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Receipt and Perpetration of Intimate Partner Violence and Condomless Anal Intercourse among gay and bisexual men in Atlanta

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Abstract

Intimate partner violence (IPV) rates are disproportionately high among sexual minority populations, with increasing evidence that gay men experience IPV at the same rates as heterosexual women. This study examines the relationship between self-reported condomless anal intercourse (CAI) and intimate partner violence (IPV) among a sample of 750 gay and bisexual men. Participants answered questions regarding recent receipt and perpetration of IPV using the IPV-GBM Scale (Cronbach Alpha 0.90). Of the sample, 46.1% reported recent receipt of any type of IPV and 33.6% reported recent perpetration of any type of IPV. Overall, 55.1% of participants reported CAI at last sex. Significant associations were determined between several forms of IPV and increased odds of reporting CAI at last sex. These findings suggest that IPV may be a risk factor for CAI among MSM, and highlight the need to understand the IPV prevention and care needs of this population.

Keywords

violence; sexual risk; male couples

BACKGROUND

Gay, bisexual, and other men who have sex with men (MSM) continue to bear a disproportionate burden of the HIV/AIDS epidemic in the United States [1]. New diagnoses of HIV/AIDS among MSM in the U.S. have increased by 12% between 2008 and 2010,

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Compliance with Ethical Standards: The research protocol and data collection tools were approved by Emory University IRB.

Conflict of Interest: The authors have no conflicts of interest to declare.

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent: Informed consent was obtained from all individual participants included in the study.

making MSM the only risk group with increasing HIV incidence [1]. These persistent disparities in HIV transmission have been described by two major theories: syndemic theory [2, 3] and minority stress theory [4, 5]. Syndemic theory states that MSM experience multiple concurrent and interacting epidemics of poor health (e.g., depression, anxiety, substance/alcohol abuse, high rates of sexually transmitted infections), all of which compound and multiply HIV risk [2, 3]. Minority Stress theory, as put forth by Meyer, argues that in addition to experiencing common stressors, MSM experience domains of stress unique to sexual minority groups (e.g., internalized homophobia, heterosexist discrimination), creating a hostile environment in which syndemic risks are exacerbated [4, 5]. Taken together, these two theories suggest that the continuing HIV epidemic among MSM is to some degree shaped by the stress and discrimination associated with residence in a heteronormative society [4, 6–9].

Recently, researchers have begun to examine intimate partner violence (IPV) as a potential syndemic risk factor that may contribute to high rates of HIV among MSM [10–14]. Researchers have used varying definitions and measurements of violence, resulting in vastly different prevalence estimates across several varying types of violence. A recent systematic review of the literature regarding IPV among MSM conducted by Finneran and Stephenson (2013) reported prevalence rates of IPV among MSM equal to or greater than prevalence rates among heterosexual couples [15]. Despite a wide variety of IPV definitions and recall periods, estimated prevalence for receipt of any form of IPV among MSM ranges from 32% [16] to 78% [17]. Perpetration rates have been comparatively less studied, and range from 8.3% [18] to 78% [19] for any type of IPV. There is evidence that rates of IPV may be higher among MSM of color [16, 20], men with lower levels of education [21], men living with HIV [2, 20, 21], and young men who have sex with men (those aged 15–24) [22, 23].

Of particular importance is emergent evidence demonstrating a link between IPV, sexual risk-taking, and risk for HIV infection [6, 13–16, 21, 24–26]. The connection between IPV and HIV risk has been well-documented among samples of heterosexual women [27–31, 36–38]. A number of studies have demonstrated that women who experience IPV may also experience a loss of power within the relationship, limiting their ability to use condoms or agency over when sex happens [35–37]. Women who experience physical IPV have been shown to be significantly more likely to perceive that requesting condom may cause retaliatory violence [38]. A growing body of evidence has documented a connection between IPV and condom use among gay and bisexual men, and other men who have sex with men [10–14, 17, 22, 25, 26, 32–34, 43]. Recent findings demonstrate increased odds of condomless oral and anal receptive sex associated with lifetime experience of IPV, and increased odds of insertive, as well as receptive, CAI associated with lifetime perpetration of IPV [32]. Additionally, IPV was used as one of five indicators of syndemic stress in a study by Starks and colleagues, that identified positive associations between total syndemic stress score and disclosure of HIV status prior to first CAI, as well as a decrease in overall condom use among gay men [12]. It has been suggested that the experience of multiple forms of syndemic stress, including IPV, not only exacerbates HIV risks, but prevents MSM from seeking available HIV prevention services [3].

