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## Association of CAI Vulnerability and Sexual Minority Victimization Distress Among Adolescent Men Who Have Sex With Men

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## BRIEF REPORT

Association of CAI Vulnerability and Sexual Minority Victimization  
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Adolescent men who have sex with men (AMSM) are at high HIV risk. Condomless anal intercourse (CAI) increases HIV risk and has been associated with interpersonal power imbalances, such as asymmetries in decision-making authority, social status, and emotional dependence, between male sexual partners. AMSM experience high levels of psychological and physical victimization due to their sexual minority status. Sexual minority victimization (SMV) is similarly associated with low interpersonal power and may relate to the extent to which AMSM are vulnerable to partner influences to engage in CAI. This online survey study of AMSM 14–17 years old ( $N = 143$ ) tested the hypothesis that experiences and attitudes reflecting vulnerability to partner CAI influence (CAI Vulnerability) and distress in response to experienced sexual minority victimization (SMV Distress) would be positively associated with participant and partner condom nonuse during anal sex (CAI frequency). Approximately 35% reported they or their partner(s) had never or rarely used a condom. Positive correlations were found among partners' CAI frequency during sex with the participant, CAI Vulnerability, and SMV Distress. Multiple regression indicated CAI Vulnerability significantly accounted for the relation between SMV Distress and partner's CAI frequency. Findings suggest that distress in response to SMV may be associated with a diminished sense of interpersonal control resulting in CAI Vulnerability and subsequent more frequent instances of partner CAI. HIV prevention strategies designed to increase condom use among AMSM have the potential to benefit from procedures aimed at increasing interpersonal sexual assertiveness and decreasing distress associated with sexual minority victimization.

**Public Significance Statement**

Adolescent men who have sex with men (AMSM) are at disproportionately high HIV risk. Engaging in condomless anal intercourse (CAI) increases HIV risk, and condom nonuse among AMSM is common. The development of effective behavioral interventions for HIV prevention requires an understanding of interpersonal factors influencing AMSM's condom use. Past research suggests that men who have low interpersonal power in their sexual partnerships engage in CAI more frequently. Being victimized because of one's sexual minority status has similarly been associated with having less interpersonal power, and may influence the extent to which AMSM are vulnerable to partner influence to engage in CAI. The aim of this study was to test whether experiences and attitudes reflecting vulnerability to partner influence to engage in CAI and distress in response to sexual minority victimization would be associated with the frequency with which AMSM engaged in CAI. Sexually active AMSM aged 14–17 who had experienced sexual minority victimization in the past 6 months completed an online survey. The results indicated that youth who experienced more distress

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in response to sexual minority victimization reported being more vulnerable to partner influence to engage in CAI, and youth who were more vulnerable to partner influence over CAI reported more frequent engagement in CAI. Practitioners and policymakers designing HIV prevention strategies to increase condom use among AMSM should incorporate procedures aimed at increasing interpersonal assertiveness and decreasing distress associated with sexual minority victimization.

*Keywords:* condoms, HIV risk, LGBT victimization, adolescents, MSM

Adolescent men who have sex with men (AMSM) account for disproportionately high numbers of new HIV diagnoses and are at increased risk for sexually transmitted infections (STIs; Centers for Disease Control and Prevention, 2016, 2018a, 2018b). In 2014, 13–24-year-olds accounted for 40% of new HIV cases, and in 2016, 81% of new HIV cases reported for 13–24-year-olds were among gay and bisexual youth (Centers for Disease Control and Prevention, 2018a; Ocfemia, Dunville, Zhang, Barrios, & Oster, 2018). Condomless anal intercourse (CAI) is a significant HIV risk factor for AMSM (Mustanski, Newcomb, Du Bois et al., 2011; Poteat, Russell, & Dewaele, 2019; Starks et al., 2019; Valencia et al., 2018). Condom nonuse is common among AMSM. In a recent study, 44% of AMSM sampled reported CAI in the past six months (Valencia et al., 2018). The development of effective behavioral interventions for HIV prevention requires an understanding of factors influencing AMSM's decisions regarding condom use.

Condom self-efficacy and interpersonal factors have been associated with CAI among men who have sex with men (MSM). In an early study, lower "Safer Sex Communication" skills were related to CAI among MSM ages 17–25 years (Molitor, Facer, & Ruiz, 1999). More recently, Newcomb and Mustanski (2014) found that condom self-efficacy, defined as confidence one would have condoms available, refuse CAI, and leave an "unsafe sexual situation," decreased likelihood of CAI among MSM 16–40 years old. Lower engagement in HIV prevention behaviors and CAI specifically have been related to interpersonal power imbalances such as older partners, experiences of physical or sexual partner violence, and feeling trapped in a relationship (Mustanski, Newcomb, & Clerkin, 2011; Newcomb & Mustanski, 2016). These findings are consistent with the concept of interpersonal power defined as the "ability to influence a relationship partner to achieve one's own goals" (Bentley, Galliher, & Ferguson, 2007, p. 3). Examples of high interpersonal power include greater decision-making authority, humiliating or shaming a partner, and having higher social status or desirability to others. Examples of low interpersonal power include emotional dependence or submissiveness and lower social status or desirability. AMSM with lower interpersonal power may find it more difficult to persuade their sexual partners to use condoms.

