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18 April 2011
Date

Intimate partner violence, minority stress, and sexual risk-taking among U.S. MSM

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2008

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An abstract of
a thesis submitted to the Faculty of the
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Abstract

Intimate partner violence, minority stress, and sexual risk-taking among U.S. MSM

By Catherine Finneran

Background: Recent research suggests that men who have sex with men (MSM) experience a significantly higher prevalence of intimate partner violence (IPV) than heterosexual men. However, little research has examined how IPV is associated with sexual risk-taking among MSM. Additionally, little research has examined how experiences of minority stress, particularly homophobia and racism, are associated with both IPV and sexual risk-taking.

Objective: To examine the relationships between intimate partner violence, homophobia, racism, and sexual risk-taking among a population of self-identified gay and bisexual men in the United States.

Methods: A national, internet-based survey of U.S. MSM (N = 2,086) recruited from social networking sites was conducted in 2010. From a subset of these data (*n* = 1,575), five outcomes were modeled using logistic regression: experiences of physical violence, experiences of sexual violence, perpetration of physical violence, perpetration of sexual violence, and sexual risk-taking as defined by unprotected anal intercourse (UAI) at last sexual encounter with a male partner. IPV was limited to a one-year recall period. Models controlled for age, race/ethnicity, homosexual identity, education, employment, HIV status, experiences of homophobic discrimination, experiences of racism, internalized homophobia, UAI, and experiences of IPV.

Results: Approximately 48% of MSM respondents reported UAI at last sex. MSM reported prevalence rates of 8.8% for experiences of physical IPV, 3.6% for experiences of sexual IPV, 4.3% for physical IPV perpetration, and 0.8% for sexual IPV perpetration. MSM who reported experiencing more homophobic discrimination were more likely to report experiences of sexual IPV (OR: 1.28, 95% CI: 1.11, 1.47) and perpetration of sexual IPV (OR: 1.70, 95% CI: 1.25, 2.31), as were MSM who reported more internalized homophobia (OR: 1.08, 95% CI: 1.03, 1.13). MSM who reported engaging in UAI were more likely to report perpetrating physical IPV (OR: 2.21, 95% CI: 1.29, 3.79); accordingly, MSM who reported perpetrating physical IPV were more likely to report UAI (OR: 2.08, 95% CI: 1.12, 3.85). Experiencing racism was associated with increased odds of experiencing sexual IPV (OR: 1.19 95% CI: 1.06, 1.34).

Conclusions/Implications: To date there has been a dearth of research on IPV among MSM, and almost no attention has been paid to the intersection of violence and sexual risk-taking among MSM. The high prevalences of IPV and UAI among MSM reported here suggest an immediate and pressing need for violence support and counseling services geared towards MSM. IPV screening should be incorporated into routine HIV/STI counseling and testing, with a focus on discussions around the relationship between sex and violence. The associations identified between racism, homophobia and both IPV and UAI point to the need for prevention messages to address the social, cultural, and attitudinal contexts in which MSM take sexual risks.

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I would be remiss if I did not thank the men who participated in this research study, whose stories I have done my best to tell with honor and fidelity.

Lastly, I would like to thank my family – my brother, Richard E. Finneran, my best friend, touchstone, and guide, and my aunt, Nora FitzGerald, whose generosity and selflessness I can only hope to emulate in my life.

***

in memoriam Mary FitzGerald Finneran and Richard J. Finneran, academics both, who instilled in me a love of learning and a thirst for truth for which I am forever grateful.

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Author's Note: The term LGBTQ (lesbian, gay, bisexual, transgendered, queer/questioning) has emerged as an umbrella term for persons expressing non-heterosexual sexualities and/or gender identities. Within this group, homosexual/gay and bisexual men are often described as part of a larger community of Men who Have Sex with Men (MSM), which encompasses both self-identified homosexual/gay and bisexual men and men who identify as queer, questioning, heterosexual, transgendered, pansexual, down low, different gender loving, or any other sexual orientation (including lack thereof) and have sex with men. While MSM are identified as a major risk group for HIV/AIDS incidence, this paper seeks to examine the unique situation of intimate partner violence, homophobia, racism, and HIV/AIDS as it relates to the communities of self-identified homosexual/gay and bisexual men. Terms will be used where appropriate.

CHAPTER I: INTRODUCTION

Since the nascent description of an odd clustering of Kaposi's sarcoma and *pneumocystis pneumonia* among populations of homosexual men in California and New York in 1981, gay and bisexual men have borne the brunt of the HIV/AIDS epidemic in the U.S. (CDC, 1981, 2008). This trend is still apparent today: in 2006, 53% of incident HIV occurred among men who have sex with men (MSM), and nearly half of persons current living with HIV in the U.S. are MSM (CDC 2008). Although a great body of research has illuminated differing aspects of the HIV/AIDS epidemic among men who have sex with men in developed countries, especially the United States, the majority of this research has thus far been focused on individuals and their individual risk behaviors. Far less attention has been paid to the ways in which contextual factors place gay and bisexual men at greater risk for sexually transmitted infections (STIs) and HIV. Particularly, the confluence of multiple sources of minority stress – intimate partner violence, homophobia, and racism, among others – creates a backdrop that is of critical importance when considering the milieu in which individual risk behaviors occur. As current prevention efforts have failed to stem the spread of HIV among MSM, a more thorough understanding of this context is needed in order to both address the societal influences that place MSM at increased risk for HIV and provide better services geared to MSM to reduce the risk of HIV infection.

Objectives & Aims

The **objective** of this study is to examine the relationships between intimate partner violence, homophobia, racism, and sexual risk-taking among a population of self-identified gay and bisexual men in the United States. Included in this objective are several **aims**:

1. To describe the prevalence of experienced and perpetrated intimate partner violence, both physical and sexual, reported among self-identified gay and bisexual men in the U.S.

2. To examine the associations between intimate partner violence and homophobia among self-identified gay and bisexual men in the U.S.

3. To examine the influence of race and racism on the perpetration and experience of intimate partner violence among self-identified gay and bisexual men in the U.S.

4. To examine how perpetration and/or experiences of intimate partner violence influence unprotected anal sex at last sex among self-identified gay and bisexual men in the U.S.

HIV among MSM in the U.S.

Worldwide, it is estimated that 33.3 million persons are currently living with HIV (UNAIDS, 2010). Despite a recent decline in the rate of incident HIV infection worldwide, approximately 2.6 million new HIV infections occurred among adults and children in 2009 (UNAIDS, 2010). The U.S. Centers for Disease Control and Prevention (CDC) estimates that over 1.1 million persons in the U.S. were living with HIV in 2006,

48% of whom were MSM (Hall, et al., 2008). Over 56,000 new cases of HIV occurred in the U.S. in 2006, over half of which (53%) occurred among MSM, despite MSM accounting for less than 5% of the total adult population (**Figure 1**) (CDC, 2010).

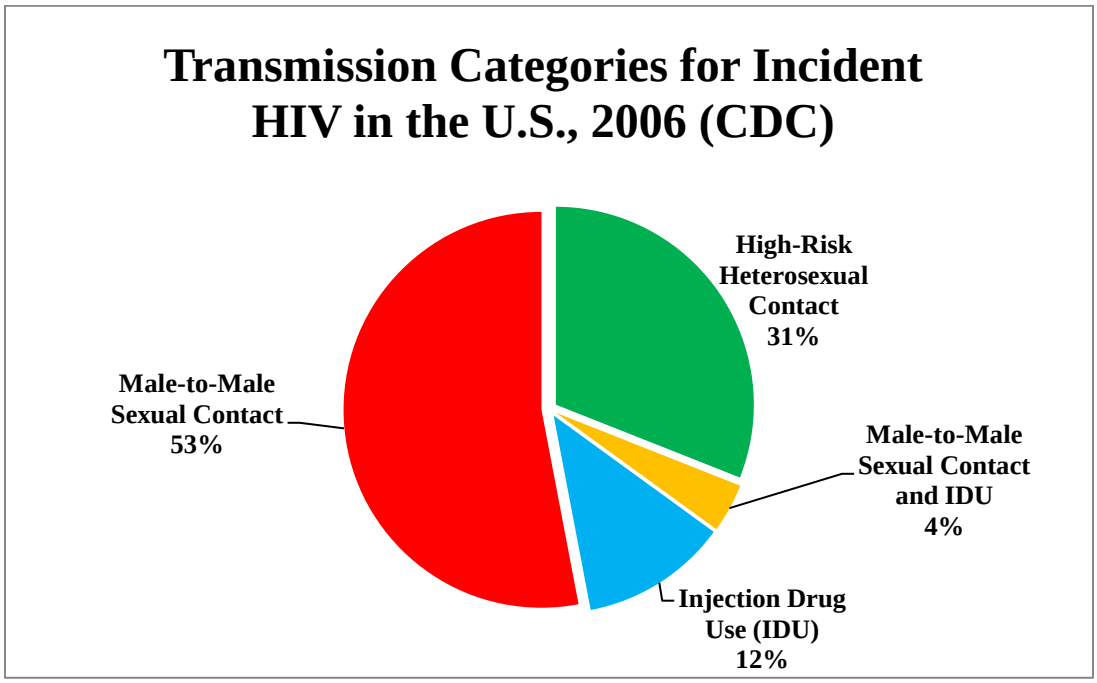

Figure 1. Estimated incident HIV infections in the U.S. by transmission category, 2006 (CDC, 2008)

Even in the third decade of the pandemic, MSM continue to be disproportionately affected by HIV/AIDS. While there is evidence that national HIV incidence has stabilized since 1999, MSM continue to be the only risk group in which incidence rates are currently *increasing* after declining between the mid-1980s and the mid-1990s (**Figure 2**) (CDC, 2010). This increase in incidence is present despite *decreases* in incidence observed among heterosexuals and injection drug users (IDUs); the rate of HIV diagnosis among MSM is now 44 times that of men who do not have sex with men (CDC 2009). The increasing HIV rate among MSM is a significant driving force in the increasing prevalence of HIV nationwide – 72% of incident HIV among men in 2008 was

attributable to male-male sexual contact (CDC 2009). However, this increase in HIV incidence rates is not evenly distributed over the national MSM population. Two critical subgroups of MSM have shown dramatically increasing rates of HIV over the past decade: MSM of color, and young (under 25 years) MSM (CDC, 2010).

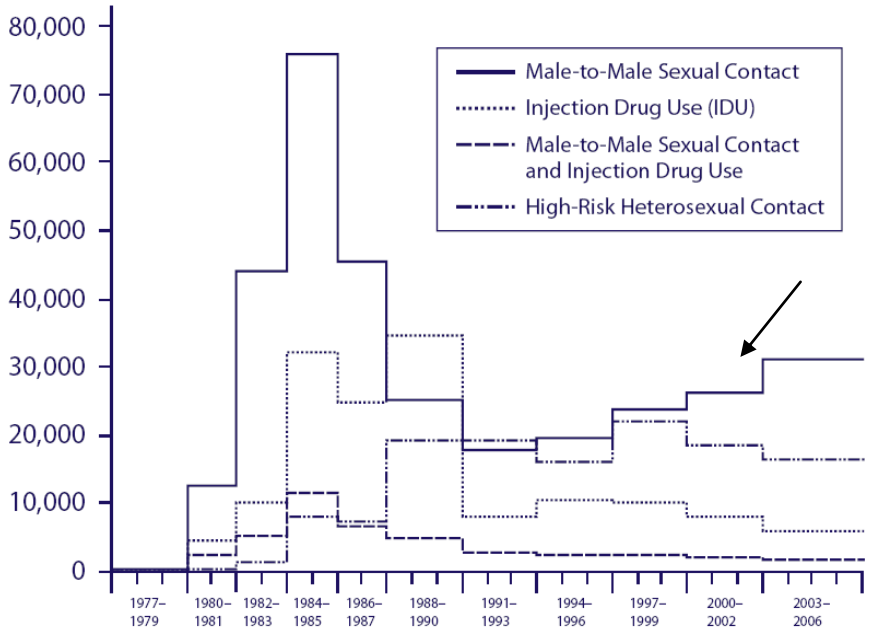

Figure 2. Estimated number of new HIV infections from extended back-calculation model by transmission category, 1977-2006 (CDC, 2008). Arrow: MSM are the only risk group for which incidence rates are increasing.

Racial disparities

In 2006, black male Americans experienced HIV incidence rates nearly eight times higher than those of white male Americans (131.9 versus 16.6 per 100,000 persons) (Hall, et al., 2008). While accounting for only 14% of the general population, more than half of incident HIV in 2008 (52%) occurred among African Americans (CDC 2008). Hispanics/Latinos experienced an incidence rate more than three times that of whites (52.3 per 100,000 persons), and represented 17% of incident HIV in 2008 (Hall, et al.,

2008). MSM of color are particularly affected by this disproportionate burden. In 2008, black/African American MSM and Hispanic/Latino MSM accounted for 40% and 20% respectively of incident HIV among MSM (CDC 2008). Additionally, 64% cases of new HIV infection among African American men were attributable to male-male sexual contact; this percentage was 69% for Hispanic/Latino men (CDC 2008).

