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Intimate Partner Violence: Associations With High-Risk Sexual Behaviors in a Men Who  
Have Sex With Men Clinic Population

by

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## Preface

Intimate partner violence (IPV) has been identified as a substantial public health problem in America, and as such has been the subject of much research, prevention, and intervention efforts. The Centers for Disease Control provides the following comprehensive definition of IPV:

Intimate partner violence is actual or threatened physical and/or sexual violence or psychological/emotional abuse directed toward an intimate partner. Many Terms are used to describe intimate partner violence: domestic or spouse abuse, battering, domestic or courtship violence, marital or date rape. We use the term "intimate partner violence" because it includes all forms of violence that occur in any type of intimate relationship, whether it is between spouses, ex-spouses, current or former boyfriends and girlfriends, or current or former dating partners. Intimate partners may be heterosexual or of the same sex." [1]

Even a short perusal of the literature on the subject of IPV against women in heterosexual relationships yield chilling statistics: In 1996, 30% of *all female murders* were perpetrated by husbands, ex-husbands, or boyfriends [2]. In 1994, women accounted for nearly 40% of all emergency department visits for violent victimization [3]. Indeed, exposing the staggering scope and consequences of IPV against women in terms of mortality as well as physical and psychological morbidity has been instrumental in exposing the extent of this epidemic, along with mobilizing social, political, and public health efforts to address IPV.

When I worked in a community prenatal clinic, there were several steps taken to address IPV. Posters in English and Spanish covered the walls, addressing IPV during pregnancy through a powerful combination of photography and quotes from IPV victims. Part of the intake interview for new prenatal patients consisted of screening questions for IPV. In addition, each patient was sent home with a card giving information on hotlines

and resources in the community for victims of IPV. Combined, these efforts were meant to alert women about the high frequency of IPV during pregnancy, to empower a woman to recognize whether she was involved in an abusive relationship, and to provide her with community resources in her decision to leave a violent relationship. Using this example as a model of intervention in a community-based clinic, it is clear that the first step in creating the network of services necessary to address IPV is the acknowledgement that IPV not only exists, but that it is a reality in many women's lives. In other words, no intervention could occur without first "breaking the silence" around IPV.

My thesis work began with an interest in "breaking the silence" about victims of IPV who have remained hidden, partly by the powerful belief that IPV only occurs between men and women; these are individuals whose intimate partners are of the same gender. A 1997 national survey of agencies providing services to gay, lesbian, bisexual, and transgender (GLBT) victims of IPV reported 3, 327 documented cases of IPV in same-gender relationships [4, p.32]. Of those incidents, 58% were reported by men and 48% by women. It should be emphasized that this number represents only reported and documented incidents, and that the agencies participating in this report serve less than 20% of the nation's population. In fact, preliminary prevalence studies indicate that between 25 and 33% of GLBT persons are abused by their partners. This is comparable to the prevalence estimates given for IPV in heterosexual couples.

Prior to medical school, I worked in HIV prevention and provided pre and post-HIV test counseling in the gay male community of San Francisco, CA. The predominant model used in STD and HIV prevention centers around risk-reduction and empowering individuals to negotiate safer-sex practices with their partners. Many of the discussions I

had with my clients involved discussing barriers to behaviors that decrease one's risk of STD infection. IPV was never discussed in that context. Or maybe it was, but I was not listening for it.

I was aware of research demonstrating that, beyond physical consequences, heterosexual women victims of IPV suffer increased depression, suicidal thoughts and attempts, lowered self-esteem, alcohol and other drug-abuse, as well as post traumatic stress disorder [5]. Was this true of IPV in same-gender relationships? My interest in STD prevention further led me to ask what effect IPV may have on the sexual decision-making of victims of violence in same-gender couples.

In order to answer these questions, I completed two papers. The first paper is a literature review, providing a conceptual framing to my research questions, addressed in the second paper. The literature review had the dual goals of summarizing the, as yet, small body of research focusing on IPV in same-gender relationships, as well as examining specific correlates of IPV such as high-risk sexual behavior, substance abuse, condom negotiation, and HIV infection.

In the second paper, I reported the results of a secondary data analysis provided by a survey of patients attending a STD clinic in San Francisco as part of an ongoing behavioral surveillance effort by the San Francisco Department of Health. Bivariate and multivariate analyses were conducted on a sample of 635 men who have sex with men, to determine the effects, if any, of IPV experience on several sexual high-risk behaviors. In addition, I examined the relationships between IPV experience and HIV status in this population.

My goals in completing this thesis were twofold: to address the gaps in knowledge surrounding IPV in same-gender relationships and the role it may play in sexual-decision making, as well as using quantitative methods to contribute to the growing pool of research focusing on same-gender IPV. Finally, it was my goal to contribute to the voices speaking out about IPV in same-gender couples, in the hope that no victim of violence suffer in silence.

## **Intimate Partner Violence in Same-Gender Relationships:**

### **A Literature Review**

The National Violence Against Women Survey of 2000 confirms that intimate partner violence (IPV) is pervasive in U.S. society, with 25 % of surveyed women and 7.6 % of surveyed men reporting rape and/or physical assault by a current or former spouse, cohabiting partner, or date at some time in their life [1]. The CDC has developed a broad definition of IPV in which an intimate partner can include current or former spouse, boyfriend, girlfriend, or date. According to this definition, violence can include physical, sexual assault, stalking, and psychological abuse. Violence can also involve enforced social isolation, intimidation, and the deprivation of resources such as food, clothing, money, transportation, or health care [2].

Beginning in the early 1970's, the women's movement fueled research on partner abuse. Today, the prevalence of IPV in heterosexual relationships is established, and there is a plethora of research findings on the correlates of IPV in heterosexual women's lives. However, research on the theory, prevalence and correlates of IPV in lesbian/gay/bisexual/transgendered (GLBT) communities lags much behind research on IPV in heterosexual relationships.

Theories advanced to explain the dearth of research on IPV in same-gender relationships include a tenacious belief that partner abuse is perpetrated solely by men toward women [3]. Certainly, the feminist model, which frames the issue in terms of gender inequity and patriarchal oppression of women, has fostered this understanding. Social prejudice toward gays and lesbians has also contributed to a lack of support to



study IPV in same-gender relationships, both from within and without GLBT communities. Advocacy efforts to address IPV within the GLBT community have encountered resistance due to the fear that this would fuel homophobic stereotypes of same-gender relationships [4, p.131]. IPV advocates and researchers in the field of violence against women have also contributed to the silence around IPV in same-gender relationships, fearing challenge to the feminist paradigm discussed below [5, p.6]. Therefore research exploring violence and abuse in same-gender partnerships has had to evolve within an theoretical context fraught with the limitations of pioneering fields of research, namely competing conceptual models of etiology in same-sex violence resulting in conflicting applications for intervention and treatment, as well as research design [6]. The sparse body of literature on violence in same-gender relationships has been conducted on small and often unrepresentative samples of gay and lesbian couples. Methodological issues, such as differing definitions of IPV and time frame (current vs. lifetime) have contributed to the limitations of these studies [6]. However, despite the lack of accurate IPV prevalence from the literature, the general consensus among advocates working in agencies that serve victims of intimate violence in the GLBT community is that IPV rates in same-gender relationships are the same as those of heterosexual relationships, with 25% to 33% of couples reporting abuse [7].

This paper will review the extant literature on IPV in same-gender relationships, including a review of competing conceptual paradigms proposed to explain same-gender battering. In a second section, sexual high-risk behaviors, sexually transmitted diseases, and HIV diagnosis will be discussed in terms of their correlation to IPV experience, with

the goal of understanding the repercussions of IPV both in the short and long terms specific to individuals involved in same-gender partnerships.

### **Conceptual Models of Same-Gender Partner Abuse**

One of the challenges in the field of research pertaining to IPV in same-gender relationships has been to construct theories of partner abuse specific to the reality of same-gender relationships that do not fundamentally conflict with theories of violence pertaining to IPV in heterosexual relationships. The primary conflict arose from tension between the feminist model, discussed below, and theoretical paradigms that could include the notion of women batterer and males as victims of intimate violence. Clearly, the experience of all individuals involved in abusive relationship overlaps in many ways. The very definition of what constitutes an abusive intimate partnership defies barriers of gender or sexual orientation. Hart defined IPV in same-gender couples as a “pattern of violent coercive behavior whereby a lesbian (or gay man) seeks to control the thoughts, beliefs or conduct of her/his intimate partner or to punish the intimate partner for resisting the perpetrator’s control over her/him” [8, p. 173]. “Violent coercive behavior” can take the form of physical, emotional, economic, or sexually abusive means. There is nothing in this definition inherently true for gays or lesbians that sets it apart from the experience of heterosexual women in abusive relationships.