Vulnerability to partner influence among AMSM may also be related to other social vulnerabilities marked by power imbalances (Aalsma & Brown, 2008). Sexual minority victimization (SMV) is defined as forms of bullying, name-calling, threats of or actual physical violence, and unfair or rude treatment that is directed at individuals because of their sexual orientation. Prior research indicates that AMSM are at increased risk of SMV and are bullied at school at higher rates than heterosexual youth (Robinson, Espelage, & Rivers, 2013). For adolescents in general, peer sexual

harassment and bullying have been linked to a lack of interpersonal power, low social competence with peers, and dating violence (Espelage & Holt, 2007; Josephson & Pepler, 2012; S. Miller et al., 2013; Reed, McNall, & Forney, 2013).

A lowered sense of interpersonal power associated with SMV might, for some AMSM, generalize to a sense of powerlessness in asserting condom practices with sexual partners. Prior research has found associations between SMV and an increase in inconsistent condom use, STIs, and other HIV risk behaviors among sexual and gender minority (SGM) youth (Bontempo & D'Augelli, 2002; Li, Distefano, Mouttapa, & Gill, 2014; R. L. Miller et al., 2013; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). It is not clear from prior research the mechanisms through which SMV influence CAI among SGM youth. When assessing the impact of SMV on mental health, Balsam, Beadnell, and Molina (2013) underscored the importance of distinguishing between experiencing victimization and the degree of distress it causes, with the latter associated with depression and other affective disorders. High levels of distress in response to SMV, especially when it is associated with physical abuse, could potentially be related to PTSD as prior research indicates sexual minorities who have been victimized by peers or sexually abused as children have increased risk of PTSD (Batchelder et al., 2017; Boroughs, Provenzano, Mitchell, & O'Cleirigh, 2019; O'Cleirigh et al., 2019).

To date, the relations among frequency of CAI, vulnerability to a partner's influence over condom use, and distress in response to sexual minority victimization among AMSM have not been empirically examined. The purpose of this study was to explore these relations through the responses of AMSM 14–17 years of age to an online survey. We hypothesized that vulnerability to partner CAI influence and distress in response to SMV would be positively and significantly related to each other and condom nonuse by participants and by their partner(s) during sexual engagement with the participant (CAI frequency). We also hypothesized that vulnerability to CAI would significantly account for the association between distress in response to SMV and CAI frequency.

## Method

### Participants

The sample included 143 AMSM ages 14–17 years from a national Internet-based survey on AMSM HIV risk behaviors, attitudes toward and experiences with sexual health care practitioners, and perceived risks and benefits of participating in HIV prevention research (Fisher, Fried, Macapagal, et al., 2018; Fisher, Fried, Puri, et al., 2018; Gray et al., 2020; Macapagal et al., 2018). We conducted the survey using LimeSurvey software over four

weeks in early 2017. We recruited participants through paid Facebook advertisements. Online ads featured pictures of adolescent males, our research program logo “IMPACT LGBT Health and Development Program,” and an invitation to “Join our online study, share your opinions, improve the health of your community, Earn \$.” Recruitment, screening, and informed consent materials indicated that “The survey asks about things related to being LGBTQ, your health and sexual behavior, and what you think and feel about studies related to HIV prevention.” Interested participants completed an 11-item screening questionnaire to determine eligibility. Inclusion criteria for the larger study included being 14–17 years old, living in the United States, identifying as a cisgender male, reporting at least one male anal sex partner, and self-reporting HIV seronegative or unknown status. For the current study, we included only participants who had complete data on primary measures and who had experienced at least one type of sexual minority victimization during the past six months, since our focus was on the degree of distress in response to such victimization. Of the 1,351 individuals who clicked on the ad and completed the online screener, 959 did not pass the eligibility screener. The majority of those who did not pass the eligibility screener either did not report an anal sexual encounter with another male or were over 18; we expected this result because we used ad language that was intentionally broad to reduce the occurrence of desirability effects and fraudulent responding. Of the 392 who completed the screener and met inclusion criteria, 178 did not complete the survey. There were no significant differences between completers and noncompleters on any demographic or sexual behavior variables. Of the 214 who completed the survey, we eliminated 14 participants because they failed attention and consistency validation checks. We excluded the following: 2 participants from the analysis because they identified as female, 12 respondents due to missing data on primary measures, and 28 participants who had not experienced at least one type of sexual minority victimization. The final sample size was 143.

