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Sexual Agreements and Intimate Partner Violence among
Men Who Have Sex with Men

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Sexual Agreements and Intimate Partner Violence among Men Who Have Sex with Men

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Bachelor of Arts
University of South Carolina
2009

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An abstract of
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Abstract

Sexual Agreements and Intimate Partner Violence among
Men Who Have Sex with Men

By Kaitlyn Pruitt

In the U.S., HIV continues to disproportionately affect MSM. Research in this area has emphasized the need for the development of behavior interventions for men in same-sex relationships at the individual and dyadic level. One promising area of research that has gained recent attention is within the realm of sexual agreements; however, it is not yet clear how sexual agreements are associated with certain relationship dynamics, most notably the experience of IPV. The purpose of our analysis was to determine whether respondents who report an open agreement or an agreement breakage also report a higher incidence of recent (<12month) IPV compared to respondents who report a monogamous agreement or no agreement breakage after controlling for demographic variables. The results highlight the need for the development of dyadic behavior interventions that address sexual agreements and stress management in order to encourage open communication and mutual respect between male-male partners.

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Chapter 1: BACKGROUND AND INTRODUCTION

The human immunodeficiency virus, or HIV, is the virus that leads to acquired immunodeficiency syndrome (AIDS). The virus debilitates the human body by attacking the immune system, making a person less and less able to fight off opportunistic infections over time. Although HIV may have existed in humans as far back as the late 1800s (CDC 2014a), it wasn't officially discovered until a team of scientists at the Centers for Disease Control and Prevention (CDC) reported the occurrence of a rare lung infection in previously healthy gay men called *Pneumocystis carinii pneumonia* (PCP) in the summer of 1981. By the end of the year, doctors in the United States had reported a total of 270 cases of PCP and other rare and aggressive infections affecting gay men, and 121 of those individuals had died as a result of their illness. In September 1982, the CDC released the first case definition of HIV, which would eventually include the four major routes for the virus's transmission: blood, seminal fluid, vaginal fluid, and breast milk (USDHHS 2014). Scientists have yet to discover a cure for HIV, but they have made great strides in developing anti-retroviral therapy (ART) medications that can help suppress the virus's progression and prolong the lives of people living with HIV/AIDS (CDC 2014a). While the annual number of new infections in the United States has remained relatively stable over the past decade, HIV still disproportionately affects certain populations in the United States (USDHHS 2012a, Hall 2008).

The U.S. HIV epidemic overburdens men who have sex with men (MSM) more than any other risk group, with young people and racial minorities also heavily affected, as shown in Figures 1 and 2. While MSM represent approximately 2% of the total population, in 2010 it was estimated that 56% of all diagnosed cases of HIV in the US were among MSM of all races and ethnicities (CDC 2013a). In the same year, MSM accounted for 78% of new infections among men and 63% of all new infections of HIV overall, as illustrated below in Figure 3 (CDC 2013a).

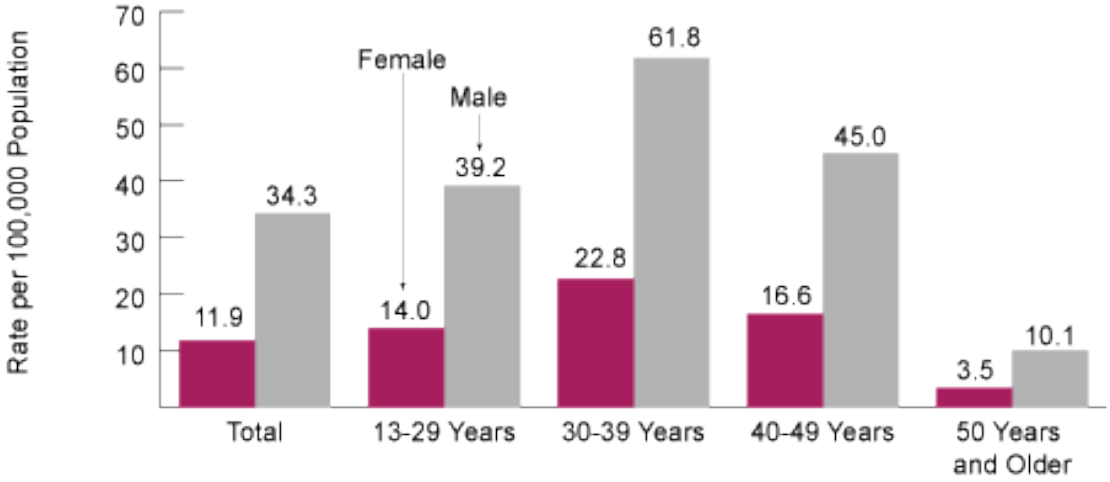
The high prevalence of HIV among this population means that MSM are at an increased risk of exposure to the virus through unprotected anal sex (CDC 2013a), with young MSM under age 34 accounting for the largest number of new infections among MSM of all races and ethnicities (CDC 2013a). Since the beginning of the epidemic until 2010, an estimated 302,148 MSM with an AIDS diagnosis have died, representing 48% of all deaths among persons with an AIDS diagnosis in the United States (CDC 2013a).

MSM are most at risk for contracting HIV through unprotected anal intercourse (UAI) (CDC 2013a). The odds of contracting HIV through receptive anal intercourse are higher than for any other sexual behavior, particularly if the participant does not use lubrication during intercourse. Insertive anal sex without a condom is also considered a high-risk sexual activity for the transmission of HIV (USDHHS 2012b). CDC data indicate that many MSM living with HIV do not know they have been infected; as a result, they do not seek medical care and can unknowingly transmit the virus to others (CDC 2013a). Numerous initiatives at the local, state, and national levels are currently underway to address the HIV epidemic in MSM through a combination of efforts to promote harm reduction strategies and healthy behaviors, increase testing rates, and direct those who test positive into treatment. Behavioral intervention messages and initiatives must be specifically tailored to reflect the cultural norms of the MSM community in order to be effective at reducing HIV transmission.

Figure 1

Estimated HIV Incidence Among Persons Aged 13 and Older, by Age and Sex, 2006

Source II.13: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



US Department of Health and Human Services. (2009). HIV/AIDS. *Women's Health USA 2009.*

Retrieved from: http://mchb.hrsa.gov/whusa09/hstat/hi/pages/222ha.html

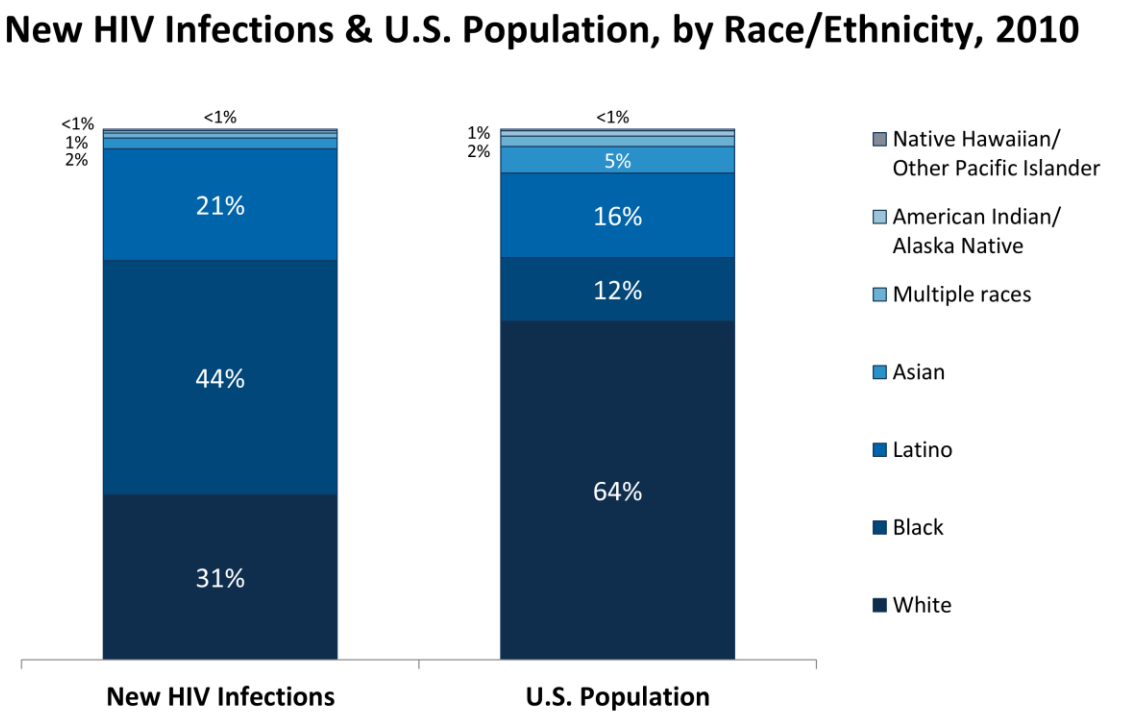
One area that has gained significant attention recently is the notion of agreements among male-male couples whereby a dyad sets rules and conditions for having sex with outside partners. There are many types of sexual agreements that do not fall under discrete classifications but rather span across a spectrum of more lenient to more restrictive in allowing for sex with outside partners (Hoff 2009, Crawford 2001, Parsons 2013). For those couples that have an established agreement, the agreement type can be subdivided into one of three broad categories: monogamous and not allowing for any sexual intercourse with outside partners; open and allowing for sexual intercourse with outside partners with certain rules, limitations, or conditions; or open and allowing for sexual intercourse with any outside partners without rules,