While there are clear differences between the experience of heterosexual women in our society and the experience of gays and lesbians in the same society, these experiences overlap in fundamental ways. A woman is subjected to a patriarchal and sexist world whether her intimate partner(s) is a woman or a man. She is surrounded by a community where sexual intimidation/terrorism, lower wages and fewer resources are the

norm. In addition, for men and women of color of any sexual orientation, there cannot be a discussion of interpersonal violence without incorporating a discussion of the role racism plays in this.

Nonetheless, the presence of homophobia at individual and societal levels, the social isolation which results from living in a homophobic environment, as well as the internalization of violence against gays and lesbians are examples of components of experience specific to same-gender relationships. As a result, the theoretical framework addressing IPV in same-sex domestic partnerships has had to expand from the original feminist paradigm developed in the 1970's literature on domestic violence to include facets of experience specific to same-gender relationships. This section will review the existing paradigms for understanding IPV in the context of gay and lesbian domestic partnerships<sup>1</sup>.

#### *The Feminist Model*

Beginning in the late 1960's and early 1970's, the feminist movement flourished in this country and, among other things, provided an analytical framework to approach the question of domestic violence. According to this model, gender-based oppression is at the root of and provides the context for the physical and psychological abuse of women by men. Violence against women is the logical progression of what feminists term "cultural misogyny and sexism". It arises out of sexist gender-role socialization in which cultural prescriptions of male dominance and female subordination set the stage for violence against women. As such, interventions to halt the cycle of violence must

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<sup>1</sup> Although I favor the use of the term "same-gender" as the most inclusive in this paper, "gay and lesbian domestic partnership" is used as well, in part because I wanted this review of literature to reflect the diversity of terminology used in the body of research devoted to this topic. It is in no way meant to limit

address the patriarchal institutions and socialization that allows violence against women to exist—in fact, foster it [9, p.11].

While feminist theory allowed the epidemic proportions of violence against women to be exposed and provided a model for research, advocacy, and intervention, it has been recognized as insufficient an explanation for IPV in same-gender relationships [10, p.4]. How does a gender-based theory of IPV include same-gender relationships where men can be victims of battering and women batter their female partners? Certain authors have argued that, ironically, the feminist theory, so instrumental in defining and denouncing violence against women, has contributed to keeping same-gender IPV invisible, denying its existence, or giving it token reference as “exception to the rule” [10, p.6, 11, p.7].

#### *Psychological Theory*

With its emphasis on sociopolitical factors, feminist theory does not address the root of the problem of intimate violence. So argue Island and Letellier in their seminal 1991 work on the topic of IPV in gay male relationships. In defining what they termed a “psychological theory” to frame the discussion of the contributory factors to IPV in gay male relationships, the authors argue that the focus of IPV research and intervention should be the behavioral and psychological characteristics of batterers, not their gender [12]. It is the mental health disorder of the batterer that is responsible for his behavior.

While expanding the definition of IPV to include same-gender intimate violence, Island and Letellier’s psychological theory fail to address an essential distinction between

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the definition of domestic partnerships which can exist between individuals who define themselves as gay, lesbian, bisexual, transgendered persons, or who refuse to define themselves within these categories.

rates of violence experienced by women and men in this country reported in the most recent findings from the National Violence Against Women Survey:

Same-sex cohabiting women were nearly three times more likely to report being victimized by a male partner than by a female partner. Moreover, opposite-sex cohabiting women were nearly twice as likely to report being victimized by a male partner than were same-sex cohabiting women by a female partner... Same-sex cohabiting men were more likely to report being victimized by a male partner than by a female partner... *These findings suggest that intimate violence is perpetrated primarily by men, whether against male or female partners*<sup>23</sup>[1, p. 31].

If gender doesn't define batterers and IPV is perpetrated by individuals exhibiting clusters of psychological patterns that can be grouped as psychiatric diagnostic criteria under "batterer characteristics" such as poor impulse control, then one would expect batterers to be equally distributed among men and women in the population. This is simply not the case. Though it is true that sociopolitical feminist theory is insufficient to address same-gender IPV, Island and Letellier's psychological theory also proves inadequate on several fronts. First, it does not "fit" reality, in the sense that it does not address the fact that batterers, whether involved in heterosexual or homosexual relationships, are mostly male. In other words, gender matters. Furthermore, by suggesting that abuse results from psychological impairment solely, the psychological theory is viewed by many to be detrimental to the women's movement struggle to empower victims of violence and to relieve the abuser of responsibility for his behavior.

#### *Social-Psychological Model*

The next logical step was to integrate the feminist/social and psychological models into a unifying theory that can be applied to lesbian, heterosexual, and gay male relationships in which battering occurs. Greg Merrill [9] advocates for the social-

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<sup>2</sup> My emphasis

psychological model. This model states that, while gender is one important variable in IPV, but so are social and psychological factors. Gender-based assumptions about IPV are real and supported by the experience of abused heterosexual women. However, the definition of IPV needs to encompass components of experience particular to abuse in same-sex relationships.

Merril agrees with the psychological theory in admitting that certain individual psychological factors predict violent behavior in intimate relationships. However, such psychological factors exist within the context of cultural, political, and economic environments that facilitate and sanction the disenfranchisement of one group of individuals. The combination of individual psychological factors and the social environment of same-gender couples create an environment where an abusive partner can batter without consequence or intervention. In the case of same-gender relationships, Merrill explains, “homophobia, heterosexism, and other oppressions operate to isolate the battered person ... permitting the violence to continue”[9, p.15].

The link between Merrill’s theory and that of his intellectual predecessors appears to be power. While there are psychological characteristics that predispose individuals to react violently against their partner, batterers are opportunistic and take advantage of the existing power differential in their intimate relationship. In the case of heterosexual relationships, this power differential is influenced by gender. In any relationship, race and economics play a crucial role in the power differential between partners.

The balance of power in gay/lesbian/bisexual/transgender (GLBT) couples is further impacted by the social isolation resulting from homophobia, and from living in a society where violence against GLBT individuals is too often condoned and encouraged.

By taking into account sociopolitical and psychological dynamics, Merrill has been able to formulate a comprehensive model that can be used to discuss IPV whether it occurs in heterosexual or same-gender relationships.

**Sexually transmitted diseases, HIV, high-risk sexual behaviors and IPV in same-gender relationships**

This section will review the literature pertaining to the above specific correlates of IPV, whether they exist in heterosexual or same-gender relationships.

*HIV and IPV*

The intersection of the AIDS epidemic and intimate partner violence has staggering implications with respect to policy, legal, and ethical considerations. Numerous studies have documented a strong correlation between both physical and sexual abuse and HIV exposure risk and/or HIV infection [13-19] [20]. A national survey of individuals living with AIDS in 1992 reported that 12.3% of respondents experienced violence within their intimate relationship. In particular, 10% of the gay men and 23.7% of the bisexual men surveyed reported IPV [19, p.99]. The challenge lies in defining at what point, and how, do HIV and IPV intersect.

This section will first review the literature analyzing the relationship between domestic abuse and HIV infection in heterosexual relationships. Next, the literature specifically addressing the interaction of IPV and HIV in the gay and bisexual population will be reviewed. It is my belief that many of the points raised in the literature regarding women's experience of HIV and IPV are pertinent to an analysis of the co-occurrence of HIV infection and IPV in a population of men whose intimate partners are men. In a

separate section, I will review the literature on the impact IPV has on safer-sex practices, which may lead to STD/HIV infection.

Questions currently challenging investigators center about elucidating whether the association between HIV and IPV is a direct one mediated through rape and sexual coercion, or whether certain HIV prevention practices (such as safer sex negotiation) increase the risk for IPV. The impact a history of abuse may have on HIV infection risk is also discussed. In addition, the question of whether IPV occurs in the context of disclosure of seropositivity remains extremely pertinent, especially with respect to policy decisions around partner notification programs.

