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ORIGINAL ARTICLE

"I Kept It to Myself": Young Jamaican Men Who Have Sex with Men's Experiences with Childhood Sexual Abuse and Sexual Assault

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Abstract
The prevalence of HIV is exceptionally high among Jamaican men who have sex with men (JMSM) compared to similar populations within the Caribbean. A noticeable gap in the literature is the impact of childhood sexual abuse (CSA) and sexual assault on the state of the epidemic among this population. This study focused on JMSM's experiences with CSA and sexual assault and how these domains relate to HIV prevention. We analyzed qualitative data from 20 semi-structured in-depth interviews and focus group discussions with 10 men. Common themes emerged that highlight the patterns and nature of the abuse, the characteristics of the perpetrators, and the ways in which participants engage agency and resiliency as a basis to reclaim personal power. These findings serve as a catalyst for understanding how experiences with CSA and sexual assault affect the lives of young JMSM; how those experiences may impact attitudes and behaviors regarding HIV testing, engagement in care; and have implications for shaping legal policy, clinical, and mental health services for JMSM survivors.

Keywords Men who have sex with men · Jamaica · Sexual assault · Childhood sexual abuse · HIV · Sexual orientation

Introduction

The island of Jamaica has one of the highest rates of HIV infections among men who have sex with men (MSM) in the Caribbean (Figueroa et al., 2015; Hutton-Rose, Blythe, Ogbonna, & McGrowder, 2008). The HIV prevalence among Jamaican MSM is estimated at 32% (Budhwani, Hearld, Barrow, Peterson, & Walton-Levermore, 2016; Figueroa et al., 2013), which is significantly higher than the general adult HIV prevalence of 1.7% among persons 15–49 years (Losina et al., 2008; Ministry of Health, 2012). Despite substantial progress in eliminating mother-to-child transmission of HIV, early initiation of antiretroviral therapy (Hutchinson et al., 2007), and promotion of other prevention efforts, the incidence of HIV among Jamaican MSM appears to have remained high for the past two decades (Barrow & Barrow, 2013; Figueroa et al., 2013, 2015).

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Public health experts and behavioral researchers have theorized that the social vulnerabilities experienced by Jamaican MSM have contributed to HIV acquisition and transmission (Figueroa et al., 2013; Logie et al., 2016a, b). Social vulnerabilities for Jamaican MSM include inequality, unemployment, limited education, homelessness, sexual violence, poverty, and criminalization of same-sex sexual behavior (Figueroa et al., 2013, 2015; Harris, 2014). Stigma and discrimination against sexual minorities also compound the problem by driving men at high risk for HIV infection underground, making the provision of prevention, treatment, and social support services difficult to access for many Jamaican MSM (Logie et al., 2016a, b; Norman, Carr, & Jiménez, 2006; White & Carr, 2005).

There is limited research that focuses on the sexual violence experienced by Jamaican and other MSM in the Caribbean. This gap in the literature limits the ability to provide a complete examination of the impact of childhood sexual abuse (CSA) and sexual assault, and how those experiences impact the HIV prevention efforts among this population. The issue of sexual violence such as CSA has been identified in the literature in the U.S. with Black and Latino MSM who experience disproportionately higher rates of HIV and have had other adverse health outcomes (Benoit & Downing, 2013; Fields, Malebranche, & Feist-Price, 2008; Williams et al., 2015). One limitation in the literature on CSA is the lack of a consistent definition of

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this construct (Paul, Catania, Pollack, & Stall, 2001; Phillips et al., 2014). This limitation is also true in Jamaica and the Caribbean, especially with respect to cultural nuances around gender, sex, and sexuality (Reid, Reddock, & Nickenig, 2014; Samms & Cholewa, 2014). In this article, we will use the definition by Fields et al. (2008) that defined CSA as both nonconsensual noncontact sexual acts (e.g., sexual comments, flashing, voyeurism, and showing a child pornography), and nonconsensual sexual contacts (e.g., genital touching, frottage, digital or object penetration, oral sex, or penile penetration).

Like CSA, there is no consensus definition for sexual assault. Therefore, in this article, we used the definition provided by the United States Department of Justice, which is any type of sexual contact or behavior that occurs outside of the explicit consent of the recipient (Department of Justice, 2017). The prevalence of sexual assault has been reported between 12 and 54% among MSM in the U.S. (Rothman, Exner, & Baughman, 2011); however, a true representation of the prevalence is also difficult to ascertain because of the barriers faced by men when reporting sexual violence (Sable, Danis, Mauzy, & Gallagher, 2006). The same is true in Jamaica and the rest of the Caribbean where only anecdotal information from MSM survivors is available (Human Rights Watch, 2014). Barriers to reporting sexual assault include shame, guilt, fear of being judged because of their sexual orientation, concerns around confidentiality, and mistrust of the law enforcement (Sable et al., 2006).

Nearly 30% of sexually active men in the Caribbean reported a coerced or forced first sexual experience (Reid et al., 2014). This figure is likely underestimated due to the reluctance of male victims reporting sexual crimes to the police (Reid, 2017; Reid et al., 2014). A 2013 report from the one of the island's child care and protection agencies provided some perspective into the nature of sexual violence against children (Kirkland, 2013). Sexual violence is the third most commonly cited reason for children being taken to the hospital and relocated into homes of safety in Jamaica (Kirkland, 2013). Similar to findings in other countries (Fields et al., 2008; Williams et al., 2015), the report suggested that the perpetrators were often male, known to the victim, or a member of the family (Kirkland, 2013). The current data on CSA in Jamaica are mostly among young girls (Baumgartner, Geary, Tucker, & Wedderburn, 2009); therefore, an accurate assessment of the prevalence of CSA among boys is not currently available because of homophobia and the taboo nature of the topic of homosexuality.

Compounding the issue of data concerning sexual violence among males is the gendered difference between how the law regarding rape and sexual assault is applied in Jamaica. Under Jamaican law, sexual assault and rape are defined and punished differently for girls than they are for boys. The legal age for sexual consent in Jamaica is 16 years (Samms & Cholewa, 2014). Under Jamaica's Sexual Offences Act of 2009, the term rape is defined as nonconsensual penetration of the vagina by a penis (Jamaica Ministry of Justice, 2009). The definition therefore fails to recognize and protect male survivors of rape via anal penetration (Reid, 2017). Additionally, section 76 of the Offences Against the Persons Act (Jamaica Ministry of Justice, 1864) criminalizes "buggery" (sodomy). The law makes no distinction between consensual and nonconsensual anal sex between men and prescribes a sentence of up to 10 years imprisonment at hard labor for the crime of buggery (Figueroa et al., 2013; Human Rights Watch, 2014; Reid, 2017).