limitations, or conditions (Hoff 2009, Mitchell 2013a, Crawford 2001). The guidelines for having sex with outside partners are often nuanced and reflect the variability of MSM couples' views in navigating between sexual activity and emotional intimacy in a relationship (Parsons 2013). For example, a 2010 study conducted by Hoff et al found that couples that allow for threesomes in their relationships sometimes describe their agreement as open and sometimes as closed with an exception for threesomes (Hoff 2010b). In the same study, couples with an open agreement reported that the conditions and limitations of the agreement aimed to separate physical from emotional intimacy while balancing one or both partners' sexual desires with the desire to form a meaningful and lasting partnership. Agreements are dynamic: over time, some couples decide to change their agreement, allowing for more or less rules and conditions for sex with outside partners as the relationship progresses (Mitchell 2013a, Hoff 2010b). Thus, agreement types are fluid, their definitions often overlapping and sometimes changing over the course of the relationship via renegotiation (Hoff CH 2010b, Mitchell 2013a).

The process for establishing a sexual agreement is as fluid and varied as the agreements themselves. Agreements may be established or renegotiated at the beginning of the relationship, at any point in the relationship when one or both partners wishes to open or close the agreement, or immediately after an agreement breakage is disclosed (Hoff 2010b, Mitchell 2013a). Having a sexual agreement can provide structure that helps clearly define the relationship and offer a sense of security for both partners when both feel that their sexual and emotional needs are being heard (Hoff 2010b). In recent studies, researchers found that most men explicitly discussed the terms of their agreement one or more times with their primary partner since their relationship began (Hoff 2009, Mitchell 2013a, Hoff 2012, Mitchell 2012, Kippax 1993, Crawford 2001). The longer the length of a relationship, the more likely male-male

couples are to make an agreement but also the more likely they are to disagree on the parameters of their current agreement type (Mitchell 2014).

Figure 2

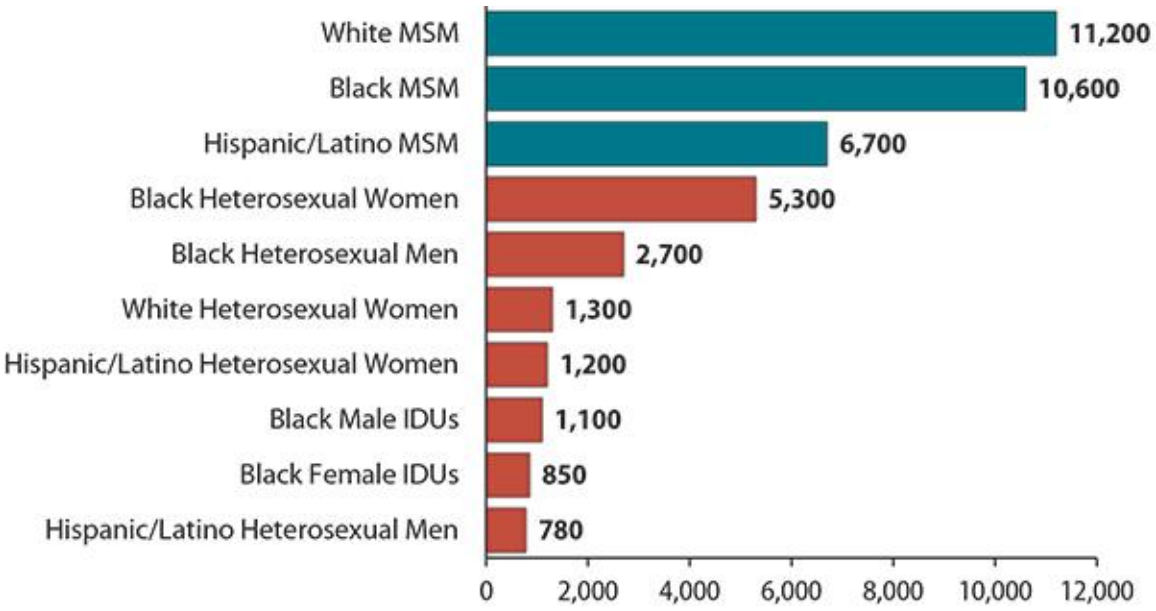


Retrieved from: http://kff.org/hivaids/fact-sheet/the-hivaids-epidemic-in-the-united-states/

The motivations for making an agreement are similar across all agreement types and include the desire to build trust, encourage honesty, to protect or strengthen the relationship, and sometimes to avoid HIV infection (Hoff 2010a, Hoff 2010b, Mitchell 2013a). While a study conducted by Mitchell found that almost 25% of participants established their sexual agreement to minimize their risk of contracting HIV and STIs (Mitchell 2013a), other researchers found that this was not one of the top three motivators for making an agreement listed by couples with any agreement type (Hoff 2010a). In the latter study, couples across all three HIV serostatus groups

had similar motivations for making a sexual agreement as those previously mentioned, and while monogamous couples reported higher investment in their agreements as

Figure 3: Estimates of New HIV Infections in the United States for the Most-Affected Subpopulations, Centers for Disease Control and Prevention, 2010[12]



Centers for Disease Control and Prevention. (2012). Estimated HIV Incidence Among Adults and Adolescents in the United States, 2007-2010. *HIV Surveillance Supplemental Report, 17*(4).

well as more trust, intimacy, commitment, and attachment to their partner, an individual's reported autonomy and overall satisfaction with the relationship did not significantly differ across agreement types (Hoff 2010a). One study found that couples that have strong constructive communications skills and report a high level of satisfaction with their relationship

[1] Subpopulations representing 2% or less of the overall HIV epidemic are not included in this chart

[2] Abbreviation: Injection Drug User (IDU)

are more likely to be highly invested in and committed to their sexual agreement (Mitchell 2013b).

The context of agreement breakages and the risk associated with breakages is dependent on the wide variety of agreement types and their corresponding guidelines and conditions. Prior research indicates that men most frequently break their agreements due to lack of self-control or because they do not feel sexually satisfied with their main partner (Hoff 2009, Mitchell 2013a, Hoff 2012). A disclosure of a breakage is often met with an emotional reaction in response to the person's feelings of betrayal or loss of trust in their partner, leading some men to choose not to disclose a break for fear of jeopardizing the relationship (Mitchell 2013a); however, disclosure of a breakage can also help couples reevaluate their agreement or clarify limitations for engaging in risky sexual behavior (Hoff 2010b). Indeed, one study found that although disclosing a broken agreement can be challenging for a couple's relationship, it may actually lead to increased communication and renegotiation surrounding the agreement, resulting in greater levels of parity between partners as well as increased emotional satisfaction (Hoff 2010b).

Agreement types are associated with varying degrees of sexual risk taking behaviors (Crawford 2001, Parsons 2013, Hoff 2012). Open agreements are associated with greater odds of engaging in sexual activity with outside partners, and couples whose agreement allows for anal intercourse with outside partners are at an elevated risk for HIV and STI transmission, particularly if the agreement allows for unprotected anal intercourse with partners who are either sero-discordant or of unknown sero-status (Hoff 2012, Crawford 2001, Kippax 1993). One recent study found that men with monogamous agreements or open agreements with restrictions had reduced levels of substance abuse and sexual risk behaviors compared to men with open agreements that had very few or no restrictions (Parsons 2013). In addition, prior

research has shown that sexual agreements can change over time to allow more or less freedom to have sex with outside partners, thereby shifting both partners' level of risk for HIV and STD transmission (Hoff 2012, Mitchell 2013a, Kippax 1993).

Missing from discussions of agreements has been an understanding of how agreements influence violence in male-male relationships. The CDC defines intimate partner violence (IPV) as the "physical, sexual, or psychological harm by a current partner or spouse" (CDC 2014b). The occurrence of IPV exists on a spectrum, varying in both severity and frequency. In addition, the various forms of IPV, whose definitions are outlined below, incorporate a multitude of behaviors that have some overlap and can occur simultaneously. According to a CDC research team led by Saltzman, there are four main categories of IPV whose definitions are presented below: physical, sexual, psychological, and threats (Saltzman 2002). Physical violence is the intentional use of physical force that has the potential for causing death, disability, injury, or harm. It includes, but is not limited to, the following acts of aggression: pushing, shoving, shaking, hitting, biting, punching, and/or using a weapon. Sexual violence can be subdivided into three distinct categories: 1) use of physical force to compel a person to engage in a sexual act against his/her will (whether or not the act is actually completed), such as forcing someone to not use a condom during intercourse; 2) an attempted or completed sexual act with a person who is unwilling or unable to understand or consent to the act due to illness, disability, drug or alcohol inhibition, or other intimidation factors; and 3) abusive sexual contact. The threat of physical and/or sexual violence includes the use of words, gestures, or weapons to indicate one's intent to cause physical harm, disability, injury, or death. Finally, psychological violence may be the most broad of the four forms. It includes, but is not limited to, humiliation, controlling behaviors, withholding information or resources such as money, embarrassing or belittling one's partner, and isolating one's partner from family and friends (CDC 2013b).

