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The Effects of Three Types of Sexual Orientation Victimization on HIV Sexual Risk Behavior Among Black South African Men Who Have Sex With Men (MSM)

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Abstract

The goal of this study is to examine the relations between histories of three types of sexual orientation victimization (childhood, personal, and institutional) and HIV sexual risk behavior among Black South African men who have sex with men (MSM). Secondly, this study examines whether marijuana use and problem drinking mediate the relations. Participants were 125 Black MSM recruited from neighborhoods in Eastern Cape Province, South Africa. Questionnaires administered through audio computerized self-interviewing assessed sexual orientation victimizations, problem drinking and marijuana use, and unprotected anal sex with casual partners. Data were analyzed using multiple regression and multiple mediation modeling.

Personal and institutional sexual victimizations were associated with condomless anal sex. Childhood sexual orientation victimization was positively associated with problem drinking. Neither problem drinking nor marijuana use mediated the relations between sexual orientation victimizations and having condomless anal sex with casual partners.

Keywords

South African; MSM; sexual; victimization; childhood; personal; institutional; condomless; sex

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Disclosure statement

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Globally, men who have sex with men (MSM) are disproportionately at risk for exposure to HIV (Beyrer et al., 2010). Research strongly indicates in South Africa the odds of being infected with HIV are higher among MSM than the general population. A study of 378 Black MSM in Soweto showed 13.2% of all MSM and 33.9% of gay-identified men were HIV-positive (Lane et al., 2011). Among the estimated 1.2 million MSM in South Africa, the HIV prevalence is between 13% and 49% (University of California, 2015).

The association between psychological stress and HIV risk behavior among MSM is well established (Burnham et al., 2016; Kamen et al., 2012, 2013; Stall et al., 2003). The term *sexual orientation victimization* refers to psychological stress stemming from discrimination or violence based on an individual's sexual identity, sexual orientation, or gender nonconformity (OSCE, 2009; Waldo, Hesson-McInnis, & D'Augelli, 1998). Numerous studies have reported sexual orientation victimization among South African MSM. Surveys conducted in 2008 revealed approximately 10%–20% of MSM in Johannesburg and Cape Town and 35% of MSM in KwaZulu-Natal and the Eastern Cape reported experiencing sexual violence (Dunkle, Jewkes, Murdock, Sikweyiya, & Morrell, 2011). Recent data has suggested that these experiences are continuing to rise (University of California, 2015).

Cultural context

In 1996 South Africa became the first country in the world to adopt a constitution protecting the rights of gays and lesbians. However, to date South Africa has no formal laws against hate crimes relating to discrimination against people on the basis of their race, gender, sexual orientation, or sexual identity. Data collected in the 2004 South Africa Social Attitudes Survey (SASAS) revealed that 78% of the respondents felt that sexual relations between adults of the same gender were always wrong (Roberts & Reddy, 2008). Respondents who reported being strongly religious and belonging to a conservative religious denomination reported having more disapproving attitudes toward gays and lesbians (Roberts & Reddy, 2008). Black South Africans tend to report higher levels of disapproval of attitudes toward gays and lesbians than White and Coloured South Africans (Roberts & Reddy, 2008).

A study of 487 self-identified Black and White gays and lesbians residing in the Gauteng Province of South Africa found hate speech followed by physical assaults were the most common forms of victimization experienced regardless of race or gender (Wells & Polders, 2006). The findings from this study also showed higher rates of rape or sexual abuse reported by Black gays (32%) compared to White gays (7%) (Wells & Polders, 2006). A survey of 1,738 households conducted in the Eastern Cape and KwaZulu-Natal found that 34% of the male respondents who identified as MSM reported experiencing sexual orientation victimization (Dunkle et al., 2011).

Black South African MSM occupy a distinct social position in which they are viewed as sexually deviant (Murray & Roscoe, 1998; Roberts & Reddy, 2008), a source of HIV contamination (Lane, Mogale, Struthers, McIntyre, & Kegeles, 2008), and in opposition to dominant cultural norms (Oswin, 2007). Cultural shunning and social discrimination, and their additive influences, can produce excessive psychological stress, increasing the prospect of HIV transmission behavior among these men.