Age disparities

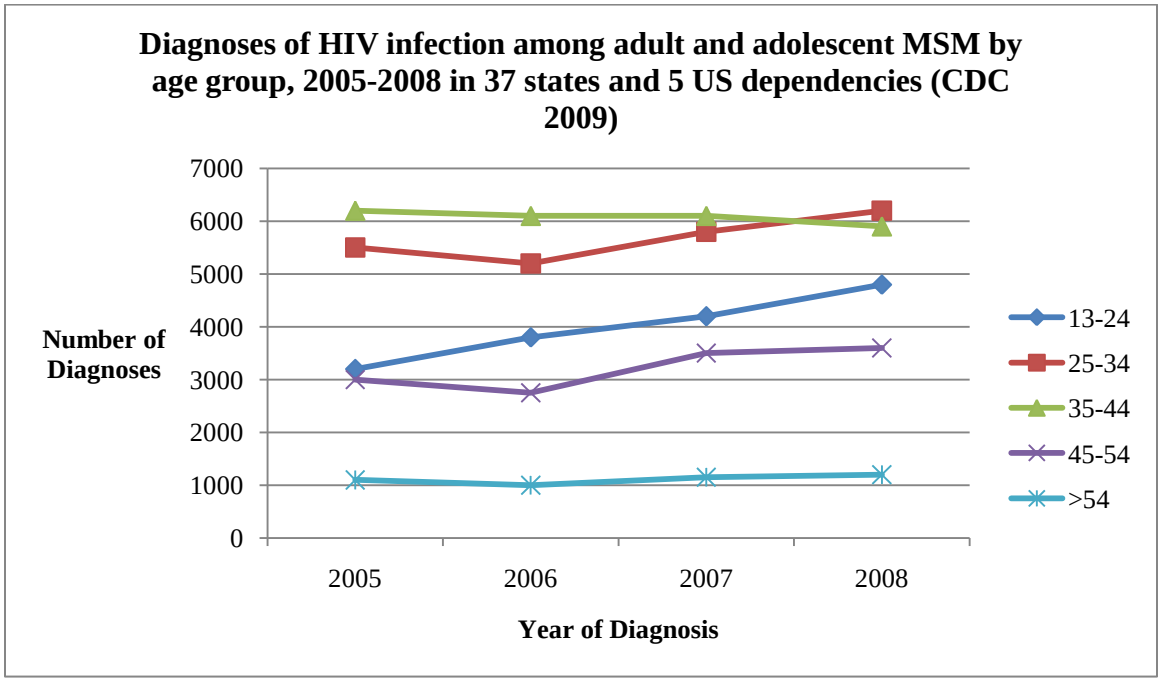

Figure 3. Diagnoses of HIV infection among adult and adolescent MSM by age group, 2005-2008 in 37 states and 5 U.S. dependencies (CDC 2009)

Although infections among persons aged 13-29 make up only 34% of all incident HIV in the U.S., young MSM aged 13-24 are currently experiencing surging rates of HIV infection over an extremely short time span, mirroring the increase in incidence seen among MSM aged 25-34 (**Figure 3**) (CDC 2008). Among males diagnosed with HIV in 2008, male-male sexual contact was the transmission mode for 89.1% of cases among young men aged 13-19, and 87.3% cases among men aged 20-24 (CDC 2008). When the

dual risk factors of young age and racial minority status combine, the trends become yet clearer and yet more alarming: among young black, non-Hispanic MSM aged 13-24, HIV infection rates have nearly doubled over a period of five years (CDC 2008).

Despite the overwhelming need for reduction of HIV incidence among MSM, the majority of studies of HIV and sexual risk behavior among MSM have focused on individual risk behaviors, such as unprotected anal intercourse, serosorting, or multiple concurrent partnerships, rather than critically examining the context in which such behaviors occur. Among such contextual factors is intimate partner violence (IPV), defined as "physical, sexual, or psychological harm by a current or former partner or spouse" (CDC 2002). IPV is conceptualized as taking on four main forms: physical violence, sexual violence, threats of violence, and psychological violence (Saltzman, Fanslow, McMahnon, & Shelley, 2002). Emerging literature is beginning to show that intimate partner violence, with its known adverse mental and physical health effects (for example, suicidal ideation and physical trauma), occurs in same-sex partnerships of men at about the same rate observed among heterosexual women, if not higher (Blosnich & Bossarte, 2009; Tjaden, Thoennes, & Allison, 1999). Current published estimates of intimate partner violence among MSM range from 23-52%, though reporting varies widely and measurements used are inconsistent.

Given the paucity of information regarding IPV among MSM, there is a further lack of data as to how IPV, perpetrated and/or experienced, may affect sexual risk-taking among MSM. This ignorance is possibly due to the fact that traditional, paternalistic theories of intimate partner violence, and in particular sexual violence, posit this violence as occurring between an aggressive male perpetrator and a helpless female victim; male-

male partnerships do not fit these explanatory models (McClennen, 2005). Accordingly, violence in male-male partnerships has been incorrectly assumed to be mutual or non-sexual in nature (McClennen, 2005) -- for example, no data on perpetration rates of IPV among MSM can be found in the past decade in the literature. Although studies have begun to refute these myths, the incongruity between same-sex IPV and traditional theories of IPV has hampered efforts, and consensus is lacking. Yet fewer authors have considered the possible ways in which violence interacts with other sources of minority stress, such as racism and homophobia.

The current study will address these issues in multiple ways. It will use a sample to examine intimate partner violence among MSM that is among the largest to-date, and will use a diverse sample from across the United States. Rates of experiencing intimate partner violence as well as perpetrating intimate partner violence will be measured among the same cohort with CDC-standardized definitions of intimate partner violence and a definite recall period to mitigate both recall bias and the possible confounding factors of non-same-sex and/or childhood violence. Both externalized and internalized manifestations of homophobia will be measured and experiences of race-driven discrimination will considered as a risk factor for increased intimate partner violence, all of which will be assessed in relation to sexual risk-taking. A more thorough understanding of how such contextual factors interact to influence mental health, physical health, and HIV risk can lead to better interventions targeting the reemerging HIV epidemic among gay and bisexual men in the U.S.

CHAPTER II: LITERATURE REVIEW

Minority Stress

The concept of *minority stress* is an amalgamation of sociological, anthropological, and psychological theories about the additive nature of multiple stressors experienced by persons of minority status. Meyer (1995, 2003) seminally defined minority stress as the "excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position" (Meyer, 2003). Minority stress is conceptualized to be separate from other forms of experienced stress insofar as it is:

> (a) unique – that is, minority stress is additive to general stressors that are experienced by all people, and therefore, stigmatized people are required an adaptation effort above that required of others who are not stigmatized; (b) chronic – that is, minority stress is related to relatively stable underlying social and cultural structures; and (c) socially based – that is, it stems from social processes, institutions, and structures beyond the individual rather than individual events or conditions that characterize general stressors or biological, genetic, or other nonsocial characteristics of the person in the group (Meyer, 2003).

Largely due to these conceptualizations, the majority of theory surrounding minority stress among LGBTQ persons centers around the idea that experiences of minority stress stem directly from identification with non-normative sexualities and/or participation in non-normative sexual practices. Specifically, Meyer (2003) further describes LGBTQ-related minority stress as resultant from three different processes: external events and conditions, vigilance against said events due to expectations thereof, and the internalization of anti-LGBTQ stigma and attitudes (Meyer, 2003). An analysis of a

sample of 741 self-identified gay men living in New York City by Meyer laid the groundwork for these theories, as three primary sources LGBTQ-specific minority stress (stigma, internalized homophobia, and prejudice) were all significantly independently associated with all considered adverse mental health outcomes, including demoralization, guilt, suicide attempts and/or ideations, problems with sexual function and/or sexual satisfaction, and AIDS-related traumatic stress (Meyer, 1995). Of all sources, internalized homophobia was demonstrated to have the most powerful effects on mental health, but all facets of minority stress were associated with two- to three-fold increases in psychological distress (Meyer, 1995).

Indeed, the majority of research regarding minority stress and health among LGBTQ persons has concerned adverse mental health outcomes. Seminal work by Mays and Cochran (2001) found that homosexual and bisexual persons reported experiencing considerably more discrimination in everyday life than their heterosexual-identifying counterparts, and that such high levels of daily discrimination increased odds of lifetime reporting of psychiatric disorder(s), self-rating of "poor" or "fair" mental health, and reporting of a current psychiatric problem (Mays & Cochran, 2001). Similar trends among urban, Latino MSM were reported by Diaz and colleagues (2001), in which minority stress stemming from homophobia, racism, and poverty was associated with depressive symptoms such as suicidal ideation, depression, and anxiety (Díaz, Ayala, Bein, Henne, & Marin, 2001). Lewis and colleagues (2003) found significant associations between gay-related stress, including internalized homophobia, and depressive symptoms. Gay-related stress was found to be an independent predictor of depressive symptoms, and a dose-response effect was evident in that those reporting the highest

levels of gay-related stress also reported higher levels of depressive symptoms (Lewis, Derlega, Griffin, & Krowinski, 2003).

The preponderance of studies about the health effects of minority stress among LGBTQ persons has centered on adverse *mental* health outcomes. Although relationships between adverse mental health outcomes and adverse physical health outcomes are known, a possible direct relationship between experiences of minority stress and adverse physical health outcomes – such as HIV infection or experiences of intimate partner violence – are comparatively un-researched. Two studies in particular are noteworthy insofar as they are among the first to examine such relations.

A study published by Hatzenbuehler, Nolen-Hoeksema and Erickson (2008) is also one of very few examinations of minority stress to use a prospective cohort: a community-based cohort of 74 self-identified gay men caregivers to the terminally ill who experienced loss during the study. Both experiences of homophobic discrimination and internalized homophobia were found to be associated with adverse physical health outcomes. Men who reported more experiences of discrimination were significantly more likely to report substance abuse, and men who reported increasing internalized homophobia were significantly more likely to report both increased frequency of unprotected anal intercourse and increased number of sexual partners (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008). Despite the small sample size used by the authors, the results are strengthened by the prospective study design, strongly suggesting that experiences of minority stress (including homophobic discrimination and internalized homophobia) may be predictive of adverse physical health outcomes in MSM.

The most recent study of note was conducted by Hamilton and Mahalik (2009) using a population of 351 MSM recruited from gay-targeted internet groups. Experiences of physical violence due to homosexuality were correlated with substance abuse, and internalized homophobia was correlated with alcohol abuse, substance abuse, and unprotected anal intercourse (Hamilton & Mahalik, 2009). Regression analyses confirmed that minority stress overall was associated with unprotected anal intercourse (Hamilton & Mahalik, 2009). These data mirror the data presented by Hatzenbuehler and colleagues (2008), suggesting that minority stress does indeed have a significant effect on risky sexual behavior. However, despite the emergence of evidence linking the concept of minority stress to adverse mental and physical health, most scientific literature posits minority stress among LGBTQ persons as stemming exclusively from their identity as LGBTQ. Far less literature has examined how other sources of minority stress, which themselves may or may not be directly related to LGBTQ identification, may act as additional stressors. By definition, these additional stressors would act with an additive effect on the persons experiencing minority stress, leading to further adverse health outcomes.

Intimate Partner Violence among MSM

It is only recently that intimate partner violence among MSM has begun to be researched, and nearly all published data are drawn from U.S. populations. To date, no published data describe any facet of IPV in MSM among a sample that is nationally representative of U.S., and the existing data are primarily drawn from specific, targeted groups such as young MSM or MSM of color. The considerable majority of the data come from small convenience samples of MSM, and researchers have used a variety of

definitions and measurements of varying aspects of IPV, making comparisons of data difficult and generalization imprudent. All studies are cross-sectional, limiting conclusions of causality, and very few are randomized, limiting generalizability. Table 1 demonstrates the paucity of information about IPV among MSM and provides the current state of scientific knowledge of prevalence rates of IPV. It is due to this scattershot approach to IPV research among MSM that researchers have found vastly different reported rates of differing kinds of violence, as will be demonstrated through a review and synthesis of the current scientific literature on IPV among MSM.

Waterman and colleagues (1989) published what is among the first studies of sexual violence among homosexual persons (both gay and lesbian), finding that 12.1% of self-identified male gay students at a university (n=34) reported a lifetime history of forced sex, compared to 5.9% who reported perpetrating forced sex (Waterman, Dawson, & Bologna, 1989). Importantly, reporting experiencing forced sex was significantly associated with also reporting perpetration of forced sex: 50% of forced men reported perpetration, compared to 10.3% of non-forced men. This association was not found among lesbians, suggesting a pathway theoretically unique to male-male partners in which the abused becomes the abuser or visa-versa (Waterman, et al., 1989). However, in addition to the non-generalizability of the study due to the small convenience sample, the researchers did not endeavor to define what constituted "forced sex." Participants may or may not have viewed verbal threats/abuse as a type of force, and may or may not have viewed other sexual acts apart from penetrative sex (groping, kissing, masturbation, etc.) as part of "sex."

Table 1. Current state of data on IPV in MSM in the U.S. and other selected countries; adapted from Relf (2001). "Black" denotes both black and African American respondents. "A/PI" refers to "Asian/Pacific Islander." "NR" is not reported. If information is missing (e.g., location of study), it was not provided in the original study. (Relf, 2001) [a] In current or most recent relationship [b] Surrogate definition (same-sex cohabitation) used for determining men who have sex with men.

Study	**Characteristics**				**IPV Prevalence**	
Source/ Year	**Age**	**Race**	**Size & Location**	**Design**	**Experiences**	**Perpetration**
Houston & McKirnan 2007	Mean: 33 (SD 9.8)	Black: 51% White: 22% Latino: 16% Other: 10%	n = 817 Chicago	Targeted multi-frame sampling: Black Gay Pride, Latino clubs, street fair	*Lifetime Recall* Overall: 32.4% Verbal: 20.6% Physical: 19.2% Sexual: 18.5%	NR
Feldman et al. 2007	Mean: 31.2 20-40: 89%	Latino: 100%	n = 912 Miami, New York City, Los Angeles	Venue-based sampling of Latino gay venues	*Childhood Recall* Sexual: 35% *Adulthood Recall* IPV: 52% Psychological: 45% Physical: 33% Sexual: 10%	NR
Koblin et al. 2006	15-18: 38% 19-22: 62%	Latino: 41% Black: 24% Multi: 17% White: 12% A/PI: 6%	n = 539 New York City	Venue-based sampling from MSM-frequented public places	*Lifetime Recall* Threats: 32.3% Violence: 23.4% Either/Both: 36.9%	NR
Braitstein et al. 2006	Median: 25	Aboriginal: 8%	n = 932 Vancouver, Canada	Drawn from prospective cohort of gay/bisexual men	*Lifetime recall* Sexual: 28%	NR
Greenwood et al. 2002	18-29: 20% 30-39: 39% 40-49: 25% 50-59: 10% Over 59: 6%	White: 79% Black: 4% A/PI: 8% Latino: 9% Native Amr.: 3%	n = 2881 San Francisco, Los Angeles, NYC, Chicago	Probability-based, disproportionate sampling telephone interviews	*Five year recall* Any/All: 39% Psychological: 34% Physical: 22% Sexual: 5%	NR

Table 1 (continued). Current state of data on IPV in MSM in the U.S. and other selected countries; adapted from Relf (2001). "Black" denotes both black and African American respondents. "A/PI" refers to "Asian/Pacific Islander." "NR" is not reported. If information is missing (e.g., location of study), it was not provided in the original study (Relf, 2001). [a] In current or most recent relationship [b] Surrogate definition (same-sex cohabitation) used for determining men who have sex with men.