Although anyone can be a victim of IPV regardless of gender or sexual orientation, historically IPV has been perceived as a heterosexual phenomenon in which the woman is most often the victim. As a result, the discussion of intimate partner violence (IPV) has been absent from same sex research as well as health behavior and policy initiatives directed towards same sex couples (McClennen 2005, Finneran 2013, Houston & McKirnan 2007). There are numerous factors that can increase the risk of perpetration of IPV in heterosexual couples and which can manifest at the individual, relationship, community, or societal level. Having been a victim of physical or psychological abuse is one of the strongest predictors of perpetration of IPV. Other risk factors for perpetration at the individual level include heavy drug or alcohol use, low-income, young age, emotional dependence and insecurity, and the desire for power and control. Conflict and instability within a relationship increase the likelihood of the occurrence of IPV, as does poverty, lack of social capital, and the belief in traditional gender norms that encourage men to be powerful and dominant and require women to be subservient (CDC 2013d). Because the study of IPV in same-sex couples is relatively new, it is not yet certain if these factors pose similar risks for the occurrence of IPV among MSM.

Nevertheless, emerging research indicates that a relatively high percentage of MSM experience IPV over their lifetime at similar or higher rates as heterosexual women (Blosnich 2009, Koblin 2006, Greenwood 2002, Stephenson 2011, Tjaden 1999), with reported prevalence rates of the experience of any form of IPV ranging from 29.7% (Waldner-Haugraud 1997) to 78% (Pantalone, 2007). Prevalence estimates for reported IPV among MSM vary widely due to the methodological limitations of IPV measurement scales, most of which are geared towards measuring the occurrence of IPV in heterosexual females (Tjaden 1999, Greenwood 2002, Finneran 2013). The screening tools are not always consistent in their sensitivity of capturing the incidence of IPV in heterosexual relationships due to different administration standards as well

as the types of IPV the tool aims to measure (Rabin 2009, Hussain 2013). Because the majority of screening tools are not adapted for same-sex couples, current efforts are underway to develop new and more accurate scales to measure various forms of IPV among MSM (Stephenson 2013b).

Although various forms of IPV are not always separated or standardized in the study design, the reported occurrence of physical IPV among MSM is measured most often, followed by reported sexual and psychological or emotional IPV (Finneran 2013, Stephenson 2011). Little consensus has been reached on underlying demographic factors that put MSM at risk for experiencing IPV (Finneran 2013). The most commonly studied demographic correlates have been age, race/ethnicity, income and socioeconomic status, education (similar to factors known to shape IPV risk in heterosexual couples), and HIV status; however, many studies that have focused on these particular risk factors have published contrasting results (Finneran 2013). For example, a recent study by Stephenson determined that HIV status was significantly associated with the reported experience of sexual violence (Stephenson 2011); conversely, other researchers found that HIV positive men were not significantly more likely to report the experience of sexual IPV (Greenwood 2002, Feldman 2007). One study that examined dyadic risks found that MSM who reported a higher degree of concordance with their partner on lifestyle choices were less likely to report violence, which illustrates that relationship stress can also be a risk factor for the experience of IPV (Stephenson 2011). This study echoes the findings of Bartholomew and Cobb, who found that MSM in relationships in which both partners practice mutual communication and have high levels of trust report having less stress, resulting in both partners being less likely to experience IPV (Bartholomew & Cobb 2010).

Women's exposure to IPV is associated with the risk of contracting HIV in the following ways: 1) through forced sex with an infected partner; 2) through a lack of or less autonomy to

negotiate safer sex practices; and 3) through increased sexual risk taking behaviors (Maman 2000). The link between IPV and HIV risk-taking behaviors that may increase transmission among MSM has not been studied extensively; however, existing research indicates that the experience of IPV may heighten the risk for HIV infection due to the lack of ability to negotiate safe sex, leading to an increased likelihood of engaging in UAI (Finneran 2013, Houston & McKirnan 2007, Stephenson 2011, Heintz 2003). A study led by Houston and McKirnan found that men who had been abused by their partner were more likely to have had UAI in the past six months, and men who reported the experience of IPV were also more likely to report frequent use of substances before or during sex, which may further increase the likelihood of UAI (Houston & McKirnan 2007, Stall 2003).

The costs of IPV are numerous. In 1995, monetary costs incurred as a result of IPV against women were estimated to exceed $5.8 billion, including $4.1 billion for directly associated medical costs and $1.8 billion in indirect costs associated with lost economic productivity. While these numbers are staggering, they are generally considered an underestimate because they do not include costs associated with the criminal justice system. A myriad of negative health, psychological, and social effects are associated with women's experience of IPV. The main health risks for female victims of IPV are physical injuries such as bruises, broken bones, brain injuries and, in extreme cases, death. Sexual IPV is associated with reproductive health risks including sexually transmitted infections, unintended pregnancy, and gynecological disorders such as pelvic inflammatory disease. Other chronic conditions and behaviors are also associated with the experience of IPV including migraines, cardiovascular disease, asthma, and gastrointestinal disorders as well as increased rates of smoking, alcohol use, and abuse of other substances (CDC 2013d). Both physical and sexual violence are often accompanied by emotional violence, which can result in anxiety, depression, trouble sleeping,

and suicidal behavior. Women who are subjected to long-term IPV tend to experience more severe health consequences over time (CDC 2013d). While preliminary studies indicate that MSM who are victims of IPV may suffer the same negative health consequences as heterosexual females (Blosnich 2009), further research is needed to determine the particular health and behavioral consequences that affect MSM in abusive relationships.

In sum, the study of IPV among same-sex couples is in its infancy, and while significant knowledge has been gained over the past decade, the need for increased understanding of the occurrence of IPV in same-sex couples is needed in order to develop effective prevention and response strategies. Male-male couples remain an important focal point in HIV transmission prevention, but no efficacious dyadic interventions currently exist. One potential intervention area is sexual agreements, but it is not yet clear how the presence or management of agreements in relationships may be linked to IPV among MSM. Understanding how sexual agreements and agreement breakages influence the experience of IPV has the potential to inform the design and development of culturally appropriate interventions and messages aimed at reducing IPV in the MSM population. The purpose of this study is to determine associations between agreement type and the reported experience of IPV among MSM and provide recommendations for future research and action public health prevention and response efforts.

Sexual Agreements and Intimate Partner Violence among Men Who Have Sex with Men

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Sexual Agreements and Intimate Partner Violence among Men Who Have Sex with Men

Abstract

In the U.S., HIV continues to disproportionately affect MSM. Research in this area has emphasized the need for the development of behavior interventions for men in same-sex relationships at the individual and dyadic level. One promising area of research that has gained recent attention is within the realm of sexual agreements; however, it is not yet clear how sexual agreements are associated with certain relationship dynamics, most notably the experience of IPV. The purpose of our analysis was to determine whether respondents who report an open agreement or an agreement breakage also report a higher incidence of recent (<12month) IPV compared to respondents who report a monogamous agreement or no agreement breakage after controlling for demographic variables. The results highlight the need for the development of dyadic behavior interventions that address sexual agreements and stress management in order to encourage open communication and mutual respect between male-male partners.

Keywords: IPV, MSM, Sexual Agreements

Introduction

The U.S. HIV epidemic disproportionately burdens men who have sex with men (MSM) more than any other risk group. While MSM represent approximately 2% of the total population, in 2010 it was estimated that 56% of all diagnosed cases of HIV in the US were among MSM (1). In the same year, MSM accounted for 78% of new infections among men and 63% of all new infections of HIV overall (1). The high prevalence of HIV among this population means that MSM are at an increased risk for being exposed to the virus through unprotected sex (1), and recent studies have shown that a substantial number of MSM acquire HIV from having unprotected anal intercourse (UAI) with their main partner (2, 3, 4). These studies

highlight the need for the development of behavior interventions and risk reduction efforts that target MSM couples as well as individuals (2, 4, 5, 6).

