cultural Diversity & Ethnic Minority Psychology, 10*, 268–286.
- Wolitski, R. J., Gomez, C. A., Parsons, J. T., & the SUMIT Study Group. (2005). Effect of a peer-led behavioral intervention to reduce HIV transmission and promote serostatus disclosure among HIV-seropositive gay and bisexual men. *AIDS, 19*(Suppl. 1), S99–S109.
- Wyatt, G. E. (1984). *The Wyatt sex history questionnaire*. Los Angeles: University of California at Los Angeles.
- Wyatt, G. E. (1985). The sexual abuse of Afro-American and White-American women in childhood. *Child Abuse and Neglect, 9*, 507–519.
- Wyatt, G. E., Guthrie, D., & Notgrass, C. M. (1992). Differential effects of women's child sexual abuse and subsequent sexual revictimization. *Journal of Consulting and Clinical Psychology, 60*, 167–173.
- Wyatt, G. E., Longshore, D., Chin, D., Carmona, J. C., Loeb, T. B., Myers, H. F., et al. (2004). The efficacy of an integrated risk reduction intervention for HIV-positive women with child sexual abuse histories. *AIDS and Behavior, 8*, 453–462.
- Wyatt, G. E., Rivkin, I., Loeb, T. B., Carmona, J. V., Chin, D., Liu, H., et al. (2006). *The effects of a risk reduction intervention for HIV-positive women with histories of child sexual abuse: A longitudinal study*. Manuscript submitted for publication.