Given the high prevalence of HIV (Figueroa et al., 2015; Ministry of Health, 2012) and the limited literature on CSA and sexual assault, an examination of these forms of sexual violence among Jamaican MSM is warranted. While the negative impact of CSA and sexual assault has been documented elsewhere (Fergusson, Horwood, & Lynskey, 1997; Fields et al., 2008; Lloyd & Operario, 2012; Williams et al., 2015), little is known about the impact of these forms of sexual violence among MSM survivors in Jamaica (Harris, 2014; Reid, 2017). Additionally, given that sexual violence toward children is often part of other forms of abuse and neglect (Lowe, Gibson, & Christie, 2008; Samms & Cholewa, 2014), an accurate qualitative assessment of these intertwined issues is vital for understanding their impact on young Jamaican MSM. This qualitative study is the first step in describing young Jamaican MSM experiences with CSA and sexual assault. We also provided an explanation as to why survivors decline to report these crimes to the relevant authorities. Our findings may inform public and mental health professionals about the needs and challenges of young Jamaican MSM who have experienced CSA and sexual assault and pave the way for effective structural interventions such as legal and policy changes to improve the health and lived environments of the Jamaican MSM community.

Method

This qualitative study on childhood sexual abuse and sexual assault originates from a broader study on the social and cultural determinants of HIV risk for young Jamaican MSM (Harris, 2014). Qualitative individual interviews and a confirmatory focus group discussion were used to understand the experiences of young Jamaican MSM drawing from their interactions with the culture and society (Portney & Watkins, 2009; Sandelowski, 2000; Streubert-Speziale & Carpenter, 2003). The confirmatory focus group discussion was to share general themes that emerged from the individual interviews and to solicit additional perceptions, opinions, and ideas from other members of the community (Krueger & Casey, 2009). The study received oversight approval from the Research Subjects Review Board of the University of Rochester Medical Center in the U.S., and from the Ethics Committee of the University of the West Indies, Mona Campus in Kingston, Jamaica.

Participants

Men were eligible to participate in the study if they were 18–30 years of age, biologically male at birth, and reported having sex with another man in the previous 3 months. Eligible men were offered participation in the study if willing to provide verbal and written informed consent. They were given a date and location for a semi-structured 90-min individual interview. Participants for the confirmatory focus group discussion were recruited shortly after the completion of all individual interviews. Participant interviews were conducted at a local university and a community-based organization that provides health services to the population. The confirmatory focus group discussion took place in a private area on the grounds of a local university.

Procedure

The lead author recruited participants from several parishes across the island using purposive sampling and through peer referrals (Kristensen & Ravn, 2015; McLafferty, 2004). The lead author made promotional materials available at locations known to be frequented by members of the gay and bisexual community. The lead author conducted recruitment activities via direct contact with potential participants at social events (community-based organization sponsored events, gay and lesbian peer support groups on the campus of the University of the West Indies, and private social gatherings) and through peer referrals. Participants who were interested in the study contacted the lead author via telephone for more information about the study and to answer several screening questions. Screening questions include: (1) sex assigned at birth, (2) their age at the time of contact, (3) whether they were born in Jamaica, (4) and if they ever had sex with a man within the past 3 months. Men who were screened and were deemed eligible were invited to participate in the study. The lead author obtained verbal and written informed consent from all participants. Regardless of their participation in the individual interviews or the confirmatory focus group discussion, all participants were remunerated US $20 for their time and travel to the interview site. The individual interviews and confirmatory focus group discussion were conducted by the lead author, a Jamaican-American, familiar with the target population and culture, which assisted in building rapport (Anthias, 2002; Kristensen & Ravn, 2015; Milner, 2007; Rose, 1997).

Measures

A demographic and behavioral survey was administered to all participants prior to their participation in the individual interviews or the confirmatory focus group discussion. Participants were asked to provide general information regarding their age, hobbies, religious background, education and income, sexual identity, sexual behaviors, and relationship history. Under the sexual behaviors section of the instrument, participants were asked to respond yes or no to the question—"has anyone every forced you to have sex?" An affirmative response to this question was further explored during the in-depth interviews. Additionally, general themes around sexual violence were explored further during the confirmatory focus group discussions. Based on previous research (Figueroa, 2008; Norman et al., 2006; White & Carr, 2005), the interview guide was created through consultation with key stakeholders from the community. See Table 1 for a list of the individual content areas and the questions asked. Although the guide was created prior to the interviews to allow for systematic sequencing of the content, flexibility facilitated deviations to less sensitive topics (Krueger & Casey, 2009). After the completion of the interviews ($N=20$), the lead author convened a confirmatory focus group discussion with ($n=10$) men to clarify disagreements and to resolve complex ideas (Carlsen & Glenton, 2011; McLafferty, 2004; Tong, Sainsbury, & Craig, 2007). The intention of the focus group was to canvas the opinions from other members of the community to explore the themes and other key findings that emerged from the individual interviews. It was our determination that in this format participants possesses

Table 1 In-depth interview and focus group guides

Content Areas	Sample Questions
Sexual identity development	At what age did you realize that you were (gay, straight, or bisexual)? How did you come to that realization?
Cultural influences around sex	From you experience, what do people generally think about MSM? How did those thoughts affect you?
Self-maintenance and HIV testing practices	Have you ever been tested for HIV? What led you to get tested?
Sexuality-based violence	Have you ever been in a situation where you were forced to have sex? Was it with someone your age or older than you? Did you tell anyone? Can you tell me about an instance where you felt discriminated against when reporting sexuality-based violence to the police?
Protective factors that mitigated HIV risk and vulnerability	In your experience, have you done anything to prevent yourself from getting HIV? If so, what were those things?

the capacity to become more than the sum of their individual parts (Krueger & Casey, 2009). To maximize participants' protection and confidentiality, a pseudonym was assigned.

The lead author is a family nurse practitioner with experience providing clinical services to young men in the U.S. and has experience providing counseling regarding sex and sexuality health-related issues. Participants received immediate support and were provided referrals for mental health and other social support services when requests were made during the interviews.