Three types of sexual orientation victimization

The term *stress* is generally used to refer to heightened psychological distress resulting from physical, verbal, or sexual abuse, in addition to discrimination from family, peers, and adverse experiences with schools, churches, and other institutions (Freyd, 2014; OSCE, 2009; Waldo et al., 1998). Studies have indicated that sexual minorities, including MSM, consistently report higher rates of psychological stress compared with the general population (Kamen et al., 2013; Meyer, 2003; Sandfort, de Graaf, Bijl, & Schnabel, 2001). According to the minority stress theory, sexual orientation victimization is a result of the transactions between gays, lesbians, bisexuals, and other sexual minorities with hostile social environments, which leads to adverse mental health consequences (Meyer, 2003).

Some researchers have examined sexual orientation victimization as a single construct that includes both personal and institutional sexual orientation victimization (D'Augelli et al., 2005; Waldo et al., 1998). However, theory and research has indicated that sexual orientation victimization can be reliably subtyped into three categories: childhood, personal, and institutional sexual orientation victimization (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 2003).

Childhood sexual orientation victimization refers to childhood experiences of physical or emotional abuse based on an individual's sexual orientation, sexual identity, or gender nonconformity. Much of the literature on stress and HIV sexual risk behavior among MSM has focused on the link between childhood sexual abuse and adult vulnerability (Arreola, Neilands, Pollack, Paul, & Catania, 2008; Kalichman, Gore-Felton, Benotsch, Cage, & Rompa, 2004; Mimiaga, 2009; Mimiaga et al., 2009a). Studies on the effects of childhood sexual-orientation victimization on HIV sexual risk behavior among MSM are rare. Research on childhood sexual-orientation victimization has examined the consequences that childhood gender nonconformity has on the mental health of adolescent and young adult sexual minorities. Results from these studies found that adolescents and young adults who report being bullied or victimized based on their gender nonconformity exhibit elevated risks of depression and suicidal thoughts and behaviors (Friedman, Koeske, Silvestre, Korr, & Sites, 2006; Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Based on a sample of gay and bisexual men in New York City, Pachankis et al. (2015) found boyhood gender role nonconformity to be associated with sexual compulsivity among adult MSM. Using the minority stress framework, studies have also found childhood peer-rejection, internalized homophobia, discrimination experiences, and expectations of rejection to be associated with HIV risk behavior among MSM (Hatzenbuehler et al., 2008; Pachankis et al., 2015).

Personal sexual orientation victimization can result from individual or personal conditions such as losing a job, being beaten, being raped by another male, or being verbally abused (Brand, 2015; Kelly et al., 1998). For example, a descriptive study of the effects of rape on men in Britain observed victims experiencing long-term adverse psychological symptoms of anxiety, depression, increased feelings of anger and vulnerability, and loss of self-image (Walker, Archer, & Davies, 2005).

Institutional sexual orientation victimization involves systematic forms of action or inaction based on sexual orientation, sexual identity, or gender nonconformity that contribute to physical mistreatment and emotional stress (Meyer, 2003). This includes discriminatory institutional policies (e.g., the lack of nondiscriminatory or anti-bullying school policies), being denied a job, being fired from a job, and being denied housing based on an individual's sexual orientation, sexual identity, or gender nonconformity. Studies examining the effects of institutional factors found that gays and lesbians who experience institutional sexual orientation victimization report significantly more mental health disorders than heterosexual respondents. Using data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), researchers examining states that enacted constitutional amendments against same-sex-marriage found significant increases in mental disorders among lesbian, gay, and bisexual respondents compared to heterosexual respondents in these states (Hatzenbuehler, Keyes, & Hasin, 2009). Another study found that sexual minority youth who were in non-supportive or discriminatory social environments (e.g., schools) toward sexual minority youth were at a significantly higher risk of suicide compared to heterosexual youth (Hatzenbuehler, 2011).

Problem drinking and marijuana use

Alcohol is the most commonly abused substance, followed by marijuana (*dagga*), in South Africa (Dada et al., 2013; HSRC, 2013). Approximately 46% of South Africans over age 18 report problem or binge drinking (i.e., heavy episodic drinking) in comparison to the global average of 11.5% (Stassen, 2014). A population-based study conducted in South Africa in 2012 revealed that among households reporting consumers of alcohol, 31% were male and 10% were female (Dada et al., 2013). Studies have shown that sexual minorities are more vulnerable to alcohol and substance abuse than the general population (Haas et al., 2011; Herek, Gillis, & Cogan, 1999; Stall et al., 2001). Research has shown that excessive alcohol use is a predictor of HIV risk behavior among MSM (Woolf & Maisto, 2009). A study by Irwin, Morgenstern, Parsons, Wainberg, and Labouvie (2006) showed a positive correlation between drinking alcohol and HIV risk behavior among HIV-negative MSM. Studies have also evidenced a positive relation between marijuana use and HIV risk behavior among MSM (Mimiaga et al., 2009b; Morgan et al., 2016; Purcell, Parsons, Halkitis, Mizuno, & Woods, 2001). Lane et al. (2011) observed in a sample of MSM in South Africa that men who reported smoking marijuana in the past 6 months were more likely to report being infected with HIV.