## Measures

In the larger survey, we included measures on anticipated SGM stigma in health care settings, attitudes toward HIV testing, and perceived risks and benefits of participation in preexposure prophylaxis (PrEP) clinical trials. In the current study, we analyzed the following subset of items and measures.

**Demographics and sexual orientation disclosure.** Participants completed questions about race, ethnicity, sexual identity, living situation, student status, employment, and SES as measured by primary and secondary guardian’s education. A single 4-point Likert-type question examined public disclosure of sexual orientation: *not out to anyone* (1), *only out to a select few people* (2), *out to most people* (3), *out to everyone* (4), and one item assessed whether youth had disclosed their sexual orientation to at least one parent or guardian: *no, I’m not out to my parents/guardians* (1), *yes, I am at out to at least one (but not all) of my parents/guardians* (2), *yes, I am out to all parents/guardians* (3).

**CAI frequency and sexual behaviors.** One question assessed frequency of lifetime condom use by the participant: “How frequently have you worn a condom during anal sex with male partners in your lifetime?” A second question assessed frequency of condom use by the participant’s partner when engaging in anal

sex: “How frequently has your male or transgender female partner(s) worn a condom during anal sex in your lifetime?” These two items were reversed for all analyses to reflect participant and partner CAI frequency. Two Likert-scale items assessed frequency of alcohol and drug use before sex in the past 12 months. All four items used a 5-point Likert scale (1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *frequently*, 5 = *always*). Two items measured lifetime number of male and transgender female anal sexual partners on a continuous scale; however, we did not ask participants to distinguish between insertive or receptive sexual partners.

**CAI vulnerability.** Drawing on prior work, we adapted six items to tap into experiences and attitudes reflecting vulnerability to a sexual partner’s influence over condom nonuse during anal sex (Molitor et al., 1999; Newcomb & Mustanski, 2014). Items included (1) “I have not used condoms because I was not comfortable talking about them with my male or transgender female sexual partner,” (2) “I have agreed to have anal sex even when my male or transgender female partner refuses to use a condom,” (3) “I have not used condoms because I am afraid my male or transgender female partner will react violently,” (4) “It has been difficult for me to say no to male or transgender female partners who refuse to use a condom,” (5) “My male or transgender female sexual partners have a strong influence on my use of condoms,” and (6) “I take the lead in deciding whether my male or transgender female partner or I will use a condom.” We reverse-scored the sixth item so that higher scores reflected greater vulnerability to a sexual partner’s influence not to use a condom during anal sex. All items used 5-point Likert scales (1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *frequently*, 5 = *always*). The scale yielded acceptable interitem reliability ( $\alpha = .73$ ).

**Sexual minority victimization distress.** We adapted a 4-item scale from the Daily Heterosexist Experiences Questionnaire (Balsam et al., 2013), the LGBT People of Color Microaggressions Scale (Balsam, Molina, Beadnell, Simoni, & Walters, 2011), and the Adolescent Discrimination Distress Index (Fisher, Wallace, & Fenton, 2000) to assess the occurrence and distress in response to different instances of SMV. Items assessed whether, in the past six months, participants had been teased or bullied, hit or beaten up, treated rudely or unfairly, or called bad names because someone thought they were gay, lesbian, bisexual, transgender, or queer. We dichotomized each item (it never happened vs. it happened) to assess the occurrence of each victimization behavior. To assess associated distress, participants rated how much the experience upset them on a 5-point scale (1 = *it never happened*, 2 = *it happened and did not upset me*, 3 = *it happened and upset me a little*, 4 = *it happened and upset me moderately*, 5 = *it happened and upset me quite a bit*). A cumulative distress score reflected the mean level of distress across the four items. The scale yielded acceptable interitem reliability ( $\alpha = .73$ ).

## Procedure

We contacted participants whose screener responses met inclusion criteria via e-mail and provided them with a website address to access the full survey. The survey website directed ineligible youth to a university registry for other available studies. The survey website included firewall protections with data encryption, and the investigators received a Certificate of Confidentiality from the Department of Health and Human Services. Participants could end their participation

at any time. Piloting indicated that the average length of time for survey completion was 25–30 min. All questions included the option “I prefer not to answer.” The participating university institutional review boards approved the study and waived parental permission requirements. Youth who completed the survey received a \$30 online gift certificate for participation.