Data Analysis

All interviews were conducted in a private space (library, chapel, or offices). Individual interviews were the primary source for data collection. The confirmatory focus group discussion was used to confirm general themes that emerged from the individual interviews as well as to explore unresolved issues and clarify potential disagreements (Milner, 2007; Rose, 1997). Participants expressed gratitude for having someone familiar with the Jamaican culture and language with which to speak, suggesting that it assisted in making them comfortable discussing such sensitive topics (Anthias, 2002; Caretta, 2014; Merriam et al., 2001; Sultana, 2007).

The qualitative data were managed using the computer software ATLAS.ti. Interviews were audio-recorded and transcribed. The audio files were de-identified and assigned a four-digit identifier. The qualitative analysis involved a stepwise process, which included: code development, extraction, and the creation of the codebook; tagging or coding large portions of text that represented key thoughts or ideas; and narrative thematic statements construction (Miles & Hurberman, 1994). Code development was conducted by using an open-coding technique, allowing for the labeling of large sections of text that describes a particular concept that was found in the collective narrative (Braun & Clarke, 2006). The tagging of key concepts was necessary to assess key thoughts and ideas within the data (Miles & Hurberman, 1994; Patton, 2002). A codebook was created at the onset as codes were being generated. Codes were analyzed and compared with each other for similarities. Coding continued until saturation was achieved. The final list of codes retained in the codebook was central to the investigation (Ando, Cousins, & Young, 2014; Patton, 2002). The next step in the analysis process was clustering codes together to form categories—and all new categories were presented as thematic statements.

Another component of the analysis process included consultation with qualitative data analysis experts and with people familiar with the Jamaican cultural. These experts enhanced rigor and validity of the study findings through weekly meetings over the course of the analysis process to review the codebook, ensure that codes were being used consistently and that the codes were valid, or the best possible label for what was observed in the data (Burla et al., 2008; Miles & Hurberman, 1994). Peer debriefing with other qualitative investigators and expert supervision from the lead author's dissertation committee contributed significantly to the reliability and validity of study findings. Disagreements were discussed and resolved through consensus with all members of the team. Member checking was conducted by engaging key stakeholders with the data in order to also achieve consensus on the findings. The results presented in this article describe Jamaican MSM's experiences with sexual violence, particular childhood sexual abuse, and sexual assault.

Results

Sample Characteristics

The characteristics of this sample are shown in Table 2. The age of the men in this sample ranged from 18 to 29 years, and the mean age was 22 years. The majority of the participants were recruited from the Kingston metropolitan area; others were recruited from neighboring parishes. Forty percent of the sample reported some high school or a high school diploma. Almost half of the sample reported no sources of income or was self-employed, while the remaining individuals were commercially employed. The majority of the participants identified as gay or bisexual. The age of first sexual intercourse ranged from 7 to 24 years, and the mean age was 15 years.

A binary question of force sex (yes/no) was included on the demographic survey. Of the 30 participants responding to the question, less than half ($n = 12$; 40%) of the sample reported a history of sexual violence, and 18 did not report any history of sexual violence. A total of ten participants indicated that they were forced to have sex as children and two were victims of sexual assault. The two participants who experienced sexual assault were both 17 years of age.

In the sections that follow, we first describe men's experiences with CSA and sexual assault. Within these experiences, we highlighted the ways in which these acts of violence were initiated, the age of onset of the sexual violence, and the characteristics of the perpetrators. Finally, we described one of the main reasons why participants chose not to report the sexual violence they had experienced.

Childhood Sexual Abuse

Participants reported that their first experience with sexual abuse was typically unwanted touching. In many instances, the abuse was from an older male family member. One young man, Mark (pseudonym), described his first experience with abuse from a male cousin:

Table 2 Sociodemographic characteristics of the sample ($N = 30$)

Variables	*n*	%
Age ($M = 22.40$ years)		
18–20 years	8	26.7
21–24 years	16	53.4
25–29 years	6	19.9
Parish of residency		
St. James	1	3.3
St. Catherine	7	23.3
St. Andrew	5	16.7
St. Thomas	1	3.3
Kingston	16	53.3
Levels of education completed		
Grade school	1	3.3
Some high school	8	26.7
High school diploma	4	13.3
Some college	9	30.0
College degree	8	26.7
Primary source of income		
None	8	26.4
Employment (*Receive a paycheck*)	11	36.3
Self-employed[a]	11	36.3
Sexual orientation		
Gay	18	60.0
Bisexual	12	40.0
Age of first sexual experience ($M = 15.73$)		
7–14	12	39.6
15–19	13	42.9
20–24	5	16.5
Been forced to have sex	12	40.0

[a]Self-employment included persons who were consultants, dance teachers, hairdressers, web and fashion designer, or engaged in sex work

> I think I was around age 5 or 6 when my cousin started molesting me…He was much older, around 18 at the time. He started with the touching. I remember waking up in the middle of night with him touching me all over…My brother was sleeping nearby but when my brother started waking up he stopped. Mark (age 23)

Another participant discussed abuse that began with unwanted sexual touching from an older relative that then escalated. Omar's narrative, the participant below, revealed that the molestation continued with his cousin making further sexual advances, and in order to get away from him he had to run away:

> My cousin who was 15, I was about 7 at the time, used to touch me while I was sleeping. He made a statement one day when we were alone in a room together. He took out his penis and said to me…"Come and sit on it." I said no and ran away from him. I climbed up on top of a barrel and stayed up there to get away from him. I was afraid at that time…he didn't say anything to me he just left the room. Omar (age 23)

In other examples, men described unwanted sexual touching as a tool that abusers used to test limits before they advanced to other sexual acts. Many participants expressed that the abuser shied away from penile penetration because of the potential for injury, which may expose the abuse:

> There was this one time when I came home early from school and he told me to undress and go take a shower… but he got naked and came into the shower, too! He forced me to do oral on him. You know, that is why I hate oral sex now as an adult. He didn't try to penetrate me because he knew that my aunt, older brother, or sister would bathe me eventually and if they saw anything different it would cause a problem. Kevin (age 23)

It appeared that the sexual trauma experienced by some of the participants extended into adulthood. In many of these examples participants who had experienced physical sexual abuse in childhood reported ongoing psychosexual trauma that has led to sexual dysfunctions in their adult relationships.