Study	**Characteristics**				**IPV Prevalence**	
Source/ Year	**Age**	**Race**	**Size & Location**	**Design**	**Experiences**	**Perpetration**
Kalichman et al. 2001	Median: 33 Range: 17-72	White: 71% Black: 21%, Hispanic: 3% Other: 5%	n = 595 Atlanta	Convenience sample of gay pride event	*Adulthood Recall* Sexual: 20.3% Physical: 39%	NR
Merrill & Wolfe, 2000	< 26: 8% 26-35: 54% 36-50: 35% > 50: 2%	Black: 39% White: 29% Latino: 19% A/PI: 12% Other: 7% Native Amr.: 4%	n = 52 San Francisco, Boston, Dallas, Los Angeles, NYC	Convenience sample from gay domestic violence program	*Lifetime Recall* Physical: 87% Emotional: 100% Financial: 90% Sexual: 73%	NR
Nieves-Rosa et al. 2000	Mean: 31 Range: 13-55	Latino: 100%	n = 273 NYC	Convenience sample from gay and non-gay venues, snowballing	*Lifetime Recall* Psychological: 33% Physical: 35% Any: 51% *15-Year Recall* Sexual: 12%	NR
Tjaden et al. 1999[a,b]	Mean: 40.5	White: 76.6%	n = 66	Subsample of national probability sample	*Lifetime Recall* Sexual: 5.4% Physical: 23.1%	NR
Waldner-Haugrud et al. 1997	Mean: 32	White: 100%	n = 165	Snowball sample	*Lifetime Recall* Any: 29.7%	21.8%
Stermac et al. 1996	<26: 93%	Not reported	n = 29	Clinical sample	*Lifetime Recall* Sexual: 100%	NR

Table 1 (continued). Current state of data on IPV in MSM in the U.S. and other selected countries; adapted from Relf (2001). "Black" denotes both black and African American respondents. "A/PI" refers to "Asian/Pacific Islander." "NR" is not reported. If information is missing (e.g., location of study), it was not provided in the original study (Relf, 2001). [a] In current or most recent relationship [b] Surrogate definition (same-sex cohabitation) used for determining men who have sex with men.

Study	**Characteristics**				**IPV Prevalence**	
Source/ Year	**Age**	**Race**	**Size & Location**	**Design**	**Experiences**	**Perpetration**
Kalichman and Rompa, 1995	Mean: 37.1	White: 58% Black: 31% Hispanic: 7% Other: 4%	n = 196 "Moderate sized city in the Midwest U.S."	Convenience sample of STD clinics, gay bars, businesses, media	*Lifetime Recall* Coerced UAI: 29% Forced UAI: 6%	Coercion18%
Harms, 1995[a]	Not reported	White: 82%	n = 393 San Francisco	Convenience sample of gay venues	*Lifetime Recall* Physical: 26.1%	25.5%
Hickson et al. 1994	Median: 29	"Predominately white"	n = 930 England and Wales	Clinic-based cohort	*Lifetime Recall* Sexual: 27.6%	NR
Waterman et al. 1989[a]	Median: 23	Not reported	n = 34	Convenience sample of University students	*Lifetime Recall* Sexual: 12.1%	5.9%

It is likely that the ambiguity of measurements by Waterman and colleagues (1989) contributed to the different rates of violence found a few years later by Kalichman and Rompa (1995), who conducted one of the first larger-scale (n=196) studies on violence among MSM. A convenience sample drawn from STD clinics, gay venues, and gay businesses yielded a lifetime reported rate of coerced unprotected anal intercourse of 29% and a reported rate of forced unprotected anal intercourse of 6% (Kalichman & Rompa, 1995). Among men who reported sexual coercion, the overwhelming majority (92%) reported that this coercion took the form of either attempted or completed coerced UAI, and the most common method of coercion was verbal abuse (Kalichman & Rompa, 1995). Importantly, differences in "age, ethnicity, income, relationship status, rates of unprotected anal intercourse and condom use, HIV testing history, [and] substance use in relation to sex" were *not* found when comparing men who reported sexual coercion to those who did not (Kalichman & Rompa, 1995). This finding is significant in that demographic differences in reported IPV rates are frequently observed in heterosexual populations, but were not found in this sample of gay and bisexual men. However, men who reported a history of sexual coercion did indeed differ from those not reporting coercion in several critical areas: they reported a greater number of past sexually transmitted diseases, were more likely to report depressive symptoms, had lowered self-esteem, were less likely to discuss safer sexual practices with their partners, and were less likely to engage in other HIV risk reduction strategies, such as keeping condoms nearby or not drinking or using drugs before sex (Kalichman & Rompa, 1995). Overall, the authors concluded that sexually coerced men "appear less inclined to act to protect themselves from HIV" (Kalichman & Rompa, 1995).

A descriptive study of relationship violence by Waldner-Haugrud and colleagues (1997) among both gays and lesbians yielded data similar to that presented by Kalichman and Rompa (1995). An all-white snowball sample of gay men reported an overall rate of violence from a partner of 29.7%; the most common form of reported violence was receiving threats (19.4%), but reported violence also encompassed severe acts such as being stricken with an object (6.7%) or violence involving a weapon (2.4%) (Waldner-Haugrud, Gratch, & Magruder, 1997). The rate of reported perpetration of violence among gay men was, expectedly, somewhat lower than the rate of reporting experiencing violence – 21.8%, with similar patterns in the typology of violence, providing further evidence for the severity of IPV among homosexual populations (Waldner-Haugrud, et al., 1997). This high rate of violence among homosexual couples was observed again by Tjaden and colleagues (1999): 23.1% of cohabiting same-sex male respondents to the National Violence Against Women survey reported a history of rape and/or physical assault by a spouse or cohabiting partner (Tjaden, et al., 1999). This observed rate was considerably higher than the reported rates of partner violence for non-same sex cohabitating men. However, the use of same-sex cohabitation as a proxy for sexual identity and activity presents the distinct possibility of misclassification bias and would, by definition, exclude MSM who were not cohabitating with a male partner, as evidenced by the small subset sample size from a large national survey (n = 66).

Among the first studies to examine IPV among exclusively MSM of color was conducted by Nieves-Rosa and colleagues (2000). Reported rates of experiencing violence were high in the all-Latino sample. Over half of men (51%) reported instances of physical, psychological, and/or sexual abuse, but, importantly, only 26% of

respondents identified themselves as having been victims of abusive behavior (Nieves-Rosa, Carballo-Diéguez, & Dolezal, 2000). This indicates a possible misalignment between clinical and scientific definitions of violence and perceptions of violence among men. Men, and in particular MSM, may be less likely to see themselves as potential victims of domestic abuse due to the influence of feminist theory in the heterosexual-centered narrative of how domestic abuse happens and to whom it happens. As in previous studies, no significant differences in age, education, income, or HIV status were found among persons reporting abuse versus those who did not (Nieves-Rosa, et al., 2000).

Further exploration of the typologies of violence among MSM, including for the first time financial violence, were examined by Merrill and Wolfe (2000) using a sample of 52 MSM from gay domestic violence programs in U.S. urban centers. The prevalence of reported IPV was high in the sample, ranging from 73% for sexual abuse to 100% for emotional abuse, due to the fact that it was drawn exclusively from programs that sought to serve abused gay men (Merrill & Wolfe, 2000). The majority of MSM reporting experiencing violence (86%) disagreed that the abuse in the partnership was mutual, casting doubt on any arguments that would ignore violence in male-male relationships on the basis that violence is a "given" and mutually practiced by both persons (Merrill & Wolfe, 2000). Wide variation was present in the typologies of violence reported by respondents. In terms of physical violence, the most commonly reported behaviors were pushing, shoving, or grabbing (79%); restraining or blocking an exit (77%); punching, hitting, or striking with hands or fists (64%); and slapping (54%) (Merrill & Wolfe, 2000). Weapons were frequently used by the abuser, and 62% of men responded that they

had been threatened and/or assaulted with weapons, including knives (35%) and guns (12%) (Merrill & Wolfe, 2000). Psychological/emotional abuse was also extremely high, with among the most frequently reported forms being "being excessively jealous or possessive" (94%), "constantly criticizing" (89%), "lying in order to confuse" (87%), and "using put-downs or calling names" (85%) (Merrill & Wolfe, 2000). Verbal threats were also pervasive, with 65% responding that they had been verbally threatened with physical harm by a partner (Merrill & Wolfe, 2000). Financial abuse was somewhat less common but still high: 67% reported damaged property, and 56% reported being made to feel responsible for financially supporting the abuser (Merrill & Wolfe, 2000). The severity of sexual violence reported by the respondents is striking (**Table 2**). Over a third of respondents (39%) reported that the sexual violence in question was typified by an abuser continuing a sexual act when the respondent asked him to stop (Merrill & Wolfe, 2000). In addition, 13% of men reported that a partner had attempted to intentionally infect them with HIV; three men (6%) reported seroconversion to HIV-positive status as a result of such rape (Merrill & Wolfe, 2000).

Differences in the age of onset of first abuse is also present in the literature. Kalichman et al. (2001) found that 39% of a sample of MSM attending an Atlanta Gay Pride event reported a history of partner physical assault in adulthood; this prevalence was similar to the reported lifetime rate of sexual coercion (35%), but only 20.3% of men reported that sexual coercion occurred in adulthood. The distinction between childhood and adulthood sexual abuse is critical, as it is theorized that experiences of sexual abuse in childhood result in differing outcomes compared to experiences of sexual abuse in adulthood. Of men reporting adulthood sexual coercion, 50% reported that unwanted

intercourse occurred as a result of threatened force, 53% reported that the intercourse resulted from force, and 37% reported multiple forms of coercion (e.g., threats of abandonment, threats of force, use of force) (Kalichman, et al., 2001). The average age of first adulthood experience of unwanted sexual contact was young (21.8 years), with the perpetrator of the violence being of significantly older average age (29.4 years), suggesting that potentially uneven power distribution (economic, social, etc.) could be a contributing factor to the high rates of IPV observed among young MSM.

Table 2. Typologies of sexual violence among a sample of MSM accessing services at gay domestic abuse centers in U.S. urban centers; adapted from Merrill and Wolfe (2000).

Form of Sexual Abuse Perpetrated by Partner	**% of Respondents Reporting (N = 52)**
Becoming angry if respondent did not respond to initiation or go along with activity partner wanted	60
Wanting "make-up sex" after violence incident when respondent was still afraid	56
Constantly bothering respondent for sex and/or expecting sex on command	48
Pressuring respondent to do sexual things he knew respondent did not like	39
Continuing a sexual act even though he knew it was hurting respondent	39
Continuing a sexual act even though respondent asked him to stop	39
Expecting respondent to play a certain sexual role without negotiation, communication, or reciprocity	39
Physically forcing respondent to have sex against respondent's will	39
Attempting to infect respondent with HIV	13
Infected respondent with HIV	6

Importantly, Kalichman and colleagues (2001) were able to demonstrate demographic differences theretofore unobserved between populations reported IPV and

those not reporting IPV. Although sexual orientation was not found to be significantly associated with a reported history of IPV, men who reported experiencing IPV were significantly more likely to be of color, to be less educated, to have a lower annual income, and to have tested positive for HIV (Kalichman, et al., 2001). All of these findings serve a minority stress hypothesis, that is, vulnerability added unto vulnerability added unto vulnerability leads to increasingly poor health outcomes, including the presence of intimate partner violence. Nearly half of the men who reported a history of violence (48%) reported three or more instances of violence, a finding that is in line with "re-victimization" findings in heterosexual populations, in which a smaller subset of persons experiencing violence are more likely to have this violence be chronic in nature (Kalichman, et al., 2001). Indeed, MSM with a reported history of unwanted sexual intercourse were more likely to also report physical assaults by a male partner (Kalichman, et al., 2001).

Greenwood and colleagues (2002) were among the first to use WHO-standardized definitions of violence, and also among the first to introduce a measure of randomization into their study by conducting probability-based, disproportionate telephone sampling (Greenwood, et al., 2002). Recall of violence was also limited to a five-year period, mitigating the potentially confounding factor of childhood sexual abuse. Overall, 39.2% of urban MSM had experienced some form of abuse (psychological, physical, and/or sexual) in the previous five years (Greenwood, et al., 2002). The most common form of violence was psychological (34%), followed by physical (22%), and sexual (5%). Associations between experiencing violence and demographic characteristics were mixed. Neither race/ethnicity, income, sexual orientation, nor geography were found to

have an association with experiences of any form of IPV, but decreasing educational level, HIV-positive serostatus, and unemployment were all associated with increased prevalence of IPV. Age was significantly associated with all forms of IPV; MSM aged 18-29 were 3.8 times as likely to report any kind of IPV in the previous five years when compared to men aged 60 or older (Greenwood, et al., 2002). These associations were especially strong when considered for sexual violence alone – MSM aged 18-29 were more than five times as likely to experience violence than older MSM (Greenwood, et al., 2002). While HIV-positivity significantly increased odds of experiencing both psychological and physical violence (ORs 1.2 and 1.5, respectively), this effect was not observed for sexual violence (Greenwood, et al., 2002). Perplexingly, the inverse relationship was found for men who had never been tested for HIV, as they had lower odds of both psychological violence (OR 0.55) and physical violence (ORs 0.63) (Greenwood, et al., 2002). However, HIV-positive MSM were also more likely to have experienced multiple forms of IPV compared to HIV-negative MSM (Greenwood, et al., 2002).