#### *Past IPV History and HIV*

In women, a history of childhood sexual and physical abuse, particularly early and chronic sexual abuse, has been associated in one population survey with a seven-fold increase in HIV-risk behaviors as an adult [21]. One of the mediators proposed for the association between a past history of abuse and high-risk sexual behavior is the persistence of behaviors or beliefs that, though appropriate in the context of childhood sexual abuse, are inappropriate as an adult. For instance, believing that one is unable to refuse unwanted sexual activity is an appropriate reflection of reality for a child living through sexual abuse. However, this same belief carried into adulthood can result in poor decision-making around sexual health and result in lack of self-protection with respect to STD/HIV infection. A study found that adolescents with a history of sexual abuse were three times more likely than their peers to report inconsistent condom use, to have more sexually transmitted diseases, less impulse control, and less knowledge of HIV than adolescents without a history of abuse [22]. In addition, a history of childhood abuse has



been associated with substance use and multiple sex partners, which are risk factors for HIV infection [18, 23]. In this model, abuse is seen as an “indirect” precursor behavior that places one at risk of HIV infection. It is easy to see the direct causative link between sexual abuse and STD/HIV infection mediated through rape by an infected abuser. However, the results of the above study imply that the secondary long-term behavioral sequelae of childhood abuse may form a link between abuse history and HIV infection, even when the two events are temporally disconnected.

#### *IPV and Safer-Sex Negotiation*

In the context of STD and HIV research, “high-risk behavior” refers to behavior that increases the risk of becoming infected with a STD, including HIV. Such behavior may include sharing needles in the context of injection-drug use. However, this paper will focus on certain behaviors within sexual relationships that place individuals at risk for infection, and the role that IPV experience plays in facilitating such behaviors.

Negotiating condom use, in particular, has been studied in the context of violent relationships for several reasons. In investigations looking at how IPV may place victims of abuse at risk for STD/HIV infection, condom use negotiation is a critical point where the interaction of not simply IPV, but behavior resulting from and fostered by IPV, impact the health of the victim of abuse. Successful risk-reduction interventions stress the importance of negotiating safer-sex practices, including asking a sexual partner to use a condom. Male and female condoms are the only barrier method known to reduce the risk of transmission of several sexually transmitted infections such as gonorrhea, syphilis, chlamydia, and HIV.

Research on correlates of IPV, including physical and psychological violence, has demonstrated that the power differential resulting from a pattern of abusive behaviors lead the victims of violence to experience loss of control and power, vulnerability, and entrapment [24]. A study of prenatal patients reported that women currently involved in both physically and sexually abusive relationships were significantly more likely to be diagnosed with STD's than non-victims of violence [25]. Two studies on condom use among low-income African American women demonstrated that women who had experienced sexual coercion were significantly less likely to request condom use from their partner and more likely to be abused as a result of requesting a condom [15] [26].

It is plausible to hypothesize that the same fear and power differential which keep women in abusive heterosexual relationships from asking their partner to wear condoms during intercourse, even when they know their partner is at high risk for HIV infection, operates in violent same-gender relationships.

#### *IPV and HIV Diagnosis Disclosure*

One survey of HIV-infected women found that 18% to 35% of patients interviewed reported fear of violence around disclosure of their HIV-positive status. Examples of the spectrum of abuse around HIV infection disclosure included physical assault, emotional abuse, abandonment, and loss of access to their children [27]. Another study on a clinic population of HIV-positive women found that, although 4% of women reported experiencing abuse directly attributable to a disclosure event, 13% of the same sample reported physical, emotional, or sexual abuse that occurred only after they learned of their HIV-positive status [13].

### *Living with HIV and IPV*

Beyond the event of HIV diagnosis itself, including disclosure to intimate partners, living with HIV has been shown to place women at increased risk of illness and health care utilization. Liebschutz and colleagues [16] combined interview and chart review analysis of a clinic sample of HIV-infected women over a period of two years. Their results show that 68% of the women in their sample experienced physical and sexual abuse. When controlling for CD4 cell counts, alcohol or injection drug use, women experiencing IPV were more likely to suffer from chronic illnesses and opportunistic infections than HIV-positive women not involved in abusive relationships [16]. This study suggests that the repercussions of abuse in a person with HIV go beyond aggravated injuries, and can lead to a sharp decline in general health following assault.

Authors have defined a specific set of abusive behaviors as “HIV-related abuse”, which occur in the context of the highly stigmatized and disabling disease that is HIV. The effects of stress on the immune system are potential mediators of the increased poor health outcomes associated with IPV in the context of HIV infection. Beyond the direct debilitating effects of physical injuries in a patient with depressed immune function, abuse of an HIV-positive patient may involve withholding medication; or keeping someone from going to medical appointments, as well as participating in support groups or social services [19].

### *HIV and IPV in Same-Gender Relationships*

Narrowing the focus of the intersection of IPV and HIV to the gay and bisexual community one encounters the same issues discussed above in the context of heterosexual victims of violence who are HIV-positive. However, several distinguishing

characteristics emerge when looking at the gay and bisexual community, which need to be considered apart from the heterosexual community. The first of these is due to the demographics of the AIDS epidemic in certain parts of this country, such as California, where men who have sex with men constitute 76% of all AIDS cases [28]. One San Francisco agency providing services to victims of same-gender domestic violence reported that 30% of the battered gay and bisexual men served there are HIV-positive [17]. This illustrates the fact that there is a large interface between the community of men involved in abusive same-sex relationships, and the HIV-positive community. To health and social service providers in that community, these statistics means that seronegative battered gay and bisexual men are at extremely high risk of infection with HIV. The above statistics also speaks to the experience of many gay and bisexual men who have lost most –sometimes all—of their friends to AIDS. The loss and grief which results from this add to feelings of isolation and disconnection from the community that can compound the isolation unique to the experience of gay couples. This may lead an abused partner to stay in the abusive relationship because the loss of one more relationship, even an unhealthy one, may seem unbearable [4, p.139]

The social stigma associated with HIV infection is often used as means of control and intimidation by abusers. Batterers use the threat of revealing their partner's HIV status to employers, families, and government agencies to keep victims of abuse from seeking help or leaving the relationship. Threats against HIV-positive men whose intimate partners are men have the further potential of “outing” the abused partner who might lose his job, and consequently his health insurance, as well as suffer other forms of AIDS or anti-gay discrimination [17, p.77]. Additionally, a victim of IPV who is HIV-

positive may decide to remain in an abusive relationship out of fear that he will not find another partner because of his HIV-status, or that there will be no one to take care of him when he becomes sick [29].

#### *IPV and Substance Use*

The relationship between substance use, particularly alcohol abuse, and a history of childhood abuse has been discussed above [13, 16]. Research has documented a correlation between substance use and current battering as well. In one study, 64% of lesbians involved in an abusive relationship reported that their partner used alcohol or other drugs during or prior to battering incidents and that they used alcohol or other drugs before being battered [30]. Another study found that women who had been sexually coerced were significantly more likely to report marijuana and crack cocaine use in the past 3 months. Sexually coerced women were also more likely to answer yes on the CAGE questionnaire to two or more indicators of problem drinking [26].

The facilitative role of drugs and alcohol in violent relationships continues to be the subject of much discussion. The current consensus in the literature is that substance use by either the batterer or the victim does not cause violence. Rather, the role of drugs and alcohol in the violent partner (not taking into account addiction, in which drinking or taking a drug becomes an end in and of itself) may be the removal of inhibitions that may otherwise control violent impulses. In the victim of violence, substance use may be used to numb the experience of abuse or psychologically remove oneself from a painful situation [31]. The current mental health conceptualization of domestic violence is within a traumatic response framework and fits the pattern of behavior seen in persons

with post-traumatic shock disorder (PTSD). Substance abuse is a frequent correlate of PTSD, perhaps as part of the avoidance/numbing dynamic suggested above [32].

### **Conclusion**

The existence and extent of intimate partner violence in same-gender relationships requires novel modes of understanding the social and political implications of IPV extending beyond the feminist paradigm. However, efforts to address IPV in same-gender relationships, especially with respect to public health education and intervention efforts around STD infections, should be informed by the body of literature investigating IPV in heterosexual relationships. In particular, the established relationships between past and current IPV and the decreased ability to negotiate safer-sex behaviors demonstrated by victims of IPV, as well as the increased use of drugs and alcohol linked to IPV victimization are areas of concern specific to STD prevention efforts and need to be addressed in the gay/lesbian/bisexual/transgender communities. In addition, the multiple and complex relationships between past and current IPV experience and HIV seropositivity merit further investigative efforts specific to the experience of same-gender couples.

The following paper allows the conceptual understandings developed in this review to be applied in an investigative context. Through the use of a survey database comprised of a large sample of men who have sex with men, a cross-sectional study was conducted to establish, and perhaps further elucidate, the relationship between IPV experience and correlates of high-risk behavior for STD infection, as well as the relationship between IPV experience, STD diagnosis, and HIV status in a population of men who have sex with men.