One area that has gained significant attention recently is the notion of agreements among male-male couples whereby a dyad sets rules and conditions for having sex with outside partners. There are many types of sexual agreements that do not fall under discrete classifications but rather span across a spectrum of more lenient to more restrictive in allowing for sex with outside partners (7, 8, 9). For those couples that have an established agreement, the agreement type can be subdivided into one of three broad categories: monogamous and not allowing for any sexual intercourse with outside partners; open and allowing for sexual intercourse with outside partners with certain rules, limitations, or conditions; or open and allowing for sexual intercourse with any outside partners without rules, limitations, or conditions (7, 8, 10). The guidelines for having sex with outside partners are often nuanced and reflect the variability of male-male couples' views in navigating between sexual activity and emotional intimacy in a relationship (9). For example, a 2010 study conducted by Hoff et al found that couples that allow for threesomes in their relationships sometimes describe their agreement as open and sometimes as closed with an exception for threesomes (11). In the same study, couples with an open agreement reported that the conditions and limitations of the agreement aimed to separate physical from emotional intimacy while balancing one or both partners' sexual desires with the desire to form a meaningful and lasting partnership. Agreements are dynamic: over time, couples may decide to change their agreement, allowing for more or less rules and conditions for sex with outside partners as the relationship progresses (10, 11). Thus, agreement types are fluid, their definitions often overlapping and sometimes changing over the course of the relationship via renegotiation (10, 11).

The process for establishing a sexual agreement is as fluid and varied as the agreements themselves. Agreements may be established or renegotiated at the beginning of the relationship, at any point in the relationship when one or both partners wishes to open or close the agreement, or immediately after an agreement breakage is disclosed (10, 11). Having a sexual agreement can provide structure that helps clearly define the relationship and offer a sense of security for both partners when both feel that their sexual and emotional needs are being heard (11). In recent studies, researchers found that most men explicitly discussed the terms of their agreement one or more times with their primary partner since their relationship began (5, 6, 7, 8, 10, 12). The longer the length of a relationship, the more likely male-male couples are to make an agreement but also the more likely they are to disagree on the parameters of their current agreement type (13).

The motivations for making an agreement are similar across agreement types and include the desire to build trust, encourage honesty, to protect or strengthen the relationship, and sometimes to avoid HIV infection (10, 11, 14). While a study conducted by Mitchell found that almost 25% of participants established their sexual agreement to minimize their risk of contracting HIV and STIs (10), other researchers found that this was not one of the top three motivators for making an agreement listed by couples with any agreement type (14). In the latter study, couples across all three HIV serostatus groups (sero-concordant, sero-discordant, and sero-status unknown) had similar motivations for making a sexual agreement as those previously mentioned, and while monogamous couples reported higher investment in their agreements as well as more trust, intimacy, commitment, and attachment to their partner, an individual's reported autonomy and overall satisfaction with the relationship did not significantly differ across agreement types (14). One study found that couples that have strong

constructive communications skills and report a high level of satisfaction with their relationship are more likely to be highly invested in and committed to their sexual agreement (15).

The context of agreement breakages and the risk associated with breakages is dependent on the wide variety of agreement types and their corresponding guidelines and conditions. Prior research indicates that men most frequently break their agreements due to lack of self-control or because they do not feel sexually satisfied with their main partner (6, 7, 10). A disclosure of a breakage is often met with an emotional reaction in response to the person's feelings of betrayal or loss of trust in their partner, leading some men to choose not to disclose a break for fear of jeopardizing the relationship (10); however, disclosure of a breakage can also help couples reevaluate their agreement or clarify limitations for engaging in risky sexual behavior (11). Indeed, one study found that although disclosing a broken agreement can be challenging for a couple's relationship, it may actually lead to increased communication and renegotiation surrounding the agreement, resulting in greater levels of parity between partners as well as increased emotional satisfaction (11).

Agreement types are associated with varying degrees of sexual risk taking behaviors (6, 8, 9). Open agreements are associated with greater odds of engaging in sexual activity with outside partners, and couples whose agreement allows for anal intercourse with outside partners are at an elevated risk for HIV and STI transmission, particularly if the agreement allows for unprotected anal intercourse with partners who are either sero-discordant or of unknown sero-status (5, 6, 8). One recent study found that men with monogamous agreements or open agreements with restrictions had reduced levels of substance abuse and sexual risk behaviors compared to men with open agreements that had very few or no restrictions (9). In addition, prior research has shown that sexual agreements can change over time to allow more or less

freedom to have sex with outside partners, thereby shifting both partners' level of risk for HIV and STD transmission (5, 6, 10).

Missing from discussions of agreements has been an understanding of how agreements influence violence in male-male relationships. Historically, the discussion of intimate partner violence (IPV) has been absent from same sex research as well as health behavior and policy initiatives directed towards same sex couples (16, 17, 18). The occurrence of violence among MSM has recently gained attention, and emerging research indicates that a relatively high percentage of MSM experience IPV over their lifetime at similar or higher rates as heterosexual women (19, 20, 21, 22, 23), with reported prevalence rates of the experience of any form of IPV ranging from 29.7% (24) to 78% (25). Prevalence estimates for reported IPV among MSM vary widely due to the methodological limitations of IPV measurement scales, most of which are geared towards measuring the occurrence of IPV in heterosexual females (17, 21, 23).

Little consensus has been reached on underlying demographic factors that put MSM at risk for experiencing IPV (17). The most commonly studied demographic correlates have been age, race/ethnicity, income and socioeconomic status, education (similar to factors known to shape IPV risk in heterosexual couples), and HIV status; however, many studies that have focused on these particular risk factors have published contrasting results (17). For example, a recent study by Stephenson determined that HIV status was significantly associated with the reported experience of sexual violence (22); conversely, other researchers found that HIV positive men were not significantly more likely to report the experience of sexual IPV (21, 26). One study that examined dyadic risks found that MSM who reported a higher degree of concordance with their partner on lifestyle choices were less likely to report violence, which illustrates that relationship stress can also be a risk factor for the experience of IPV (22). This study echoes the findings of Bartholomew and Cobb, who found that MSM in relationships in

which both partners practice mutual communication and have high levels of trust report having less stress, resulting in both partners being less likely to experience IPV (27).

The link between IPV and HIV risk-taking behaviors that may increase transmission has not been studied extensively; however, existing research indicates that the experience of IPV may heighten the risk for HIV infection due to the lack of ability to negotiate safe sex, leading to an increased likelihood of engaging in UAI (17, 18, 22, 28). A study led by Houston and McKirnan found that men who had been abused by their partner were more likely to have had UAI in the past six months, and men who reported the experience of IPV were also more likely to report frequent use of substances before or during sex, which may further increase the likelihood of UAI (18, 29).

Male-male couples remain an important focal point in HIV transmission prevention, but no efficacious dyadic interventions currently exist. One potential intervention area is sexual agreements, but it is not yet clear how the presence or management of agreements in relationships may be linked to IPV among MSM. Understanding how sexual agreements and agreement breakages influence the experience of IPV has the potential to inform the design and development of culturally appropriate interventions and messages aimed at reducing IPV in the MSM population.

Methods

Ethical approval for the study was obtained from the [BLINDED FOR REVIEW] Institutional Review Board. Participants were recruited for a self-administered survey using banner ads on Facebook that were directed at men residing in the United States whose profiles indicated an interest in men. Approximately 400,000 men saw the ads over a ten-day period in October and November 2012, and 4,638 individuals clicked on the ads, which led them to additional information regarding the survey. Of these, 1,793 (39%) started the survey and 1,739

(37%) consented to participate. Eligibility criteria for participation included being male, being over 18 years of age, and self-reporting having had sex with a man in the previous six months. Of those who consented, 37 were under 18 years old (2%), 15 reported a gender other than male (0.8%), 335 had not had sex with a man in the past six months (19%), 15 lived outside the US (0.8%), and 86 did not respond to one or more of the eligibility screening questions (5%). This resulted in 454 respondents who were purposefully excluded from the survey due to ineligibility and a sample of 1,285 eligible participants.

The survey collected information on participants' demographic and socioeconomic characteristics including age, race/ethnicity, level of education, and employment status, as well as data on respondents' self-reported relationship status, HIV status, agreements and breakages, and recent (<6 month) experience of IPV. For the purposes of this study, the sample was restricted to men who indicated that they were currently in a relationship (*"Do you currently have a main partner -- that is, someone you feel committed to above all others?"*) that has lasted for at least 12 months (*"How long have you been in your current relationship with your main partner?"*). This restriction yielded a sample size of 395 that was slightly older than the unrestricted sample but was otherwise demographically similar. In order to determine agreement status, respondents were asked, *"Which of the following best describes the current agreement you and your main partner have about sex outside of the relationship?" "A) We do not have an agreement; B) Neither of us can have any sex with an outside partner; C) We can have sex with outside partners but with some conditions or restrictions; D) We can have sex with outside partners without any conditions or restrictions."* Those who responded that they do not have an agreement with their current partner were excluded from this analysis, leaving a final sample of 367 men. The final analysis sample did not differ in distribution of age, race and

ethnicity, education, employment status, relationship length, or participants' reported HIV status than the unrestricted sample.