Indeed, young MSM appear to be particularly at excess risk for the adverse effects of intimate partner violence. Data drawn from a cross-sectional sample of young MSM (15-22 years old) in New York City suggests that violent experiences begin early in life (Koblin, et al., 2006). Koblin and colleagues (2006) found that 32.3% of young MSM in their sample reported receiving threats from a partner, 23.4% reported experiencing violence from a partner, and 36.9% reported either receiving threats or experiencing violence (Koblin, et al., 2006). High levels of inter-familial violence were also found. When partner violence was examined in tandem with family violence, a staggering 67.5%

of respondents reported having either received threats or experienced violence from either partners or members of their families by the age of 22 (Koblin, et al., 2006). Reporting of IPV was significantly associated with ever having run away from home, a situation that places youth at increased risk for victimization. Additionally, young MSM in the sample who reported IPV were 3.2 times as likely to report a history of forced sex (Koblin, et al., 2006).

The mental health consequences of intimate partner violence among MSM have also begun to be examined, and largely mirror established findings about the relationships between mental health and experiences of violence. Using data drawn from a prospective cohort of self-identified gay and bisexual men in Canada, Brastein and colleagues (2006) found that 28% of MSM reported any history of sexual violence; however, 46% of men reporting violence stated that this violence began in childhood, and the authors did not assess whether or not the sexual abuse was contained to childhood, or if men who were first sexually abused as children were more likely to also report violence in adulthood (Braitstein, et al., 2006). MSM who experienced sexual violence in adulthood were more than three times more likely to report suicide attempts than men who did not report experiencing sexual violence (Braitstein, et al., 2006). This relationship suggests that the short- and long-term physiological effects of sexual violence do not differ among MSM as compared to heterosexual populations.

Rates of reported violence among MSM have been consistently high regardless of geography or sample demographics. Houston and McKirnan (2007) found that 32.4% of 817 self-identified gay and bisexual men in the Chicago area reported experiencing some form of IPV in their current relationship; 19.2% of men reported that this violence was

physical, and 18.5% reported experiencing sexual violence (Houston & McKirnan, 2007). Reporting multiple forms of abuse was common, as 54% of persons reporting experiencing IPV reported that the forms of abuse were multiple, a proportion that correlates to 17.6% of the overall sample (Houston & McKirnan, 2007). The most common form of abuse reported was verbal abuse (20.6%), followed by physical abuse (19.2%) and sexual abuse (18.5%) (Houston & McKirnan, 2007). However, the authors did not exclude instances of childhood sexual abuse, which possibly increases the reporting of past sexual and/or physical abuse: only 5.8% of men reported that sexual abuse was taking place in their current main partnership (Houston & McKirnan, 2007).

A similar trend was seen in data presented by Feldman and colleagues (2007) in a 100% Latino population. About one-third (35%) of respondents reported having a sexual encounter against their will before the age of 16, and 16% reported a consensual encounter before the age of 16 with someone who was at least five years their senior (Feldman, Ream, Díaz, & El-Bassel, 2007). The reporting of sexual intimate partner violence from the age of 18 onwards was subsequently lower, though still significant (10%), contributing to the overall IPV reporting rate of 52% (Feldman, et al., 2007). As in the majority of previous studies, demographic characteristics such as age, education, immigration status, and HIV status were in no way associated with reporting any kind of IPV (Feldman, et al., 2007).

It must be noted that almost no available data address rates of perpetration of IPV among MSM. Perpetration of IPV among MSM has heretofore been reported in only three studies. Waterman and colleagues (1989) found a reported forced sex perpetration rate of 5.9% among a convenience sample of 34 self-identified gay college students, a

rate substantially lower than the reported rate of experiencing forced sex (12.1%) (Waterman, et al., 1989). Unpublished data from Harms (1995) yielded a violence perpetration rate of 25.5% among 393 MSM sampled from gay venues in San Francisco; this reported rate is considerably closer to the reported rate of IPV experience in the same sample (26.1%) (Harms, 1995). Most recently, Waldner-Haugrud and colleagues (1997) reported an IPV perpetration rate of 21.6% in a sample reporting 29.7% experiencing violence (Waldner-Haugrud, et al., 1997). However, generalizing these rates of IPV perpetration is impossible in that Waterman et al. (1989) used an extremely small sample size, all populations in questions were 82-100% white, and Harms' data remain unpublished. The lack of knowledge of perpetration rates and typologies of IPV among MSM hampers any attempt that would be made at addressing violence in this community.

Sexual Risk-Taking

The associations between sexual risk-taking and violence among MSM are not fully understood. While several studies have demonstrated links between violence and sexual risk in MSM similar to patterns observed in heterosexual populations, causality cannot be addressed due to the cross-sectional nature of the preponderance of the data, and different studies, many of which have used differing definitions and measurements of both violence and sexual risk, have found different associations of different magnitudes. Additionally, sexual violence encompasses a range of unwanted sexual experiences with varying degrees of STI and HIV risk. Despite this, the majority of available data focus on what is considered among the highest-risk activities for HIV: unprotected anal intercourse (UAI) with a non-monogamous partner. It is immodest to place exclusive personal responsibility upon gay and bisexual men for risky sexual behavior when it is

becoming clearer and clearer in the literature that not all of this sexual activity – and in particular, UAI – always occurs under conditions of consent and want.

The first reported association between IPV and sexual risk-taking was described by Nieves-Rosa and colleagues (2000), who found a significant positive relationship between having experienced IPV and having unprotected anal intercourse, either insertive or receptive (Nieves-Rosa, et al., 2000). These conclusions were reflected in findings by Kalichman and colleagues (2001) who found that, when compared to men who did not report a history of sexual coercion in adulthood, MSM who did were 60% more likely to report unprotected insertive anal intercourse, 60% more likely to report any unprotected anal intercourse, and 2.8 times as likely to report UAI with two or more partners in the previous six months (Kalichman, et al., 2001). This group was also 26.3 times as likely to report being afraid of asking their partners to use condoms and was more likely to trade sex for money or drugs (OR 2.3), indicating a lack of self-efficacy in condom negation and further vulnerability as an at-risk population (Kalichman, et al., 2001). Accordingly, MSM who reported being sexually coerced as adults were more likely to report having tested positive for HIV infection (Kalichman, et al., 2001). Importantly, these effects were present among men who reported sexual coercion in adulthood regardless of whether or not they also reported a history of childhood sexual abuse, indicating that the effects of such violence exist ipso facto. However, causality cannot be determined; it remains unknown if men living with HIV are at an increased risk for experiencing IPV, or if experiencing IPV places men at an increased risk for HIV seroconversion.

Similar delineations between the effects of childhood versus adulthood sexual abuse were also observed among MSM in Canada. Those who experienced sexual

violence beginning in adulthood were significantly more likely to engage in receptive unprotected anal intercourse compared to men who did not report any history of sexual violence (OR: 2.5) (Braitstein, et al., 2006). This association was not found for persons reporting a first instance of sexual violence in either childhood or adolescence, suggesting a pathway in which sexual violence correlates to sexual risk that is unique to those men for whom sexual abuse first occurs in adulthood, and a pathway distinct from the evidenced relationship between sexual abuse/rape in childhood and increased sexual risk in adulthood discussed by Relf (Relf, Huang, Campbell, & Catania, 2004). This correlation was not found, however, for insertive unprotected anal intercourse, although findings bordered on significance (Braitstein, et al., 2006).

Current literature also suggests that men who report experiences of intimate partner violence may be similar to those not reporting abuse in some areas that are considered classic risk factors for HIV infection, while showing excess risk in other areas. Houston and McKirnan (2007) found that while men reporting abuse did not differ in their overall number of sexual partners when compared to non-abused men, men reporting abuse were 61% more likely to report unprotected anal intercourse over a six-month recall period (Houston & McKirnan, 2007). They were also 40% more likely to report recent treatment of an STI, a finding of critical importance as infection with ulcerative STIs is known to increase risk of HIV seroconversion (Houston & McKirnan, 2007).

One theory to explain this increased risk behavior is that a history of violence leads to sexual situations where negotiation is difficult and agency is constrained. For example, regression models built by Feldman and colleagues determined that

psychological abuse, physical abuse, and sexual abuse were all significantly associated ($p < 0.001$) with circumstantially constrained sexual situations, such as having sex while intoxicated or having sex in a club or bathhouse (Feldman, et al., 2007). These circumstantial constraints were then themselves associated in multiple models with unprotected anal intercourse with a non-monogamous partner. However, a direct relationship between violence and UAI with a non-monogamous partner was found for only sexual abuse and not for either psychological abuse or physical abuse, suggesting different mediators of UAI in these situations (Feldman, et al., 2007). Interestingly, the data also failed to demonstrate a relationship between IPV and participating in sexual situations that were *personally* constrained, such as situations in which a partner does not want to use a condom (Feldman, et al., 2007).

Homophobia and Gay Pride

The word *homophobia* was coined by psychologist George Weinberg in the 1960s and was conceptualized as an irrational hostility towards and fear of persons with same-sex attraction and/or behaviors (Herek, 2004). Today, the word has come to represent a wide range of anti-LGBTQ sentiments, including sexual stigma (the view that homosexual sexual activity is sinful, bad, sick, etc.), heterosexism and heteronormativity (in which non-heterosexual-centered understandings of sexuality are viewed as deviant, wrong, and dangerous), and sexual prejudice (including, for example, prejudice of homosexual men against bisexual men) (Herek, 2004). Internalized homophobia refers to the phenomenon that occurs when LGBTQ persons, living in a society where heterosexuality is the pervasive norm and alternative sexualities are stigmatized, internalize this anti-LGBTQ bias. Specifically, the term often refers to the struggle that

many LGBTQ persons face between internally negative views of alternative sexualities and the emergence and presence of an alternative sexuality. Homophobia is theorized to correlate to adverse health outcomes such as violence and sexual risk-taking both through internalized homophobia and external experiences of homophobia such as homophobic discrimination, stigma, and/or violence. However, the data are in disagreement in several critical areas, and use of multiple definitions of homophobia (external and/or internalized) make comparisons difficult.

Although literature on internalized homophobia is emerging, the relationship between generally homophobic views and adverse mental health outcomes among LGBTQ persons is comparatively well-documented. Researchers have demonstrated positive relationships between views such as negative homosexuality identity and depression (Alexander 1987), lower self-esteem (Allen & Oleson, 1999), increased shame (Allen and Oleson 1999), and psychological distress (Allen & Oleson, 1999; Meyer, 1995). Nieves-Rosa and colleagues were able to demonstrate relationships between experiencing IPV and lowered self-esteem and lowered self-worth (Nieves-Rosa, et al., 2000). Braitstein and colleagues found that men who reported sexual violence in childhood were 3.8 times as likely to have attempted suicide; this effect was also present in men who reported sexual violence that began in adulthood (OR: 3.1) (Braitstein, et al., 2006).

Direct associations between internalized homophobia and sexual risk taking, however, have been examined far less. Greenwood et al. (2002) failed to demonstrate any relationship between sexual orientation and IPV outcomes (Greenwood, et al., 2002). While Ross and colleagues (2001) were able to demonstrate a relationship between

certain aspects of internalized homophobia and drug use, and between drug use and unsafe sexual behavior, and direct associations between internalized homophobia and unsafe sexual behavior were not found (Ross, et al., 2001). For example, increased reporting of anti-gay stigma and discrimination based on homosexuality was found to be significantly associated with unprotected anal intercourse among Latino MSM, but this association was not found for UAI with either a primary or secondary partner among Asian and Pacific Islander MSM (Jarama, Kennamer, Poppen, Hendricks, & Bradford, 2005; Yoshikawa, Wilson, Chae, & Jih-Fei Cheng, 2004). This lack of association between internalized homophobia and any form of anal intercourse was also found by Flores et al. (2009).

An illustration of the difficulty in comparing different findings regarding homophobia can be seen in the lack of association found between "outness as MSM" and experiencing any form of violence by Houston and McKirnan (2007). Rather than using a validated scale, "outness as MSM" was measured by a single item, that is, a scale of how much respondents would rather most people not know that they had sex with men (Houston & McKirnan, 2007). Such a simplistic measurement conflates the idea of internalized homophobia, in which an individual is ashamed of and/or repulsed by his own homosexual feelings, and "closetedness," that is, how comfortable a man is with other people knowing he engages in homosexual activity. It is possible for one to be completely at ease with his homosexuality, yet would still rather that other people know, since he views his sexuality as a private matter. Additionally, this single-item assessment does not address other critical areas of internalized homophobia, such as feeling that

being gay harms one's family, or lowered self-esteem and feelings of worth due to one's homosexuality.

Nonetheless, a few recent seminal works have indeed found relationships between homophobia, either internal or external, and correlates such as intimate partner violence and sexual risk-taking; however, the directionality of these associations is in dispute. Relf et al. (2004) found that *positive* gay identity, as measured by years of being "out" as homosexual, participation in gay community events, viewing one's self as affiliated with the gay community, and self-identifying as gay, was significantly associated with *increased* HIV risk behaviors (Relf, et al., 2004). That is, *increasing* internalized homophobia was correlated with *decreasing* HIV risk behavior. Positive gay identity was found to correlate to increased HIV risk both directly and through mediated pathways of increased substance abuse, increased partner violence, increased feelings of alienation due to HIV status, and increased mental health problems (Relf, et al., 2004). Flores and colleagues (2009) presented similar findings from a diverse sample of 950 MSM in the San Francisco area (Flores, Mansergh, Marks, Guzman, & Colfax, 2009). MSM reporting increased involvement in the gay community were 32% more likely to have recently engaged in unprotected receptive anal intercourse (Flores, et al., 2009). Similarly, MSM with increased gay bar/club attendance were 20% more likely to engage in unprotected insertive anal intercourse, and 32% more likely to engage in unprotected anal intercourse with a serodiscordant partner or a partner of unknown serostatus (Flores, et al., 2009).

However, other data suggest that increasing internalized homophobia is indeed correlated with increased sexual risk. Diaz and colleagues (2004) found alarmingly high homophobia among Latino MSM living in major urban areas:

> 64% reported that they were verbally harassed in childhood on account of being gay or effeminate; 70% felt that their sexual orientation hurt and embarrassed their families; 64% had to pretend to be straight in order to be accepted. In addition, 29% reported that they had to move away from their families and friends on account of their sexual orientation (Díaz, Ayala, & Bein, 2004).

