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Intimate Partner Abuse among Gay and Bisexual Men: Risk Correlates and Health Outcomes

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ABSTRACT *Little is known about the patterns and types of intimate partner abuse in same-sex male couples, and few studies have examined the psychosocial characteristics and health problems of gay and bisexual men who experience such abuse. Using a cross-sectional survey sample of 817 men who have sex with men (MSM) in the Chicago area, this study tested the effect of psychological and demographic factors generally associated with intimate partner abuse and examined their relationship to various health problems. Overall, 32.4% (n = 265) of participants reported any form of relationship abuse in a past or current relationship; 20.6% (n = 168) reported a history of verbal abuse ("threatened physically or sexually, publicly humiliated, or controlled"), 19.2% (n = 157) reported physical violence ("hit, kicked, shoved, burned, cut, or otherwise physically hurt"), and 18.5% (n = 151) reported unwanted sexual activity. Fifty-four percent (n = 144) of men reporting any history of abuse reported more than one form. Age and ethnic group were unrelated to reports of abuse. Depression and substance abuse were among the strongest correlates of intimate partner abuse. Men reporting recent unprotected anal sex were more likely to also report abuse, Wald (1, n = 773) = 9.02, p < .05, Odds Ratio (OR) = 1.61, Confidence Interval (CI) = 1.18–2.21. We discuss psychosocial issues faced by gay and bisexual men who experience intimate partner abuse as they may pertain to interventions among this group.*

KEYWORDS *Intimate partner abuse, Domestic violence, Men who have sex with men, Sexually transmitted infections, Sexual risk*

INTIMATE PARTNER ABUSE AMONG GAY AND BISEXUAL MEN: RISK CORRELATES AND HEALTH OUTCOMES

Men in same-sex relationships experience abuse rates similar to those faced by women in heterosexual pairings,[1,2] and by as much as three times higher than those reported by men involved with women.[3] Despite this high prevalence, few studies have focused on abuse in same-sex male relationships.[2,4–8] This lack of attention occurs in the face of growing evidence that intimate partner abuse among gay and bisexual men may pose a significant threat to health outcomes, including sexually transmitted diseases and HIV.[9,10]

The purpose of this paper is to describe the patterns of intimate partner abuse among men who have sex with men (MSM) and the psychosocial factors associated

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with this abuse. It has long been maintained in the research literature that a constellation of psychological and demographic factors may increase an individual's risk for becoming a victim of intimate partner abuse. These risk correlates include a history of physical abuse (e.g., childhood abuse and prior domestic abuse), economic distress, and young age.[3,11–13] We sought to explore these issues within the context of physical, mental, and behavioral health outcomes. In addition, this study examined the help-seeking behaviors of abused men to provide a better understanding of where and how victims of intimate partner abuse are likely to seek care.

Intimate partner abuse has been referred to variously as "domestic violence," "intimate partner violence," and "battering." We will use the term "intimate partner abuse," employing a broad definition, which characterizes abuse as a pattern of coercive behaviors that could include physical, psychological and verbal threats, sexual assault, and bodily injury.[14] In addition to a diversity of behaviors, intimate partner abuse among MSM encompasses a wide array of relationships.[7,15–18] To be culturally sensitive, therefore, we did not regard intimate partner abuse among MSM as limited to cohabitating people. This approach is consistent with that used in the National Violence Against Women Survey.[3]

Studies focusing on intimate partner abuse have generally addressed women in heterosexual relationships. Within that population, abuse has been shown to have serious health consequences.[19–23] Little is known, however, about the overall health effects of intimate partner abuse among same-sex male couples or about the help-seeking behaviors of MSM abuse victims. There are signs that these gaps in the research literature may be narrowing. Intimate partner abuse has become so intertwined with health problems that some researchers consider this pattern of coercive behavior a health problem itself. Partner abuse has been described as the third most severe health problem among gay men, after AIDS and substance abuse, and may affect 15–20% of both gay and lesbian couples.[9] More investigations into the relationship between partner abuse and health outcomes are critical as they may help health care providers to more effectively aid men affected by abuse.