> It was my father's cousin that first molested me when I was 12 years old. Whenever he came to visit from out of town he would stay with us. He would wait until no one was home with us and forced himself on me. He started out with the oral and then moved on to anal penetration. I hate that man…these things never leave you…to this day I am still scared of him. Alex (age 26)

Participants' narratives revealed a link between psychosexual trauma experienced as a child and relationship problems experienced in adulthood. Men described problems which included not trusting others, poor communication, low self-esteem, difficulty interacting with others, and a generalized fear of older men they perceived as having a sexual interest in them.

Another participant discussed being coerced into performing a sexual act on a young man in his community who was twice his age. When he refused, the perpetrator made several claims to others in the neighborhood, which resulted in the participant being unnecessarily punished by his father. The participant explained that in the community and general Jamaican society, the person (regardless of gender) performing oral sex or receiving anal penetration is viewed less favorably than the recipient of the sexual act.

> There was this older boy, a teenager, who wanted to play "hide and go seek" with us smaller children. He asked me to give him oral sex…so I was like no way, that's nasty. I wasn't going to do it and he was really

> upset and said he was going to tell everybody if I didn't do it. I didn't do it to him so he went and told the other older kids in the neighbourhood that I tried to give him oral [sex], which caused a big excitement in the community. The rumour got back to my father and he gave me some good beating for it. Sean (age 20)

Participants also experienced sexual violence from members within their communities. Those participants, who reported being different, feminine or gender nonconforming, experienced a significant amount of the sexual violence. According to one participant, he was seen as a prey because the perpetrator saw him as an easy target due to his feminine behavior:

> I was like 11 years old when this man in the community approach me for sex. He was maybe in his 20's at the time…He must have wanted to release him [*sic*] tension so that's why he approached me…I wasn't sure why he came after me…but the only thing I can think of was because I was the really girly type at that age. Zack (age 21)

In another example, a participant described his experience with older boys from his neighborhood who suspected he was gay because of his feminine behavior. To prove that he was not gay, he was forced to have sexual intercourse with a female. These acts of sexual coercion often left participants confused about their sexual orientation:

> I was twelve and living in the country [rural community] when I was forced by older boys to have sex with a girl. They forced me to do it because I didn't seem to fit the ghetto [rude boy] or masculine enough type. I felt like I had to do it to prove myself to them… It left me very confused about my own sexuality. Garry (age 26)

Participants also discussed sexual abuse within their religious communities. While these experiences were not common, they highlighted a pattern of abuse that reflected the age difference of the perpetrator and how they used their power and privilege to force sexual contact with young participants like the man below:

> I mean at 14 I had an experience with an older person from my church…Well he forced himself on me and put his genitals between my legs. We weren't fully naked, we were actually in the bathroom…he was about late 30 s…It was youth night at the church that night after bible study, he came to me and asked me to go somewhere with him. We were walking when he drew me into a little corner and started to do stuff [to me]. Wade (age 20)

Another participant discussed a similar encounter with an older member of his church. In this example, the assault began with physical violence, was on the grounds of the church, and ended with the perpetrator forcing himself onto the participant. He explained:

> I was about maybe 11 or 12. One Sunday, while my grandmother and I were at church, I left her to go use the bathroom, which was outside to the back of the church. At the time, it felt like someone followed me in the bathroom. When I was getting ready to leave I felt a hand grabbed me….He then locked the door, grabbed on to my hand tighter, then grabbed my neck and then he said "don't scream." He eventually started to draw my shirt out of my pants and tried to pull my pants down. Boe (age 19)

The participant above perceived that he came close to being raped; however, because of the intervention of his grandmother the assault was averted. He also said that his grandmother confronted and threatened the perpetrator to not enter the church or the community again.

> I think my grandmother saved me from what he could have done to me. She noticed that I was taking too long to come back from the bathroom…She knocked on the door…he told me to answer her…When I opened the door she questioned why was this 40 something year old man locked up in the bathroom with me alone? She wasn't stupid she knew something was wrong…so I told her what he done to me…If my grandmother hadn't showed up when she did more than likely I would have been raped. Boe (age 19)

Men in this sample often blamed themselves for the abuse. Participants felt as though they gave away their power to their abuser. In addition, there was concern that they did something to cause the abuse to happen to them. For example, one participant explained: "I felt so guilty…Like I caused this to happen to me."

Sexual Assault

Two participants reported being survivors of sexual assault. In one instance, a weapon (e.g., a gun or knife) was brandished to force the participant into preforming a sexual act. While many perpetrators of CSA were a male relative or someone in their neighborhood, perpetrators of sexual assault were not previously known to the participant, and the attack occurred at random. In one example, the participant was on his way home from school as a passenger in a public transportation vehicle. He offered a detailed description of his experience:

> I was 17 at the time when I was sexually assaulted. I was coming from school and jumped into a robot taxi

> [unregistered]. I jump in the car with two other guys in the back seat with me and one was at the front with the driver. I noticed the driver made a wrong turn so I asked where he was going. He told me he was going to turn off because he had to pick up something. It was a little dark outside, like evening hours…I feel a hand touching my leg…So, I looked at the person and I was like a wah gwan yah so [what's going on here?]. The driver parked the car at a dead end and one of the guys in the back put a knife to my throat and ordered me out the car. Steve (age 25)

He went on to further detail the multiple layers of the assault and his emotional and physical response to the sexual acts he was forced to perform:

> They forced me to my knees and ordered me to give them oral sex then they took turns forcing themselves inside me. I was crying because it was so painful. At some point, I was able to escape, so I took off running into a nearby gully [rainwater runoff system] where I hide from them. I stayed there until I couldn't hear them anymore. Steve (age 25)

The retelling of the experience during the one-on-one interview was distressing for this participant. It was clear that other than reporting the assault to law enforcement, he did not receive any form of psychological care to treat the emotional pain the assault left behind. During the interview, the participant became visibly distraught talking about his near-death experience, rape, and abduction. It was clear that the experience left him traumatized.