Critically, it was also found that these experiences of homophobia were significantly correlated to increased sexual risk, as defined recent history of unprotected anal intercourse with a non-monogamous partner. Men who were classified as being at increased sexual risk were more likely to report verbal assault in childhood ($p < 0.001$), feeling that their sexuality embarrassed and hurt their families ($p < 0.01$), and experiencing police harassment ($p < 0.0001$). Overall, these men had significantly more reporting of homophobic experiences than men who were classified as having low sexual risk ($p < 0.001$) (Díaz, et al., 2004). These apparently contradictory findings in the literature suggest a theoretical bimodal effect of internalized homophobia in MSM, in which MSM with either extremely high *or* extremely low internally homophobic sentiments are at increased sexual risk for HIV.

Emerging research also suggests that MSM living with HIV may be especially susceptible to the excess sexual risk associated with internalized homophobia. Using a racially diverse sample of 675 MSM drawn from attendees of HIV prevention workshops in major U.S. cities, Ross, Rosser, and Neumaier (2008) theorized two possible pathways by which internalized homophobia places HIV-positive MSM (and thus their partners) at increased risk for serodiscordant unprotected anal intercourse (Ross, Rosser, & Neumaier, 2008). First, high internalized homophobia was associated with being less "out" as a gay man, that is, being open about one's homosexuality to family, friends,

colleagues, etc. (Robinson, Bockting, Simon Rosser, Miner, & Coleman, 2002; Ross, et al., 2008). This "closetedness" in turn was associated with decreased disclosure of positive serostatus to non-primary sexual partners, which itself in turn was associated with serodiscordant unprotected anal intercourse (Ross, et al., 2008). Second, internalized homophobia was associated with decreasing comfort with one's body and one's sexuality, which was correlated with decreasing self-efficacy in condom use and negation, resulting in increased serodiscordant unprotected anal intercourse (Ross, et al., 2008). Though novel, additional research is needed to generalize these pathways to HIV-negative MSM and to confirm the effect modification of the theorized intermediary elements.

Race and Racism

There is very little literature on the relationship between racism, intimate partner violence, and sexual risk-taking. Although race/ethnicity was nearly always measured in the aforementioned literature, very few studies have considered how race and experiences of racist discrimination affect intimate partner violence. Those studies that have attempted to analyze such comparisons have found mixed associations, and the literature is in disagreement. Several studies have found that there is no relationship between race, racism, and IPV, while others have. Yoshikawa and colleagues (2004) were able to demonstrate that experiences of anti-immigrant discrimination were significantly associated with UAI with a secondary partner among a population of Asian/Pacific Islander MSM (Yoshikawa, et al., 2004). However, Greenwood et al. (2002) failed to find any relationship between race/ethnicity and experiences of IPV (Greenwood, et al.,

2002). Houston and McKirnan (2007) also failed to find an association between race and reporting IPV victimization (Houston & McKirnan, 2007).

While IPV prevalence may or may not vary across races/ethnicities, there is some evidence that indicates that experiences of racist discrimination may affect intimate partner violence and/or sexual risk-taking. MSM of color have been shown to experience high levels of racist discrimination, including racist discrimination within gay communities. Using data drawn from a sample of Latino MSM, Diaz and colleagues (2004) found that:

> 31% were verbally harassed in childhood, and 35% were treated rudely in adulthood on account of their race or ethnicity. Racial discrimination in the context of gay community was highly prevalent, with 62% reporting racially based sexual objectification and 26% reporting experiences of discomfort in White gay venues, on account of their ethnicity (Díaz, et al., 2004).

Accordingly, these experiences of racism were correlated with risky sexual behavior. Men who reported rude treatment because of their race, racial discomfort in White gay venues, and race-based sexual objectification were significantly more likely to report a recent history of unprotected anal intercourse with a non-monogamous male partner ($p < 0.01$, $p < 0.001$, and $p < 0.001$, respectively) (Díaz, et al., 2004). Those who reported such high-risk sexual behavior had significantly more reporting of experiences of racism – nearly twice the reporting of low-sexual-risk MSM, suggesting that the effects of racism may be concentrated.

African-American/Black MSM may be at particular risk for experiencing racism, but the effects of such experiences are unknown. For example, a study by Flores and

colleagues (2009) showed that black MSM were less likely identify as homosexual/gay than white MSM, and attended gay bars and gay community events less frequently (Flores, et al., 2009). The same study showed that gay community involvement and gay bar attendance were both independently associated with increased unprotected anal intercourse, suggesting a potentially protective health effect of racism (Flores, et al., 2009). However, there are other pathways through which racism could adversely affect the health of African-American MSM. African-American MSM were shown by Ross et al. (2008) to have increased levels of internalized homonegativity, which Ross and colleagues argue leads to unsafe sexual behavior through multiple pathways, including discomfort with one's sexuality and "outness" as man who has sex with another man (Ross, et al., 2008). Indeed, Kennamer and colleagues (2000) have shown that African American MSM are far less likely to disclose their sexuality than their white counterparts, strengthening Ross and colleagues' theory (Kennamer, Honnold, Bradford, & Hendricks, 2000). Whether racism is the specific intermediary that places MSM of color, and particularly Black MSM, at excess risk for HIV and STIs, or if other confounders play some role (for example, homophobia in the black church), is currently not understood.

Gaps in the Literature

The scientific knowledge regarding violence among MSM, and in particular intimate partner violence, is in its infancy. Perpetration rates of intimate partner violence have not been published in the past decade. The most significant methodological shortcoming in current literature lies in the fact that the majority of information published on violence among MSM comes from small convenience samples of MSM, many of

which targeted specific groups of MSM, such as MSM of color or young MSM. In addition, the variety of definitions used to define violence hamper comparison, as does the wide range in recall periods used by different researchers. Some researchers included history of childhood sexual abuse in a lifetime recall of any form of sexual violence where others did not; this distinction is critical as emerging knowledge indicates that sexual violence experienced in childhood has similar but independent effects on sexual risk behavior, identity formation, and mental health compared to sexual violence experienced in adulthood. Despite this, the preponderance of studies did not distinguish between childhood sexual violence and sexual violence experienced in adulthood. These discrepancies, as well as inconsistent use of definitions of violence, likely account for the wide range in the prevalence of all types of intimate partner violence reported in the literature.

Connections between intimate partner violence (and indeed specific types of intimate partner violence) and sexual risk-taking among MSM are also in dispute, although a general association between violence and sexual risk-taking is observed, mirroring known associations in heterosexual populations. However, the magnitude of these associations are unknown, and there is some evidence to suggest that intermediaries, such as drug use or being in sexually difficult situations, modify the effect of partner violence on sexual risk.

The intersections of intimate partner violence and other sources of potential minority stress have not yet been thoroughly examined. Even though a few studies have examined internalized homophobia, and definitions and measurements of internalized homophobia vary widely, the literature is already in disagreement as to the effect of

internalized homophobia versus gay pride on violence and/or sexual risk taking. However, it is possible that an as-of-yet-unobserved bimodal effect exists in which MSM with either high internalized homophobia or high gay pride are at excess sexual risk; more data are needed.

Finally, the effect of race and racism on the interplay of the aforementioned areas, particularly the area of intimate partner violence, remains unknown. While race/ethnicity has been shown to have mixed associations with both intimate partner violence and sexual risk taking, far fewer studies have examined the concept of racism ipso facto as a risk factor for adverse health outcomes among MSM. This is an area of critical need in the literature, as HIV is spreading rapidly through communities of MSM of color, particularly young, black MSM.

The present study will addressed the aforementioned gaps in the literature in several ways. Although the sample used is a convenience sample, the fact that the survey instrument was internet-based means that a nationwide sample was obtained, with representation from all areas of the U.S., and the sample is demographically diverse, particularly in terms of race/ethnicity. Recall of violence is limited to a one-year period, all but eliminating potential confounding from histories of childhood sexual abuse. Perpetration rates of intimate partner violence are reported with a sample five times the size of the largest study to report perpetration rates of IPV. Both externalized and internalized manifestations of homophobia are assessed, and experiences of race-driven discrimination are considered as a risk factor for increased intimate partner violence. The most significant gap filled by this study, however, is an examination of all of the

aforementioned sources of minority stress in congress, an analysis heretofore not present in the literature.

CHAPTER III: MANUSCRIPT

Intimate partner violence, minority stress, and sexual risk-taking among U.S. MSM

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Contribution of the Student

The work herein is the product of a secondary data analysis performed by the student. The student did not have a role in producing the survey or the collection of data through survey implementation. However, the student did perform all work after data collection independently, including the analysis of the data, the construction of regression models, summation of results in tables, and all writing. Advisement throughout this process was provided by the student's thesis advisor.

Abstract

Title: Intimate partner violence, minority stress, and sexual risk-taking among U.S. MSM

Authors: Rob Stephenson, Ph.D.; Catherine Finneran, MPH; Patrick Sullivan, Ph.D.

Background: Recent research suggests that men who have sex with men (MSM) experience a significantly higher prevalence of intimate partner violence (IPV) than heterosexual men. However, little research has examined how IPV is associated with sexual risk-taking among MSM. Additionally, little research has examined how experiences of minority stress, particularly homophobia and racism, are associated with both IPV and sexual risk-taking.

Objective: To examine the relationships between intimate partner violence, homophobia, racism, and sexual risk-taking among a population of self-identified gay and bisexual men in the United States.

Methods: A national, internet-based survey of U.S. MSM (N = 2,086) recruited from social networking sites was conducted in 2010. From a subset of these data (*n* = 1,575), five outcomes were modeled using logistic regression: experiences of physical violence, experiences of sexual violence, perpetration of physical violence, perpetration of sexual violence, and sexual risk-taking as defined by unprotected anal intercourse (UAI) at last sexual encounter with a male partner. IPV was limited to a one-year recall period. Models controlled for age, race/ethnicity, homosexual identity, education, employment, HIV status, experiences of homophobic discrimination, experiences of racism, internalized homophobia, UAI, and experiences of IPV.

Results: Approximately 48% of MSM respondents reported UAI at last sex. MSM reported prevalence rates of 8.8% for experiences of physical IPV, 3.6% for experiences of sexual IPV, 4.3% for physical IPV perpetration, and 0.8% for sexual IPV perpetration. MSM who reported experiencing more homophobic discrimination were more likely to report experiences of sexual IPV (OR: 1.28, 95% CI: 1.11, 1.47) and perpetration of sexual IPV (OR: 1.70, 95% CI: 1.25, 2.31), as were MSM who reported more internalized homophobia (OR: 1.08, 95% CI: 1.03, 1.13). MSM who reported engaging in UAI were more likely to report perpetrating physical IPV (OR: 2.21, 95% CI: 1.29, 3.79); accordingly, MSM who reported perpetrating physical IPV were more likely to report UAI (OR: 2.08, 95% CI: 1.12, 3.85). Experiencing racism was associated with increased odds of experiencing sexual IPV (OR: 1.19 95% CI: 1.06, 1.34).

Conclusions/Implications: To date there has been a dearth of research on IPV among MSM, and almost no attention has been paid to the intersection of violence and sexual risk-taking among MSM. The high prevalences of IPV and UAI among MSM reported here suggest an immediate and pressing need for violence support and counseling services geared towards MSM. IPV screening should be incorporated into routine HIV/STI counseling and testing, with a focus on discussions around the relationship between sex and violence. The associations identified between racism, homophobia and both IPV and UAI point to the need for prevention messages to address the social, cultural, and attitudinal contexts in which MSM take sexual risks.

Introduction

Recent research suggests that men who have sex with men (MSM) experience a significantly higher rate of intimate partner violence (IPV) compared heterosexual men (25-50%), a rate that is similar to rates of intimate partner violence observed among heterosexual women (Blosnich & Bossarte, 2009; Tjaden, et al., 1999). This emerging research further suggests relationships between these experiences of intimate partner violence and sexual risk-taking (Braitstein, et al., 2006; Feldman, et al., 2007; Hatzenbuehler, et al., 2008; Houston & McKirnan, 2007; Kalichman, et al., 2001; Kalichman & Rompa, 1995; Koblin, et al., 2006; Stall, et al., 2003). While typologies of intimate partner violence (Merrill and Wolfe 2000) and the associations between intimate partner violence and childhood sexual abuse (Feldman et al. 2007) have been examined, very few studies in the literature report perpetration rates of intimate partner violence among MSM. Yet fewer studies have examined how other sources of minority stress, such as homophobia and racism, affect experiences of intimate partner violence, or how these stressors may be associated with sexual risk-taking. To date, no published study has examined how the combination of these contextual factors influences sexual risk-taking among MSM. Understanding these influences, which fall outside the realm of the traditional risk factors for HIV, is critical, as the HIV epidemic is resurging among MSM in the United States. In 2006, 53% of incident HIV in the U.S. occurred among MSM, and MSM are now 44 times more likely to receive a HIV diagnosis compared to men who do not have sex with men (CDC, 2010). In order to provide better HIV prevention services to MSM, a more thorough understanding of the context in which MSM take sexual risks is needed. Particularly, the confluence of multiple sources of minority stress

– intimate partner violence, homophobia, and racism, among others – create a backdrop that is of critical importance when considering the milieu in which individual risk behaviors occur.

Background

The concept of *minority stress* is an amalgamation of sociological, anthropological, and psychological theories about the additive nature of multiple stressors experienced by persons of minority status. Meyer (1995, 2003) seminally defined minority stress as the "excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position" (Meyer, 2003). The majority of research regarding minority stress and health among LGBTQ persons has examined adverse mental health outcomes derived from LGBTQ-specific minority stress. Researchers have demonstrated positive relationships between views of negative homosexuality identity and depression (Alexander 1987), lower self-esteem (Allen & Oleson, 1999), increased shame (Allen and Oleson 1999), and psychological distress (Allen & Oleson, 1999; Meyer, 1995). Similar trends among urban, Latino MSM were reported by Diaz and colleagues (2001), in which minority stress stemming from homophobia, racism, and poverty was associated with depressive symptoms such as suicidal ideation, depression, and anxiety.

