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Intimate Partner Violence among HIV Positive Persons in an Urban Clinic

Shruti Ramachandran¹, Michael A. Yonas², Anthony J. Silvestre³, and Jessica G. Burke¹

¹ Department of Behavioral and Community Health Sciences, University of Pittsburgh Graduate School of Public Health, Pittsburgh, PA

² Department of Family Medicine, University of Pittsburgh School of Medicine, Pittsburgh, PA

³ Department of Infectious Diseases and Microbiology, University of Pittsburgh Graduate School of Public Health, Pittsburgh, PA

Abstract

While the intersection of HIV/AIDS and intimate partner violence (IPV) has gained increased attention, little focus has been given to the relationship among minority men and men who have sex with men (MSM). This pilot study, conducted at an urban clinic, explores the IPV experiences of HIV positive persons involved in both heterosexual and homosexual relationships. Fifty-six HIV positive individuals were interviewed to assess for verbal, physical, and sexual IPV, and for HIV-related abuse and attitudes regarding routine IPV screening. Approximately three quarters (73%) of the sample reported lifetime IPV and 20% reported current abuse. Physical IPV (85%) was cited the most by abused participants. IPV rates were highest among African Americans and men who have sex with men (MSM). More than one fourth (29%) of those abused felt the abuse was related to their HIV status. A majority of participants favored IPV screening by providers, but felt it might increase risk of IPV. IPV and its association to HIV are significant issues among this sample. Findings support the need for developing new programs that address these epidemics simultaneously.

Introduction

Intimate partner violence (IPV) and the human immunodeficiency virus (HIV) are two significant public health issues that intersect and cause excess burden of disease. In recent years there has been a growth in evidence of this dual epidemic among women and men (Bogart et al., 2005; Burke, Thieman, Gielen, O'Campo, & McDonnell, 2005; Galvan et al., 2004; Zierler et al., 2000). National prevalence data reveals a 23% abuse rate among women and 15% among men in the U.S. (Breiding, Black, & Ryan, 2005). Most investigations have mainly targeted women and African Americans.. An estimated 12% of HIV/AIDS infections among women in intimate relationships in the U.S. have been caused by IPV (Sareen, Pagura, & Grant, 2009). Conversely, the study of IPV among HIV-infected minority men and non-heterosexual populations is limited. However, recent evidence suggests significant rates of IPV perpetration by heterosexual African American males and higher risk for sexually transmitted infections (STI) and HIV among perpetrators (Raj, Reed, Welles, Santana, & Silverman, 2009). Existing research also shows rates of IPV victimization among MSM range from 12% to 56% (Ramachandran, 2008). While the overlap between HIV and IPV is noted to disproportionately affect women, this syndemic is also significant

among MSM (Zierler et al., 2000; Merrill & Wolfe, 2000; Nieves-Rosa, Carballo-Diequez, & Dolezal, 2000; Craft & Serovich, 2005; Friedman, Marshal, Stall, Cheong, & Wright, 2007; Heintz & Melendez, 2006; Houston & Mckirnan, 2007).

IPV is associated with numerous physical and mental health effects (Campbell, 2002; Greenwood, Relf, Huang, Pollack, Canchola, & Catania, 2002; Shelton, Atkinson, Risser, McCurdy, Useche, & Padgett, 2005), including such chronic conditions as cardiovascular disease, stroke, joint disease, and asthma in women and men (Coker et al., 2002; Woods, Hall, Campbell, & Angott, 2008). Health sequelae of HIV/AIDS are equally burdensome and significantly reduce health-related quality of life (HRQOL) (Hays et al., 2000, Lorenz, Shapiro, Asch, Bozzette, & Hays, 2001; Miners, Sabin, Mocroft, Youle, Fisher, & Johnson, 2001). Lower HRQOL has also been found among HIV positive abused women (McDonnell, Gielen, O'Campo, & Burke, 2005). Ultimately such indicators suggest negative health effects could be further exacerbated among individuals experiencing the dual burden of HIV and IPV.

The exact relationship between HIV and IPV is complex and characterized by multiple points of interaction whereby IPV increases risk of HIV infection and where a positive HIV status can lead to victimization (Campbell, Baty, Ghandour, Stockman, Francisco, & Wagman, 2008; Gielen, Ghandour, Burke, McDonnell, & O'Campo, 2007; Maman, Campbell, Sweat, & Gielen, 2000). Focusing on the latter, studies exploring factors associated with onset of IPV among HIV infected individuals indicate violence often occurs following HIV status disclosure and IPV is more likely among people with HIV positive partners than HIV negative/unknown status partners (Zierler et al., 2000; Galvan et al., 2004; Gielen, McDonnell, Burke, & O'Campo, 2000; Koenig & Moore, 2000).