Key covariates for the analysis were agreement type and agreement breakage. Agreement type was defined as a binary variable that categorized respondents' agreements into either monogamous or open (with or without conditions and restrictions). Agreement breakages were determined through the respondents' agreement type and whether the respondent reported that their last sex was with an outside partner. Respondents who indicated that they have a monogamous agreement with their main partner and reported having had more than one sexual partner in the past six months or that their last sexual intercourse was with someone other than their main partner (*"Was this most recent anal sex partner your main partner?"*) were classified as having broken their agreement. In addition, respondents who indicated that they have an open agreement that does not allow for unprotected anal intercourse (UAI) with outside partners ("*Does this agreement permit unprotected (without a condom) receptive (bottom) or insertive (top) anal sex with outside partners?"*) and who reported having more than two UAI partners in the past sex months or reported that their last sexual intercourse was unprotected and with someone other than their main partner was classified as having broken their agreement. Respondents who reported that they only had sexual intercourse with their main partners in the past six months or who indicated that they had an open agreement with no conditions or restrictions were classified as not having broken their agreement.

Data were analyzed using STATA 12. Four separate logistic models were fitted for each of the four outcome variables. This analysis examines whether respondents who report an open agreement or an agreement breakage also report a higher incidence of recent (<12month) IPV compared to respondents who report a monogamous agreement or no agreement breakage, after controlling for other demographic characteristics. In order to measure participants'

reported experience of IPV with their current partner, we used the GBM scale (30), a scale that was developed to more accurately measure IPV as experienced by gay and bisexual men by expanding on the CDC and CTS2S definitions of IPV. The first of its kind, the GBM is a 23-item scale that addresses five unique domains of IPV among MSM: physical and sexual violence (including hitting, slapping, or pressure to engage in unwanted sexual activity), monitoring behaviors (such as observing emails and texts), controlling behaviors (including limiting access to friends and family), HIV-related violence (feeling pressured to have sex without a condom), and emotional violence (including feeling threatened or afraid within a relationship). From the GBM scale, we created six survey questions that addressed each of the five domains of IPV, and from these six questions, we developed four binary outcome variables measuring the self-reported recent experience of physical, sexual, emotional, or any IPV (including the experience of physical, sexual, and/or emotional IPV) in the previous 12 months.

In addition to agreement type and agreement breakage, covariates for analysis included age (categorized as 18-24, 25-34, 35-44, and $\geq$45), race/ethnicity (categorized as white, non-Hispanic; other, non-Hispanic; or Hispanic), education (categorized as high school or less; college or a 2-year degree; or college and beyond), employment status (categorized as part-time, full-time, or unemployed or retired), relationship length (categorized as 1 to $<$ 2 years, 2 to $<$ 7 years, and $\geq$7 years), and HIV status (categorized as negative; positive; or don't know, never been tested, or prefer not to answer). Key covariates in all models included agreement type and agreement breakage; we also examined potential interaction between the two variables.

Results

The final sample used for analysis was predominantly young (25-34 years of age), white and non-Hispanic (79.6%). Most had completed college (43.1%) or received some college education or a two-year degree (38.7%). The majority was employed full-time (64.0%) and

reported being HIV-negative (77.1%). While most respondents reported that they have been in their current relationship between two and seven years (45.5%), many also reported that they have been in their current relationship more than seven years (33.5%) or 1 to 2 years (21.0%).

Table 1 displays the sample characteristics as well as the breakdown of different agreement types and the prevalence of reported agreement breakages in the sample. About two-thirds of respondents (66.2%) indicated that they have a monogamous agreement with their main partner while the remaining third (33.8%) reported that they have an open agreement with or without restrictions for allowing sex with outside partners. The vast majority of MSM in the sample reported that they had not broken the guidelines of their agreement in regards to having sex with outside partners (85.6%), which includes men who report that they have a monogamous agreement with their main partner as well as those who report that they have an open agreement that does not allow for sex with outside partners. Table 2 shows the prevalence of IPV reported among men. Almost 35% of men reported having experienced any form of self-reported IPV, including physical, sexual, and/or emotional IPV within the last 12 months. In addition, 14.8% reported the experience of physical IPV, 7.6% reported the experience of recent sexual IPV, and 27.9% reported the experience of recent emotional IPV.

The results of the logistic regression models are summarized in Table 3. MSM who reported that they have an open agreement with their main partner had significantly less odds of reporting experiencing physical IPV (*OR* 0.45; *95% CI:* 0.21-0.97) than men who reported having a monogamous agreement. Respondents who identified as Hispanic had significantly higher odds (*OR:* 2.39; *95% CI:* 1.01, 5.65) of reporting having experienced physical IPV than men who identified as white and non-Hispanic. Those who responded that they either didn't know, had never been tested, or preferred not to answer the question "*What was the result of your most recent HIV test?"* had significantly higher odds of reporting the experience of sexual IPV

within the last 12 months than men who reported having an HIV-negative status (*OR:* 3.32; *95% CI:* 1.12, 9.83).

MSM who identified as Black and non-Hispanic as well as those who reported working part-time had significantly lower odds of reporting the recent experience of emotional IPV than those who identified as White or reported working full- time. While MSM who reported that their highest level of schooling was college or beyond had significantly less odds of reporting having experienced emotional violence in the last 12 months than those who had only completed high school or less schooling (*OR:* 0.47, *95% CI:* 0.23, 0.95), men who reported that they are HIV-positive had significantly higher odds (*95% CI: 0.61, 3.08)* of having reported the recent experience of emotional IPV compared to men who reported that they are HIV-negative. Similar factors associated with the reporting of the experience of emotional IPV in the last 12 months were found among men who reported the recent experience of any IPV, including physical, sexual, and/or emotional IPV. For example, men who reported that they had completed college or beyond or who reported working part-time had significantly less odds of reporting the recent experience of any IPV than those who reported that they had a high school education or less. Conversely, men who reported being HIV-positive had significantly higher odds of reporting the experience of any IPV in the last 12 months (*OR: 1.68; 95% CI:* 0.80, 3.54) compared with men who reported being HIV-negative. Notably, agreement breakages, relationship length, and age were not significantly associated with the self-reporting of physical, sexual, emotional, or any IPV in the last 12 months. We tested for interaction between key covariates and none were found to be significant.

Discussion

Prior research indicates that a substantial proportion of MSM couples have established some form of sexual agreement, and the results presented here confirm these findings (6, 7, 8,

10, 12, 13). The majority of respondents reported that they were monogamous, with approximately one-third reporting the allowance of sexual activity outside of the relationship with or without conditions. In other studies of MSM and sexual agreements, the proportion of men whose agreements are monogamous versus open varies widely, and the breakdown of our sample by agreement type is not exceptional. Previous studies on sexual agreements suggest that anywhere from one-fifth to one-half of MSM have not adhered to the guidelines of their agreement at some point in their current relationship (7, 10, 11, 12, 13); in contrast, only 15% of the respondents in our study reported breaking their agreement. These studies' rates of agreement breakage may be higher due to the fact that all used dyadic samples in which both men in the relationship were asked about agreement breakages, and a breakage was often counted whether both or only one of the partners admitted to violating the rules of the agreement – our study takes the report of one man in the dyad. A relatively small number of studies have examined the self-reported experience of recent IPV among MSM, and most have not examined multiple forms of violence but rather focus on physical, sexual, or emotional IPV in isolation (17). Nevertheless, current research suggests that one-quarter to one-half of all same-sex relationships are affected by IPV (16, 31, 32, 33). Our results show comparable levels of the experience of each form of IPV (17, 21, 25, 34, 35, 36). Respondents were least likely to report the recent experience of sexual IPV, but a relatively high number reported experiencing emotional IPV, a form a violence that has been comparatively less studied than other types of IPV among MSM (17).

The primary aim of this study was to determine associations between agreement type and the reported experience of IPV among MSM. Our results show that men who have an open agreement are less likely to report recent physical IPV. In heterosexual couples, the experience of IPV has been linked to various forms of stress within the relationship (37, 38, 39); thus, in

order for both partners to manage stress levels and prevent the occurrence of violence in a relationship, constructive communication skills as well as stress management techniques are essential (37). Having an open agreement may be a marker for a relationship that also has stronger communication skills: for a couple to explicitly discuss their sexual needs with their partner and negotiate boundaries for sexual behavior they need to be able to communicate and set goals as a dyad. Indeed, results from a recent dyadic study with male-male couples suggest that the construction and renegotiation of a sexual agreement strengthen MSM's communication skills over time, leading to greater investment in the relationship and increased feelings of fulfillment and satisfaction (15). The same communication skills male-male couples use to establish an open sexual agreement can be employed to manage stress within a relationship, and may lead to a greater ability for male-male couples with an open agreement to facilitate trust and avoid the experience of IPV.