Another participant described being forced to perform a sexual act before he was allowed to leave the home of his attacker:

> I was on my way home from school one day and this older man…always talking to me, asking to pick me up after school, things like that…I was about 17 at the time and he was like 40 plus years old…so one day he asked if I needed a ride home. I hesitated at first but then said ok. Next thing I knew we ended up at his house. He locked me in the room and held me down on the bed. Then he started forcing himself on me so I tried to fight him off. He didn't get to rape me but he forced me to perform oral sex on him before he would let me go. I did it just to get it over with. Barry (age 20)

"I Kept It to Myself"

Participants described their reasoning for choosing not to report their experiences with CSA or sexual assault to the police, an adult, or a member of their family. While some described reaching out to their family for help, others described keeping the molestation or assault to themselves because of the fear that no one would believe them. Men who kept the molestation to themselves reported feeling ashamed or blamed themselves for the sexual abuse. The decision to disclose the abuse was weighed against whether they would be believed. One participant explained how the perpetrator's influence over him continued into adulthood to the point that he was still afraid of his abuser:

> I tried confronting him a few years ago but I try not to get him upset over it. He knows I am still scared of him. I wanted to stay something to my father and older brother but I couldn't tell them because I was so ashamed. Growing up in a Christian household I felt like they wouldn't believe me or they would blame me. There were just not a lot of people that you could tell. Alex (age 26)

The theme of persistent fear was expressed in several narratives of the survivors of CSA and sexual assault. Participants reported fearing the perpetrator who often threatened them with physical violence if they disclosed the abuse. Additionally, the theme of "I just keep it to myself" was common, perhaps because of embarrassment sustained from the assault and fear of retribution. These examples offered insights into unresolved psychosexual trauma. Another participant expressed this theme in the example below:

> I was so afraid. I didn't know what he was going to do to me. I didn't report it to the police…I kept that to myself. You go to the police to report it and they laugh at you… So, I just avoid the embarrassment. Barry (age 20)

Finally, of all the examples provided, one participant, a victim of sexual assault, disclosed that he reported his assault to law enforcement. He was brought by the police to seek medical attention from Jamaica's Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA), a branch of the Jamaica Constabulary Force.

> After they left I went and reported it to the police. The police basically told me that if they caught them they would be charged with indecent assault. They took the report and took me to CISOCA for medical testing. Steve (age 25)

This one example illustrated the care and dedication this participant received from law enforcement in investigating his experience as a victim of sexual assault.

Discussion

This qualitative study provided detailed descriptions of young Jamaican MSM experiences with sexual violence, which included childhood sexual abuse and sexual assault.

Given the lack of literature on CSA in Jamaica among MSM, the current study sought to add to the literature on the experiences of CSA among MSM survivors (Fields et al., 2008; Swaby & Morgan, 2009). Men in this sample also described how these experiences have led to continued psychosexual trauma which extended into adulthood (Hornor, 2010). Previous studies on this topic have identified early sexual initiation, HIV infection, sexual dysfunction, and the silence of the abuse as common factors among CSA and sexual assault survivors (Fergusson, Boden, & Horwood, 2008; Lowe et al., 2008). Our study supports many of these findings particularly those related to early sexual initiation (which for some was before age 15), HIV infection, and the silence or fear of reporting the abuse. While most of these issues are well documented in the CSA and sexual assault literature for girls in the Caribbean (Baumgartner et al., 2009; Reid et al., 2014) and Black and Latino MSM in the U.S. (Arreola, Neilands, & Díaz, 2009; Fields et al., 2008), limited research exists for gay and bisexual youth in Jamaica and the rest of the Caribbean. Our findings serve as a catalyst for understanding how experiences with CSA and sexual assault affects the lives of young Jamaican MSM, and how those experiences may impact attitudes and behaviors regarding HIV testing, engagement in care, and overall mental health for the participants in this study.

For many participants, being gender nonconforming or feminine during their early childhood years made them more vulnerable to sexual violence than those who were masculine appearing. According to some participants, they were preyed on because they were perceived to be sexually available, and, because of their assumed homosexuality, the survivors were less likely to report the abuse or assault. These findings are supported by prior research on CSA among MSM of color in other settings (Arreola et al., 2009; Fields et al., 2008). These two distinctions, gender nonconformity and feminine behavior, have been corroborated by previous research that explores the strictness of traditional gender norms in Jamaica, which reinforces heterosexual notions of masculinity and femininity (West & Hewstone, 2012). One of the most common themes expressed by participants was the power and privilege used by perpetrators within their churches, communities, and families to force them to engage in coercive sexual contact (Moore, Robinson, Dailey, & Thompson, 2015). Like those MSM of color in the U.S., participants' experience with CSA started with unwanted touching, usually from someone from their church, community, or an older family member (e.g., male cousin or uncle) of the same sex (Mimiaga et al., 2009; Reid et al., 2014; Samms & Cholewa, 2014). Our study also found a pattern of similar acts of unwanted touching, which was used to test the limits, then escalated to exposure of genitalia, and ended in direct nonconsensual sexual acts. To ensure their silence of the sexual violence, the perpetrators often threatened survivors with physical violence or threatened to blame them publicly for seducing them. These tactics are not new, but are commonly seen in other examples of sexual assault both with young girls and boys in other settings (Baumgartner et al., 2009; Hornor, 2010; Lowe et al., 2008). However, what is different here is the societal and cultural environment in which these participants experienced sexual violence, an environment that perpetuate them suffering in silence.

Participants had little recourse for justice as the current definition of rape in Jamaica does not consider forcible anal penetration as rape (Jamaica Ministry of Justice, 1864, 2009; Reid, 2017). The current legal framework only protects young girls who are survivors of forcible sexual violence under the law criminalizing carnal abuse—the nonconsensual vaginal penetration of a female child (Jamaica Ministry of Justice, 2009). This narrow definition creates barriers for male survivors of sexual violence (Sable et al., 2006). While some participants had reported the crime of sexual assault to the police, others reported feeling embarrassed, ashamed, and fear of being judged for being gay. This finding was highlighted extensively in previous reports that gay and bisexual men in Jamaica often decline to report crimes committed against them to the police, fearing that the police would be unresponsive to their claims because of their sexual orientation (Figueroa et al., 2013; Human Rights Watch, 2014; Logie et al., 2016a, b). Other reports also suggested instances in which the police had failed to intervene and stop violent anti-homosexual mob attacks, investigate sexual crimes committed toward gender and sexual minority individuals, and arrest the perpetrators who committed physical and sexual crimes against members of the MSM community (Human Rights Watch, 2014). Additionally, a report published in 2017 by the CISOCA, a special victims' unit of the Jamaica Constabulary Force, cited police officers and ministers of religion as two of the most common perpetrators of sexual violence against children (Balford, 2017). These findings reinforce the fears expressed by participants and offer a glimpse into some of the reasons why sexual crimes against men and boys are not often reported.