These co-occurring epidemics have significant implications for prevention. Provider-delivered IPV screening is the primary strategy for identifying and preventing abuse among HIV positive women (Koenig & Moore, 2000; Gielen et al, 2000; Gielen et al., 2007). While abused and non-abused women have expressed favorable attitudes towards routine IPV screening (Gielen et al., 2000; Ramsay, Richardson, Carter, Davidson, & Feder, 2002), little is known regarding perspectives of HIV infected persons. Furthermore, there is a lack of interventions concurrently tackling the prevention and reduction of IPV and HIV (Gielen et al, 2007).

This pilot study was conducted among HIV positive patients attending an urban clinic in Pittsburgh. The primary aims of the study were to examine IPV experiences, determine IPV screening preferences and explore racial and sexual orientation subgroup differences. This study represents the first of its kind in exploring current and lifetime IPV experiences and attitudes towards routine IPV screening among HIV infected men and sexual minorities.

Methods

Sample and Procedure

In collaboration with staff from a local AIDS treatment clinic, the research team enrolled a convenience sample of 56 HIV positive patients. Patients were eligible to participate if they were 18 years of age and older and received care and services at the clinic. Study flyers were posted throughout the clinic and an on-site recruiter approached and enrolled patients and provided study information. Given the sensitive nature of the study topic, flyers and on-site recruitment did not specifically mention IPV as the focus of the survey/study. Though the final sample was not representative of the entire clinic population, it was similar since it was comprised of mostly low income patients, men and MSM.

Following informed consent, participants completed a one-time face-to-face interview conducted in a safe and secure location. The interview included a combination of standardized scales, closed-ended, and open-ended items and were adapted and modified from prior work (Gielen et al., 2000; Gielen et al., 2000, Burke, Mahoney, Gielen, McDonnell, & O'Campo, 2009; O'Campo, McDonnell, Gielen, Burke, & Chen, 2002). Participants were compensated with a \$25 grocery store gift-card. Study procedures were approved by the University of Pittsburgh Institutional Review Board.

Measures

Sample Demographics and HIV-Related Demographics—Demographic information such as age, gender, race, education, and income, and sexual orientation was gathered for all participants. HIV-related demographic measures included how many years the subject had been seropositive, mode of transmission, current use of HIV medication(s), and hospitalizations for medical problems since becoming seropositive.

Intimate Partner Violence Measures—Lifetime IPV was measured using the established Abuse Assessment Screen (McFarlane, Parker, Soeken, & Bullock, 1992) which includes three items asking participants whether they had (1) ever been in an intimate relationship where they were repeatedly called names or yelled at, belittled in public, or had their social life controlled by the other person, (2) ever been hit, slapped, kicked, pushed or shoved or otherwise physically hurt by someone they have been in an intimate relationship with, and (3) ever been forced into sexual activities by someone they have been in an intimate relationship with. Current IPV, occurring in the past 5 months, was calculated using the year the subject reported abuse by a partner and the date of the interview.

HIV Status, Disclosure, and IPV—Participants reporting one or more types of IPV were asked if they thought their HIV positive status was related to abuse they experienced, and asked for each type of abuse reported. Fear of abuse prior to and following HIV status disclosure was also measured. Participants were asked if they were ever afraid their partner(s) would get violent/physically attack them upon learning their status and whether they did get violent/physically attack them upon disclosure.

Primary Care Screening and Services—Scaled items regarding patient attitudes toward routine IPV screening and IPV-related service utilization were incorporated into the survey. Participants were asked whether they “agreed” or “disagreed” to various statements regarding routine provider-delivered IPV screening (Burke et al., 2009).

Analysis

Analysis was performed with use of SPSS Version 14.0. Univariate and bivariate analyses were conducted for distributions regarding sample demographics, HIV-related variables, lifetime abuse prevalence, abuse type, and patient attitudes toward IPV screening. Bivariate distributions were stratified by abuse type to examine differences between abused and non-abused participants. Due to small sample size, the Fisher's Exact test was used to determine significance for all bivariate analyses. Statistically significant differences ($p < 0.05$) are identified in the results.