Alternatively, the fact that male-male couples with open agreements were less likely to report recent experience of physical IPV could be an indication that couples with open agreements feel less pressure to conform to the same traditional rules of monogamy as heterosexuals and therefore have less stress in managing the boundaries of their relationship. Furthermore, monogamous couples may feel more tension regarding the stability of their relationship since the behavior guidelines are more stringent than for male-male couples with an open agreement. Due to the fluidity and variability of sexual agreements' characteristics, male-male couples across the agreement spectrum may feel intense pressure in managing the rules of the agreement in tandem with their own sexual and emotional needs. A previous dyadic study found that high levels of stress as well as lower levels of concordance on lifestyle choices are associated with increased reporting of the experience of IPV (22). Another study found that male-male couples that practice mutual communication and have high levels of trust report

having less relationship stress, resulting in a lower likelihood of reporting the recent experience of IPV (27). Future IPV research efforts should be directed towards investigating how having discrepant agreements might influence the likelihood of one or both partners experiencing or perpetrating violence in the relationship. Furthermore, helping male-male couples communicate openly to establish concordance with their sexual agreements should be included as a vital component of violence prevention efforts.

The factors significantly associated with the reporting of various forms of IPV are indicative of the role that minority and financial stressors play in MSM's experience of IPV victimization. MSM in the sample who identified as Hispanic were more likely to report the experience of physical IPV than white or black non-Hispanics; on the other hand, black MSM were significantly less likely to report the experience of emotional IPV. Some previous studies have found that racial minorities harbor high levels of stress associated with exposure to racism and homophobia in minority communities that may manifest as violence within the relationship (22, 40, 41). It is not clear why the reported experience of IPV among Hispanic respondents in our study follows this pattern while the reported experience among black respondents does not, but the sensitive often stigmatized nature of IPV in same-sex relationships may have resulted in decreased reporting of its occurrence in any of the racial groups surveyed. Because our sample was predominately white, broad conclusions about the experience of IPV among minority MSM cannot be made, and further research is needed to determine how minority stress may influence in the experience of IPV in different MSM minority communities. Having completed a college degree was found to be a protective factor for the reported experience of any form of IPV, and MSM who indicated that they are currently employed full time were less likely to report the recent experience of any form of IPV as well as emotional IPV. Lower educational levels and less than full-time employment may be associated with less financial security and a lack of

access to social capital, thereby increasing MSM's vulnerability to IPV (22, 25, 42). Being HIV positive or negative was not significantly associated with the reporting of any form of IPV; however, MSM who indicated that did not know their status, had never been tested, or preferred not to disclose their status were more likely to report the recent experience of sexual IPV. This finding should be interpreted with caution since our sample did not include a substantial proportion of men who were HIV-positive, as previous research has demonstrated that MSM who are HIV-positive are just as likely or more likely to experience various forms of IPV as men who are HIV-negative (21, 22, 25, 26).

There are several limitations to the results of the present study. First, we used an online sample of MSM, and therefore generalizations of our findings to men who do not self-identify as gay, do not have Internet access, or who do not use Facebook cannot be made. Our sample size is relatively small, and we were not able to examine the differences in the reported experience of IPV between MSM with and without agreements because virtually (>90%) all the men in our sample had an established agreement. In addition, because of the study's cross-sectional design, it is not possible to establish causality between the reporting of any form of IPV and significantly associated factors, and we cannot make any conclusions about couples' reported experience of IPV since the sample is not dyadic. Nevertheless, to our knowledge this is the first study to examine the link between sexual agreements and the experience of various forms of IPV among MSM, and it paves the way for future investigations on sexual agreements and IPV along with other associated factors in same-sex relationships.

To further understand how sexual agreements influence the experience of various forms of IPV among MSM, more in-depth research, particularly dyadic research in which both members of the couple report their understanding of their sexual agreement and their experiences of IPV, is needed. Researchers should focus on factors such as socioeconomic

stressors and the challenges of adherence to an agreement that may push one or both partners towards violence. In addition, further comparisons of the differences in IPV experience among men with and without an established agreement are needed as well as further delineation of the various rules and restrictions defined by different couples and the risks associated with agreement breakages. Finally, because a substantial number of MSM who are in a relationship have an established sexual agreement, IPV interventionists should include sexual agreements as a component of risk reduction strategies for the avoidance of HIV transmission and the occurrence of IPV. Our analysis indicates both high levels of IPV and nearly ubiquitous levels of having an established agreement among male-male couples and adds to the growing body of literature demonstrating that men are not only perpetrators of IPV but quite often are victims within same-sex relationships (21, 25). Because same-sex victims of IPV have been found to suffer similar poor health outcomes as heterosexual victims, there is a need for increased prevention and response efforts that are targeted towards persons in a same-sex relationship (19, 25). The results presented here can help to inform these efforts as well as the continuing development of screening tools and public health messages that address IPV in same-sex relationships, thus contributing to an increase in vitality and sexual health outcomes for MSM throughout the United States.

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TABLE 1: SAMPLE CHARACTERISTICS: DEMOGRAPHICS AND HEALTH, N=367

Indicators	n	%
Agreements		
Monogamous	243	66.21
Open	124	33.79
Agreement Breakages		
Breakage	53	14.44
No breakage	314	85.56
Age		
18-24	93	25.34
25-34	123	33.51
35-44	80	21.80
45+	71	19.35
Race/Ethnicity		
White, non-Hispanic	292	79.56
Other, non-Hispanic	35	9.54
Hispanic	40	10.90
Education		
High school or less	67	18.26
Some college or 2-year degree	142	38.69
College and beyond	158	43.05
Employment Status		
Part-time	61	16.62
Full-time	235	64.03
Unemployed or retired	71	19.35
Relationship Length		
1 to < 2 years	77	20.98
2 to <7 years	167	45.50
7+ years	123	33.51
HIV Status		
Negative	283	77.11
Positive	38	10.35
Don't know, never been tested, or prefer not to answer	46	12.53

TABLE 2: SAMPLE CHARACTERISTICS: EXPERIENCE OF IPV IN THE PAST 12 MONTHS, N=367

EXPERIENCE OF IPV	INDICATOR DEFINITIONS	N (%)
Any IPV	Includes having experienced any of the physical, sexual, or emotional violence indicators that are defined below with a male partner in the past 12 months	126 (34.43%)
Any Physical IPV	Have arguments in your relationship escalated into any of the following: destruction of property, grabbing, restraining, pushing, kicking, slapping, punching, threats of violence or other acts of physical intimidation?	54 (14.84%)
Any Sexual IPV		28 (7.63%)
Sexual IPV Indicator 1	Has your partner pressured or forced you to do something sexual that you didn't want to do?	19 (5.22%)
Sexual IPV Indicator 2	Has your partner pressured you to have sex without a condom after you asked to use a condom? Or do you suspect that your partner has lied to you about their HIV status, or intentionally tried to transmit HIV to you?	4 (1.1%)
Any Emotional IPV		102 (27.87%)
Emotional IPV Indicator 1	Has your partner insulted, criticized, threatened or yelled at you in any way?	76 (20.82%)
Emotional IPV Indicator 2	Has your partner prevented you from communicating with or seeing your friends/family/coworkers? Or monitored or demanded access to your cell phone, email, social networking sites, finances or spending?	40 (10.93%)
Emotional IPV Indicator 3	Have you ever felt afraid, threatened, isolated, trapped or like you were walking on eggshells within your relationship? Or have your friends or family raised concerns about your safety within your relationship?	53 (14.52%)