## Analytic Approach

We calculated means, standard deviations, and percent agreement/disagreement for each item. We conducted interitem reliability calculations on scales representing the six items on CAI Vulnerability and four items on SMV Distress. Multivariate analysis of variance and Pearson correlations assessed the effect of ethnicity, age, sexual orientation disclosure to others, and other key demographics on participant and partner CAI frequency, CAI Vulnerability, and SMV Distress. Further correlations assessed the hypothesized relations among participant and partner CAI frequency, CAI Vulnerability, and SMV Distress. Given the cross-sectional nature of our sample, we could not test true mediation. However, we used mediation analysis methods to test the variance accounted for by CAI Vulnerability as a third variable. Although we hypothesized that CAI Vulnerability would significantly account for the association between SMV Distress and participant CAI frequency, we did not test this model because of the nonsignificant correlation between SMV Distress and participant CAI frequency. To test for the variance accounted for by CAI Vulnerability on the association between SMV Distress and partner CAI frequency, we conducted three linear regressions to test the associations between SMV Distress and CAI Vulnerability, CAI Vulnerability and partner CAI frequency, and SMV Distress and partner CAI frequency. We then conducted a stepwise linear multiple regression to assess the indirect effect of SMV Distress on CAI frequency, adjusting for CAI Vulnerability (Baron & Kenny, 1986). We used the bootstrapping method to test the significance of the variance accounted for by CAI Vulnerability (Preacher & Hayes, 2004). The study was adequately powered. The bootstrapping method requires a sample size of 126 to detect a third variable effect at the power level of 0.80 with a small-to medium-sized regression coefficient (0.26) for SMV Distress predicting CAI Vulnerability and a medium-sized regression coefficient (0.39) for CAI Vulnerability predicting partner CAI frequency (Fritz & MacKinnon, 2007). We estimated a small to medium effect for SMV Distress predicting CAI Vulnerability because there may be other psychological and interpersonal factors that explain variation in CAI Vulnerability and because previous studies found small to medium effects for the relation between victimization and CAI (Bontempo & D’Augelli, 2002; Li et al., 2014). We estimated a medium effect for CAI Vulnerability predicting partner CAI frequency because conceptually, these two constructs are more closely related, and because previous research found medium to large effects for associations between different measures of interpersonal power imbalances and CAI.

## Results

### Demographic Data

Respondents lived in 32 states and, as illustrated in Table 1, in all four regions of the U.S., with the majority living in the South

or West (U. S. Census Bureau, 2019). The majority of youth were between 16 and 17 years old, lived with parents, identified as gay, had one guardian with at least some college education, and had disclosed their sexual orientation to most or all people and to at least one parent/guardian. The majority of youth self-identified as non-Hispanic white (49.0%) or Hispanic/Latinx (37.1%) and approximately 14% as other racial/ethnic minorities.

### CAI Frequency and Sexual Behaviors

Youth reported on average 3.33 (median = 2.00) lifetime male or transgender female anal sexual partners, and 35.7% and 34.3% reported they or their partner had never or rarely used a condom, respectively (see Table 1). Participant and partner CAI frequency were highly correlated,  $r = .73$ ,  $p < .001$ . The number of male sexual partners was not significantly associated with participant or partner CAI frequency. Nearly half reported using alcohol or drugs at least once before having sex. There were no other significant associations among participant or partner CAI frequency and other demographic variables.

### CAI Vulnerability

Table 2 provides means, standard deviations, and percent agreement (sometimes–always) for the six items representing CAI Vulnerability, and the resulting scale score. Approximately 40% agreed to CAI when their partner refused condom use and indicated their sexual partners had a strong influence on their use of condoms either sometimes, frequently, or always (minimum score of 3). CAI Vulnerability was positively associated with lifetime number of male anal sex partners,  $r = .19$ ,  $p < .05$ . Both CAI frequency for participants,  $r = .53$ ,  $p < .001$ , and partners,  $r = .52$ ,  $p < .001$ , were positively associated with CAI Vulnerability.

### Sexual Minority Victimization Distress

Table 3 provides means and standard deviations of the SMV Distress scale ( $M = 2.30$ ,  $SD = 0.87$ ) and frequencies of occurrence of the four different types of victimization. The majority of respondents (80.4%) had experienced at least two forms of victimization, and 56.7% had experienced three or more types. Table 3 illustrates the proportion of participants who experienced each victimization type who reported associated distress. There were no significant associations between SMV Distress and demographic variables, with one exception: SMV Distress significantly decreased with age,  $r = -.18$ ,  $p < .05$ . SMV Distress was significantly correlated with partner CAI frequency ( $n = 131$ ,  $r = .20$ ,  $p < .05$ ) and CAI Vulnerability ( $N = 143$ ,  $r = .20$ ,  $p < .01$ ), but not with participant CAI frequency.