The negative effects of CSA and sexual assault can lead to profound lifelong social, physical, and mental challenges for survivors of sexual violence (Baumgartner et al., 2009; Mimiaga et al., 2009; Reid, 2017). MSM, particularly those most vulnerable like the men in this report, were not exempt from such consequences (Arreola et al., 2009; Fields et al., 2008; Mimiaga et al., 2009). Jamaican MSM, specifically those who are gender nonconforming or feminine, are more often likely to experience CSA than their heterosexual counterparts (Paul et al., 2001; Phillips et al., 2014), and their experiences with CSA and sexual assault have led them to experience maladaptive social adjustments including addiction and substance misuse (Dube et al., 2005; Figueroa et al., 2015; Swaby & Morgan,

2009). Among MSM in the U.S., CSA was associated with high-risk sexual behaviors and increased HIV prevalence (Arreola et al., 2009; Lloyd & Operario, 2012; Williams et al., 2015). Other adverse impacts include poor educational outcome, sexual dysfunction (Boden, Horwood, & Fergusson, 2007; Buckle, Lancaster, Powell, & Higgins, 2005), destructive adult romantic relationship dynamics (Swaby & Morgan, 2009), and opening the door for revictimization (Fergusson et al., 1997; Hornor, 2010). While there was no direct link between those participants' experiences with CSA earlier in life and those reporting sexual assault later in life, previous research in the area of sexual assaults has found a link between sexual revictimization in among women with a history of CSA (Ullman, Najdowski, & Filipas, 2009). These findings are consistent in our study, with participants reporting dissatisfactions with some acts of intimacy with their adult partners. MSM survivors also reported negative mental health challenges such as depression, suicidal ideation and attempts, self-inflicted cutting, and poor self-esteem (Benoit & Downing, 2013; Fergusson et al., 2008; Rosario, Schrimshaw, & Hunter, 2006).

Findings from this report highlight the importance of strengthening legislation in Jamaica that corrects the inconsistency in the definition of rape to include sexual violence toward men and boys. Although the island of Jamaica is a signatory to the United Nations Convention on the Rights of the Child, and as such is charged with protecting all children, regardless of sex or gender identity, gendered differences exist that infringe on the human rights of MSM and other sexual minorities (Human Rights Watch, 2014; Logie et al., 2016a, b; Losina et al., 2008). Jamaica has made some progress by creating several state agencies that deal with the safety and protection of all children. However, there are considerable shortfalls that relate to the experiences of boys who are survivors of sexual violence. The enactment of the Child Care and Protection Act (2004) has led to the creation of additional state agencies such as the Office of the Children's Advocate and the Child Development Agency to further protect the welfare of all children and to investigate all cases of child abuse (Samms & Cholewa, 2014). Our research highlights the need for a more thoughtful approach in sensitizing personnel such as those within these agencies and the police, to investigate and charge perpetrators who commit sexual violence against boys.

Limitations

Our report has several limitations. The majority of participants were from the parish of Kingston, a major metropolitan area; however, while efforts were made to recruit participants from more rural parishes, distance and cost of travel were prohibitive. Jamaican MSM residing in the most rural parts of the island may have different experiences with sexual violence; therefore, further investigation is needed to uncover those differences. Additionally, participants were recruited from social events and spaces that were known to be frequented by members of the community, and as such our findings are limited to those persons. Although less than half the men in this sample reported experiencing sexual violence, the prevalence of those crimes is relatively high for this sample. Given the social and cultural circumstances constraining the lives of many Jamaican MSM and the social vulnerabilities they have experienced, we assert that there may be a much higher, perhaps hidden epidemic of CSA and sexual assault among MSM and further research is needed to unearth this epidemic. In spite of these limitations, our study is among the first that examines these forms of sexual violence experienced by Jamaican MSM; and those experiences must be addressed in terms of the implications for potential high-risk sexual behaviors.

Despite these limitations, the lead author's clinical background in nursing and sensitivity to the subject matter yields confidence that participants were willing to disclose their traumatic experiences. In addition, the primary author's nonjudgmental stance, familiarity with the culture, and nonstigmatizing attitudes toward sexual minority populations may have also increased the probability that participants felt comfortable speaking authentically.

Conclusions

Much of the research to date among Jamaican MSM has focused extensively on HIV incidence and prevalence. However, in recent years, several studies have begun to explore the social and cultural factors driving the epidemic among Jamaican MSM (Figueroa et al., 2013; Harris, 2014; Logie et al., 2016a, b). Many of these social factors are rooted in rigid societal and cultural perceptions of sex and sexuality. Findings from our study uncovered another layer of this complex issue—Jamaican MSM experiencing CSA and sexual assault as forms of sexual violence. Jamaican MSM who did not fit the strict definition of masculinity were perceived to be easy targets for sexual violence and due to their fear of retaliation, these crimes are often not reported. Our findings emphasize the need for a reevaluation of the relevant child protection agencies to make them more responsive to MSM survivors. Additionally, Jamaican MSM survivors of CSA may conflate their childhood experiences as normal, which may lead to negative perceptions of their sexual orientation, sexual dysfunction, and maladaptive adult social relationships.

This report was nested in a larger qualitative study whose purpose was to explore the social and cultural determinants of HIV risk among young Jamaican MSM. The findings presented were based on us asking one simple question: "has

anyone every forced you to have sex?" According to some participants this was the first time anyone has ever asked them that question and it was the first time they ever had an opportunity to assign a meaning to that experience. Some participants had believed it to be a normal experience for a child exploring their sexual identity/orientation. The interview session was a cathartic opportunity for participants to recognize that these "explorations" were in fact molestation as they were incapable of giving consent. Previous research has suggested that men who viewed their sexual debut as non-consensual have the tendency for engaging in transactional sex, substance misuse as adults, and other high-risk sexual behaviors (Benoit & Downing, 2013; Hickson et al., 1994).

Our findings suggest that exploration of these sensitive topics can give survivors an opportunity to communicate their experiences with sexual violence and can also serve as a first step in creating both clinical guidelines for supportive services for MSM survivors. Additionally, future research exploring these topics among Jamaican MSM requires sensitivity in the approach to the framing of these questions. This is necessary because it does not ascribe a value judgment nor does it make assumptions about the sexuality of the victim or sex of the perpetrator. This approach also takes into account the context in which these violent situations occur—the perpetrator's privilege, access, power, and control over their victims. Moreover, it is important that questions addressing CSA and sexual assault are incorporated into interventions targeting Jamaican MSM and that healthcare providers are equipped with the necessary tools to address these issues.