The impact that problem drinking and marijuana use have in mediating the effects that sexual orientation victimization has on HIV sexual risk behavior is unknown. Plausibly alcohol abuse and marijuana use may function as buffers in reducing the stress from sexual victimization, thus lessening the probability for engaging in condomless sex. Alternately, sexual orientation victimization may foster alcohol abuse and substance use, which could lead to condomless sex among MSM. This is an area requiring investigation.

The primary aim of this study is to advance understanding of the psychosocial correlates of the three sexual orientation victimizations and HIV sexual risk behavior among Black South African MSM, taking into consideration relevant factors including social support, outness,

gender identity, and perceived masculinity. Secondly, this study examines whether marijuana use and problem drinking mediate the relationship between the three types of sexual orientation victimization and HIV risk behavior among this high-risk population.

Methods

The institutional review board (IRB) at Temple University reviewed and approved this study. Study participants comprised 125 Black men residing in Port Elizabeth and the adjoining townships of Kwazakhele and New Brighton who self-reported having sex with men. Participants were recruited using snowball sampling by two Black South African recruiters who were members of the target population and who lived in the targeted communities. Eligible participants had to be 18 years or older, reported having had sex with another man within the past year, and could speak and read English. Participants received R20 (approximately 5 U.S. dollars) and light refreshments for completing a 90-minute survey. Surveys were administered in small groups and were read aloud in English and IsiXhosa by two research assistants who were Black MSM fluent in IsiXhosa and English. Each participant completed a written survey administered in small groups.

Measures

Demographic measures included questions on age, education, and religious participation. Education was measured as the highest level of education completed, and the responses included: less than 7th grade (standard 5), finished grade 7 (standard 5), some high school, matriculated – finished grade 12 (standard 10), some university/technicon/college, received technicon diploma, received bachelor's degree, received master's degree or more. Participants who reported highest education level of having finished grade 12 (standard 10) or above were coded as having completed high school. Otherwise, they were coded as not having completed high school.

Religious participation was measured as the mean response to seven items regarding the frequency of participating in religious activities validated in previous research (O'Leary et al., 2012; Rutledge, Jemmott, O'Leary, & Icard, 2018): About how often do you (1) go to church, worship services, or other religious activities; (2) read the Bible or other religious works; (3) listen to worship music (church or gospel); (4) listen to religious radio stations; (5) watch religious television programs; (6) say grace or pray before you eat; (7) pray before going to bed? Responses ranged in 1 (*never*), 2 (*a few times a year*), 3 (*about once a month*), 4 (*about 2–3 times a month*), and 5 (*once a week or more*; Cronbach's $\alpha = 0.88$).

Social support was measured as the mean response to five items regarding participants' perceived capability of receiving support: There is someone I can rely on (1) in case I need money; (2) to talk to if I have problems; (3) to go to the doctor or hospital with me; (4) if I need a meal or a place to stay; (5) if I get beaten up or hurt. Responses ranged from 1 (*strongly disagree*) to 5 (*strongly agree*; $\alpha = 0.74$).

Outness was measured as the degree of the revelation of participants' sexual partners to their families, friends, and co-workers. Participants provided true or false answers to the following questions: Some members of my (1) family/(2) friends/(3)co-workers, but not all,

know I have sex with men; all of my (4) family members/(5) friends/(6) co-workers know that I have sex with men. We then created three new items indicating outness to families, friends, and co-workers. For instance, outness to families was coded as 0 if the answer to question 1 was false, 1 if the answer to question 1 was true, and 2 if the answer to question 4 was true. We then averaged the three items to generate an overall outness score ($\alpha = 0.71$).

Gender identity was measured by asking participants: "What do you consider yourself?" Responses included a man in a man's body and a woman in a man's body.

Masculinity was measured by asking participants: "Do you think other people see you as more masculine or more feminine than most other men?" Responses ranged from 1 (*much more masculine*) to 5 (*much more feminine*).