### Regression Analyses

Consistent with the hypothesized relations in Figure 1, we ran three linear regressions to test paths between SMV Distress and partner CAI frequency (path c), SMV Distress and CAI Vulnerability (path a), and CAI Vulnerability and partner CAI frequency (path b; Baron & Kenny, 1986). As Table 4 illustrates, the standardized regression coefficient between SMV Distress and partner CAI frequency was statistically significant. The standardized regression coefficient of SMV Distress pre-

Table 1

Frequency of Responses and Percent Agreement for Demographic Characteristics, Sexual Orientation Disclosure, and Sexual Behaviors

General demographics	Frequency and percent ( $N = 143$ )	
Age	$M = 16.17, SD = .83$	
14	7 (4.9%)	
15	18 (12.6%)	
16	61 (42.7%)	
17	57 (39.9%)	
Geographic region ( $N = 129$ )		
Northeast	23 (16.1%)	
South	18 (12.5%)	
Midwest	40 (27.9%)	
West	48 (33.6%)	
Race/ethnicity		
Black or African American	7 (4.9%)	
Asian/Pacific Islander	6 (4.2%)	
Non-Hispanic White	70 (49.0%)	
Hispanic/Latino	53 (37.1%)	
More than one race	5 (3.5%)	
Other	1 (0.7%)	
Living with parents	185 (98.4%)	
Highest education of primary parent/guardian		
High school or less	44 (30.8%)	
Some college	26 (18.2%)	
College degree	21 (14.7%)	
Graduate degree	48 (33.6%)	
Highest education secondary parent/guardian ( $N = 126$ )		
High school or less	49 (27.3%)	
Some college	16 (11.2%)	
College degree	23 (16.1%)	
Graduate degree	44 (30.8%)	
Sexual Orientation		
Gay	117 (81.8%)	
Bisexual	20 (14.0%)	
Pansexual	4 (2.8%)	
Other	2 (1.4%)	
Sexual orientation disclosure		
Not out to anyone	0 (0.0%)	
Only out to a select few people	33 (23.1%)	
Out to most people	53 (37.1%)	
Out to everyone	57 (39.9%)	
Out to at least one guardian	101 (72.3%)	
	$M (SD)$	
Sexual health behaviors		
Lifetime number of male anal sexual partners	3.33 (4.23)	Range 1–32 Median = 2.00
Lifetime CAI (participant)	2.88 (1.56) <sup>a</sup>	51 (35.7%) <sup>b</sup>
Lifetime CAI (partner)	2.88 (1.59) <sup>a</sup>	49 (34.3%) <sup>b,c</sup>
Frequency consuming alcohol before having sexual contact with a male or transgender female partner in the past 12 months	1.73 (1.06) <sup>a</sup>	34 (23.8%) <sup>d</sup>
Frequency using drugs before having sexual contact with a male or transgender female partner in the past 12 months	1.51 (.90) <sup>a</sup>	25 (17.5%) <sup>d</sup>

Note. CAI = Condomless anal intercourse.

<sup>a</sup> Mean score based on response options 1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *frequently*, 5 = *always*. <sup>b</sup> Percent calculated on those responding they had *never* or *rarely* used a condom. <sup>c</sup> Total youth responding to this item  $N = 131$ . <sup>d</sup> Percent calculated on those responding they had *sometimes*, *often*, or *always* consumed alcohol/drugs before sex).

dicting CAI Vulnerability was statistically significant, as was the standardized regression coefficient of CAI Vulnerability predicting partner CAI frequency. The standardized indirect effect of SMV Distress predicting partner CAI frequency (path  $c'$ ) was 0.10. Bootstrapping with 10,000 samples (Preacher & Hayes, 2004) revealed a significant indirect effect of SMV Distress on partner CAI frequency via CAI Vulnerability, 95%

CI = [0.02, 0.37]. CAI Vulnerability significantly accounted for the association between SMV Distress and partner CAI frequency. The proportion of the effect that was accounted for (indirect effect divided by the total effect) was 0.50. Given the cross-sectional nature of the sample, we also tested the alternative model with SMV Distress as the third variable. We did not find a significant indirect effect of CAI Vulnerability on

Table 2

*Means, Standard Deviations and Percent Agreement for the Condomless Anal Intercourse (CAI) Vulnerability Scale and Individual Items*

Scale item	<i>M (SD)</i>	% Agreement <sup>a</sup> ( <i>N</i> = 143)
CAI Vulnerability scale score ( $\alpha = .71$ )	1.97 (0.78)	
I have not used condoms because I was not comfortable talking about them with my male or transgender female sexual partner(s)	1.44 (1.03)	17 (11.9%)
I have agreed to have anal sex even when my male or transgender female partner refuses to use a condom	2.30 (1.51)	57 (39.9%)
I have not used condoms because I am afraid my male or transgender female partner will react violently	1.13 (0.49)	7 (4.9%)
It has been difficult for me to say no to male or transgender female sexual partners who refuse to use a condom	1.96 (1.36)	42 (29.4%)
My male or transgender female sexual partners have a strong influence on my use of condoms	2.39 (1.38)	63 (44.1%)
I take the lead in deciding whether my male or transgender female partner or I will use a condom <sup>†</sup>	3.43 (1.34)	71 (77.7%)

*Note.* AMSM = Adolescent men who have sex with men.