TABLE 3: FACTORS ASSOCIATED WITH THE EXPERIENCE OF PHYSICAL, SEXUAL, EMOTIONAL, OR ANY IPV IN THE PAST 12 MONTHS, N=367

Parameter	**PHYSICAL IPV**		**SEXUAL IPV**		**EMOTIONAL IPV**		**ANY IPV**	
	Odds Ratio (95% CI)	*p-value*	*Odds Ratio (95% CI)*	*p-value*	*Odds Ratio (95% CI)*	*p-value*	*Odds Ratio (95% CI)*	*p-value*
Agreements								
Monogamous	1.00 (reference)		1.00 (reference)		1.00 (reference)		1.00 (reference)	
Open	0.45 (0.21, 0.97)	*0.042*	2.09 (0.82, 5.24)	0.121	1.05 (0.60, 1.84)	0.868	1.04 (0.61, 1.75)	0.894
Agreement Breakage								
No breakage	1.00 (reference)		1.00 (reference)		1.00 (reference)		1.00 (reference)	
Breakage	1.02 (0.44, 2.35)	0.967	1.71 (0.65, 4.53)	0.278	1.09 (0.55, 2.17)	0.800	1.27 (0.67, 2.38)	0.462
Age								
18-24	1.00 (reference)		1.00 (reference)		1.00 (reference)		1.00 (reference)	
25-34	0.85 (0.38, 1.90)	0.697	0.58 (0.20, 1.70)	0.319	1.34 (0.68, 2.64)	0.392	0.98 (0.53, 1.84)	0.955
35-44	0.69 (0.24, 1.99)	0.492	0.56 (0.13, 2.32)	0.425	0.80 (0.34, 1.92)	0.624	0.64 (0.29, 1.43)	0.282
45+	0.80 (0.28, 2.26)	0.667	0.60 (0.15, 2.46)	0.473	0.80 (0.34, 1.88)	0.607	0.74 (0.34, 1.63)	0.453
Race/Ethnicity								
White, non-Hispanic	1.00 (reference)		1.00 (reference)		1.00 (reference)		1.00 (reference)	
Black, non-Hispanic	1.37 (0.52, 3.61)	0.529	1.70 (0.52, 5.61)	0.383	0.19 (0.05, 0.64)	*0.008*	0.68 (0.31, 1.53)	0.358
Hispanic	2.39 (1.01, 5.65)	*0.047*	1.53 (0.45, 5.19)	0.495	0.91 (0.42, 1.96)	0.814	1.32 (0.64, 2.71)	0.447
Education								
High school or less	1.00 (reference)		1.00 (reference)		1.00 (reference)		1.00 (reference)	
Some college or 2-year degree	0.86 (0.38, 1.97)	0.729	0.92 (0.32, 2.67)	0.877	0.99 (0.51, 1.94)	0.983	0.76 (0.40, 1.45)	0.408
College and beyond	0.63 (0.26, 1.51)	0.298	0.50 (0.15, 1.66)	0.261	0.47 (0.23, 0.95)	*0.035*	0.46 (0.23, 0.89)	*0.021*
Employment Status								
Part-time	1.00 (reference)		1.00 (reference)		1.00 (reference)		1.00 (reference)	
Full-time	0.78 (0.35, 1.75)	0.548	0.62 (0.22, 1.73)	0.360	0.39 (0.21, 0.75)	*0.004*	0.42 (0.23, 0.78)	*0.006*
Unemployed or retired	1.25 (0.48, 3.26)	0.648	0.78 (0.22, 2.70)	0.691	0.58 (0.27, 1.26)	0.169	0.62 (0.29, 1.30)	0.203
Relationship Length								
1 to <2 years	1.00 (reference)		1.00 (reference)		1.00 (reference)		1.00 (reference)	
2 to <7 years	0.78 (0.36, 1.68)	0.531	2.15 (0.68, 6.79)	0.192	0.95 (0.50, 1.82)	0.877	1.09 (0.59, 2.00)	0.789
7+ years	0.90 (0.36, 2.27)	0.823	0.75 (0.18, 3.04)	0.682	1.02 (0.47, 2.21)	0.958	1.02 (0.49, 2.12)	0.953
HIV Status								
Negative	1.00 (reference)		1.00 (reference)		1.00 (reference)		1.00 (reference)	
Positive	1.77 (0.68, 4.64)	0.245	1.37 (0.35, 5.37)	0.654	1.37 (0.61, 3.08)	0.452	1.68 (0.80, 3.54)	0.172
Don't know, never been tested or prefer not to answer	1.23 (0.49, 3.10)	0.659	3.32 (1.12, 9.83)	*0.030*	1.74 (0.82, 3.70)	0.149	1.72 (0.84, 3.53)	0.139

Chapter 3: PUBLIC HEALTH IMPLICATIONS

The primary finding of this study shows that MSM who have an open sexual agreement with their main partner are less likely to report the recent experience of physical IPV. Although additional dyadic research in the realm of IPV and sexual agreements is needed to better understand the individual-level risk factors that are associated with the recent experience of IPV, the importance of addressing relationship dynamics in IPV prevention is apparent. Public health practitioners working in IPV prevention programs need to be made aware of the nearly ubiquitous presence of sexual agreements in male-male relationships as well as some of the underlying motivations for making a sexual agreement, namely: to facilitate trust and open communication, to acknowledge each partner's sexual needs, and to practice negotiated safety in terms of HIV and STI prevention (Hoff 2010a, Hoff 2010b, Mitchell 2013a). In addition, practitioners working in IPV prevention must assist MSM in cultivating healthy relationships as well as managing relationship and personal stress. Finally, there is a need to further develop existing IPV screening and response mechanisms that are geared towards MSM, including clinical and mobile screening tools, referral procedures for MSM who report the recent experience of IPV, and training in culturally appropriate response strategies that acknowledge men as victims as well as perpetrators of IPV. These recommendations are described in detail below.

The best way to prevent IPV is through primary prevention, that is, by preventing violence from occurring in the first place. In order to effectively prevent IPV, efforts should be made to promote healthy, non-violent relationships in which both partners demonstrate mutual respect for each other through their words and actions. Efforts to cultivate positive relationship dynamics must take place at the individual, dyadic, community, and societal level; in addition, practitioners should aim to reduce or respond to the factors that lead to an increase risk for IPV and enhance the protective factors. For example, at the individual level, men who abuse alcohol and other substances or who experienced childhood physical or sexual abuse have a higher risk for IPV perpetration and victimization, while men who have an extensive social support system may be better protected from the experience of IPV (CDC 2013e). Due to the fact that young people are more likely to experience IPV,

activities and media campaigns that encourage healthy dating behavior and relationship dynamics could be particularly effective in educating MSM about IPV prevention and equipping them with the necessary tools for open and honest communication in their relationships.

In May 2006, the CDC introduced an initiative called Choose Respect that aims to help young people aged 11-14 forge healthy relationships and to recognize the danger signs of IPV in order to prevent abuse before it begins. Choose Respect focuses on reaching out to young people whose attitudes towards relationships are still forming, meaning that values training and clarification can potentially have a strong impact on the prevention of IPV. The program has been particularly effective because it involves stakeholders in various realms of community life, including parents, teachers, and youth leaders. The four primary goals of the initiative are 1) to provide effective messages that encourage adolescents to treat others with respect; 2) to create opportunities for adolescents and parents to learn about positive relationship behaviors; 3) to increase adolescents' skills in differentiating healthy from unhealthy behaviors in relationships and identify warning signs that could lead to IPV; and 4) to help young people, parents, and other stakeholders have access to information and tools that help prevent IPV. Choose Respect utilizes various methods to achieve these goals, including the dissemination of behavior change communication materials such as eCards, posters, bookmarks, and pocket guides as well as the promotion of online games, television and radio spots, and online quizzes that encourage young people to develop respect and empathy for others (USDHHS 2014). Initiatives like Choose Respect are extremely important for youth development in terms of cultivating healthy relationships and preventing IPV; however, it is crucial for these programs to include materials that are targeted towards same-sex couples and for the campaigns to highlight the fact that adolescent boys and young men can be victims as well as perpetrators of IPV. Programs that focus exclusively on heterosexual couples or that primarily illustrate men as abusers towards women will fail to effectively prevent the occurrence of IPV among male-male couples.

For adult MSM, fostering healthy communications surrounding sexual agreements is a key factor in IPV prevention. With ever increasing advances in technology and greater accessibility to mobile devices such as

smart phones and tablet computers, there is potential for mobile applications ("apps") to play a role in helping MSM to negotiate their agreements. A mobile application has the capacity to help male-male couples establish and document the conditions of their agreement explicitly and in sufficient detail, thereby serving as a tool for adding structure to the relationship and clarifying boundaries (Mitchell 2013a). To assist couples in establishing an agreement, an app could provide examples of typical agreement types, such as monogamous, open with restrictions, and open without restrictions; in addition, the app could offer strategies on how to meet the sexual and emotional needs of both partners, thereby increasing a couple's investment in their sexual agreement. The application could also pave the way for renegotiating the terms of a sexual agreement at a pre-scheduled time among couples that feel the desire to reexamine their agreements on a regular basis. For example, both partners may receive an update once a month reminding them to discuss or rate the benefits and/or challenges of adhering to the terms of the agreement or to reopen the lines of communication for renegotiation. Thus, a mobile application is an ideal tool to facilitate trust and open communication in male-male relationships by introducing a framework for establishing a sexual agreement as well as a timeline for renegotiation if necessary.

Another important focus area in IPV prevention is addressing macro-level stigma surrounding both homosexuality and male victimization. Despite recent gains in legal protection for MSM in the past decades, including the most recent movement to legalize gay marriage in the US, stigma towards MSM is not extinct. The presence and/or perception of various forms of stigma—self-stigma, institutionalized stigma, and social stigma, for example—can cause high levels of stress for MSM individuals and male-male couples. Racial minority MSM are especially at risk for experiencing stress as a result of pervasive negative stigma towards MSM (Stephenson 2011, Adams 1997, Savin-Williams 1994). GMHC's I Love My Boo campaign aims to address this stigma by normalizing male-male relationships in black and Latino culture. I Love My Boo (ILMB) is a social marketing campaign based in New York City whose aim is to increase the visibility of black and Latino MSM in order to promote acceptance and understanding in the community at-large. The campaign invites racial minority male-male couples across the US to post a picture of themselves to the ILMB Facebook page in any pose that

celebrates a healthy and trusting relationship. ILMB attempts to tackle homophobia in the communities whose MSM members have a high risk for contracting HIV as well as experiencing IPV by challenging the community to consider non-traditional representations of love and relationships (GMHC 2014). The ILMB campaign has great potential for reducing stigma towards MSM as well as promoting healthy relationships among male-male couples through the use of social media. While it is based in New York City, the fact that ILMB uses social media platforms means that it can reach MSM all across the country as long as they have access to a computer and utilize sites like Facebook, Twitter, and Instagram. Campaigns like ILMB help to desexualize society's views towards male-male couples by turning away from scantily clad, muscled, glossy, airbrushed photos and instead choosing to represent MSM as loving, caring human beings in healthy relationships.