## References

1. Thoennes, P.T.a.N., *Extent, Nature, and Consequences of Intimate Partner Violence*, . 2000, U.S. Department of Justice and Centers for Disease Control and Prevention: Washington. p. 29-36.
2. Saltzman L.E., F.J.L., McMahon P.M., Shelley G.A., *Intimate Partner Violence Surveillance: Uniform Definitions and Recommendations Data Elements, Version 1.0*, . 1999, National Center for Injury Prevention and Control Center for Disease Control and Prevention: Atlanta.
3. Follingstad, L.K.B.a.D.R., *Violence in Lesbian and Gay Relationships: Theory, Prevalence, and Correlational Factors*. *Clinical Psychology Review*, 1999. 19(5): p. 487-513.
4. Merrill, G.S., *Understanding Domestic Violence Among Gay and Bisexual Men*, in *Issues in Intimate Violence*, R.K. Bergen, Editor. 1998, Sage Publications, Inc: Thousand Oaks. p. 129-141.
5. Elliot, P., *Shattering Illusions: Same-Sex Domestic Violence*, in *Violence in Gay and Lesbian Domestic Partnerships*, C.M.R.a.C.H. Miley, Editor. 1996, Harrington Park Press: New York. p. 1-9.
6. Lisa K. Waldner-Haugrud, L.V.G., and Brian Magruder, *Victimization and Perpretation Rates of Violence in Gay and Lesbian Relationships: Gender Issues Explored*. *Violence and Victims*, 1997. 12(2): p. 173-184.
7. Community United Against Violence, and Gay Men's Domestic Violence Project, personal communication.
8. Hart, B., *Lesbian battering: An Examination*, in *Naming the Violence: Speaking out about lesbian battering*, K. Lobel, Editor. 1986, Seal Press: Seattle.

9. Merrill, G.S., *Ruling the Exceptions: Same-Sex Battering and Domestic Violence Theory*, in *Violence in Gay and Lesbian Domestic Partnerships*, C.M.R.a.C.H. Miley, Editor. 1996, Harrington Park Press: New York. p. 9-23.
10. Letellier, P., *Gay and Bisexual Male Domestic Violence Victimization: Challenges to Feminist Theory and Responses to Violence*, in *Domestic Partner Abuse*, L.K.H.a.C. Renzetti, Editor. 1996, Springer Publishing Company: New York. p. 1-23.
11. McClennen, J.C., *Prevailing Theories Regarding Same-Gender Partner Abuse: Proposing the Feminist Social-Psychological Model*, in *A Professional Guide to Understanding Gay and Lesbian Domestic Violence*, J.C.M.a.J. Gunther, Editor. 1999, The Edwin Mellen Press, Ltd.: Lewiston. p. 3-13.
12. Letellier, D.I.a.P., *Men Who Beat the Men Who Love Them*. 1991, New York: Harrington Press.
13. Andrea Carlson Gielen, K.A.M., Jessica G. Burke, and Patricia O'Campo, *Women's Lives After an HIV-Positive Diagnosis: Disclosure and Violence*. *Maternal and Child Health Journal*, 2000. 4(2): p. 111-120.
14. Basinait-Smith, L.D.M.a.C., *Revisiting the Intersection Between Domestic Abuse and HIV Risk*, . 1998: *American Journal of Public Health*. p. 1267-1268.
15. DiClemente, G.M.W.a.R.J., *The Effects of an Abusive Primary Partner on the Condom Use and Sexual Negotiation Practices of African-American Women*. *American Journal of Public Health*, 1997. 87: p. 1016-1018.
16. Jane M. Liebschutz, G.F., Lisa Sullivan, Michael Stein, and Jeffrey Samet, *Physical and Sexual Abuse in Women Infected With the Human Immunodeficiency Virus*. *Archives of Internal Medicine*, 2000. 160: p. 1659-1664.
17. Letellier, P., *Twin Epidemics: Domestic Violence and HIV Infection Among Gay and Bisexual Men*, in *Violence in Gay and Lesbian*



*Domestic Partnerships*, C.M.R.a.C.H. Miley, Editor. 1996, Harrington Park Press: New York. p. 69-83.

18. Linda J. Koenig, a.J.M., *Women, Violence, and HIV: A Critical Evaluation with implications for HIV Services*. Maternal and Child Health Journal, 2000. 4(2): p. 103-109.

19. Maroney, B.H.a.T., *HIV and Same-Sex Domestic Violence*, in *Same-Sex Domestic Violence*, B.L.a.S.E. Lundy, Editor. 1999, Sage Publications, Inc.: Thousand Oaks. p. 97-111.

20. Nabila El-Bassel, L.G., Satya Krishnan, Robert F. Schilling, Theodore Gaeta, Stacey Purpura and Susan S. Witte, *Partner Violence and Sexual HIV-Risk Behaviors Among Women in an Inner-City Emergency Department*. Violence and Victims, 1998. 13(4): p. 377-393.

21. Lillian S. Bensley, J.V.E., and Katrina W. Simmons, *Self-Reported Childhood Sexual and Physical Abuse and Adult HIV-Risk Behaviors and Heavy Drinking*. American Journal of Preventive Medicine, 2000. 18(2): p. 151-157.

22. Brown, L.K.L., Kevin Lourie J; Zlotnick Caron; Jennifer Cohn, *Impact of sexual abuse on the HIV-risk-related behavior of adolescents in intensive psychiatric treatment*. The American Journal of Psychiatric, 2000. 157(9): p. 1413-1415.

23. Zierler S., F.L., Laufer D., Velentgas P., Kantrowitz-Gordon I, Mayer K., *Adult survivors of childhood sexual abuse and subsequent risk of HIV infection*. American Journal of Public Health, 1991. 81: p. 572-575.

24. Ann L. Coker, P.H.S., Robert E. Mc Keown, and Melissa J. King, *Frequency and correlate of Intimate Partner Violence by Type: Physical, Sexual, and Psychological Battering*. American Journal of Public Health, 2000. 90(4): p. 553-559.

25. Sandra Martin, L.M., Lawrence Kupper, James C. Thomas, Matthew Daly, Suzanne Cloutier, *Domestic Violence and Sexually Transmitted Diseases: The Experience of Prenatal Care Patients*. Public Health Reports, 1999. 114: p. 262-268.

26. Seth C. Kalichman, E.A.W., Charsey Cherry, Lisa Belcher, and Dena Nachimson, *Sexual Coercion, Domestic Violence, and Negotiating Condom Use Among Low-Income African American Women*. *Journal of Women's Health*, 1998. 7(3): p. 371-378.
27. Paskey, K.R.a.S.J., *The Risk of Domestic Violence and Women with HIV Infection: Implications for Partner Notification, Public Policy, and the Law*. *American Journal of Public Health*, 1995. 85(11): p. 1569-1576.
28. California Department of Health Services, Office of AIDS, *HIV-AIDS Surveillance Report for California Dec. 31, 2000*, . 2000.
29. Firestone, J.M.C.a.J., *Exploring Violence and Abuse in Gay Male Relationships*. *Violence and Victims*, 1998. 13(2): p. 159-173.
30. Schilit, R.L., G.; and Montagne, M., *Substance use as a correlate of violence in intimate lesbian relationships*. *Journal of Homosexuality*, 1990. 19(3): p. 51-65.
31. Melzer-Lange, M.D., *Violence and Associated High-Risk Health Behaviors in Adolescents*. *Pediatric Clinics of North America*, 1998. 45(2): p. 307-316.
32. Lewandowski, J.C.C.a.L.A., *Mental and Physical Health Effects of Intimate Partner Violence on Women and Children*. *The Psychiatric Clinics of North America*, 1997. 20(2): p. 353-373.

## **Intimate Partner Abuse: Associations with High-Risk Sexual Behaviors in a Men Who Have Sex With Men Clinic Population**

### **Introduction**

Intimate partner violence (IPV) is pervasive in U.S. society. A recent report of the National Violence Against Women survey confirms that 25% of surveyed women and 7.6% of surveyed men reported rape and/or physical assault by a current or former spouse, cohabitating partner, or date at some time in their life [1]. While the body of literature on violence in same-gender relationships lags far behind research on IPV in heterosexual relationships, the general consensus among advocates working in agencies that serve victims of intimate violence in the gay/lesbian/bisexual/transgender (GLBT) community is that IPV rates in same-gender relationships equal those of heterosexual relationships, with 25% to 33 % of couples reporting abuse [2, 3].