Using a diverse, urban sample, we sought to assess the psychosocial and demographic characteristics of MSM who experience intimate partner abuse, and to describe health-related problems that may be closely associated with abuse. We hypothesized that demographic characteristics such as education and income, which are often associated with economic distress, would be inversely related to intimate partner abuse. We also predicted that abuse victims would be more likely than nonvictims to report lower levels of social support, higher levels of sexual safety coping burnout, less "outness" as gay, and lower self-esteem or positive appraisal of one's identity as gay or MSM.

We hypothesized that MSM who report intimate partner abuse would be more likely to experience physical as well as mental and behavioral health problems, including alcohol or drug abuse, smoking, depression, anxiety, heart disease, hypertension, sexually transmitted diseases, and HIV. In addition, we proposed that abuse victims would be more likely to engage in unhealthy behaviors, in some cases as a means of coping and in others as part of the coercive relationship.[24] Along these lines, we hypothesized that MSM who report abuse would be more likely to engage in unprotected sex, have more sexual partners, and use drugs or alcohol before or during sex.

Finally, we sought to assess the help-seeking behaviors of abused MSM relative to those who have not experienced such abuse. We proposed that abuse victims would be more likely to report seeking treatment from physicians and therapists

and more likely to use a range of health resources. It was predicted that lower income levels among abuse victims would result in them being more likely to seek aid from community health centers.

METHOD

Participants

Data are from 15-min anonymous surveys administered at 11 diverse gay/bisexual venues of Chicago during 2001. All participants reported sex with another man in the previous 6 months or were self-identified as MSM ($n = 817$). We used a targeted multiframe sampling approach developed over successive community surveys to avoid bias stemming from reliance on a single sampling source. The sample was collected at "Black Gay Pride" events, Latino clubs or organizations, and a local street fair.

Procedure

Trained outreach workers from the MSM community randomly approached potential respondents within target venues, and requested that they complete an anonymous survey of health-related attitudes and behaviors, drug and alcohol use, and sexual practices. Participants received a stipend of $5. We took a participant's decision to complete the seven-page survey as informed consent. Participants completed the survey in private spaces at the recruitment site. The intercept survey format did not allow for a formal sampling framework, so we could not calculate an enrollment rate. Eligible participants were men 18 and over. Participants were allowed to complete the survey only once. Research assistants briefly examined item responses and instructed respondents to complete any skipped sections of the questionnaire before providing the stipend. Institutional Review Boards of Howard Brown Health Center and The University of Illinois at Chicago approved the survey and procedures.

Measures

The survey addressed: demographics; intimate partner abuse; health care, including recent sexually transmitted infections [STIs] and HIV sero-status; sexual behavior; drug and alcohol use; and psychosocial factors, including attitudes toward sexuality and sexual risk, social support, and depression.

Demographics consisted of ethnicity, education, sexual orientation, annual income, and age. Education and income were standardized and summed to reflect socioeconomic status (SES; $r = 0.47$).

We assessed three forms of *intimate partner abuse*: sexual, physical, and verbal. Sexual abuse was assessed as the participant ever feeling "forced to have unwanted sexual contact in a relationship." Physical abuse was defined as "unwanted physical harm within a relationship (i.e., being hit, kicked, shoved, burned, cut, or facing other undesired physical harm)." We assessed verbal abuse as whether the participant experienced unwanted "physical and sexual threats, physical humiliation, or control in a relationship." Participants indicated whether each form of abuse had occurred in a current relationship, a past relationship, or both. For past relationships, participants indicated how many years ago they were in the relationship.

Health care addressed primary care and related issues. We asked participants to indicate any physical health diagnosis (e.g., hypertension, heart disease, obesity, smoking-related illness). Participants were asked to indicate any STI diagnosis in the previous 2 years: syphilis; genital warts (HPV); gonorrhea, chlamydia, or nonspecific urethritis; herpes, or hepatitis A, B, or C. Participants checked "no," "yes," or "not sure" for each. Participants also reported their HIV status. In addition to physical health problems, participants were also asked to indicate any mental health diagnoses.