Personal victimization was measured by five items asking: In the past year, how many times did this happen to you because someone thought you were lesbian, gay, or bisexual?: "personal property damaged or destroyed," "threatened with physical violence," "chased or followed," "punched, hit, kicked, or beaten," and "sexually harassed" (Waldo et al., 1998). Responses were summed to create the scale.

Institutional victimization was measured by seven items asking: How often did any of the things listed ever happen to you because you are attracted to other men?: "denied employment or fired from a job," "evicted or denied housing," "harassed by the policy," "refused services in a bar, restaurant, club, or similar establishment," "denied a promotion or salary increase," "received an unfair performance appraisal at work," and "refused services in a hotel, motel, or similar establishment" Responses were summed to create the scale.

Childhood victimization was measured by four items asking: Thinking back on the time when you were growing up: How often were you made fun of or called names for being attracted to other men?; How often were you hit or beaten up for being attracted to other men?; How often were you made fun or called names for being effeminate?; and How often were you hit or beaten up for being effeminate? Responses included 1 (*never*), 2 (*once or twice*), 3 (*a few times*), and 4 (*many times*; $\alpha = 0.61$)

A history of drinking problems was assessed with the 4-item CAGE (Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers) Questionnaire (Ewing, 1984), the most commonly used screening instrument for alcohol use disorders. The CAGE was designed to quickly screen adults for drinking problems by asking them four questions about their drinking experiences across their lifetime. We used a continuous variable to assess problem alcohol consumption ($\alpha = 0.73$). We measured marijuana use as a continuous variable with the question: How many days in the past month did you smoke dagga (marijuana)?

Condomless anal sex with casual partners was measured by asking participants "When you had anal intercourse with a casual partner in the past month, how often did you use a condom?" Responses were 1 (*never*), 2 (*sometimes*), 3 (*often*), 4 (*almost every time*), and 5 (*every time*).

Data analysis

Descriptive statistics, including percentages, means, and standard deviations, were used to describe the sociodemographic characteristics of the sample. Three multiple regressions were conducted to analyze psychosocial correlates of the three types of victimization: childhood, personal, and institutional. Each regression model included age, education, social support, outness, gender identification, and other's perception on masculinity. Mean differences and corresponding 95% confidence intervals (CI) are reported for the regression analyses. The $p = 0.05$, two-tailed statistical significance criterion was employed. Multiple regressions were conducted to analyze the relations between the three types of sexual orientation victimization and having condomless anal sex with casual partners.

Mediation path analyses with multiple parallel mediators were conducted to test direct effects of sexual orientation victimizations on condomless anal sex, and potential mediators including problem drinking and marijuana use that mediated the relations between sexual orientation victimizations and having condomless anal sex with casual partners. We analyzed three mediation models for the three different victimizations. We used PROCESS, a computational tool for path analysis-based mediation analysis, to conduct the analyses. This method generates direct and indirect effects in mediation models with multiple mediators functioning in parallel. It constructs heteroscedasticity-consistent standard errors and percentile-based bootstrap confidence intervals and is recommended as superior to a normal theory approach. All analyses were conducted using SPSS (version 19.0) with the PROCESS macro for Windows. The significance criterion was $p < .05$ two-tailed, and the number of bootstrap samples for bias-corrected bootstrap confidence interval was set at 5000.

Results

Table 1 gives basic demographic information and information on the variables of interest for all participants. The 125 participants ranged in age from 18 to 56 years with a mean age of 24.36 ($SD = 6.93$). Less than half (44.8%) of the men had a high school degree. Only 4% were married, and 80.8% reported currently being involved in a relationship with a man. Of the men reporting that they were in a relationship with a man, 41.6% reported that the relationship was more than one year. The majority of the men were unemployed. Only 17% reported being employed full-time or part-time. More than half (60%) reported their gender identity being a man in a man's body, while 31.2% reported being a woman in a man's body. Childhood victimization was reported by 18.4%, and institutional victimization was reported by 9.4%. The majority of the participants (65.2%) reported experiencing personal victimization.

Table 2 shows the unstandardized regression coefficients. None of the psychosocial variables was related to childhood victimization. Outness was negatively associated and others' perceptions on masculinity was positively associated with experiencing personal victimization. Age was positively associated with experiencing institutional victimization.

Table 3 shows the complete results of the three mediation models. Personal and institutional sexual orientation victimization were directly associated with condomless anal sex. For all

three types of victimization stressors, neither problem drinking nor marijuana use mediated the relations with having unprotected anal sex with casual partners. This is because neither problem drinking nor marijuana use was associated with condomless anal sex. Importantly, childhood sexual orientation victimization was positively associated with problem drinking.