Numerous studies on women in abusive relationships have documented a strong correlation between both physical and sexual abuse and STD/HIV exposure risk and/or infection [7-13] [14] [15][4-7]. In a cohort of lesbians, significant associations have been documented between prior abusive experiences and high-risk sexual behaviors [8]. The interface between HIV infection and IPV in gay and bisexual men merits further investigation, particularly in certain areas of our country such as California, where men who have sex with men (MSM) constitute 76% of all AIDS cases [9]. Thirty percent of the battered gay and bisexual men served in a San Francisco agency providing services to victims of same-gender IPV were HIV-positive [10]. In a national survey of individuals

living with AIDS, 10% of the gay men and 23.7% of the bisexual men surveyed reported experiencing IPV [7, p.99].

A vast body of literature is devoted to the relationship between IPV and substance abuse. Alcohol abuse has been linked to a history of childhood abuse [13, 16]. Research has also documented a correlation between substance use and current battering. In one study, 64% of lesbians involved in an abusive relationship reported that their partner used alcohol or other drugs during or prior to battering incidents and that they used alcohol or other drugs before being battered [22]. Studies have also shown that having sex while high was significantly related to both substance abuse and sexually transmitted disease history [11].

We know of no studies examining the associations between IPV and the sexual behaviors of MSM patients attending an urban public STD clinic. The San Francisco City Clinic '96 Survey of Knowledge, Attitudes, Beliefs and Behaviors (KABB) provided a survey sample for such a population and addressing a wide variety of questions, including high-risk sexual behaviors, history of IPV, and history of STD/HIV diagnosis [12]. Our research questions were the following: What are the relationships between IPV history and correlates of high-risk behavior for STD infection such as lack of condom use at last anal intercourse, use of alcohol and drugs at last sex, partner infidelity, and more than one new sexual partner in the last three months. In addition, we wanted to explore the association between IPV history, history of STD diagnosis, and HIV-status in this population.

## Methods

The City Clinic in San Francisco provides confidential STD diagnosis and treatment, HIV testing and counseling, and contraception services. From October 1996 to March 1997, a cross-sectional self-administered survey was conducted as part of on-going public health behavioral surveillance efforts [12].

Upon registering for services, patients were informed about the survey and asked to participate. The voluntary nature of this survey was emphasized to patients, along with the fact that responses were confidential and that refusal to participate in the survey would not affect their care in any way. Patients who agreed to participate were instructed to fill out the questionnaires while waiting for services. Shortage of clinic space did not allow us to provide a private space to fill out the survey, and patients answered the questionnaire in a public waiting area. Due to staffing shortages, the survey was not distributed regularly during the study period. However, this variation was not associated with specific personnel or shifts and is not likely to have resulted in significant selection bias.

The staff at the San Francisco STD Prevention and Control Program, the San Francisco City Clinic, as well as the San Francisco Department of Public Health collaborated to develop the questionnaire<sup>1</sup>. Patient demographics were collected, along with information on sexual identity and partner gender, sexual risk behaviors, history of ever being diagnosed with a STD/HIV, and partner violence history. Sexual risk behaviors included lack of condom use at last anal intercourse, number of new sexual partners in last three months, whether they were “high on alcohol or drugs” the last time

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<sup>1</sup> Paul Gibson, MPH, Maria Hernandez, MPH, Charlotte Kent, MPH, Jeffrey Klausner, MD, MPH, and Gail Bolan, MD from San Francisco Department of Public Health, San Francisco, California.

they had sex. In addition, participants were asked whether they thought their main sexual partner “has had sex with someone else in the past three months” (partner infidelity). Experience of IPV was assessed by asking: “Have you been hit, slapped, kicked, pushed, or physically hurt by a main sex partner (the partner with which you have a close ongoing relationship)?” Response choices included never, within the past three months, between 3 and 12 months ago, or more than 12 months ago.

The study was administered in English and Spanish. Following pilot testing of the instrument for content and validity, it was determined that the questionnaire could be completed in an average of thirty minutes. Since waiting time at the City Clinic is on average one hour, the majority of participants had sufficient time to complete the questionnaire.

Any male participant who identified as gay, bisexual, or reported a male partner in the last three months was included in the group MSM (men who have sex with men), and used in our analysis. Approximately 5,329 patients attended the clinic during the study period. Among these patients, 2,197 (41.2%) were invited to participate. Out of these patients, 2,115 (96%) agreed to participate in the survey. Over 75% of the participants completed the survey without skipping any pages. Only 38 (1.7%) refused and 44 (2.0%) declined because they were not fluent in English or Spanish.

In total, 1509 men completed the survey. Of these, 635 (42.1%) identified as gay or bisexual, or reported male sex partners in the past 3 months. Of the 635 men, 17 identified as heterosexual, but reported male sex partners in the past 3 months. Completed surveys from these 635 men who have sex with men (MSM) were included in the analysis.

The outcome variables included STD and HIV history, IPV experience, and the following four risk factors: More than one new sexual partner in the last three months, lack of condom use at last anal intercourse, use of alcohol or drugs at last sex, and partner infidelity in the last three months. The outcome variable of interest was IPV experience, stratified into the following hierarchical exposure categories: recent (within the past 12 months), past only (more than 12 months ago), and never.

Data were analyzed using SPSS statistical software (Version 8) in order to assess the relationship between IPV, sexual risk behaviors, and STD/ HIV diagnosis. For comparisons of means, ANOVA was used to determine statistical significance. Any estimates based on fewer than five responses were deemed unreliable and, therefore, not tested for significant differences between or among groups and were not presented in the tables. Pearson chi square test was used to determine statistical significance in cross-tabulations. Statistical significance was defined as  $P < .05$ .

Results from studies examining the relationship between IPV and sexually transmitted diseases show that both IPV and STDs are associated with lower socioeconomic status, lower education, non-white ethnicity, and younger age [4]. In order to examine whether these associations were present in our study sample, we systematically evaluated the interrelationships between our outcome variables and the following demographic and socioeconomic factors: Age, race/ethnicity, education, homeless status, employment, whether respondent was currently receiving public assistance, and whether respondent had private medical insurance or received MediCal insurance.

All demographic variables were based on self-report. Missing items are included in parentheses. Ethnicity was coded as White, Black, Latino, and Other (4 missing). The education variable was coded into the following categories: Less than high school, high school, some college, and college or advanced degree (5 missing). Employment was coded as: Full time, some/part-time, unemployed, and student (2 missing). Income was coded as: No income, less than \$10,000/year, \$10-29,000/year, \$30,000/year or more (3 missing).

Outcome variables were also based on self-report and coded as follows: History of STD diagnosis was coded as never, ever/any (20 missing). IPV history was coded as never, within 12 months, over 12 months ago (23 missing). Condom use at last anal intercourse was coded as yes or no (10 missing). Partner infidelity in the past 3 months was coded as yes or no (0 missing). More than one new partner in the last 3 months was coded yes or no (0 missing). Alcohol and drug use at last sex was coded as yes or no (10 missing). HIV diagnosis was coded as yes or no (20 missing).

Based on the results of our bivariate analyses, logistic regression models were adjusted for age, race/ethnicity, education, and income. Out of a total of 635 cases, 52 were rejected because of missing data, leaving 583 cases to be included in the multivariate analysis. Logistic regression analysis was used to estimate adjusted odds ratios (OR) and 95% confidence intervals (95% CI) for the relationship between IPV and each sexual risk behavior.



## Results

### *Descriptive Statistics*

Descriptive characteristics of MSM participating in the survey are presented in Table 1. The mean age was about 33 years, with a range of 17-68 years. Most of the study participants were white (68.7%), with 7.2% African American, 11.5% Latino, and 12.0% other and mixed. Educational attainment was high, with 53.5% of the participants having a college or graduate degree. Forty-five percent of participants were employed full-time and 21.8% had an annual income over \$30,000. Most (64.9%) were medically insured, and 78.7% were US-born. Recent intimate partner violence (within the last 12 months) was reported by 7.5% of the participants. Past IPV was reported by 8.5% of MSM.

Over 75% of MSM reported a history of STD diagnosis. Reported frequencies of five behaviors shown in previous work to be associated with increased risk of STD are presented in Table 2. Survey participants commonly reported high-risk behaviors, including more than one new sexual partners in the last 3 months (53.4%). Twenty-three percent reported being high on alcohol or drugs the last time they had sex. In addition, of the participants reporting engaging in anal sex, 31.5% did not use a condom at last anal intercourse. Approximately 35.0% of MSM reported they knew or suspected that their main partner had sex with someone else in the past 3 months (referred to in this paper as “partner infidelity”).