To assess *sexual behavior*, we asked participants to indicate whether they had one "primary" partner, defined as "a man you are emotionally close to and have sex with." We then asked participants to indicate how many men they had sex with during the past 6 months "other than your primary partner." Next, we presented a block of rating scales for all HIV-positive partners, and for all HIV-negative or unknown partners; each elicited the frequency of any anal sex, unprotected receptive and unprotected insertive anal sex. Ratings were made on a six-point scale ranging from "Never" (0) to "Nearly every day" (6). For analyses, we computed three variables: any report of unprotected anal sex (insertive or receptive); "transmission risk", any report of unprotected sex with a partner who was of unknown or different sero-status; and overall number of sex partners.

Participants rated their *drug and alcohol use* generally and in the sexual context. General use of each of 11 substances (e.g., alcohol, marijuana, cocaine) was assessed via seven-point frequency ratings ranging from "never" (0) to "about daily" (6), plus two items reflecting substance use problems (how often others expressed concern over drug use interfering with functioning, $r = 0.63$). *Substance use during sex was* assessed by how often men used alcohol, "poppers," cocaine, ecstasy, or any other drug during sex with any partner, from "never" (0) to "every time" (6). For analysis, we computed four categorical substance abuse variables: intoxication on alcohol monthly or more frequently, any "hard" drug use (drugs excluding alcohol or marijuana); any substance use problem reported more than "rarely"; and substance use on 50% or more of sexual occasions.

Psychosocial factors consisted of burnout for sexual safety, depression, social support/isolation, positive appraisal of one's sexual orientation, and "outness" as gay or bisexual. Coping burnout represented the mean of two items ($r = 0.39$; "It takes a lot of effort to keep my sexual behavior safe" and "I find it difficult to maintain my commitment to safer sex") rated on a five-point scale attitude ranging from "Do not agree at all" (1) to "Strongly Agree" (5). Depression was assessed based on the number of items endorsed in a 12-item scale (alpha = 0.91) taken from the Center for Epidemiological Studies' Depression Scale (CES-D). Each item was rated on a four-point frequency scale ranging from "rarely" (0) to "Most or all of the time" (3). We assessed social support by five face-valid items (alpha = 0.86) reflecting the availability of instrumental and emotional supports. Items asked participants to indicate whether they had someone to: 1) have a good time with; 2) give you food or a place to stay; 3) listen to you talk about yourself or your problems; 4) go with you to an appointment for moral support; 5) show you that they love or care for you. Participants rated each of the social support items on a five-point scale of "none of the time" (1) to "all of the time (5). Positive appraisal of one's identity as MSM was the mean of two items reflecting healthy self-esteem as an MSM (i.e., "Being gay/bisexual has a positive effect on me as a person" and "Being gay or bisexual is important to my sense of who I am"). The alpha reliability for the scale was .72. Items were rated on a five-point scale ranging from "Do not agree at all" (1) to "Strongly Agree" (5).

Outness as MSM was assessed by a single item where participants rated their preference to conceal their sexual orientation ("I would rather most people not know I have sex with men") on a five-point scale ranging from "do not agree at all" to "strongly agree".

Help-seeking behaviors were assessed using survey items that asked participants about using specific sources of assistance, such as physicians and therapists. All items used simple check boxes or rating scales, with skip patterns where appropriate. We also asked participants to report the number of medical visits they have had in the past 2 years and where they sought care (e.g., community clinic, county hospital, emergency room).

Method of Analysis

We tested hypotheses using the Wald statistic from the hierarchical logistic regression procedure in SPSS.[25] The Wald produces a chi-square value testing the statistical significance of each coefficient (β) in a regression model with a dichotomous outcome variable. We entered age, socioeconomic status, and ethnicity as an initial step for all analyses.