Two studies by Kalichman et al. demonstrated that MSM who had recently experienced IPV were significantly more likely to report feeling unable to talk about condom use with their sexual partners [20, 24]. These findings were confirmed by a recent study conducted by Stephenson and colleagues that demonstrated a significant increase in low condom negotiation efficacy associated with physical, sexual, controlling and emotional IPV among MSM, with low negotiation efficacy scores increasing with each additional type of IPV [26]. Diminished condom negotiation efficacy appears to be one process by which IPV works to prevent condom use. Studies conducted with young men who have sex with men (YMSM), have demonstrated that YMSM who experienced IPV had significantly higher odds of reporting depression, drug use, positive HIV status, unprotected oral sex and anal sex and other high-risk sexual behaviors [2, 23, 32]. Receipt of IPV is highly correlated with substance and alcohol use/abuse in MSM, suggesting a plausible mediating impact on the relationship between IPV and sexual risk-taking [2, 16, 23, 33, 34]. However, existing studies of the connection between IPV and CAI among MSM have focused almost exclusively on the experience of IPV, and there is very little evidence that has examined the association between CAI and the perpetration of IPV. Additionally, studies have focused on the experience of physical or sexual violence, with a lack of consideration of other forms of IPV (i.e. emotional violence). This study examines the association between the experience and perpetration of multiple forms of IPV among a large, diverse sample of gay men in Atlanta, US, and examines associations between IPV and CAI. Understanding the relationships between IPV and CAI has the potential to inform the development of IPV prevention messages, and to highlight the need to consider IPV screening in HIV testing and counseling.

METHODS

This study was approved by _____ University's ethics committee. The data for this study were drawn from project Let Us Stand Together (LUST), a study of gay and bisexual men in Atlanta, GA, conducted in August – December, 2011. The venue-based recruitment strategy and overarching goals of Project LUST have been described previously [15, 39]. In short, we conducted a gay-friendly venue-based systematic recruitment of men who self-identified as gay or bisexual, were aged 18 and older, lived in the Atlanta metro area and reported having had sex with a man in the previous six months. Over the five months of recruitment, approximately 1,100 gay and bisexual men completed the anonymous, 20-minute online survey. The survey covered several domains, including demographic characteristics, sexual risk-taking behavior with the respondent's most recent male anal sex partner, and reports of recent receipt and perpetration of intimate partner violence (IPV).

Measurements

Intimate Partner Violence—Both receipt of IPV and perpetration of IPV were assessed using the IPV-GBM Scale (Cronbach Alpha 0.90) [15], a novel IPV measurement empirically derived from a sample of gay and bisexual men. The IPV-GBM scale consists of 22 items of IPV in five unique domains six items of physical/sexual IPV (being punched/hit/slapped, kicked, pushed/shoved, raped, forced to do something sexual, and having property damaged), six items of monitoring IPV (demanding access to a cell phone, demanding

access to email, reading text messages without permission, reading emails without permission, and repeatedly posting on social networking sites), four items of controlling IPV (being prevented from seeing friends or family, or being prevented from seeing one's partner's friends or family), three items of HIV-related IPV (being lied to about HIV status, having HIV status not disclosed prior to sex, and intentionally transmitting HIV), and three items of emotional IPV (being told to "act straight" around certain people, being called fat or ugly, and having clothes criticized). All items were assessed using a recent (one-year) recall period. A respondent was classified as having recently experienced a particular domain of IPV if he endorsed any item from that domain; forms of IPV were not mutually exclusive. Perpetration of IPV was similarly measured. In addition to measuring receipt and perpetration of each individual form of IPV, variables were also created to measure receipt and perpetration of any domain of IPV within the past year.