Although direct relationships between experiences of minority stress and adverse physical health outcomes – such as HIV infection or experiences of intimate partner violence – are comparatively un-researched, emerging evidence points to relationships between homophobia and such outcomes. Hatzenbuehler, Nolen-Hoeksema and Erickson

(2008) found that both homophobic discrimination and internalized homophobia increased the risk of substance abuse, increased number of sexual partners, and increased frequency of unprotected anal intercourse. Hamilton and Mahalik (2009) accordingly found that experiences of physical violence related to anti-gay stigma were correlated with substance abuse, and internalized homophobia was correlated with alcohol abuse, substance abuse, and unprotected anal intercourse. These novel findings refute previous studies that have failed so demonstrate such associations (Jarama, et al., 2005; Ross, et al., 2001; Yoshikawa, et al., 2004). There is also some evidence that positive gay identity increases sexual risk. Flores and colleagues (2009) found that men who reported increased involvement in the gay community were 32% more likely to have recently engaged in unprotected receptive anal intercourse.

It is only recently that intimate partner violence among MSM has begun to be researched, and the scattershot approach to IPV research among MSM, in which researchers have used varying definitions and measurements of violence, has resulted in vastly different reported rates of differing kinds of violence in the literature. To date, no published data describe any facet of IPV in MSM among a sample that is nationally representative of U.S., and the existing data are primarily drawn from specific, targeted groups such as young MSM or MSM of color that were sampled conveniently. When using lifetime recall, estimated prevalences for IPV among MSM range from 19.2% (Houston and McKirnan 2007) to 39% (Kalichman et al. 2001) for physical violence, 5% (Greenwood et al. 2002) to 28% (Braitstein et al. 2006) for sexual violence, and 32% (Koblin et al. 2006) to 52% (Feldman et al. 2007) for any violence. Perpetration rates of

violence have been comparatively less studied, and range from 5.9% (Waterman et al. 1989) to 21.6% (Waldner-Haugrud 1997).

There is also evidence that rates of IPV may be higher among MSM of color (Houston & McKirnan, 2007; Kalichman, et al., 2001; Koblin, et al., 2006), less educated men (Greenwood, et al., 2002), and men with positive HIV status (Greenwood, et al., 2002; Kalichman, et al., 2001; Stall, et al., 2003). Additionally, evidence for associations between experiences of racism and risky sexual practices among MSM of color is emerging in the literature (Díaz, et al., 2004; Ross, et al., 2008; Yoshikawa, et al., 2004). All of these findings serve a minority stress hypothesis, that is, vulnerability added unto vulnerability added unto vulnerability leads to increasingly poor health outcomes, including the presence of intimate partner violence.

While several studies have demonstrated links between violence and sexual risk in MSM similar to patterns observed in heterosexual populations, causality cannot be addressed due to the cross-sectional nature of the preponderance of the data, and different studies, many of which have used differing definitions and measurements of both violence and sexual risk, have found different associations of different magnitudes. The first reported association between IPV and sexual risk-taking was described by Nieves-Rosa and colleagues (2000), who found a significant positive relationship between having experienced IPV and having unprotected anal intercourse, either insertive or receptive (Nieves-Rosa, et al., 2000). These conclusions were reflected in findings by Kalichman and colleagues (2001) who found that, when compared to men who did not report a history of sexual coercion in adulthood, MSM who did were 60% more likely to report unprotected insertive anal intercourse, 60% more likely to report any unprotected anal

intercourse, and 2.8 times as likely to report UAI with two or more partners in the previous six months (Kalichman, et al., 2001). Accordingly, MSM who reported being sexually coerced as adults were more likely to report having tested positive for HIV infection (Kalichman, et al., 2001). These associations were similarly found by Houston and McKirnan (2007), who found that men reporting abuse were 61% more likely to report unprotected anal intercourse over a six-month recall period when compared to men not reporting abuse (Houston & McKirnan, 2007).

The present study will addresse the aforementioned gaps in the literature in several ways. Although the sample used is a convenience sample, the fact that the survey instrument was internet-based means that a nationwide sample was obtained, with representation from all areas of the U.S., and the sample is demographically diverse, particularly in terms of race/ethnicity. Recall of violence is limited to a one-year period, all but eliminating potential confounding from histories of childhood sexual abuse. Perpetration rates of intimate partner violence are reported with a sample five times the size of the largest study to report perpetration rates of IPV. Both externalized and internalized manifestations of homophobia are assessed, and experiences of race-driven discrimination are considered as a risk factor for increased intimate partner violence. The most significant gap filled by this study, however, is an examination of all of the aforementioned sources of minority stress in congress, an analysis heretofore not present in the literature.

Data & Methods

This research was reviewed by Emory University Institutional Review Board (IRB) and was ruled exempt. The data for this study were collected via an internet-based survey over a ten day period in October and November 2010. Participants were recruited through advertisements on three social networking websites: Facebook, MySpace, and www.blackgaychat.com. On Facebook and MySpace, advertisements were shown to U.S. men who listed their ages as at least 18. All users of www.blackgaychat.com were eligible to view an advertisement. Clicking on the advertisement redirected a participant to the survey, hosted on SurveyGizmo, at which point he was informed that his participation in the survey was anonymous and voluntary. Although any person to whom an advertisement was shown could access the survey through the advertisements, only persons reporting themselves as least 18 years old and male were eligible for survey completion.

A total of 8,645 people clicked on the advertisements and were thus exposed to the survey. Of these, 4,379 people, or 50.7%, began the survey. Two hundred of these respondents were disqualified due to not meeting inclusion criteria. A total of 2,106 respondents completed the survey, or 24.3% of the population exposed to the survey. Of these, 531 responses contained incomplete information, resulting in an analysis sample size of $n = 1{,}575$.

Measurements

Participants were asked to report both experiencing and perpetrating physical and/or sexual intimate partner violence over the previous twelve months. Standard CDC definitions of IPV were used (Saltzman et al. 2002). For physical violence, respondents

were asked if any of their partners attempted to hurt them, including "pushing, holding you down, hitting you with a fist, kicking, attempting to strangle [you], [and/or] attacking you with a knife, gun, or other weapon." Experiences of sexual violence included instances in which a partner "used physical force or verbal threats to force you to have sex when you did not want to." The same criteria were used to measure reporting of perpetration of physical and sexual violence.

Sexual risk was measured by experiencing of unprotected anal intercourse (UAI) at last sex. Men who did not engage in anal intercourse were classified as not experiencing UAI at last sex. Both penetrative and receptive parties to anal sex were assessed for UAI at last sex. If a condom was not used, was used for part of the time, or broke without being replaced, the respondent was classified as having UAI at last intercourse. If a respondent had both penetrative and receptive anal sex at last sex, a condom must have been used during both behaviors and the entire duration of the intercourse in order to be categorized as not having UAI.

Demographic data were collected for age, race, educational level, and employment status. Age was categorized into discreet groups: 18-20, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, and ≥50. Race was defined as four categories: White non-Hispanic, Black/African American non-Hispanic, Hispanic/Latino, and other. Respondents who responded with other races (such as Native American or Asian/Pacific Islander) or being of multiple races were classified as "other." Educational attainment was classified as less than high school completion, high school diploma/GED, some college or a two-year degree, or completed college. Employment was classified as either currently employed or currently unemployed.

Participants were asked to identify their sexual orientation as "homosexual/gay," "heterosexual/straight," "bisexual," "unsure," or "other." Only men who self-identified as homosexual/gay or bisexual were included in analysis.

Internalized homophobia was quantified using the Gay Identity Scale (GIS) (Brady & Busse, 1994), a validated 20-item scale that assesses acceptance of homosexual feelings and thoughts, as well as how open a respondent is about his homosexuality with family, friends, and associates. From these data, an index variable of internalized homophobia was created. No points were added to the index for neutral responses to any scale item. Positive point values were assigned to agreement with internally homophobic sentiments, and negative points were assigned for agreement with statements of gay pride. For example, responding "agree" to the statement, "I dread having to deal with the fact that I may be homosexual" resulted in one index point; accordingly, a response of "strongly agree" to the statement "I am very proud to be gay and make it known to everyone around me," would result in negative two index points. Thus, openness and pride in homosexuality decreased with increasing index score. Forty points were added to each score in order to shift the range from –40-40 to 0-80.

Experiences of homophobic discrimination were assessed by creating an index scale of reported responses to eleven possible experiences of discrimination due to sexual orientation: being made fun of a child, experiencing violence as a child, being made fun of as an adult, experiencing violence as an adult, hearing as a child that gay men would grow up alone, hearing as a child that gays are not normal, feeling that your gayness hurt your family as a child, having to pretend to be straight, experiencing job discrimination, having to move away from family, and experiencing police harassment. Respondents

were awarded one point for each positive response, creating an index that theoretically ranged from 0-11.

Experiences of racism were assessed by creating an index scale of responses to ten possible experiences of racist discrimination: being made fun of as a child, experiencing violence as a child, being made fun of as an adult, experiencing violence as an adult, being treated rudely or unfairly, experiencing police harassment, experiencing job discrimination, feeling uncomfortable in gay white spaces, having difficulty finding lovers, being objectified sexually, and being rejected for sex. Respondents were awarded one point for each positive response, creating an index that theoretically ranged from 0-10.

Respondents were asked if they had ever been tested for HIV, and if so, what their HIV status was. Those who had never been tested for HIV, had an indeterminate result on their most recent HIV test, or could not remember their HIV results were classified as "unknown status;" persons reporting positive and negative HIV status were classified accordingly.

The data were analyzed using STATA 11 (StataCorp. 2009. *Stata Statistical Software: Release 11*. College Station, TX: StataCorp LP.). Differences in outcomes across group strata were assessed using ANOVA testing at the $\alpha=0.05$ level. Five logistic regression models were created for the five outcomes of interest: UAI, experiencing physical IPV, experiencing sexual IPV, perpetrating physical IPV, and perpetrating sexual IPV. Age, race/ethnicity, sexual identity, education level, employment status, and HIV status were for controlled for in all models excepting perpetration of sexual violence due to the low reported prevalence of sexual violence perpetration in the sample. All

models controlled for internalized homophobia, experiences of homophobic discrimination, and experiences of racist discrimination.

Results

[Insert Table 1]

Demographic characteristics of the sample are summarized in Table 1. The mean index score for internalized homophobia, homophobic discrimination and racist discrimination, as well as the total prevalence of reported IPV and UAI, are summarized in Table 2. Although the homophobic discrimination theoretically ranged from 0-11, every respondent reported experiencing at least one instance of homophobic discrimination over their lifetimes. Unprotected anal intercourse was common in the sample, with 48.51% of men reporting UAI at last sexual encounter. Experiencing physical violence was the most commonly reported form of IPV, with 8.76% of respondents indicating that they had experienced some form of physical violence from a partner in the previous twelve months. However, only 4.32% reported perpetrating physical violence. Sexual violence experiences were less prevalent, with 3.62% of men reporting such experience in the past year. Perpetration of sexual violence was only reported by twelve respondents (0.76%).

[Insert Table 4]

Differences in outcomes across exposure strata are summarized in Table 3. Variation in UAI prevalence was found for age group ($p = 0.0175$), education level ($p < 0.0001$), and HIV status ($p = 0.0476$). Physical violence victimization varied by age

group (p = 0.0104), education level (p < 0.0001), and occurrence of UAI at last sex (p = 0.0199), and prevalence of experiencing sexual violence varied by race (p = 0.0333). Physical violence perpetration varied only by education level (p = 0.0004) and UAI at last sex (p = 0.0005). No significant variation was found for perpetration of sexual violence across exposures, and neither sexual identity nor employment status significantly varied by any outcome.

[Insert Table 3]

Internalized homophobia, experiences of homophobic discrimination, and experiences of racist discrimination varied significantly across most exposure strata (Table 6). Black men reported the highest rate of internalized homophobia with a mean index score 28.62, compared to a mean index score of 11.78 for white men; however, white men reported more experiences of homophobic discrimination (p < 0.0001). Self-identified bisexual men were found to have higher internalized homophobia (p < 0.0001) and report more experiences racist discrimination (p < 0.0001) compared to homosexual men, but homosexual men were more likely to report experiences of homophobic discrimination (p < 0.0001). Men who had never been tested for HIV or did not know their status were more internally homophobic than men who had ever been tested for HIV (p < 0.0001), but reported fewer experiences of both homophobic and racist discrimination (p < 0.0001 and p < 0.0001).

Men who reported perpetrating sexual violence also reported more internalized homophobia than men who did not report perpetrating sexual violence ($\bar{x}$ = 28.50 and 15.41 respectively, p = 0.0009), as well as more experiences of homophobic

discrimination ($p < 0.0001$). Perpetrators of physical violence were also found to have experienced more homophobic discrimination than those who had not perpetrated physical violence ($p = 0.0069$). Men who reported experiencing physical violence were more likely to report experiencing homophobic discrimination ($p < 0.0001$) and racist discrimination ($p = 0.0486$); the same relationships were found for men reporting experiencing sexual violence ($p = 0.0447$ and $p < 0.0001$, respectively).

[Insert Table 4]

The resultant odds ratios (ORs) and 95% Confidence Intervals are summarized in Table 4. Men with known positive HIV status had odds of engaging in UAI at last sex that were 2.03 times the odds of men who had never been tested for HIV and/or did not know their status (95% CI: 1.12, 3.85). Both Black men (OR: 0.67, 95% CI: 0.40, 0.93) and Latino men (OR: 0.84, 95% CI: 0.47, 0.95) had lower odds of engaging in unprotected anal intercourse at last sex when compared to white men.

Men who reported engaging in UAI were 2.08 times (95% CI: 1.12, 3.85) as likely to report perpetrating physical violence against a partner when compared to men without recent UAI history. The inverse of this relationship was also true; that is, men who reported perpetrating physical violence had odds of engaging in UAI at last intercourse that were 2.21 times (95% CI: 1.29, 3.79) the odds for men who did not report physical violence perpetration.