Sexual orientation was measured as an open-ended question and later coded into three groups—heterosexual, homosexual, and bisexual.. Gender was stratified by sexual orientation to explore abuse differences among homosexual, bisexual, and heterosexual women and men. Gender by sexual orientation was further recoded to combine homosexuals and bisexuals in order to compare IPV between sexual minorities and heterosexuals. Frequency calculations were performed in order to examine the proportion of participants reporting an

association between IPV and their HIV status, fear of status disclosure, and IPV following disclosure. These variables along with measures of patient attitudes regarding IPV screening and service utilization were further analyzed for differences by race and sexual orientation.

Results

The findings in this section present univariate and bivariate frequency distributions of demographics, IPV experiences, and attitudes towards routine screening among a sample of HIV seropositive patients attending a treatment center. Fisher's exact tests were found to be statistically insignificant for almost all observed differences among groups.

Socio-demographic Characteristics

Socio-demographic characteristics are displayed in Table 1. A majority of the sample were men (68%), African American (54%), and between the ages of 40 and 49 (54%). More than 50% of participants obtained some form of education after high school and earned an annual household income between \$1,000 and \$30,000 (84%). More than half self-identified as heterosexual, 34% as homosexual, and 11% as bisexual. Overall, 41 (73%) participants reported ever experiencing some form of abuse. Lifetime abuse rates varied by race, with African Americans reporting more abuse (61%) compared to Whites (34%). Relatively equal rates were found between homosexuals/bisexuals and heterosexuals (51% vs. 49%) (Table 1).

HIV Status & History

Forty three percent of participants had been HIV positive for 10 to 20 years and majority cited unprotected sex (73%) as the primary mode of transmission. Close to three quarters of the participants (73%) reported taking HIV medications at the time of interview. Non-abused participants were significantly more likely to report taking HIV medication than abused participants (93% vs. 66%) (p -value = 0.04).

Intimate Partner Violence Experiences, HIV Status and Disclosure

Abuse experiences are reported in Table 2. Of the 41 participants who reported lifetime abuse, 61% were injured from this abuse and 27% reported either verbal or physical abuse by a partner in the past 5 months. Physical abuse (85%) was the most commonly reported type of lifetime abuse, followed by verbal (73%), and sexual abuse (22%). More than one third of abused participants (44%) reported both physical and verbal abuse, while 17% reported lifetime physical, verbal, and sexual abuse by a partner.

More than one fourth of abused participants felt the abuse was related to their HIV status. When asked about HIV status disclosure, 16% reported feeling afraid to disclose their positive status to an intimate partner. Upon disclosure, 7% of the total sample reported their partner became violent and/or physically attacked them. Abuse following status disclosure only occurred among African American participants, most of whom were heterosexual men (75%).

After combining gender and sexual orientation categories (Table 3), female heterosexuals and male homosexuals held the highest rates of IPV. Also, female heterosexuals compared to male homosexuals, reported slightly higher rates of verbal (37% vs. 27%), physical (37% vs. 31%), and sexual abuse (44% vs. 33%), however these differences might not be statistically significant. In combining percentages for male homosexuals and bisexuals, MSM reported higher rates of IPV than female heterosexuals, for all types of abuse.

IPV Service Utilization & Attitude Towards Screening

One fourth of the sample reported ever using IPV-related services in the local area. Of those reporting service utilization, most (85.7%) reported some form of lifetime IPV. Majority (95%) agreed that routine IPV screening would make it easier for patients to get help and patients would be glad the doctor took an interest (Table 4). When asked about screening for IPV among all patients at all visits, 68% agreed to this option though 38% felt patients might be more at risk of being hurt by their partner (Table 4). Almost half (48%) felt patients would be embarrassed or offended if routinely screened for IPV by a provider but less than one fourth (23%) felt patients would be insulted by this practice. Heterosexual and homosexual/bisexual participants held similar attitudes towards routine IPV screening.

Discussion

Findings from our pilot study of 56 HIV positive individuals show alarming rates of current and lifetime partner violence among both women and men. Rates of IPV across all types of abuse were higher among MSM compared to heterosexual women, and higher among African Americans than any other race. Risk of experiencing IPV is valid and identification and prevention through routine screening should be standard clinical practice, particularly among racial and sexual minorities. This study represents one of the first investigations to explore current and lifetime IPV among HIV positive men and sexual minorities. And though tests of association failed to show significant bivariate relations, findings still suggest a notable overlap of HIV and IPV and a need for further research and practice in this area.