RESULTS

Sample Characteristics

African Americans comprised 51.3% of the overall sample ($n = 419$), followed by Whites (22.4%, $n = 183$), Latinos (16.3%, $n = 133$), and Asian/Pacific Islanders, other ethnic groups, or unknown ethnicities (10%, $n = 82$). Mean age was 33 years (SD = 9.8). Median education was "some college," median annual income was $31,000–$40,000. Participants described their sexual orientation primarily as "gay" (74.5% of complete sample) or "bisexual" (12.7%). The remaining participants described their sexual orientation using other terms that indicate MSM behavior, including "same-gender loving" and "down low."

Prevalence and Types of Domestic Violence

Overall, 32.4% ($n = 265$) of the total sample reported experiencing intimate partner abuse in either a current or past relationship. Nearly 21% of the total sample reported verbal abuse (63.4% of abuse victims, $n = 168$); 19.2% reported physical abuse (59.2% of abuse victims, $n = 157$); and 18.5% reported sexual abuse (57% of abuse victims, $n = 151$).

Most abuse victims reported experiencing more than one form of abuse (54% of abuse victims, or 17.6% of the total sample, $n = 144$); 30.8% of abuse victims (10% of total sample, $n = 82$) indicated that they had experienced two forms; and 23.3% of abuse victims (7.6% of total sample, $n = 62$) reported all three forms.

The time frame in which participants reported experiencing partner abuse is given in Table 1. The first column shows the percentage of the total sample reporting each form of abuse in a current relationship; the second for those experiencing abuse in a past relationship; the third shows percentages who experienced both current and past abuse; and the fourth column provides the percentages of men reporting each form of abuse at any time. For men who reported abuse in a previous relationship, the mean number of years since the end of the relationship was about 5 years for each form of abuse: sexual ($M = 5.1$ years, SD = 4.7); physical ($M = 5$ years, SD = 4.3); and verbal ($M = 5.1$, SD = 5.1).

TABLE 1 Percentage of total sample experiencing different forms of abuse, by time frame

	Relationship time frame			
Type of abuse	Any current	Any past	Past + current	Any time
Sexual	5.8% ($n = 47$)	14.6% ($n = 119$)	1.8% ($n = 15$)	18.5% ($n = 151$)
Physical	6.2% ($n = 51$)	15.5% ($n = 127$)	2.6% ($n = 21$)	19.2% ($n = 157$)
Verbal	6.5% ($n = 53$)	17% ($n = 139$)	2.9% ($n = 24$)	20.6% ($n = 168$)
Any form	12.5% ($n = 102$)	27.3% ($n = 223$)	7.3% ($n = 60$)	32.4% ($n = 265$)

Demographic and Psychosocial Characteristics of Abuse Victims

In this diverse, urban sample of MSM, reports of current and past intimate partner abuse did not significantly vary by ethnic group: 33% of African Americans reported abuse, 33% of Whites, 35% of Latinos, and 27% of Asian/Pacific Islanders and other ethnic groups. Nearly 40% of the sample reported having a primary partner. There was, however, no significant difference in intimate partner abuse reported by men who had a primary partner versus those with no primary partner.

We hypothesized that younger men would be more likely to report abuse, as would those with lower education and income. Contrary to our prediction, age was not significantly related to abuse. Controlling for age and ethnicity, abuse was least likely in the highest SES group, and increasingly likely among middle and lower SES men, 30.1% versus 33.5% versus 36.5%, Wald (1, 810) = 6.5, $p < 0.05$.

Health Behaviors and Sexual Risk

We examined the relation of abuse with three key health behaviors: alcohol and drug use, unprotected sex, and smoking. We hypothesized that abuse victims would be more likely to engage in unhealthy behaviors. As shown in Table 2, abused men were more likely to report monthly or more frequent alcohol intoxication and problems caused by substance use. Abused men were also more likely to report frequent use of substances before or during sex. Abused and nonabused men, however, did not differ in their use of "hard" drugs.

Abuse patterns significantly related to men's reports of unprotected anal intercourse: abused men were more likely to report unprotected sex in the previous 6 months. There was a marginal effect on specifically transmission risk (sero-discordant unprotected sex). The groups did not differ in their overall number of sexual partners, or in their likelihood of smoking tobacco.