Frequencies of specific STD diagnoses are presented in Table 3. A past diagnosis of syphilis was reported by 11.2% of the participants. Other past diagnoses included gonorrhea (44.1%), non-gonococcal urethritis (22.2%), genital warts (26.9%), genital

herpes (18.7%), and chlamydia (11.2%). An HIV diagnosis was reported by 18.3% of MSM participants.

#### *Bivariate Analysis*

Table 4 presents our bivariate findings concerning the association between IPV experience and high-risk behavior indicators. IPV experience was significantly associated with report of being high on alcohol or drugs at last intercourse ( $\chi^2=20.64$ ,  $df=2$ ,  $p=0.000$ ), with MSM who had recently been victims of IPV over twice as likely as MSM with no IPV experience to report being high on alcohol or drugs at last anal intercourse (42.2% Vs. 19.3%). In addition, IPV experience was significantly associated with not using a condom ( $\chi^2=10.80$ ,  $df=2$ ,  $p=0.005$ ). When compared with MSM with no history of IPV, MSM with a recent experience of IPV were almost twice as likely to report not using a condom at last anal intercourse (53.3% Vs. 29.7%).

Although MSM abused in the past were more likely to report being diagnosed with a STD than MSM with no IPV experience (86.5% Vs. 78.0%), the association was not statistically significant ( $\chi^2=2.12$ ,  $df=2$ ,  $p=0.347$ ). The association between reported HIV diagnosis and IPV experience approached statistical significance ( $\chi^2=5.82$ ,  $df=2$ ,  $p=0.054$ ), as did partner infidelity ( $\chi^2=5.70$ ,  $df=2$ ,  $p=0.058$ ). No individual STD diagnosis was significantly associated with IPV experience (data not shown), nor was reporting more than one new partner in the past three months ( $\chi^2=1.49$ ,  $df=2$ ,  $p=0.473$ ).

#### *Multivariate Analysis*

Multivariate logistic regression models were constructed to investigate IPV experience as an independent risk factor for STD-related behaviors, controlling for

potentially confounding variables. In examining potential confounders for inclusion in our model, we looked at bivariate associations between a range of patient characteristics, IPV experience, and outcome variables (data not shown). Older age was associated with a past diagnosis of syphilis, gonorrhea, chlamydia, non-gonococcal urethritis, and genital herpes. African-American race was associated with reported history of syphilis, gonorrhea, chlamydia, genital warts, and with reporting more than one partner in the last 3 months. Lower educational attainment was associated with a diagnosis of chlamydia, non-gonococcal urethritis, genital warts, as well as with use of alcohol and drugs at last intercourse, and with not using a condom at last anal intercourse. Receiving public assistance, being medically insured, receiving Medi-Cal, employment status, and income were relatively co-linear as measures of socioeconomic status; thus, income was the only variable included in the final models.

Table 5 presents the results of the multivariate logistic regression models of the six STD-related outcome measures considered. Interaction terms were tested and none were found to be significant (data not shown). The final models included age, ethnicity, education and income, in addition to IPV history. When these additional variables were controlled for, history of past IPV was significantly associated with reported diagnosis of HIV. Compared to MSM with no history of abuse, MSM with a history of past intimate partner violence had approximately twice the odds of having a positive HIV diagnosis (Adjusted OR=2.05; 95% CI 1.04, 4.05). In addition, recent history of IPV was associated with more than twice the odds of not using a condom at last anal intercourse (Adjusted OR=2.36; 95% CI 1.24, 4.49). MSM with recent and past history of abuse were approximately three times as likely to have been high on drugs or alcohol at their

last sexual encounter (Adjusted OR for recent abuse = 2.84; 95% CI 1.44, 5.57; Adjusted OR for past abuse = 2.92; 95% CI 1.54, 5.52). A history of recent abuse was also associated with increased likelihood of partner infidelity (Adjusted OR = 2.04, 95% CI 1.09, 3.81).

### **Discussion**

Due to the limited body of research as well as methodological problems plaguing the literature on IPV in same-gender relationships, it is difficult to compare the findings of our survey to published results documenting IPV prevalence in a similar population. While 8.5% and 7.5% of our MSM respondents reported past and recent history of IPV respectively, the question assessing IPV history in our survey was restricted to specific components of physical abuse. According to the CDC, IPV can include physical, sexual assault, stalking, and psychological abuse. Furthermore, violence can involve enforced social isolation, intimidation, and the deprivation of resources such as food, clothing, money, transportation, or health care [13]. These were not components of abuse measured by our survey and may explain the lower prevalence of IPV found in our population, when compared to the 25%-33% prevalence reported by agencies addressing intimate partner violence in the GLBT community who may use broader definitions of IPV [2].

However, it is significant that approximately 8% of MSM respondents experienced being “kicked, pushed, or physically hurt” by their main sex partner. It is also significant that the MSM category was not defined solely by men who self-identified as gay or bisexual, but also included male respondents who self-defined as heterosexual but had a male sexual partner within the last 3 months. From the perspective of IPV

screening and prevention efforts, these results imply that self -definitions of sexual orientation should not be used to place men in high-risk categories for IPV. Because some men may choose not to disclose their sexual orientation to health care providers, yet may be involved in same-gendered intimate relationship, all men may be considered to be at risk of IPV and screened accordingly.

The results of our multivariate logistic regression demonstrate a strong association between past history of abuse and HIV-positive status in MSM. These findings echo numerous studies that have documented a strong correlation between both physical and sexual abuse and HIV exposure risk and/or HIV infection [7-13, 14]. Within the context of an abusive relationship, there are several points where IPV may lead to HIV infection. Figure 1 presents a schematic representation of the often complex and multi-layered documented interactions between IPV and HIV. Although arrows on this simplified diagram imply directionality of the cause-effect relationship between IPV and HIV infection risk, it is impossible to determine the direction of causal pathways in a cross-sectional survey such as ours. The purpose of Figure 1 is simply to clarify through schematization the web of interactions linking IPV and HIV.

The most direct association between IPV and HIV infection is through rape or sexual coercion by an infected abuser. However, HIV infection may also be the result of the long-term sequelae of abuse. Studies in women with a history of childhood sexual and physical abuse have demonstrated a significant increase in HIV-risk behaviors as adults [13,15,16]. The postulated mediators of this association include poor self-esteem, depression, impaired decision-making, and learned helplessness resulting from the psychological trauma of violence and abuse [18].

An additional point of interaction between IPV and HIV/STD infection occurs during safer-sex negotiations, particularly condom use. Our results show that, when compared with MSM with no history of IPV, MSM with a recent history of IPV were more than twice as likely not to use a condom at last anal intercourse. Researchers have postulated that victims of IPV experience loss of control and power, vulnerability, and entrapment [18]. Two studies on condom use demonstrated that women who had experienced sexual coercion were significantly less likely to request condom use from their partner and more likely to be abused as a result of requesting a condom [19, 21]. It is plausible that the same fear and power differential which keep women in abusive heterosexual relationships from asking their partner to wear condoms during intercourse operate in violent same-gender relationships. Disclosure of HIV seropositivity, whether voluntary or in the context of partner notification programs, is another point at which IPV may occur. Studies have shown that up to 35% of HIV-positive women report fear of violence around disclosure of their HIV status, including physical and emotional abuse, abandonment, and loss of access to their children [8, 17].

Finally, HIV and IPV interact when the victim of abuse is someone living with HIV. One study found that HIV-infected women involved in abusive relationships were more likely to suffer from chronic illnesses and opportunistic infections than HIV-positive women with no experience of IPV [11]. To an HIV-positive individual, IPV may involve withholding medication, keeping someone from going to medical appointments, participating in support groups or social services [11].

While IPV and HIV may interface in the ways discussed above in any relationship, certain associations between HIV and IPV are specific to same-gender

relationships. These are represented by the bold arrows in Figure 1. Men who are part of communities such as San Francisco where MSM make up the large majority of AIDS cases have often suffered from the loss of many friends and loved ones to this disease. The resultant loss of social support may compound feelings of isolation and disconnection from the community unique to the experience of victims of IPV [10, p.139]. In addition, abusers can use the social stigma associated with HIV infection, as well as the presence of homophobia in the larger community, as threats to keep victims of abuse from leaving the relationship or seeking help [3, p.77, 27].

Multivariate analysis results showed that MSM who had experienced IPV within the past were twice as likely to report partner infidelity (answering “yes” to the question “in the last three months, do you think your main sex partner has had sex with anyone else?”). It is important to emphasize that “partner infidelity” is an outcome variable which was defined and tested in its association to IPV as part of the literature on violence against women who have sex with men. Previous work has demonstrated that heterosexual women with a history of IPV were 4.2 times more likely than nonabused women to have sex with a high-risk partner, i.e. a partner who had sex with other men [4]. While partner infidelity may be part of a continuum of abuse in the MSM community, it is important to first define this outcome variable within the MSM community before ascertaining its meaning as a correlate of IPV.