<sup>a</sup> *N* and percent reflect AMSM responding 3 = *sometimes*, 4 = *frequently*, or 5 = *always*.

<sup>†</sup> Item reverse scored to calculate scale total.

partner CAI frequency via SMV Distress, 95% CI = [−0.0004, 0.24].

### Discussion

Engagement in CAI has been associated with the disproportionately high number of HIV infections among AMSM (Centers for Disease Control and Prevention, 2018a; Kann et al., 2018; Poteat et al., 2019; Valencia et al., 2018). There is an urgent need for research identifying psychosocial factors influencing CAI to inform empirically based condom use behavioral interventions with this population. This study extends to 14-year-old AMSM, who are beginning to have their first sexual encounters, data demonstrating relations among perceived lack of interpersonal power (vulnera-

bility to CAI) in sexual relationships and CAI. To our knowledge, this is the first study to examine relations among CAI frequency, distress associated with SMV, and vulnerability to a sexual partner's influence over condom nonuse during anal sex in this population.

Consistent with prior research reporting a high prevalence of CAI among AMSM (Mustanski, Newcomb, Du Bois et al., 2011; Poteat et al., 2019; Valencia et al., 2018), approximately 40% of the sample reported they and their partners never or rarely used condoms during anal sex. An adapted scale assessing vulnerability to CAI yielded good interitem reliability and demonstrated significant associations with CAI. Youth with higher vulnerability to CAI endorsed items indicating difficulty refusing CAI when pres-

Table 3

*Means (M) and Standard Deviations (SD) for Sexual Minority Victimization (SMV) Distress Cumulative Score, Number and Percent of Participants Indicating the Individual SMV Item Occurred, and Means (M), Standard Deviations (SD), and Number (N) and Percent (%) of Participants Who Reported Distress Associated With an Occurrence*

Scale item	SMV distress <i>M (SD)</i>	Occurrence <i>N (%)</i>	<i>N (%)</i> reporting distress for an occurrence <sup>a</sup>	<i>M (SD)</i> for distress reported for an occurrence
SMV Distress scale ( $\alpha = .73$ )	2.30 (0.87)			
In the past 6 months, have you been teased or bullied because someone thought you were gay, lesbian, bisexual, transgender, or queer?	2.76 (1.13)	127 (88.8%)	75 (59.1%)	2.98 (0.98)
In the past 6 months, have you been hit or beaten up because someone thought you were gay, lesbian, bisexual, transgender, or queer?	1.21 (0.76)	13 (9.1%)	8 (61.5%)	3.31 (1.25)
In the past 6 months, have you been treated rudely or unfairly because someone thought you were gay, lesbian, bisexual, transgender, or queer?	2.61 (1.40)	97 (67.8%)	75 (77.3%)	3.37 (1.04)
In the past 6 months, has someone called you bad names because they thought you were gay, lesbian, bisexual, transgender, or queer?	2.62 (1.28)	112 (78.3%)	67 (60.0%)	3.07 (1.07)

<sup>a</sup> Participants who provided a rating of 3 or above where 3 = *it happened and upset me a little*, 4 = *it happened and upset me moderately*, 5 = *it happened and upset me quite a bit*.

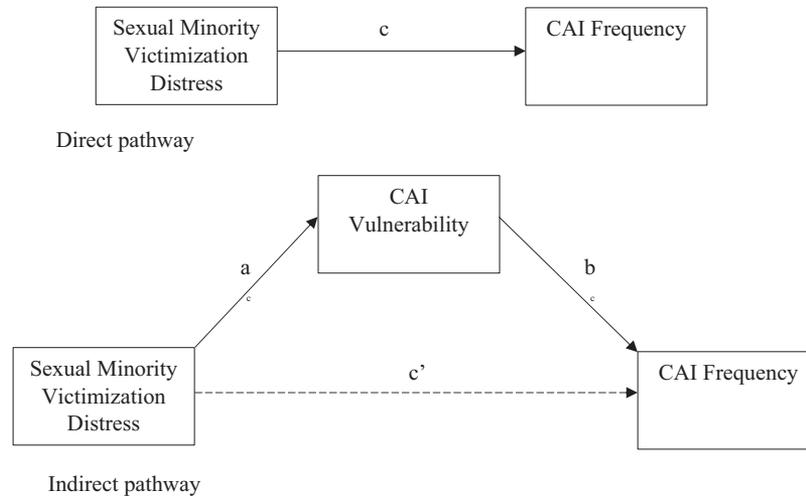


Figure 1. Conceptual model for the association between sexual minority victimization (SMV) distress and Condomless anal intercourse (CAI) frequency, accounted for by CAI vulnerability. Path a illustrates the association between SMV distress and CAI vulnerability. Path b illustrates the association between CAI vulnerability and CAI frequency. Path c and c' illustrate the direct and indirect effects of the model, respectively.