Discussion

This study addresses the question of what are the relationships between the three forms of sexual orientation victimization stressors and HIV sexual risk behavior among South African MSM. Second, this study tests whether problem drinking and marijuana use mediate the relationships between the three forms of victimization and HIV sexual risk behavior. The finding that personal and institutional sexual orientation victimizations were directly associated with condomless anal sex is consistent with studies exploring the relationships between adverse health behavior and experiences of personal victimization among sexual minorities (Cochran & Mays, 2000; Houston & McKirnan, 2007; Kamen et al., 2013).

The finding that others' perceptions of participants' masculinity was associated with personal sexual orientation victimization is notable. This finding may reflect the concerns that these men have about negative cultural and societal attitudes on gender nonconformity. As posited by the minority stress theory (Meyer, 2003), personal victimization may heighten the concern that these men have of being perceived by others as deviant if they do not comply with cultural masculine gender norms.

The finding that older participants tended to report experiencing institutional sexual orientation victimization stress more than younger participants may reflect a heightened sensibility and awareness of systemic discrimination among older men.

Surprising and not consistent with other studies with MSM is the finding that neither problem drinking or marijuana use was associated with condomless anal sex. However, caution is suggested in making inferences from this finding. Alcohol abuse is a major health problem in South Africa. Problem drinking was measured using the CAGE questionnaire, which focuses on attitudes. Plausibly, social and cultural attitudes on drinking alcohol may be less inhibitory in South Africa. Therefore, measures on the frequency and amount of consumption may be more culturally appropriate. The finding that childhood sexual orientation victimization was positively associated with problem drinking is consistent with other studies exploring the relationship between childhood sexual abuse and the health and mental health of MSM (Kalichman et al., 2001; Lloyd & Operario, 2012; O'Leary, Purcell, Remien, & Gomez, 2003).

Strengths of this study include examining the effects of three types of sexual orientation victimization on HIV sexual risk behavior among Black South African MSM in a middle-income country with a high HIV prevalence. Early studies examined the effects of sexual orientation victimization as a construct that combined personal and institutional stressors (D'Augelli, 1993; Waldo et al., 1998). More recent studies have either examined the consequences of one type of sexual orientation victimization, e.g., personal victimization (Walker et al., 2005), or institutional sexual orientation victimization (Hatzenbuehler, 2011)

on the health and mental health of MSM. To our knowledge the current study is the first to concurrently examine the consequences of both types of sexual orientation victimization. The emphasis on exploring experiences of childhood sexual orientation victimization among adult MSM is also notable. This is one of the few studies to examine the effects of childhood sexual orientation victimization on health behavior among MSM. Although childhood sexual orientation victimization was not associated with HIV risk behavior, the association with problem drinking is important, indicating the need for further research in this area.

The reliance on self-reports of behavior is a limitation. Additionally, while the nature of the sample afforded a unique opportunity to learn about the effects of problem drinking and marijuana use among South African MSM with histories of experiences of sexual-based stressors in the Eastern Cape, it may limit the generalizability of the study.

Globally, MSM are disproportionately infected with HIV. The results of this study suggest the need for further research to better understand the effects of different types of sexual orientation victimization experiences on HIV sexual risk behavior among Black South African MSM.

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Table 1.

Demographic, psychosocial, and behavior characteristics of the 125 participating Black South African MSM.

| Variable | Mean (SD)/Number (Percentage) |
|---|-------------------------------|
| Age | 24.36 (6.93) |
| Education | |
| Some or less than H.S. | 56/125 (44.8%) |
| Matriculated | 48/125 (38.4%) |
| Some university | 9/125 (7.2%) |
| Technicon | 4/125 (3.2%) |
| Bachelors | 1/125 (0.8%) |
| Marital Status | |
| Never Married | 115/125 (92.0%) |
| Married | 5/125 (4.0%) |
| Separated | 4/125 (3.0%) |
| Divorced | 1/125 (0.8%) |
| Currently involved with a man | 101/125 (80.8%) |
| Length of relationship | |
| Less than one month | 21/125 (16.9%) |
| Seven months to a year | 24/125 (19.2%) |
| More than one year | 52/125 (41.6%) |
| Currently working | 22/125 (17.6%) |
| Religion | |
| Christian | 115/120 (95.8%) |
| Muslim | 4/120 (3.3%) |
| Atheists | 1/120 (0.8%) |
| Gender identity | |
| A man in a man's body | 80/125 (64.0%) |
| A woman in a man's body | 39/125 (31.2%) |
| Condomless anal sex with casual partner | 50/102 (49.0%) |
| Experiencing any sexual orientation victimization | |
| Childhood Victimization | 23/121 (19.0%) |
| Personal Victimization | 58/89 (65.2%) |
| Institutional Victimization | 9/96 (9.4%) |
| Problem drinking | 1.54 (1.1) |
| Used marijuana | 38/118 (32.2%) |