Sexual Risk—Sexual risk was defined as any condomless anal intercourse (CAI) at last sex with a male partner in the past six months. Respondents were asked if a condom was used for the entire duration of either insertive anal sex (topping) or receptive anal sex (bottoming), or both insertive and receptive anal sex if the respondent reported engaging in both receptive and insertive anal sex at last sex. If the respondent reported that a condom was not used, was used for part of the time, or that the condom broke and was not replaced, he was classified as having CAI at last sex. The survey did not assess partner type, for example, whether the last male sex partner was a primary or casual partner. This should be considered a limitation of the current analysis: it is plausible that the relationship between IPV and condom use may be different for primary versus casual partners given the likely differences in trust, communication and conflict management style that may exist between primary and casual partners.

ANALYSIS

A logistic regression model was fitted to the outcome of CAI at last sex in the past 6 months. The key covariate of interest was IPV; five binary variables measuring the recent experience of each form of IPV were included (physical or sexual, controlling, monitoring and emotional and five binary variables measuring the recent perpetration of IPV were included (physical or sexual, controlling, monitoring and emotional). Variance inflation factors were examined to assess collinearity: the receipt and perpetration of IPV variables proved not to be collinear. Each model controlled for age groups based upon quartile distribution, race/ethnicity (white non-Hispanic, Black/African-American non-Hispanic, or Latino/Hispanic/Other), education level (high school or less, some college or a 2-year degree, or college or more), employment status (currently unemployed or employed either part- or full-time), HIV status (negative, positive, or don't know/never been tested/prefer not to answer), and sexual orientation (gay/homosexual or bisexual). A Bonferroni correction adjustment was made to *P* values to reduce the chances of false positive results (Type I error). Analyses were conducted in Stata statistical software version 14.1 (StataCorp LP, College Station, TX).

RESULTS

Of 4,903 men approached during venue time-space sampling, 59.9% (n=2,936) consented to preliminary screening, 71.3% of whom (n=2,093) were eligible for study participation. Of all men eligible, 1,965 (93.9%) were interested in study participation. A total of 1,075 men completed the survey; thus 51.4% of eligible men and 21.9% of all men approached completed the survey. Of all survey responses, 750 had complete data for all covariates of interest and were included in the analysis. Chi-square tests were performed to examine differences between those with missing and complete data on the key covariates: there were no significant ($\alpha = 0.05$) differences in demographic characteristics (age, race/ethnicity or education) or reporting of IPV. Demographic characteristics of the sample are summarized in Table 1. The sample was young (approximately 50% under 35 years-old), gay/homosexual-identified (8.8% bisexual-identified), diverse (32.5% African American), employed (78.4%), and educated (51.1% college or greater). Approximately one-third of the sample (31.7%) reported positive (25.3%) or unknown (6.4%) HIV status, reflecting similarly recruited samples of MSM in Atlanta [40].

Figure 1 illustrates the high levels of both reported receipt of IPV and reported perpetration of IPV. Overall, nearly half the sample (46.1%) indicated that they had experienced at least one form of IPV in the past year from a male partner. For receipt of IPV, the most commonly reported domain of IPV was emotional IPV (28.3%), followed by physical/sexual IPV (23.6%) and monitoring IPV (21.6%). Controlling IPV (10.7%) was comparatively less reported. Over one third (33.6%) of the sample indicated that they had perpetrated any type of IPV. Perpetration of emotional IPV was the most commonly reported form of IPV perpetration (18.4%), followed by monitoring IPV (17.5%) and physical/sexual IPV (13.3%).

Over half the sample (55.1%) reported CAI at last sex. The relationships between IPV and CAI were varied (Table 1). Men who reported recent experience of physical or sexual IPV (OR: 1.58, 95% CI: 1.01, 2.46) or monitoring IPV (OR: 1.93, 95% CI: 1.24, 3.00) had significantly higher odds of reporting CAI at last sex. Similarly, men who reported perpetration of physical or sexual IPV (1.73, 95% CI: 1.01, 2.96) or monitoring IPV (OR 1.66, 95% CI: 1.05, 2.64) or emotional IPV (1.61, 95% CI: 1.03, 2.53) also had significantly higher odds of reporting CAI at last sex. Additionally, only race/ethnicity and HIV-status were significantly associated with reporting recent CAI. Black/African American men (0.32, 95% CI: 0.22, 0.47) and Latino/Other men (0.56 95% CI 0.35, 0.89) had significantly lower odds of reporting recent CAI than White men. Men with reported positive HIV status (OR: 1.70, 95% CI: 1.15, 2.51) had significantly greater odds of reporting CAI at last sex compared to men who reported negative HIV status.