African Americans, mainly heterosexuals, report disproportionate rates of IPV victimization and perpetration compared to Whites and other racial/ethnic groups (Cazenave and Straus, 1979; Hampton and Gelles, 1994; Rennison and Welchans, 2000; Sorenson, Upchurch, and Shen, 1996). Though understanding of this disparity is limited, several researchers theorized that structural factors such as higher percentages of African Americans residing in neighborhoods of severe poverty and social disorganization are related to higher prevalence and acceptance of IPV (Taft, Bryant-Davis, Woodward, Tillman, and Torres, 2009; Sampson and Wilson, 1995; Browning, 2002; Anderson, 1999). Meanwhile, high levels and risk of IPV and other forms of violence and trauma among sexual minorities, especially MSM, have been linked to an overwhelming amount of minority stress and gay-related developmental factors such as disclosure of sexual orientation and same-sex sexual debut, (Friedman et al., 2007; Stall, Friedman, and Catania, 2008). Though MSM cited more IPV, abuse following disclosure was primarily reported by heterosexual men. One explanation could be that IPV among women, upon status disclosure, is underrepresented given the small proportion of women in sample and clinic populations. However, this factor alone cannot explain the unexpected and disproportionate level of abuse among heterosexual men considering the clinic and study had a higher representation of MSM. Findings also differ from national estimates reporting higher rates of physical harm upon HIV status disclosure among women and MSM compared to heterosexual men (Zierler et al., 2000). More rigorous analysis of the nature and context in which IPV occurs among sexual minorities compared to heterosexuals is warranted, especially qualitative inquiries that explore relationship dynamics.

A subset of our sample reported fears of and/or experiences of IPV following HIV status disclosure to their partners and related IPV they experienced to their positive HIV status (29%). In accord with recommendations of prior investigators (Gielen et al., 2000; Koenig & Moore, 2000), screening and counseling for IPV by health care providers or counselors should be conducted alongside HIV counseling and testing but prior to the patient disclosing their status to their partner. Perhaps the most critical implication is the need to explore new intervention models that tackle both epidemics simultaneously. Future research efforts,

particularly prospective studies conducted among high-risk populations (i.e. minority MSM) exploring IPV before and after HIV transmission, would further our understanding of the exact relationship between these epidemics and would help inform and shape interventions.

Traumatic life events, such as IPV, are associated with non-adherence to antiretroviral (ARV) therapy, more rapid progression to AIDS, and mortality (Leserman et al., 2000; Mugavero et al, 2006). Though our study did not measure adherence, non-abused participants were significantly more likely to report using ARV medications than abused participants. Prior investigations have hypothesized that physical and mental health sequelae of abuse and general mistrust of providers might hinder HIV positive individuals from managing their health properly and refusing ARV therapy when advised by providers (Cohen et al., 2001; Cohen et al., 2004; Ricart et al., 2002; Leenerts, 1999; McNutt et al., 2000).

Overall, participants felt routine IPV screening would be helpful, but over one third felt routine screening might increase chances of IPV by one's partner. Patients might fear abusive partners could learn of the patient's disclosure of abuse to the provider during routine appointments or subsequent linkage to and utilization of IPV-related services, and become violent as a result. As articulated by Gielen et al. (2000), providers should utilize IPV screening protocols that emphasize safety planning on how best to end IPV without putting patients in more danger with abusive partners. With a low percentage of service utilization (25%), routine screening would increase case identification and IPV-specific referrals, subsequently increasing service utilization. Screening for perpetration would also prove useful for IPV and STI/HIV prevention efforts (Raj et al., 2009).

While findings indicate favorable attitudes toward routine screening, prior studies have shown provider-initiated IPV screening is low due to various barriers such as fear of offending patients, safety concerns, and lack of time and education regarding IPV (O'Campo et al., 2002; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Incidentally, when properly trained, providers overcame such barriers and increased routine IPV screening and identification/documentation of abuse (Thompson et al., 2000). IPV training among HIV specialists is a crucial investment that enhances awareness of these co-morbidities.

In light of our findings, there are several study limitations that should be considered. First, due to convenience sampling, study outcomes are not representative of the entire patient population attending the HIV treatment center. Second, sampling a clinic population consisting of mostly low income men and MSM is not representative of other HIV positive groups. Furthermore, due to sample size considerations our study was under powered to detect statistically significant relationships. And though substance abuse is a modifying factor with respect to either epidemic, our study did not measure for it. This additional overlapping epidemic should be included in future work. And finally, self-identification of sexual orientation can fail to capture same-sex behavior among those individuals who may have same-sex sexual partners but do not self-identify as homosexual and/or bisexual. This could produce different outcomes across groups and should be considered during future investigations.