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Compliance with Ethical Standards

Conflict of interest The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

References

Ando, H., Cousins, R., & Young, C. (2014). Achieving saturation in thematic analysis: Development and refinement of a codebook. *Comprehensive Psychology, 3,* 1–7.

Anthias, F. (2002). Where do I belong? *Ethnicities, 2,* 491–514.

Arreola, S. G., Neilands, T. B., & Díaz, R. (2009). Childhood sexual abuse and the sociocultural context of sexual risk among adult Latino gay and bisexual men. *American Journal of Public Health, 99,* 432–438.

Balford, H. (2017, February). CISOCA report shows clergymen, cops tops list of men having sex with children. *Jamaica Observer*. Retrieved from http://www.jamaicaobserver.com/news/Exposed-_88314

Barrow, G., & Barrow, C. (2013). HIV treatment as prevention in Jamaica and Barbados: Magic bullet or sustainable response? *Journal of the International Association of Providers of AIDS Care, 14,* 82–87.

Baumgartner, J. N., Waszak Geary, C., Tucker, H., & Wedderburn, M. (2009). The influence of early sexual debut and sexual violence on adolescent pregnancy: A matched case–control study in Jamaica. *International Perspectives on Sexual and Reproductive Health, 35,* 21–28.

Benoit, E., & Downing, M. J. (2013). Childhood sexual experiences among substance-using non-gay identified Black men who have sex with men and women. *Child Abuse and Neglect, 37,* 679–690.

Boden, J. M., Horwood, L. J., & Fergusson, D. M. (2007). Exposure to childhood sexual and physical abuse and subsequent educational achievement outcomes. *Child Abuse and Neglect, 31,* 1101–1114.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101.

Buckle, S. K., Lancaster, S., Powell, M. B., & Higgins, D. J. (2005). The relationship between child sexual abuse and academic achievement in a sample of adolescent psychiatric inpatients. *Child Abuse and Neglect, 29,* 1031–1047.

Budhwani, H., Hearld, K. R., Barrow, G., Peterson, S. N., & Walton-Levermore, K. (2016). A comparison of younger and older men who have sex with men using data from Jamaica AIDS Support for Life: Characteristics associated with HIV status. *International Journal of STD and AIDS, 27,* 769–775.

Burla, L., Knierim, B., Barth, J., Liewald, K., Duetz, M., & Abel, T. (2008). From text to codings. *Nursing Research, 57,* 113–117.

Caretta, M. A. (2014). Situated knowledge in cross-cultural, cross-language research: A collaborative reflexive analysis of researcher, assistant and participant subjectivities. *Qualitative Research, 15,* 1–17.

Carlsen, B., & Glenton, C. (2011). What about N? A methodological study of sample-size reporting in focus group studies. *BMC Medical Research Methodology, 11,* 26. https://doi.org/10.1186/1471-2288-11-26.

Department of Justice. (2017). *Office on violence against women: Sexual assault*. Retrieved from https://www.justice.gov/ovw/sexual-assault

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 28,* 430–438.

Fergusson, D. M., Boden, J. M., & Horwood, L. J. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse and Neglect, 32,* 607–619.

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviors and sexual revictimization. *Child Abuse and Neglect, 21,* 789–803.

Fields, S. D., Malebranche, D., & Feist-Price, S. (2008). Childhood sexual abuse in black men who have sex with men: Results from three qualitative studies. *Cultural Diversity & Ethnic Minority Psychology, 14,* 385–390.

Figueroa, J. P. (2008). The HIV epidemic in the Caribbean meeting the challenges of achieving universal access to prevention, treatment and care. *West Indian Medical Journal, 57,* 195–203.

Figueroa, J., Cooper, C. J., Edwards, J. K., Byfield, L., Eastman, S., Hobbs, M. M., & Weir, S. S. (2015). Understanding the high

prevalence of HIV and other sexually transmitted infections among socio-economically vulnerable men who have sex with men in Jamaica. *PLoS ONE, 10,* 1–12.

Figueroa, J. P., Weir, S. S., Jones-Cooper, C., Byfield, L., Hobbs, M. M., McKnight, I., & Cummings, S. (2013). High HIV prevalence among MSM in Jamaica is associated with social vulnerability and other sexually transmitted infections. *West Indian Medical Journal, 62,* 286–291.

Harris, O. O. (2014). *Social and cultural determination of HIV risk among young Jamaican men who have sex with men*. University of Rochester. Retrieved from https://urresearch.rochester.edu/institutionalPublicationPublicView.action?institutionalItemId=28044

Hickson, F. C., Davies, P. M., Hunt, A. J., Weatherburn, P., McManus, T. J., & Coxon, A. M. (1994). Gay men as victims of nonconsensual sex. *Archives of Sexual Behavior, 23,* 281–294.

Hornor, G. (2010). Child sexual abuse: Consequences and implications. *Journal of Pediatric Health Care, 24,* 358–364.

Human Rights Watch. (2014). *Not safe at home: Violence and discrimination against LGBT people in Jamaica*. Retrieved from https://www.hrw.org/report/2014/10/21/not-safe-home/violence-and-discrimination-against-lgbt-people-jamaica

Hutchinson, M. K., Jemmott, L. S., Wood, E. B., Hewitt, H., Kawha, E., Waldron, N., & Bonaparte, B. (2007). Culture-specific factors contributing to HIV risk among Jamaican adolescents. *Journal of the Association of Nurses in AIDS Care, 18,* 35–47.

Hutton-Rose, N., Blythe, C., Ogbonna, C., & McGrowder, D. (2008). The prevalence of other sexually transmitted infections in confirmed HIV cases at a referral clinic in Jamaica. *Journal of The Royal Society for the Promotion of Health, 128,* 242–247.

Jamaica Ministry of Justice. (1864). *Offences Against the Persons Act, Kingston, Jamaica*. Retrieved from http://moj.gov.jm/sites/default/files/laws/OffencesAgainstthePersonAct_0pdf

Jamaica Ministry of Justice. (2009). *The Sexual Offences Act, Kingston, Jamaica*. Retrieved from http://www.japarliament.gov.jm/attachments/341_TheSexualOffencesAct,2009.pdf

Kirkland, P. (2013). *The horrifying sexual and physical abuse of minors in Jamaica*. Retrieved from http://www.mnialive.com/articles/the-horrifying-sexual-and-physical-abuse-of-minors-in-jamaica?A=WebApp&CCID=14585&Page=17&Items=3

Kristensen, G. K., & Ravn, M. N. (2015). The voices heard and the voices silenced: Recruitment processes in qualitative interview studies. *Qualitative Research, 15,* 722–737.