MSM in our survey with both a past and a current history of IPV were almost 3 times as likely to be high on drugs or alcohol during their last sexual encounter, when compared with MSM with no history of IPV. This suggests a powerful association between IPV experience and substance abuse that merits further research. Our findings

with respect to IPV and substance use corroborate results in the literature linking past and current IPV experience with alcohol and drug use [13, 16, 19, 22]. The facilitative role of drugs and alcohol in violent relationships continues to be the subject of much discussion. For the victim of violence, substance use may be used as part of an avoidance/numbing dynamic to psychologically remove oneself from a painful situation [20]. According to the current mental health conceptualization, victims of chronic abuse experience responses common to victims of post-traumatic shock disorder (PTSD). Substance abuse is a frequent correlate of PTSD [24].

As mentioned previously, a cross-sectional survey does not allow us to infer the directionality of causal relationships. In particular, we had no way of assessing the temporal connection between IPV experience and HIV diagnosis. In addition, our sample population was not a random sample, but a convenience sample taken from a public STD clinic in a large urban area; as such, our results may not be applicable to all MSM communities. Other limitations of this study include recall bias, as well as bias stemming from the sensitive nature of the questions asked in our survey and the fact that respondents did not have a confidential space in which to fill out the questionnaire. However, we know of no other study where the associations between IPV and STD/HIV risk factors have emerged from a sample population of MSM as large as the one in the present survey. The present findings clearly merit further elucidation, specifically with respect to the role of IPV experience and HIV infection in the MSM community. Despite the limitations mentioned above, our findings have several implications for STD/HIV and substance abuse prevention and intervention strategies.



First, HIV/STD prevention efforts stressing the use of condoms aimed at MSM communities not only need to address the possibility of IPV existing in same-gender relationships, but the impact IPV may have on the ability of one individual to negotiate safer-sex practices with his partner(s). Further, messages aimed at risk-reduction strategies to prevent the transmission of sexually transmitted diseases, including HIV, may not be as effective in someone with a past history of IPV whose decision-making around sexual behavior may be affected by the long-term effects of intimate violence. Professionals involved in HIV testing and counseling should particularly be aware of the interactions we found between IPV and HIV, and include IPV screening within the framework of pre and post-test counseling. Finally, the results of our survey point to the potential benefit of combining IPV screening/prevention efforts with substance abuse screening/prevention programs specifically targeting the MSM community.

## Conclusion

Both the literature review and the quantitative research involved in this thesis demonstrate the fact that intimate partner violence can exist in *any* relationship, regardless of the gender or sexual orientation of the intimate partners. The results of the quantitative survey analysis also suggests that IPV, in the context of relationships in which both intimate partners are men, can operate to increase high-risk sexual behaviors in the victims of violence. Beyond adding to the growing body of research on the behavioral correlates of intimate partner victimization in same gender relationships, it is my hope that this thesis will help to contribute to dispelling myths and assumptions about intimate partner violence as solely occurring in heterosexual relationships. In so doing, may it help provide a voice to victims of intimate violence who are still too often suffering in silence.

## References

1. Thoennes, P.T.a.N., *Extent, Nature, and Consequences of Intimate Partner Violence*, . 2000, U.S. Department of Justice and Centers for Disease Control and Prevention: Washington. p. 29-36.
2. Community United Against Violence, Gay Men's Domestic Violence Project, personal communication .
3. Elliot, P., *Shattering Illusions: Same-Sex Domestic Violence*, in *Violence in Gay and Lesbian Domestic Partnerships*, C.M.R.a.C.H. Miley, Editor. 1996, Harrington Park Press: New York. p. 1-9.
4. Nabila El-Bassel, L.G., Satya Krishnan, Robert F. Schilling, Theodore Gaeta, Stacey Purpura and Susan S. Witte, *Partner Violence and Sexual HIV-Risk Behaviors Among Women in an Inner-City Emergency Department*. *Violence and Victims*, 1998. 13(4): p. 377-393.
5. Sandra Martin, L.M., Lawrence Kupper, James C. Thomas, Matthew Daly, Suzanne Cloutier, *Domestic Violence and Sexually Transmitted Diseases: The Experience of Prenatal Care Patients*. *Public Health Reports*, 1999. 114: p. 262-268.
6. Seth C. Kalichman, E.A.W., Charsey Cherry, Lisa Belcher, and Dena Nachimson, *Sexual Coercion, Domestic Violence, and Negotiating Condom Use Among Low-Income African American Women*. *Journal of Women's Health*, 1998. 7(3): p. 371-378.
7. Brown, L.K.L., Kevin Lourie J; Zlotnick Caron; Jennifer Cohn, *Impact of sexual abuse on the HIV-risk-related behavior of adolescents in intensive psychiatric treatment*. *The American Journal of Psychiatric*, 2000. 157(9): p. 1413-1415.
8. Perry, S.M., *Lesbian Alcohol and Marijuana Use: Correlates of HIV Risk Behavioes and Abusive Relationships*. *Journal of Pshychoactive Drugs*, 1995. 27(4): p. 413-419.
9. California Department of Health Services, Office of AIDS, *HIV-AIDS Surveillance Report for California Dec. 31, 2000*, . 2000.
10. Letellier, P., *Twin Epidemics: Domestic Violence and HIV Infection Among Gay and Bisexual Men*, in *Violence in Gay and Lesbian Domestic Partnerships*, C.M.R.a.C.H. Miley, Editor. 1996, Harrington Park Press: New York. p. 69-83.

11. Siegal, H.A.L.I.L., L.C.; Cole, P.A, *Under the influence: Risky sexual behavior and substance abuse among driving under the influence offenders. Sexually Transmitted Diseases*, 1999. 26(2): p. 87-92.
12. STD Prevention and Control, San Francisco Department of Public Health, *San Francisco City Clinic '96 Survey of Knowledge, Attitudes, Beliefs and Behaviors (KABB)*, . 1998, San Francisco Department of Public Health: San Francisco.
13. Saltzman L.E., F.J.L., McMahon P.M., Shelley G.A., *Intimate Partner Violence Surveillance: Uniform Definitions and Recommendations Data Elements, Version 1.0*, . 1999, National Center for Injury Prevention and Control Center for Disease Control and Prevention: Atlanta.
14. Smith D., and Mancoske R., *Contributing Issues to Violence Among Gay Male Couples*, in *A Professional Guide to Understanding Gay and Lesbian Domestic Violence*, Joan McClennen and John Gunther, Editors. 1993, The Edwin Mellen Press, Ltd: Lewiston, p. 63-77.
15. Zierler S., Cunningham W.E., Andersen R., Shapiro M.F., Bozette S.A., Nakazono T., Morton S., Crystal S., Stein M., Turner B., St. Clair P., *Violence and Victimization After HIV Infection in a U.S. Probability Sample of Adult Patients in Primary Care*. *American Journal of Public Health*, 2000. 90(2): p. 208-215.
16. Bensley L.S., Van Eenwyk J., Simmons K.S., *Self-Reported Childhood Sexual and Physical Abuse and Adult HIV-Risk Behaviors and Heavy Drinking*. *American Journal of Preventive Medicine*, 2000. 18(2): p. 151-157.
17. Coker A., Smith P.H., Bethea L., King M.R., McKeown R.E., *Physical Health Consequences of Physical and Psychological Intimate Partner Violence*. *Archives of Family Medicine*, 2000. 9: p. 451-456.
18. Coker A., Smith P.H., McKeown R.E., King M.R., *Frequency and Correlate of Intimate Partner Violence by Type: Physical, Sexual, and Psychological Battering*. *American Journal of Public Health*, 2000. 90(4): p. 553-559.
19. Kalichman S.C., Williams E.A., Cherry C., Belcher L., Nachimson D., *Sexual Coercion, Domestic Violence, and Negotiating Condom Use Among Low-Income African-American Women*. *Journal of Women's Health*, 1998. 7(3): p. 371-378.