sured by a partner and stronger partner influence over condom use decisions. Approximately 40% of participants at least sometimes engaged in anal sex even when a partner refused to use a condom, and 44% reported that at least sometimes their partners had a strong influence on condom use decisions. Somewhat inconsistently, the majority (77.1%) also reported that they took the lead on deciding condom use with their partner. A direction for future research could involve cognitive testing of the scale items with AMSM to assess its accuracy in measuring vulnerability to CAI. These findings, documenting vulnerability to a partner's decision-making authority for condom use, are consistent with research with older adolescent and adult MSM demonstrating how interpersonal power imbalances are associated with increased CAI (Bentley et al., 2007; Mustanski, Newcomb, & Clerkin, 2011; Newcomb & Mustanski, 2016).

Consistent with research reporting high rates of bullying among SGM youth (Kann et al., 2018), a majority of AMSM had experienced at least two forms of sexual minority victimization. The level of associated distress significantly decreased with age, supporting prior research demonstrating that older adolescents experience lower levels of sexual minority victimization than younger adolescents (Birkett, Newcomb, & Mustanski, 2015; Poteat, Birkett, Turner, Wang, & Phillips, 2020; Robinson et al., 2013). The mean SMV Distress score of 2.30 aligns with the response choices between "it happened and did not upset me" (response choice 2) and "it happened and upset me a little" (response choice 3). One reason for this relatively low distress score is that participants who did not experience the victimization were given a score of 1 for their level of distress. However, as Table 3 illustrates, between 59.1% and 77.3% of participants who experienced each specific

Table 4  
Effects of Condomless Anal Intercourse (CAI) Vulnerability on the Association Between Sexual Minority Victimization (SMV) Distress and Partner CAI Frequency Among Sexual Minority Youth Who Have Experienced Victimization

Model	B	B*	p	95% CI	
				LL	UL
1. SMV distress → Partner CAI frequency	.35	.20	.03	.04	.66
2. SMV distress → CAI vulnerability	.18	.20	.02	.03	.33
3. CAI vulnerability → Partner CAI frequency	1.06	.52	<.001	.78	1.36
4. Complete model					
CAI vulnerability → Partner CAI frequency	1.02	.51	<.001	.72	1.33
SMV distress → Partner CAI frequency	.17	.10	.22	-.10	.44
Indirect effect					
SMV distress → CAI vulnerability → Partner CAI frequency	.17	.10	—	.02 <sup>a</sup>	.37 <sup>a</sup>

Note. B = unstandardized beta; B\* = standardized beta; CI = confidence interval of unstandardized beta; LL = lower limit; UL = upper limit.

<sup>a</sup> Bootstrapped 95% confidence interval with 10,000 samples.

type of victimization responded with a distress score of 3 or above with mean scores ranging from 2.98 to 3.37. Consistent with our hypothesis, we found that youth who had experienced more distress in response to SMV were more vulnerable to a partner's influence over CAI and reported a higher frequency of their partner not using a condom during anal sex. The finding that vulnerability to CAI is associated with distress in response to SMV complements earlier work demonstrating relations between victimization prevalence and sexual risk behaviors among SGM youth and retrospective studies indicating long-term effects of adolescent school victimization on CAI (Bontempo & D'Augelli, 2002; Russell et al., 2011). The present study adds to prior research by assessing distress associated with victimization, its relation to CAI vulnerability to partner influence, and the relation of both of these factors to frequency of CAI. As hypothesized, vulnerability to CAI significantly accounted for the association between distress in response to SMV and partner CAI frequency. Although, as prior research indicates, sexual minority victimization is related to HIV risk (Bontempo & D'Augelli, 2002; Li et al., 2014; R. L. Miller et al., 2013; Russell et al., 2011), our findings suggest that this association is largely due to how distress in response to sexual minority victimization is related to feelings of powerlessness during sexual relationships and not directly to the victimization itself. Higher levels of distress in response to SMV might also be evidence of PTSD symptoms. Research on sexual minority bullying and sexual abuse during childhood and adolescence has been associated with internalizing problems such as PTSD (Batchelder et al., 2017; Boroughs et al., 2019; Roberts, Rosario, Corliss, Koenen, & Austin, 2012).