Notes. Problem drinking was measured by the 4-item CAGE (Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers) questionnaire.

Table 2.

Multiple regression analysis of the associations of three types of sexual orientation victimization with sociodemographic characteristics of participating Black South African MSM.

| Independent variables | Childhood Sexual Orientation Victimization | | Personal Sexual Orientation Victimization | | Institutional Sexual Orientation Victimization | |
|---|--|----------------|---|----------------|--|----------------|
| | <i>b</i> (95% CI) | <i>p</i> value | <i>b</i> (95% CI) | <i>p</i> value | <i>b</i> (95% CI) | <i>p</i> value |
| Age | -0.02 (-0.07, 0.03) | 0.479 | -0.02 (-0.04, 0.003) | 0.103 | 0.03 (0.01, 0.05) | 0.005 |
| Education | -0.09 (-0.47, 0.30) | 0.662 | 0.09 (-0.06, 0.23) | 0.252 | -0.11 (-0.25, 0.03) | 0.133 |
| Religious participation | -0.19 (-0.56, 0.19) | 0.748 | 0.03 (-0.11, 0.17) | 0.649 | -0.05 (-0.18, 0.09) | 0.475 |
| Social support | -0.01 (-0.07, 0.05) | 0.321 | -0.01 (-0.03, 0.01) | 0.317 | -0.002 (-0.02, 0.02) | 0.865 |
| Outness | -0.05 (-1.27, 1.17) | 0.939 | -0.61 (-1.07, -0.15) | 0.010 | -0.19 (-0.63, 0.26) | 0.401 |
| Gender identify | -0.32 (-1.11, 0.47) | 0.420 | 0.18 (-0.12, 0.47) | 0.248 | 0.12 (-0.16, 0.41) | 0.403 |
| Other's Perception of Man's Masculinity | 0.24 (-0.02, 0.50) | 0.066 | 0.11 (0.01, 0.21) | 0.030 | 0.03 (-0.07, 0.12) | 0.555 |

Table 3.

Mediation analyses of the relations between victimization and having unprotected anal sex with casual partners.

| Types of Victimization | Mediator | Relation between the victimization and the mediator | | Relation between the mediator and condomless anal sex | | Direct relation between the victimization and condomless anal sex | | Indirect relation through the potential mediator | |
|-----------------------------|------------------|---|----------------|---|----------------|---|----------------|--|--|
| | | α (SE) | <i>p</i> value | β (SE) | <i>p</i> value | γ (SE) | <i>p</i> value | $\alpha\beta$ (95% ACI) | |
| Childhood Victimization | Problem drinking | 0.03 (0.01) | 0.002 | 0.23 (0.20) | 0.253 | 0.02 (0.02) | 0.308 | 0.01 (-0.003, 0.03) | |
| | Marijuana use | -0.10 (0.11) | 0.380 | 0.02 (0.01) | 0.088 | | | -0.002 (-0.02, 0.01) | |
| Personal Victimization | Problem drinking | 0.04 (0.07) | 0.578 | 0.24 (0.17) | 0.154 | 0.16 (0.08) | 0.045 | 0.01 (-0.01, 0.09) | |
| | Marijuana use | 1.83 (1.06) | 0.087 | 0.02 (0.01) | 0.137 | | | 0.03 (-0.002, 0.09) | |
| Institutional Victimization | Problem drinking | 0.06 (0.06) | 0.318 | 0.24 (0.20) | 0.238 | 0.13 (0.06) | 0.024 | 0.01 (-0.01, 0.12) | |
| | Marijuana use | 1.25 (2.61) | 0.633 | 0.02 (0.01) | 0.148 | | | 0.02 (-0.03, 0.21) | |

Note. SE is standard error. ACI is asymmetric confidence interval based on bootstrap bias-corrected method with 5,000 replicates