20. Melzer-Lange M.D., *Violence and Associated High-Risk Health Behaviors in Adolescents*. Pediatric Clinics of North America, 1998. 45(2): p. 307-316.
21. Campbell J.C., Lewandowski L.A., *Mental and Physical Health Effects of Intimate Partner Violence on Women and Children*. The Psychiatric Clinics of North America, 1997. 20(2): p. 353-373.
22. Schilit R., Lie G., Montage M., *Substance Use as a Correlate of Violence in Intimate Lesbian Relationships*. Journal of Homosexuality, 1990. 19(3): p. 51-65.
23. Cruz J.M., Firestone J. *Exploring Violence and Abuse in Gay Male Relationships*. Violence and Victims, 1998. 13(2): p. 159-173.
24. Campbell J.C., Lewandowski. *Mental and Physical Health Effects of Intimate Partner Violence in Women and Children*. The Psychiatric Clinics of North America, 1997. 20(2): p. 353-357.

## Tables and Figures

**Table 1. Characteristics of the study participants (N=635)**

Characteristic	Participants n(%)
Age, mean (SD)	33.3 (8.0) years
<i>Race/Ethnicity</i>	
White	436 (68.7)
Black	46 (7.2)
Latino	73 (11.5)
<i>Other/Mixed</i>	76 (12.0)
<i>Educational attainment</i>	
<i>Less than high school</i>	27 (4.3)
High school graduate	107 (16.9)
Some college or trade school	156 (24.8)
College graduate	340 (53.5)
<i>Employment status</i>	
Full time	287 (45.2)
Part time	161 (25.4)
<i>Unemployed</i>	147 (23.1)
Student	38 (6.0)
<i>Annual income</i>	
None	84 (13.3)
< \$10,000	150 (23.7)
\$10,000-29,000	260 (41.1)
>30,000 or more	138 (21.8)
<i>Medically uninsured</i>	412 (64.9)
US-born	500 (78.7)
<i>Intimate Partner Violence</i>	
Recent (within 12 months)	46 (7.5)
Past (>12 months prior)	52 (8.5)
Never	514 (84.0)

**Table 2: Risk Behavior Frequencies**

<b>Risk Behavior</b>	<b>Participants n(%)</b>
No Condom at last anal intercourse	200 (31.5)
Partner infidelity in last 3 months	223 (35.1)
Ever diagnosed with STD	485 (76.4)
>1 new partner in last 3 months	423 (66.6)
Alcohol or drug Use at last sex	144 (23.0)

**Table 3: Frequencies of STD diagnoses**

<b>Diagnosis</b>	<b>Participants N (%)</b>
Syphilis	71 (11.2)
Gonorrhea	280 (44.1)
Chlamydia	71 (11.2)
Non-gonochococcal Urethritis	141 (22.2)
Genital Warts	171 (26.9)
Genital Herpes	119 (18.7)
HIV	116 (18.3)

**Table 4. Bivariate relationship between IPV and sexual risk behavior**

History of Intimate Partner Violence	Sexual Risk Behavior					
	History of STD (%)	HIV Dx	>1 New Partner(s) in 3 Months (%)	No Condom at Last Anal Intercourse (%)	Alcohol or Drug at Last Sex (%)	Partner Infidelity (%)
Never Abused (n=514)	78.0	17.3	86.8	29.7	19.3	33.5
Abused in Past Only (n=52)	86.5	30.8	84.8	34.6	38.5	40.4
Recently Abused (n=46)	80.4	21.7	80.8	53.3	42.2	50.0
<i>P</i> *	0.347	0.054	0.473	0.005	<0.001	0.058
$\chi^2$	2.12	5.02	1.44	10.80	20.64	5.70

\* P value derived from Pearson chi square analysis comparing the 3 categories of IPV experience with sexual high-risk behavior. Df = 2.



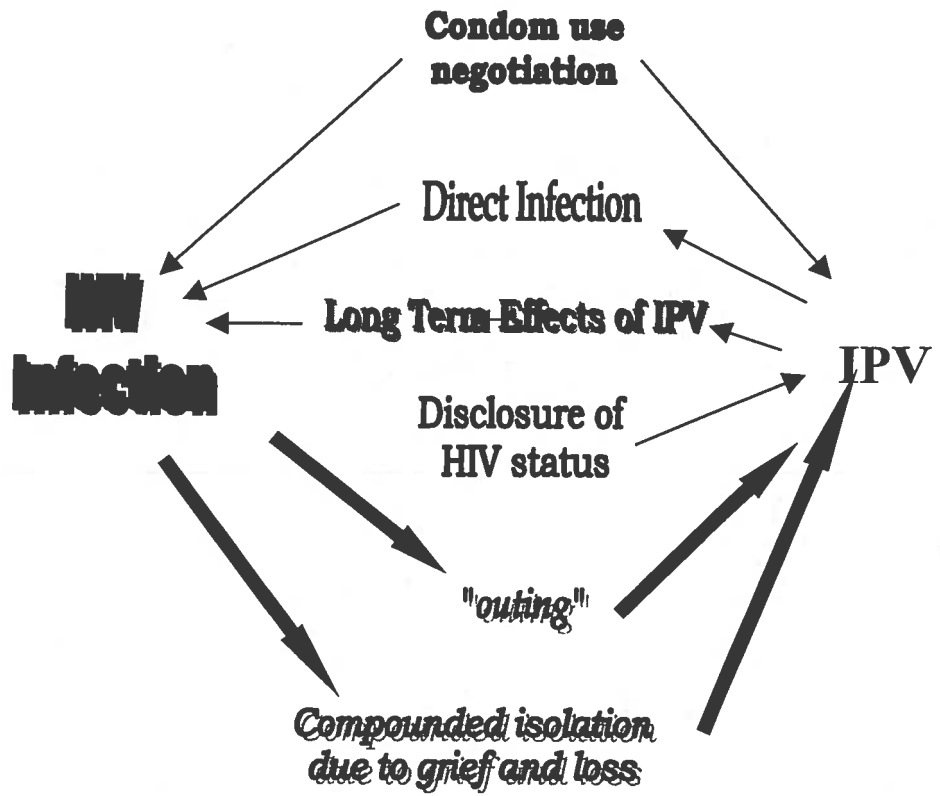
**Table 5. Multivariate analysis of association between IPV and sexual risk behaviors\***

IPV Experience	Sexual Risk Behavior					
	History of STD		HIV Diagnosis		>1 New Partner in 3 months.	
	Crude OR (95% CI)	Adjusted OR (95% CI)	Crude OR (95% CI)	Adjusted OR (95% CI)	Crude OR (95% CI)	Adjusted OR (95% CI)
<u>Never Abused</u>	1.0	1.0	1.0	1.0	1.0	1.0
<u>Abused in Past</u>	1.80 (0.79, 4.12)	1.74 (0.74,4.0)	2.11 (1.12,3.99)	2.05 (1.04, 4.05)	0.89(0.48, 1.62)	0.92(0.49 ,1.73)
<u>Recently Abused</u>	1.15 (0.54, 2.47)	1.49 (0.68,3.2)	1.32 (0.63, 2.77)	1.43 (0.66, 3.08)	0.73(0.39, 1.36)	0.77(0.40 , 1.46)

IPV Experience	Sexual Risk Behavior					
	No condom at last Anal intercourse		Alcohol/Drugs At last sex.		Partner Infidelity in Past 3 months.	
	Crude OR (95% CI)	Adjusted OR (95% CI)	Crude OR (95% CI)	Adjusted OR (95% CI)	Crude OR (95% CI)	Adjusted OR (95% CI)
<u>Never Abused</u>	1.0	1.0	1.0	1.0	1.0	1.0
<u>Abused in Past</u>	1.25 (0.68, 2.28)	1.06(0.56, 1.99)	2.62 (1.43, 4.78)	2.92 (1.54, 5.52)	1.35(0.75, 4.41)	1.31(0.72 , 2.40)
<u>Recently Abused</u>	2.70 (1.45, 5.00)	2.36(1.24, 4.49)	3.06 (1.63, 5.70)	2.84 (1.44, 5.57)	1.98(1.08, 3.64)	2.04(1.09 , 3.81)

\*Reference group is "Never abused". All models adjusted for age, ethnicity, and income.

Figure 1: Relationships between IPV and HIV



## References for Preface

1. National Center for Injury Prevention and Control. 1998. Centers for Disease Control. Atlanta, GA.
2. FBI. Crime in the United States, 1996-1997. Uniform Crime Reports: 1996, p.17.
3. Rand MR. *Violence-related injuries treated in hospital emergency departments*. Bureau of Justice Statistics, Special Report. Washington, DC: U.S. Department of Justice, August 1997.
4. Anti-Violence Project, National Coalition of Anti-Violence Programs. *Lesbian, Gay, Bisexual and Transgender Domestic Violence in 1998*, NYC Edition. 1998.