### Strengths and Limitations

The online data collection and recruitment methods yielded a national sample of sexually active young AMSM, an often difficult to reach population, and the anonymous online study design may have increased participant comfort and encouraged honest and candid responses. However, as with most online studies, we cannot claim with certainty that respondents actually met the inclusion criteria, and, aside from word-of-mouth promotion from other MSM adolescents, recruitment was limited to those who use Facebook, who have access to the Internet or mobile phones, and who frequent sexual minority social media sites (Miner, Bocking, Romine, & Raman, 2012). Almost one third of the sample self-identified as Hispanic and an additional 15% identified as either Black/African American, Asian/Pacific Islander, or more than one race. Few differences between non-Hispanic Whites and members of other ethnic groups emerged. However, there were insufficient respondents from non-Hispanic ethnic minority groups to examine issues related to how the intersectionality of ethnic and sexual minority status may influence motivation to participate in HIV research, an important area for future research (Smalley, Warren, & Barefoot, 2016).

In addition, the majority of youth were out to at least one parent and living at home. In samples with a larger proportion of youth who were not out to their family, isolation and rejection from peers or family may also lead to increased reliance on romantic partners for support, and youth may be unwilling to risk losing this support by refusing CAI. Moreover, this study did not focus on the partner pressures and victimization experienced by transgender youth,

whose dual SGM status may exacerbate these influences on CAI, a critical area for future research.

A limitation of the SMV Distress measure was the ambiguous timeframe; participants were asked to report victimization they had experienced in the past six months, but it was not clear whether the associated distress was specific to the time at which the SMV experience occurred or their level of distress in the present about that experience. A further limitation is that we did not measure PTSD, so were unable to assess whether distress in response to sexual minority victimization was associated with more serious internalizing disorders. Finally, distress in response to SMV was related to partner CAI but not to participant CAI frequency, even though participant and partner CAI were highly correlated. The relation between participant CAI frequency and distress in response to SMV may be moderated by how frequently youth performed insertive or receptive roles during anal sex, a question we did not include in the survey, and an important area for future research. Although embedded within a series of questions specifically referring to the participant's own sexual experience with partners, the question about partner condom use was not worded specific to the partner's condom use with the participant, nor did it use language specific to insertive and receptive acts. As a consequence, we cannot be certain that participants were describing their partner's condom use with them or their knowledge of the partner's use with others.

### Conclusion

The findings of this study contribute to our understanding of HIV risk among AMSM in establishing links among CAI frequency, sexual minority victimization, and vulnerability to partner influence over condom nonuse during anal sex. The study highlights the importance of examining the influence of interpersonal relationship factors on the disproportionate level of HIV and HIV risk behaviors among AMSM. The findings also underscore the importance of including measures of distress associated with sexual minority victimization in research on HIV risk among SGM youth and encourage future research examining how a sense of powerlessness experienced during victimization may translate into decreased self-efficacy in asserting condom use against a partner's objections. Although few participants in the present sample indicated physical intimidation from their partner as a reason they engaged in CAI, prior research, taken together with the findings from this study, suggests that future investigations should consider including additional measures of partner intimidation on condom use among AMSM.

Current HIV risk reduction interventions for SGM youth focus on condom use and PrEP adoption and adherence, and researchers have recently been testing the feasibility and efficacy of text message, smartphone app, and social media interventions (Patel et al., 2018; Schnell et al., 2018; Tanner et al., 2016; Ybarra, Liu, Prescott, Phillips, & Mustanski, 2018). Given the paucity of literature on SGM youths' sexual communication skills, one strategy may be to developmentally tailor for adolescents' interactive mobile app interventions designed to enhance interpersonal condom use negotiation skills (Aliabadi et al., 2015). To date, there are no interventions that address the relations between sexual minority victimization and other forms of interpersonal vulnerability to reduce HIV risk among AMSM. However, researchers have begun

to explore the development of such interventions with MSM with a history of childhood and adolescent bullying (Boroughs et al., 2019). This potential avenue for future research might adapt clinical interventions that treat PTSD in MSM with a history of child abuse as a mechanism to decrease HIV risk behaviors (O'Cleirigh et al., 2019). Although limited in generalizability, interventions for AMSM might draw upon research involving heterosexual adolescents addressing sexual power imbalances through the use of condom use negotiation, enhanced identification of condom coercion, and resources to remove oneself from a coercive relationship (Stokes, Harvey, & Warren, 2016; Teitelman, Tennille, Bohinski, Jemmott, & Jemmott, 2011; Tschann, Adler, Millstein, Gurvey, & Ellen, 2002). Effective CAI prevention strategies will also need to consider that power imbalances among sexual partners may depend on individual characteristics associated with economic, cultural, and social marginalization or privilege as well as focusing on the link between positive self-care and interpersonal power imbalances (Dworkin et al., 2017; Mustanski, Newcomb, & Clerkin, 2011).

Finally, these findings suggest that prevention scientists may be able to strengthen the effectiveness of HIV prevention programs focused on negotiation skills around condom use by linking such initiatives to school or community-based programs aimed at reducing peer sexual minority victimization and programs for AMSM focused on correcting perceived interpersonal power imbalances through addressing and reducing victimization-related distress and developing assertiveness skills in sexual relationships essential for their sexual health.

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