Physical and Mental Health Outcomes

We examined whether intimate partner abuse was related with a range of physical, mental, and behavioral-health outcomes. We found that abused men were more likely to report at least one health problem or diagnosis (e.g., high blood pressure, heart disease, obesity, smoking-related illnesses) than were nonabused men (see Table 2). When controlling for socioeconomic status, age, and ethnicity, we found no statistically significant differences between abused and nonabused men with regard to sexually transmitted infections (STIs); however, when controlling only for socioeconomic status, abused men were more likely to report a recent STI. There were no significant differences between abused and nonabused men concerning HIV sero-status. We also tested mental health outcomes, including reported diagnoses of

TABLE 2 Relationship between abuse status and health outcomes

	Percent of participants reporting abuse	Percent of participants not reporting abuse	Wald, OR (95% CI)
Behavioral health and sexual risk			
Alcohol intoxication	53	42.5	4.87, OR = 1.43 (1.04–1.96)*
Substance use problems	26.4	15.6	9.32, OR = 1.84 (1.24–2.73)*
Substance use with sex	33.5	23.6	6.8, OR = 1.8 (1.16–2.79)*
Hard drug use	18.3	15.2	0.69
Unprotected anal sex	43.6	31.9	9.02, OR = 1.61 (1.18–2.21)*
Transmission risk	23.3	16.9	3.8, OR = 1.74 (1.0–2.16)**
Number of sexual partners	18.3	15.2	0.59
Smoking	42.5	37	1.62
Physical and mental health			
Physical health problems	37.2	28.1	7.35, OR = 1.59 (1.14–2.21)*
STIs	19.2	13.2	5.3, OR = 1.4 (1.04–1.76)***
Mental health diagnoses	20.3	13.1	5.89, OR = 1.66 (1.10–2.51)*
Psychosocial factors			
Safety burnout	50.9	47.6	0.3
Depression	43.9	30.2	8.45, OR = 1.59 (1.14–2.21)*
Social support/isolation	22.9	29.9	2.56
Self-esteem	53	51	0.41
"Outness" as MSM	49.5	41.8	3.48

*$p < 0.05$, controlling for socioeconomic status, age, and ethnicity
**$p = 0.051$ (marginally significant), controlling for socioeconomic status, age, and ethnicity
***$p < 0.05$, controlling only for socioeconomic status

depression, bipolar disorder, and any psychiatric/emotional disorder. As expected, abused men reported higher levels of any lifetime mental health problem.

Psychosocial Factors and Intimate Partner Abuse

We tested five psychosocial variables: burnout for sexual safety, depression, social support/isolation, positive appraisal or self-esteem as MSM and outness. We hypothesized that the experience of intimate partner abuse would be associated with higher levels of burnout, depression, and social support as well as lower levels of positive appraisals and outness with regard to one's sexual orientation. Of these five variables, depression was the only variable that was significantly related to intimate partner abuse. Significantly more abused than nonabused men reported depressive symptoms.

Help-Seeking Behaviors

Consistent with our predictions, intimate partner abuse victims in the current study were more likely than nonabused men to report ever seeing a mental health professional (47% v. 37.2%), Wald (1, $n = 773$) = 6.81, $p < 0.05$, OR = 1.51, CI = 1.11–2.1. There was no significant difference in the number of medical visits for abused men relative to nonabused men. Finally, with the exception of gay/bisexual health centers, there was no significant difference between abused and nonabused men with regard to the specific types of places where they sought care (e.g., county hospital, emergency room, community or free clinic). We found that abused men were more

likely than nonabused men to seek treatment at gay/bisexual health centers (10.9% v. 6.5%), Wald (1, 773) = 4.3, $p < 0.05$, OR = 1.74, CI = 1.03–2.97.