Krueger, R., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage.

Lloyd, S., & Operario, D. (2012). HIV risk among men who have sex with men who have experienced childhood sexual abuse: Systematic review and meta-analysis. *AIDS Education and Prevention, 24,* 228–241.

Logie, C. H., Lacombe-duncan, A., Wang, Y., Jones, N., Levermore, K., Neil, A., … Newman, P. A. (2016a). Prevalence and correlates of HIV infection and HIV testing among transgender women in Jamaica. *AIDS Patient Care and STDs, 30,* 416–424.

Logie, C. H., Lee-Foon, N., Jones, N., Mena, K., Levermore, K., Newman, P. A., … Baral, S. (2016b). Exploring lived experiences of violence and coping among lesbian, gay, bisexual and transgender youth in Kingston, Jamaica. *International Journal of Sexual Health, 28,* 343–353.

Losina, E., Figueroa, P., Duncan, J., Divi, N., Wolf, L. L., Hirschhorn, L. R., … Gebre, Y. (2008). HIV morbidity and mortality in Jamaica: Analysis of national surveillance data, 1993–2005. *International Journal of Infectious Diseases, 12,* 132–138.

Lowe, G. A., Gibson, R. C., & Christie, C. D. (2008). HIV infection, sexual abuse and social support in Jamaican adolescents referred to a psychiatric service. *West Indian Medical Journal, 57,* 307–311.

McLafferty, I. (2004). Methodological issues in nursing research: Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing, 48,* 187–194.

Merriam, S. B., Johnson-Bailey, J., Lee, M. Y., Kee, Y., Ntseane, G., & Muhamad, M. (2001). Power and positionality: Negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education, 20,* 405–416.

Miles, B. M., & Hurberman, A. M. (1994). *An expanded sourcebook: Qualitative data analysis*. Thousand Oaks, CA: Sage.

Milner, H. R. (2007). Race, culture, and researcher positionality: Working through dangers seen, unseen, and unforeseen. *Educational Researcher, 36,* 388–400.

Mimiaga, M., Noonan, E., Donnel, D., Safren, A., Koenen, K. C., Gortmaker, S., … Mayer, K. (2009). Childhood sexual abuse is highly associated with HIV-risk taking behavior and infection among MSM in the EXPLORE study. *Journal of Acquired Immune Deficiency Syndrom, 51,* 340–348.

Ministry of Health. (2012). *Surveys of PLACE patrons, PLACE workers, and men who have sex with men*. Kingston: Ministry of Health.

Moore, S. E., Robinson, M. A., Dailey, A., & Thompson, C. (2015). Suffering in silence: Child sexual molestation and the Black Church: If God don't help me who can I turn to? *Journal of Human Behavior in the Social Environment, 25,* 147–157.

Norman, L. R., Carr, R., & Jiménez, J. (2006). Sexual stigma and sympathy: Attitudes toward persons living with HIV in Jamaica. *Culture, Health & Sexuality, 8,* 423–433.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Paul, J. P., Catania, J. A., 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 and Neglect, 25,* 557–584.

Phillips, G., Magnus, M., Kuo, I., Rawls, A., Peterson, J., Montanez, L., … Greenberg, A. E. (2014). Childhood sexual abuse and HIV-related risks among men who have sex with men in Washington, DC. *Archives of Sexual Behavior, 43,* 771–778.

Portney, L. G., & Watkins, M. P. (2009). *Foundations of clinical research: Applications to practice* (3rd ed.). Upper Saddle River, NJ: Pearson Prentice Hall.

Reid, G. (2017). *Redefining rape in Jamaica*. Retrieved from https://www.hrw.org/news/2017/02/24/redefining-rape-jamaica

Reid, S. D., Reddock, R., & Nickenig, T. (2014). Breaking the silence of child sexual abuse in the Caribbean: A community-based action research intervention model. *Journal of Child Sexual Abuse, 23,* 256–277.

Rosario, M. J., Schrimshaw, E. W., & Hunter, J. (2006). A model of sexual risk behaviors among young gay and bisexual men: Longitudinal associations of mental health, substance abuse, sexual abuse, and the coming out process. *AIDS Education and Prevention, 18,* 444–460.

Rose, G. (1997). Situating knowledges: Positionality, reflexivities and other tactics. *Progress in Human Geography, 21,* 305–320.

Rothman, E. F., Exner, D., & Baughman, A. L. (2011). The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: A systematic review. *Trauma, Violence & Abuse, 12,* 55–66.

Sable, M. R., Danis, F., Mauzy, D. L., & Gallagher, S. K. (2006). Barriers to reporting sexual assault for women and men: Perspective of college students. *Journal of American College Health, 55,* 157–162.

Samms, K. M., & Cholewa, B. E. (2014). Exploring the context of child sexual abuse in Jamaica: Addressing the deficits. *Journal of Child Sexual Abuse, 23,* 115–127.

Sandelowski, M. (2000). Focus on research: Whatever happened to qualitative description? *Research in Nursing & Health, 23,* 334–340.

Streubert-Speziale, H. J., & Carpenter, D. R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative* (3rd ed.). Philidelphia, PA: Lippincott Williams & Wilkins.

Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *Acme, 6,* 374–385.

Swaby, A. N., & Morgan, K. D. (2009). The relationship between childhood sexual abuse and sexual dysfunction in Jamaican adults. *Journal of Child Sexual Abuse, 18,* 247–266.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus group. *International Journal of Qualitative in Health Care, 19,* 349–357.

Ullman, S. E., Najdowski, C. J., & Filipas, H. H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors. *Journal of Child Sexual Abuse, 18,* 367–385.

West, K., & Hewstone, M. (2012). Culture and contact in the promotion and reduction of anti-gay prejudice: Evidence from Jamaica and Britain. *Journal of Homosexuality, 59,* 44–66.

White, R. C., & Carr, R. (2005). Homosexuality and HIV/AIDS stigma in Jamaica. *Culture, Health & Sexuality, 7,* 347–359.

Williams, J. K., Wilton, L., Magnus, M., Wang, L., Wang, J., Dyer, T. P., … Elharrar, V. (2015). Relation of childhood sexual abuse, intimate partner violence, and depression to risk factors for HIV among black men who have sex with men in 6 US cities. *American Journal of Public Health, 105,* 2473–2481.