Photo 1: I Love My Boo campaign poster presented by GMHC

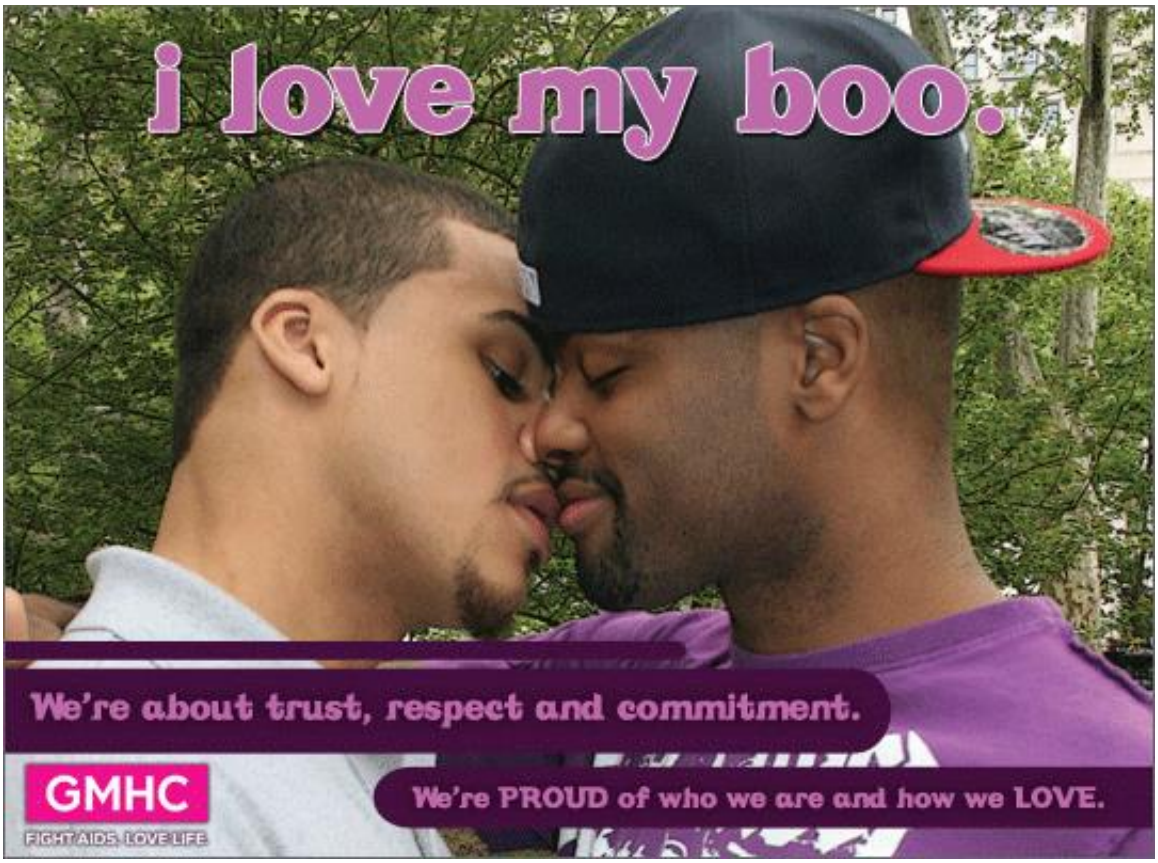

Photo taken from the GMHC I Love My Boo Campaign at

http://www.gmhc.org/i-love-my-boo-4

In addition to addressing stigma towards homosexuality, there is a need to acknowledge that MSM are victims as well as perpetrators in the realm of IPV. Currently, MSM who choose to disclose the experience of IPV to family, friends, or even clinicians or practitioners may face additional stigma or judgment that stem from traditional gender norms that stereotype men exclusively as perpetrators of violence. As previously mentioned in this analysis, MSM report relatively high levels of the experience of various forms of IPV; therefore, IPV preventionists must take steps to end the stereotype that men cannot be victims of IPV. When MSM feel that they are not able to seek out resources, professional services, or social support for IPV, they are more likely to maintain unhealthy relationships and stay trapped in a cycle of violence (McClennan 2005). Perceived stigma towards men who are victims of IPV may also discourage MSM to disclose the experience of IPV in a clinical setting. Mixed media campaigns can utilize social media forums like Facebook and Twitter along with public access sites like YouTube to spread the message that IPV affects men as well as women and same-sex couples as well as heterosexual couples. Combatting gender stereotypes that pertain to relationship violence will help address stigma towards male victims and the double-closeted nature of IPV in the gay community.

In order to capture an accurate representation of the prevalence of IPV among MSM, it is critical to introduce screening tools that are specifically tailored to MSM's experience with violence. The majority of screening tools for IPV that are currently available are geared towards heterosexual women's experience of IPV, which means that the actual prevalence of various forms of IPV may be underestimated in the MSM population (Tjaden 1999, Greenwood 2002, Finneran 2013). Researchers and public health practitioners should continue to expand on the work of Stephenson and Finneran to develop and test a systematic IPV scale adapted to MSM's experiences of IPV (Stephenson 2013). Such scales will help establish consistency in future studies of IPV among MSM and will have greater sensitivity in identifying new cases of IPV compared to hetero-normative IPV indicators. There is also a need to conduct training for clinicians and public health professionals who serve the MSM community in culturally sensitive response strategies. When a man discloses that he is the victim of IPV, the responder should do everything in their power to validate the victim's experience; in addition, he should not

be made to feel judged, stigmatized, or unworthy of a responder's time and resources. Clinicians, public health professionals, and IPV interventionists should also consider utilizing mobile applications as surveillance and response tools for the occurrence of IPV among MSM. Mobile apps can be used to provide information regarding resources for MSM who victims of IPV but who have not been identified in a formal health or social setting. At the clinical level, MSM should be screened for the recent experience of IPV both in primary care settings as well as in HIV testing and treatment facilities. When MSM do report the recent experience of IPV, clinicians will have the opportunity to refer them directly to material and human resources that specialize in IPV prevention and response.

Finally, IPV prevention could be an added component to HIV prevention initiatives. For example, the intervention Many Men, Many Voices is a group-level HIV and STI prevention workshop for black MSM that was developed by the CDC. The initiative was designed to cover several components that are discussed in this chapter, including sexual relationship dynamics, cultural and social norms, and the emotional and psychological impacts that homophobia can have on HIV risk behaviors (Effective Interventions 2012). The subject of IPV prevention could easily be woven in to these topics that are covered during the seven sessions of the program. HIV prevention workshops and skills-building programs are an ideal platform for discussing healthy relationship dynamics and the primary prevention of IPV. In addition, some MSM may benefit from the stress-reducing practices of yoga and meditation. Yoga and meditation classes geared towards the MSM community could encourage individual MSM to regularly seek out these sessions and benefit from stress reduction as a result of exercise and meditation as well as from the feeling of belonging to a strong and welcoming community of other MSM. Classes could even be geared towards male-male couples to help facilitate trust and encourage communication, mutual support, and respect for one's partner through yoga practice.

In sum, although the primary prevention of IPV is challenging in any population, there are many campaigns and initiatives already in place for MSM that can make this goal attainable. Such initiatives span from modern social marketing campaigns like the I Love My Boo initiative that aims to reduce stigma to traditional

public health workshops like the Many Men, Many Voices campaign that have the capacity to incorporate IPV prevention and response as key program components. Programs like Choose Respect encourage young people to understand how respect for others leads to healthy relationships, but they must address the relationship dynamics of same-sex couples as well as heterosexual couples in order to effectively contribute to IPV prevention among MSM. To address the role of sexual agreements in MSM's experience of IPV, mobile application technology can be utilized to help male-male couples establish, clarify, and renegotiate their sexual agreements; in addition, mobile apps can provide information on response resources specifically tailored for MSM who are victims of IPV. Finally, yoga and meditation classes created specifically for MSM and male-male couples can help to reduce stress and stimulate a positive community environment for both MSM individuals and male-male dyads, thereby potentially reducing some of the risk factors for IPV among MSM. From this study, it is clear that future research is needed when it comes to the confluence of sexual agreements and the experience of IPV in order to evaluate the effect of current initiatives on IPV incidence as well as to develop new initiatives that specifically aim to reduce IPV among same-sex couples.

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