DISCUSSION

Whereas other studies have examined health problems among intimate partner abuse victims, this investigation is one of the first to focus on a diverse sample of urban MSM. We found a significant relationship between a range of health problems and intimate partner abuse in this diverse sample of gay and bisexual men. Abused men were more likely than nonabused men to report problems such as hypertension, heart disease, obesity, smoking-related illness and, to some extent, sexually transmitted infections. Men in abusive relationships were more likely to report depression or other mental health problems, and to engage in unhealthy behaviors such as substance abuse, combining drugs with sex, or unprotected sex. These findings parallel studies of heterosexual samples, which show that intimate partner abuse is a major factor in a range of health problems.[19–21,26–28]

These findings need to be interpreted with caution. Our cross-sectional survey sample does not allow us to make any statements about causality. For example, depression, substance abuse, or sexual risk may follow from an abusive relationship, or even represent a means of coping with abuse. Alternately, these difficulties may precede the abuse and actually create vulnerability to it. Of course, both processes may operate. These health behaviors have larger implications: the use of substances in conjunction with sex has been linked to transmission of HIV and various sexually transmitted diseases. Future prospective studies could address the time course of abuse and health behaviors.

The interpretation of these data is also made difficult by the possibility of retaliatory abuse. In some cases, participants may have instigated relationship abuse, and then become subject to reprisals. In the current study, participants were asked only whether they had experienced abuse and not whether this was the result of their partners acting in self-defense. It should be noted that the primary partner mentioned by abuse victims in this study was not necessarily the perpetrator of the domestic violence; participants were not asked to identify their abuser. Future studies should utilize instruments that address the issue of retaliatory abuse.

Despite these limitations, our findings point up the importance of assessing intimate partner abuse when addressing health problems among MSM. Key health areas include depression, hypertension, obesity, or sexually transmitted infections. Given that intimate partner abuse relates to behaviors such as unprotected sex and substance abuse, abuse may serve as an effective focal point for both treatment and preventive interventions.

The study highlights several challenges for researchers and health providers in meeting the needs of abused men. Intimate partner abuse among MSM does not receive the same attention as it does among heterosexual couples. This occurs despite the fact that partner abuse among MSM couples occurs at similar or higher rates as in heterosexual couples. As a result of the lack of attention, many MSM who need help may not be recognized unless the health care provider is appropriately trained and takes time to assess for abuse.

Another challenge lies in reaching men who experience abuse, and ensuring that those who seek help are effectively served. Our analyses show that despite their heightened rates of health problems, the rate of medical visits by abused versus nonabused men did not differ significantly. The finding that abused men were more

likely to seek care from a mental health professional suggests that medical providers may want to routinely screen gay and bisexual men for depression, given its association with intimate partner abuse. Gay/bisexual health centers may play a heightened role in this area, as these sites often provide both medical and mental health services. It is imperative that future research focus on ways to assess abuse and examine strategies designed to improve outreach to bring these men out of danger and improve their overall health outcomes.

Some researchers have described the reluctance of MSM to seek help from agencies that are traditionally used by abused women.[16] Many of these agencies may not be prepared to assist men or have it as a priority. General mental health care may also present difficulties for MSM who are abused. Many mental health practitioners, even if experienced with partner abuse issues, may be inexperienced in responding to MSM. Alternately, community-based therapists who routinely see MSM may be inexperienced with relationship abuse. In both cases, abused MSM may be discouraged from seeking help. These potential barriers in accessing care may be exacerbated by a general cultural insensitivity toward men who are abused. Future research needs to address how these factors could be addressed in interventions targeting abused MSM.

This study suggests that intimate partner abuse may be an underlying factor for many men who are dealing with health problems. In addition to directing attention to the connection between health outcomes and partner abuse within same-sex male relationships, this study contributes to the literature by focusing on a diverse urban sample of MSM. Although it is important that more research be conducted to improve our understanding of intimate partner abuse among MSM, it is also important that this research be based on samples that reflect the diversity of same-sex male couples. Several previous studies on this topic have addressed ethnically and socioeconomically homogeneous samples, which may limit their generalizability. To better understand the problem of intimate partner abuse and provide effective treatment to MSM who are affected by it, it is essential that research capture the extent of this problem across various demographic groups.

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