As a pilot investigation, the scope of our study was narrow in nature and focused primarily on gathering preliminary data among a patient sample that will be used to guide large-scale investigations of this disease overlap. Though our prevalence percentages are not generalizable, the most meaningful outcome of this study indicates an overwhelming need and approval of routine IPV screening. Our results also underscore the need for future

research and intervention efforts addressing the IPV experiences of HIV positive men and women.

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Table 1**Demographic Characteristics of HIV Positive Men and Women by Abuse Status**

	Abused (N=41)	Non-Abused (N=15)	Total (N=56)
	n(%)	n(%)	n(%)
Gender			
Male	27 (66)	11 (73)	38 (68)
Female	14 (34)	4 (27)	18 (32)
Age			
20 – 29	2 (5)	-	2 (4)
30 – 39	6 (15)	2 (13)	8 (14)
40 – 49	21 (51)	9 (60)	30 (54)
50 +	12 (29)	4 (27)	16 (28)
Sexual Orientation			
Bisexual	6 (15)		6 (11)
Homosexual	14 (34)	5 (33)	19 (34)
Heterosexual	21 (51)	10 (67)	31 (55)
Race			
African American	25 (61)	5 (33)	30 (54)
White	14 (34)	8 (53)	22 (39)
Asian/Pacific Islander	-	1 (7)	1 (2)
Other	2 (5)	1 (7)	3 (5)
Education			
Some high school	4 (10)	-	4 (7)
High school	14 (34)	5 (33)	19 (34)
More than high school	21 (51)	8 (53)	29 (52)
GED	1 (2)	1 (7)	2 (4)
Vocational school	1 (2)	1 (7)	2 (4)
Income			
1,000 – 10,999	17 (42)	7 (47)	24 (43)
11,000 – 29,999	17 (41)	6 (40)	23 (41)
30,000 – 49,999	3 (7)	1 (7)	4 (7)
50,000 – 69,999	3 (7)	-	3 (5)
70,000 +	1 (2)	1 (7)	2 (4)

* Please position Table 1 at the top left corner of the page with corresponding text/results from the sub-section labeled “Socio-demographic Characteristics” to the right or directly below the table.

Table 2

Abuse Prevalence, Types of Abuse, and HIV-related Abuse

	N = 41
	n(%)
Current abuse	11 (27)
Current Verbal	11 (100)
Current Physical	4 (36)
Types of lifetime abuse	
Physical	35 (85)
Verbal	30 (73)
Sexual	9 (22)
Physical and Verbal	18 (44)
Physical and Sexual	1 (2)
Physical, Verbal, and Sexual	7 (17)
Injured from lifetime abuse	25 (61)
Lifetime abuse related to HIV Status	12 (29)
Lifetime verbal abuse related to HIV status	10 (33)
Lifetime physical abuse related to HIV status	6 (17)

* Please position Table 2 to the right of the sub-section labeled "Intimate Partner Violence Experiences, HIV Status and Disclosure".

Table 3

Gender, Sexual Orientation, and Abuse Type

	Verbal (N=56)	Physical (N=56)	Sexual (N=56)
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Male and Heterosexual	5 (17)	6 (17)	0
Male and Homosexual	8 (27)	11 (31)	3 (33)
Male and Bisexual	5 (17)	4 (11)	2 (22)
Female and Heterosexual	11 (37)	13 (37)	4 (44)
Female and Homosexual	1 (3)	1 (3)	0
Female and Bisexual	0	0	0

* Please position Table 3 directly below/at the bottom of the page and following the subsection labeled “Intimate Partner Violence Experiences, HIV Status and Disclosure”.

Table 4

Perceptions regarding routine screening of IPV by Sexual Orientation

	Sexual Orientation		Total (N=56)
	Heterosexual (N=31)	Homosexual/Bisexual (N=25)	
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Patients would be embarrassed or offended	13(42)	14(56)	27(48)
Patients would be insulted	5(16)	8(32)	13(23)
Would make it easier for patients to get help	30(97)	23(92)	53(95)
Patients might lose their health insurance	1(3)	2(8)	3(5)
Patients might be more at risk of being hurt by their partner	11(36)	10(40)	21(38)
Patients would be glad that the doctor took an interest	29(94)	24(96)	53(95)
Screen all patients at all visits	21(68)	17(68)	38(68)

* Please position Table 4 at the very top of the page with text from the sub-section labeled "IPV Service Utilization & Attitude Towards Screening" right underneath the table.