Both increasing educational level and increasing age were found to be protective against experiencing physical violence. Men who had completed college had 77% (95% CI: 88%, 31%) lower odds of experiencing physical violence from a partner in the past

year compared to men who had not completed high school, but this protective effect diminished with decreasing education level, suggesting a dose-response effect. Educational attainment was also found to be protective against perpetration of physical violence.

A significant positive association was found between increasing experiences of racist discrimination and sexual violence victimization (OR: 1.19, 95% CI: 1.06, 1.34). Additionally, men who reported experiencing more homophobic discrimination had odds of being sexually victimized by a partner that were 28% greater than the odds of men who reported less homophobic discrimination (95% CI: 53%, 89%).

Negative experiences of homosexuality were significantly associated with sexual violence perpetration. Specifically, men who reported more internalized homophobia had odds of committing sexual violence that were 1.08 times (95% CI: 1.03, 1.13) the odds of committing sexual violence among men who reported more acceptance and pride in their sexuality. Accordingly, men with increasing index scores of homophobic discrimination had odds of sexual violence perpetration that were 70% higher than the odds of sexual violence perpetration among men with fewer experiences of homophobic discrimination (95% CI: 25%, 131%).

[Insert Table 7]

Discussion

The results provide strong evidence in support of a minority stress hypothesis to conceptualize violence and sexual risk among gay and bisexual men. Racism,

homophobia, and intimate partner violence in particular were all found to have significant associations with sexual risk-taking in the form of unprotected anal intercourse. Homophobia, for example, was significantly associated with both experiencing and perpetrating sexual violence. Other sources of minority stress, such as non-White race/ethnicity, low educational attainment, and positive HIV status were also found to have significant associations with violence and/or sexual risk. MSM of color were more likely to report experiences of sexual violence, and men with lower levels of education were significantly more likely to report both experiencing and perpetrating physical violence against partners, as well as engaging in UAI at last sex.

The observed prevalence of violence reporting in the sample is significantly lower than previous studies of male-male violence among MSM, but this is likely attributable to the limited recall period for violence (one year). This limited recall period is of critical importance as it limits recall bias, eliminates the potential confounder of childhood (<17 years) sexual abuse, and demonstrates that violence in the gay/bisexual community is an ongoing problem. Additionally, the prevalence of unprotected anal intercourse at last sex observed is considerably higher than what is often observed in the literature; however, the analysis did not consider whether or not the UAI occurred with monogamous partners, as previous analyses have. Despite this, self-reported HIV-positive MSM were twice as likely to report engaging in UAI at last sex, an alarming finding that should call attention to the need for continued support for persons living with HIV.

The results are consistent with previous studies that have found relationships between violence and sexual-risk taking; however, direct comparisons are limited due to the lack of consistency in the literature. Associations were found between unprotected

anal intercourse and violence, similar to those found by Feldman et al. (2007), Houston et al. (2007), Stall et al. (2003), and Nieves-Rosa et al. (2000). Similarly, the results provide further evidence that neither sexual orientation (Koblin et al. 2006, Greenwood et al. 2002, Kalichman et al. 2001), employment status (Greenwood et al. 2002), nor race/ethnicity (Greenwood et al. 2002, Kalichman et al. 1995) have significant associations with intimate partner violence. The finding of an association between age and intimate partner violence supports findings in certain studies (Stall et al. 2003, Koblin et al. 2006, Greenwood et al. 2002, Kalichman et al. 1995) while disputing the findings of others (Fledman et al. 2007, Kalichman et al. 2001, Nieves-Rosa et al. 2000).

This study is also among the first to examine the relationships between other areas of minority stress and experiences of intimate partner violence. Experiences of homophobic discrimination were found to not have an effect on UAI, confirming Haztenbeuhler et al. (2008) and Yoshikawa et al. (2004), while disputing Diaz et al. (2004) and Jarama et al. (2005). Unlike several previous studies (Haztenbeuhler et al. 2008, Ross et al. 2008, Relf et al. 2004), no association was found between internalized homophobia and unprotected anal intercourse, but increasing internalized homophobia was found to increase odds of intimate partner violence, disputing Relf et al. (2004), who observed a protective effect of internalized homophobia on IPV. Accordingly, the data also failed to demonstrate the relationship between experiences of racism and unprotected anal intercourse as found by Diaz et al. (2004) and Yoshikawa et al. (2004). That experiences of both racist discrimination and homophobic discrimination increase the odds of intimate partner violence are novel findings, as these association are heretofore unexamined in the literature.

The primary limitations to this analysis stem from the methodology used to collect data, that is, a cross-sectional internet-based survey recruiting from social networking sites, thus creating selection bias towards persons with internet access and not accessing men who do not use social networking sites. Additionally, a portion of the surveys were incomplete, meaning that only men who answered questionnaires completely – including the module on IPV – were selected for analysis. It is possible that men who experience IPV are less likely to be willing to answer questions on IPV, pointing to the difficulty of accessing this vulnerable population. All data are self-reported, which may explain the disparities in reporting experiencing IPV versus reporting perpetrating IPV due to social desirability bias, though such bias is likely limited through the anonymity provided by internet surveys. Because the data are cross-sectional, causality cannot be ascertained; that is, whether internalized homophobia, for example, produces riskier sexual practices, or if those riskier practices themselves induce internalized homophobia, cannot be concluded. Additional research is needed is needed to clarify how these elucidated factors of minority stress effect risk for IPV and risk for HIV.

Despite these limitations, this study addresses several key gaps in the literature and examines relationships between certain areas of minority stress and intimate partner violence for the first time. To the author's knowledge, the sample used is the largest to-date to examine any facet of intimate partner violence among MSM. CDC-standardized definitions of intimate partner violence were used, allowing for greater comparison to be made to current literature on heterosexual IPV as well as to potential future studies. It is also among the first to use social networking websites to recruit participants, a method

which that enables MSM living in non-urban areas to be included in analysis. Unlike many previous studies, sexual IPV and physical IPV were differentiated, and perpetration rates of intimate partner violence among MSM are reported for the first time since Waldner-Haugrud et al. (1997).

This study provides evidence that in addition to being a significant burden in and of itself in MSM community, intimate partner violence has dynamic intersections with additional sources of minority stress, including homophobia and racism. That these sources of minority stress have an apparent additive effect on the prevalence of sexual risk-taking points to the need to address the social, cultural, and attitudinal contexts in which MSM take sexual risks. The high prevalence of intimate partner violence and unprotected anal intercourse reported here by MSM indicate an immediate and pressing need for violence support and counseling services geared towards MSM specifically. Screening for intimate partner violence should be incorporated into routine HIV/STI counseling and testing, with a focus on discussions around the relationship between sex and violence.

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Appendix A: Tables

Table 1. Demographic characteristics of study sample

Exposure	**%**	**n**
Age		
18-20	22.67	357
21-24	24.32	383
25-29	13.71	216
30-34	7.62	120
35-39	5.27	83
40-44	7.24	114
45-49	8.89	140
50+	10.29	162
Race		
White	63.17	995
Black	19	306
Latino	43	172
Other	10.92	102
Sexual Identity		
Homosexual	92.25	1,453
Bisexual	7.75	122
Education Level		
College or more	30.48	480
Some college or 2-year degree	47.24	744
High School Diploma or GED	19.43	306
No High School Diploma	2.86	45
Employment Status		
Unemployed	34.73	547
Employed	65.27	1,028
HIV Status		
Never tested/doesn't know	18.41	290
Negative	71.68	1,129
Positive	9.90	156
Sexual Risk		
Unprotected Anal Intercourse	51.59	811
No Unprotected Anal Intercourse	48.51	764
TOTAL	100	1,575

Table 2. Mean index scores for internalized homophobia, homophobic discrimination, racist discrimination, and prevalence of IPV and UAI

	Mean	**Range**
Internalized Homophobia Index	15.51	0 – 74
Homophobic Discrimination Index	5.69	1 – 11
Racist Discrimination Index	1.75	0 – 10
	%	**n**
IPV – Experienced Physical Violence	8.76	138
IPV – Experienced Sexual Violence	3.62	57
IPV – Perpetrated Physical Violence	4.32	68
IPV – Perpetrated Sexual Violence	0.76	12
Unprotected Anal Intercourse	48.51	764

Table 3. Intimate partner violence outcomes and unprotected anal intercourse (UAI) by exposure variables and ANOVA test results. Different means across strata at α=0.05 are denoted by *. (Note: -- indicates not analyzed.)

Exposure	Outcome (%)				
	Experienced Physical Violence	Experienced Sexual Violence	Perpetrated Physical Violence	Perpetrated Sexual Violence	Unprotected Anal Intercourse
Age					
18-20	10.64*	3.64	4.76	1.12	47.43*
21-24	10.44*	4.70	5.74	0.78	52.48*
25-29	9.26*	4.17	5.56	0.46	55.09*
30-34	11.67*	4.17	5.83	0	49.17*
35-39	12.05*	4.82	3.61	0	51.81*
40-44	3.51*	1.75	0.88	0.88	43.86*
45-49	5.00*	2.14	3.57	1.43	45.00*
50+	3.09*	1.85	0.62	0.62	37.04*
Race					
White	8.14	2.71*	3.72	0.70	50.45
Black	9.48	5.56*	5.23	1.63	41.50
Latino	9.88	3.49*	6.40	0	48.26
Other	10.78	6.86*	3.92	0	50.98
Sexual Identity					
Homosexual	8.88	3.44	4.27	0.69	49.07
Bisexual	7.38	5.74	4.92	1.64	41.80
Education Level					
College or more	6.46*	3.13	3.13*	1.04	45.21*
Some college or 2-year degree	7.66*	5.23	3.36*	0.40	48.25*
High School Diploma or GED	12.75*	2.96	7.19*	0.98	53.59*
No High School Diploma	24.44*	3.13	13.33*	2.22	53.33*
Employment Status					
Unemployed	8.78	3.84	3.66	0.37	47.53
Employed	8.75	3.50	4.67	0.97	49.03
HIV Status					
Never tested/DK	8.62	3.79	4.48	1.03	46.21*
Negative	8.50	3.54	4.16	0.71	47.83*
Positive	10.90	3.85	5.13	0.64	57.69*
Unprotected Anal Intercourse					
No UAI	7.15*	3.33	2.59*	0.49	--
UAI	10.47*	3.93	6.15*	1.05	--
TOTAL	8.46	3.62	4.32	0.76	48.51

Table 4. Mean index scores for internalized homophobia, experiences of homophobic discrimination, and experiences of racist discrimination across exposure strata and ANOVA test results. Different means across strata at $\alpha=0.05$ are denoted by *.

Exposure	Mean Index Score		
	Internalized Homophobia Index	Homophobic Discrimination Index	Racist Discrimination Index
Age			
18-20	14.88*	5.29*	1.28*
21-24	16.17*	5.60*	1.81*
25-29	18.28*	5.90*	2.09*
30-34	15.76*	6.01*	2.24*
35-39	14.37*	5.69*	1.86*
40-44	16.08*	6.20*	1.99*
45-49	15.29*	5.79*	2.08*
50+	11.83*	5.80*	1.35*
Race			
White	11.78*	5.87*	0.93*
Black	28.62*	5.21*	3.52*
Latino	13.65*	5.55*	2.67*
Other	15.66*	5.60*	2.95*
Sexual Identity			
Homosexual	13.68*	5.77*	1.66*
Bisexual	37.25*	4.66*	2.91*
Education Level			
College or more	15.19	5.69	1.74
Some college or 2-year degree	15.36	5.76	1.73
High School Diploma or GED	16.06	5.43	1.81
No High School Diploma	17.76	6.18	1.87
Employment Status			
Unemployed	15.09	5.73	1.76
Employed	15.74	5.66	1.75
HIV Status			
Never tested/DK	16.99*	5.12*	1.34*
Negative	15.42*	5.76*	1.75*
Positive	13.40*	6.19*	2.53*
Unprotected Anal Intercourse			
No UAI	16.20*	5.56*	1.83
UAI	14.78*	5.82*	1.67
Experienced Physical IPV			
No	15.44	5.60*	1.72*
Yes	16.12	6.57*	2.12*
Experienced Sexual IPV			
No	15.43	5.64*	1.70*
Yes	17.53	6.82*	3.25*
Perpetrated Physical IPV			
No	15.43	5.66*	1.74
Yes	17.29	6.19*	2.15
Perpetrated Sexual IPV			
No	15.41*	5.67*	1.75
Yes	28.50*	7.33*	2.25
MEAN	15.51	5.69	1.75

Table 5. Logistic regression odds ratios (ORs) and 95% Confidence Intervals for five modeled outcomes: unprotected anal intercourse (UAI), experience of physical IPV, experience of sexual IPV, perpetration of physical IPV, and perpetration of sexual IPV. Significant associations are noted in ***bold italics***. (Note: -- indicates not analyzed.)

Exposure	Outcomes				
	UAI	Experienced Physical IPV	Experienced Sexual IPV	Perpetrated Physical IPV	Perpetrated Sexual IPV
Age					
18-20	1.0	1.0	1.0	1.0	--
21-24	1.29 (0.95, 1.76)	0.96 (0.57, 1.59)	1.29 (0.59, 2.82)	1.24 (0.62, 2.50)	--
25-29	1.44 (1.00, 2.10)	0.77 (0.41, 1.45)	1.01 (0.39, 2.66)	1.16 (0.49, 1.72)	--
30-34	1.07 (0.69, 1.67)	0.94 (0.46, 1.93)	0.93 (0.30, 2.91)	1.17 (0.43, 3.11)	--
35-39	1.16 (0.70, 1.93)	1.00 (0.44, 2.25)	1.25 (0.36, 4.37)	0.67 (0.18, 2.54)	--
40-44	0.82 (0.51, 1.29)	***0.24 (0.08,0.73)***	0.41 (0.08, 2.02)	0.17 (0.02, 1.40)	--
45-49	0.84 (0.55, 1.29)	***0.40 (0.16, 0.98)***	0.54 (0.14, 2.13)	0.80 (0.27, 2.41)	--
50+	***0.61 (0.47, 0.95)***	***0.27 (0.10, 0.75)***	0.61 (0.16, 2.39)	0.16 (0.02, 1.30)	--
Race					
White	1.0	1.0	1.0	1.0	--
Black	***0.67 (0.40, 0.93)***	0.97 (0.54, 1.77)	1.17 (0.50, 2.73)	1.08 (0.48, 2.42)	--
Latino	***0.84 (0.47, 0.95)***	0.97 (0.52, 1.78)	0.73 (0.27, 2.00)	1.32 (0.61, 2.89)	--
Other	0.98 (0.59, 1.19)	1.18 (0.58, 2.42)	1.63 (0.63, 4.25)	0.52 (0.30, 2.80)	--
Sexual Identity					
Homosexual	1.0	1.0	1.0	1.0	1.0
Bisexual	0.97 (0.62, 1.52)	0.67 (0.29, 1.27)	1.40 (0.51, 3.84)	0.83 (0.30, 2.30)	0.70 (0.10, 4.89)
Education Level					
College or more	1.08 (0.87, 1.34)	***0.23 (0.12, 0.69)***	0.45 (0.13, 1.57)	***0.26 (0.85, 0.77)***	0.65 (0.07, 6.39)
Some college or 2-year degree	0.81 (0.43, 1.52)	***0.32 (0.15, 0.68)***	0.37 (0.12, 1.20)	***0.25 (0.09, 0.68)***	0.20 (0.02, 2.17)
High School Diploma or GED	1.08 (0.57, 2.07)	0.57 (0.26, 1.27)	0.70 (0.21, 2.31)	0.59 (0.22, 1.60)	0.68 (0.06, 7.39)
No High School Diploma	1.0	1.0	1.0	1.0	1.0
Employment Status					
Unemployed	1.0	1.0	1.0	1.0	1.0
Employed	1.08 (0.87, 1.34)	1.18 (0.79, 1.74)	1.05 (0.58, 1.89)	1.50 (0.85, 2.63)	2.82 (0.57, 13.90)
HIV Status					
Never tested/DK	1.0	1.0	1.0	1.0	1.0
Negative	1.15 (0.87, 1.52)	1.16 (0.70, 1.90)	0.90 (0.43, 1.87)	1.08 (0.55, 2.12)	0.55 (0.13, 2.30)
Positive	***2.03 (1.30, 3.15)***	1.74 (0.82, 3.72)	0.75 (0.24, 2.40)	1.59 (0.56, 4.47)	0.60 (0.06, 6.45)

Table 5 (continued). Logistic regression odds ratios (ORs) and 95% Confidence Intervals for five modeled outcomes: unprotected anal intercourse (UAI), experience of physical IPV, experience of sexual IPV, perpetration of physical IPV, and perpetration of sexual IPV. Significant associations are noted in ***bold italics***. (Note: -- indicates not analyzed.)

Exposure	Outcomes				
	UAI	Experienced Physical IPV	Experienced Sexual IPV	Perpetrated Physical IPV	Perpetrated Sexual IPV
Internalized Homophobia Scale	0.99 (0.99, 1.00)	1.01 (0.99, 1.03)	1.00 (0.98, 1.02)	1.01 (0.99, 1.03)	***1.08 (1.03, 1.13)***
Homophobic Discrimination Scale	1.04 (0.99, 1.10)	1.25 (1.14, 1.37)	***1.28 (1.11, 1.47)***	1.13 (0.99, 1.28)	***1.70 (1.25, 2.31)***
Racist Discrimination Scale	0.98 (0.92, 1.03)	1.02 (0.93, 1.11)	***1.19 (1.06, 1.34)***	1.02 (0.90, 1.16)	0.91 (0.71, 1.17)
Unprotected Anal Intercourse	--	1.33 (0.92, 1.92)	1.17 (0.67, 2.03)	***2.21 (1.29, 3.79)***	1.97 (0.57, 6.79)
Experienced Physical IPV	1.00 (0.64, 1.57)	--	--	--	--
Experienced Sexual IPV	0.28 (0.47, 1.66)	--	--	--	--
Perpetrated Physical IPV	***2.08 (1.12, 3.85)***	--	--	--	--
Perpetrated Sexual IPV	1.85 (0.46, 7.43)	--	--	--	--

CHAPTER IV: RECOMMENDATIONS

Public Health Implications

The results of this study are clear: intimate partner violence, both physical and sexual, occurs in partnerships among gay and bisexual men at alarming rates. This study is also among the first to examine how non-traditional risk factors, such as experiencing homophobia and racist discrimination, are associated with increased reporting of violence among men who have sex with men, and how reporting of such violence is linked to risk for HIV infection. Despite this, and despite the growing body of evidence that points to both the high prevalence of IPV among MSM and its adverse health consequences, IPV among MSM is yet to be recognized as a significant health issue by the larger public health community. For example, the World Report on Violence and Health, published by the WHO as the first comprehensive summary of violence globally, barely mentions that intimate partner violence occurs among non-heterosexual couples before presenting an extensive analysis of literature on male-battered/female-battered violence (WHO, 2002). The public health response to intimate partner violence among same-sex couples has been all but non-existent. In order for intimate partner violence among same-sex couples to begin to be addressed, several actions must be taken. This response should mirror the response to heterosexual domestic violence, though it will not be identical to it. Nonetheless, as the response to heterosexual domestic violence has involved partnerships

between multiple levels of interventionists, so too will the response to LGBTQ domestic violence require a multi-faceted approach.

1. Raise awareness of intimate partner violence in the LGBTQ community through education and advocacy

As homophobia, both internalized and externalized, is shown in this study to increase reporting of intimate partner violence, the LGBTQ community must continue to take wider action to reduce anti-LGBTQ stigma and bias in society and culture through continued advocacy and leadership. The LGBTQ community must recognize intimate partner violence as an issue that affects LGBTQ persons, and must take action to both raise awareness of IPV and demand LGBTQ-aware IPV services**.** The LGBTQ community already faces stigma from a variety of sources, as discussed in this study, and few communities are eager to add to stigma by vocalizing the problems within their communities to the general public. However, the LGBTQ community has repeatedly shown considerable resilience and willingness to tackle stigmatized topics, such as homophobia, intolerance, and HIV/AIDS.

Non-governmental organizations that advocate for equality for LGBT persons, such as The National Gay and Lesbian Task Force; the Human Rights Campaign (HRC); the Gay and Lesbian Alliance Against Defamation (GLAAD); and Parents, Families, and Friends of Lesbians and Gays (P-FLAG) should add intimate partner violence in same-sex partnerships to their lists of priorities for advocacy. Leaders in the LGBTQ community, from these organizations and/or others, should design public education campaigns directed towards the LGBTQ community about the prevalence of all forms of intimate partner violence among LGBTQ persons, including emotional violence and

psychological violence. Campaigns should also educate the public regarding the adverse physical and mental health consequences of intimate partner violence, and provide resources such as domestic violence hotlines and information about legal rights of victims. These campaigns should be implemented in public fora, such as Gay Pride events, as well as disseminated to LGBTQ websites and social media networks. In addition, educational workshops about intimate partner violence can be held at LGBTQ community centers.

2. Codify legal protections for victims of same-sex intimate partner violence in statutory law and establish federal grants for organizations addressing same-sex intimate partner violence

The National Violence Against Women Act (VAWA) was first passed under President William J. Clinton in 1994 and was most recently re-authorized under President George W. Bush in 2006. The Act makes it a federal crime to cross state lines to perpetrate intimate partner violence, including stalking or the violation of protection orders. The language of the Act is gender-neutral; as such, the Office of the United States Attorney General issued an official Memorandum in April 2010 stating that the protections granted under the law would apply in situations when the offender and the victim are of the same sex. Though this Memorandum is not law, it does represent the policy position of the Department of Justice, and would instruct all federal prosecutors to apply the law, when appropriate, to cases of same-sex domestic abuse. In order for these protections to be codified *de jure* for LGBTQ persons, VAWA should be amended to specifically include LGBTQ persons in its scope.

VAWA also provides federal funding to U.S. states to implement a variety of programs related to domestic violence. This competitive, grant-based system is

administered by Office of Violence Against Women (OVW), a branch of the U.S. Department of Justice (DOJ). Though VAWA allows for many different types of grants, and OVW policy states that funding may go to organizations working with female and/or male victims of abuse, no single funding stream is allocated to issues specific to LGBTQ domestic violence. Therefore, when re-authorized, VAWA should be expanded to provide funding for grants directed at dealing specifically with LGBTQ violence. The majority of VAWA funding is distributed to STOP Programs (Services. Training. Officers. Prosecutors.), which are aimed to build capacity in criminal justice and legal systems to address domestic violence. The STOP Program, which is widely used and is among the principle efforts to address domestic violence in the legal system, should therefore be modified to include cultural sensitivity training for LGBTQ violence. It is essential to strengthen the capacity of such legal bodies in order to address the high prevalence of intimate partner violence seen in LGBTQ communities. Additionally, the Sexual Assault Services Program (SASP), which provides direct assistance to victims of domestic violence through grant-based funding of, for example, sexual assault hotlines and rape crisis centers, should be modified to include funding for LGBTQ-specific services.

Despite federal law, the act of enforcing statutes protecting victims of intimate partner violence mainly falls to the purview of U.S. state and state statutes. While the vast majority of LGBTQ persons living in America do not enjoy legal recognition of their partnerships (in the form of marriage and/or civil unions) or the legal protections that such recognition carries, LGBTQ persons are still protected against physical and sexual violence through statutory laws. Many states, however, have additional statutes that

provide extra protections for victims of domestic violence, such as civil protection orders, forms of restraining orders meant to specifically address intimate partner abuse. According to the American Bar Association, as of 2008, only ten U.S. states (CA, HI, ME, NH, NJ, OH, PA, RI, VT, WA) and the District of Columbia had amended their state statues granting extra protections in the form of civil protection orders to battered persons to include victims of same-sex violence. A further twenty-six states had statutes with legal language that did not specifically protect LGBTQ persons, but used liberal constructions and/or gender-neutral language meaning LGBTQ persons would likely be granted protection under these laws. Eleven states had statutes that were completely silent on the inclusion/exclusion of LGBTQ persons, and three states (Louisiana, Montana, and South Carolina) had statutes with specifically excluded LGBTQ persons from legal protection granted under domestic violence laws and/or narrowly defined these laws such that LGBTQ persons would be, by definition, excluded from protection. State laws, therefore, must be amended to extend legal protections granted to heterosexual victims of domestic violence to LGBTQ victims of domestic violence.

3. Screen LGBTQ persons for intimate partner violence in healthcare settings, especially during routine screening for STIs/HIV

The connections between reporting of violence and sexual risk-taking elucidated in this study point to the pressing need for LGBTQ persons, especially MSM, to be screened for IPV during testing for STIs and HIV. However, according to a comprehensive report of the evidence base for IPV screening tools compiled by the CDC National Center for Injury Prevention and Control (2007), no evidence-based screening tools for intimate partner violence specific to LGBTQ persons and/or MSM exist. Most tools are oriented towards female victims of IPV, even going as far as providing outlines

of female bodies for use by victims in reporting violence (Basile, Hertz, & Back, 2007). Such tools are inappropriate for men, including men who have sex with men who are abused by a male partner. Screening tools appropriate to LGBTQ persons, particularly MSM, must be developed and tested to ensure sensitivity and specificity. Providers should be trained in these screening tools as part of larger cultural sensitivity training that would encompass education about the prevalence and typologies of IPV in the LGBTQ population, including how violence can and does occur in male-male partnerships, and epidemiological findings to understand who is most at risk for violence to screen more effectively. Providers should also be trained to provide resources to MSM experiencing violence, such as information about LGBTQ-friendly domestic violence shelters and referral to avenues of legal recourse.

Among the most common locations for health care providers to screen clients for IPV are primary health care settings and emergency departments. While screening in these venues is still recommended, as these are among the locations that IPV victims experiencing the acute effects of violence are most likely to encounter the formal healthcare system, it is also recommended that screening for IPV occur at HIV/STI testing clinics. HIV/STI clinics often provide free or low-cost screening, meaning that persons without health insurance would still be able to access these services, and many MSM encounter HIV testing services more regularly than they do the formal healthcare system. Many HIV testing clinics are LGBTQ-aware if not LGBTQ-targeted, and incorporation of violence screening into these venues provides an opportunity for providers to discuss the inherent relationship between sexual violence and risk for HIV infection. To this end, lay providers of voluntary counseling and testing services for

HIV/STIs should be trained in LGBTQ-appropriate screening tools for intimate partner violence, and, when violence is found, be similarly able to provide victims of violence with resources and referrals.

4. Provide support for and services to victims of same-sex intimate partner violence

As a result of feminist theories of how intimate partner violence occurs and how heterosexual women are main persons at risk for experiencing partner violence, domestic violence programs are geared towards providing services heterosexual women. Little to no attention is paid to the excess risk of violence experienced by men who have sex with men or women who have sex with women. To this end, LGBTQ-aware domestic violence resources should be created with input from both the LGBTQ community and experts on intimate partner violence. National domestic abuse hotlines should be created specific to violence within the LGBTQ community. LGBTQ-specific domestic violence shelters should be founded, as the majority of domestic violence shelters are currently designed for and exclusive to female victims of violence. Community domestic violence/intimate partner violence programs should include services specific to sexual minorities, including counseling and support services.

This multi-faceted approach to addressing same-sex IPV -- raising awareness of intimate partner violence in the LGBTQ community, codifying legal rights for LGBTQ victims of IPV in law and policy, creating funding streams for organizations addressing IPV among LGBTQ persons, strengthening the capacity of healthcare providers and lay STI/HIV counselors to screen for IPV, and providing support for victims of same-sex IPV – will begin to address IPV in same-sex partnerships by creating a social and legal safety net for victims of IPV similar to the one being created for heterosexual female

victims of domestic violence. However, both continued surveillance of IPV in same-sex partnerships and research to create an evidence base for best practices for both prevention and treatment of violence are needed urgently in order for these recommendations to be most effective.

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