DISCUSSION

As more evidence emerges documenting high levels of IPV affecting gay, bisexual and other MSM [41, 42], it is important to continue to examine the role of IPV as a risk factor for HIV transmission. This study offers several key findings. Primarily, receipt and perpetration of recent intimate partner violence were both significantly associated with reporting

condomless anal intercourse at last sex. The associations found between receipt of IPV and increased CAI are similar to those found in previous studies involving gay, bisexual and other MSM, [2, 16, 25, 32, 34]. The results show that it is not only men who experience IPV who report increased CAI: reporting of CAI was also significantly associated with reporting perpetration of IPV. The results also suggest that not all forms of IPV are significantly associated with condomless anal intercourse.

Decreased condom negotiation efficacy is one mechanism by which receipt of IPV may be linked to CAI. A study involving heterosexual women demonstrates that women who experience IPV often fear that requesting condom use or attempting to negotiate safer sex will result in violence [38]. A similar relationship was observed in a sample of gay and bisexual men, who reported experiencing sexual, physical and/or verbal abuse in response to requesting safer sex from an abusive partner [43]. MSM with a history of IPV have been shown to be significantly less likely than men without a history of IPV to discuss safer sex with their partners [24]. IPV may alter the survivor's perceived and actual ability to communicate around sex with their partner. In addition, it is plausible that lowered self-esteem and self-worth associated with experiencing IPV [34] could reduce the perceived need or desire to engage in safer sex. As has been suggested, IPV is one syndemic stressor which may hinder the survivor's perceived or actual ability to seek HIV prevention services [12]. Lastly, the high prevalence of substance use/abuse among MSM who experience perpetrate IPV [33, 34] may help to explain the link between IPV and CAI, as substance use is known to inhibit decision-making processes and has been identified as a direct predictor of sexual risk-taking behaviors [33]: however, the current study did not collect data on substance use, and therefore the mediating effect of substance use the relationship between IPV and CAI could not be established in this analysis, but warrants further research attention.

The results also show that men who report perpetrating IPV also report increased CAI, and the association was significant for physical/sexual, monitoring and emotional forms of IPV. Although relatively less studied in the same sex literature, studies of male perpetrators and female victims have suggested that male perpetrators of IPV often display other behavioral risk factors [27–31]. Male IPV perpetrators often have more outside sexual partners and are less likely to use condoms with their partners, in addition to higher rates of substance use. It is possible that we are observing similar relationships in male couples: men who perpetrate IPV against their male partners may be more likely to be 'risk takers' and therefore less likely to use condoms. Not using condoms with a male partner may also be a form of control, which may also explain the associations between perpetrating IPV and recent CAI. It is interesting to note that the experience and perpetration of non-physical, non-sexual forms of IPV were also shown to have significant association with recent condomless anal intercourse. It is not only the threat of immediate physical/sexual harm that negatively impacts condom use; it is possible that living in an environment of emotionally damaging and controlling behavior can also reduce efficacy to negotiate condom use by creating an atmosphere that threatens to escalate into violence, or one in which self-esteem is significantly lowered.

LIMITATIONS

There are several potential limitations to this study. Venue-based recruiting may exclude men who do not access gay-friendly or gay-themed venues, and it is possible that men who experience IPV have restricted mobility and are therefore less likely to be recruited through venue-based sampling, and therefore the sample is potentially biased towards the null hypothesis. Another limitation is the cross-sectional design of this study, which prevents inference of causality. The analysis only considered CAI as an indicator of sexual risk. The recent roll-out of PrEP (pre-exposure prophylaxis) means that CAI is not necessarily considered high risk sex if participants are using PrEP. However, the data were collected prior to the mass availability of PrEP. The analysis also did not control for measures of condom self-efficacy that may help to explain the associations between IPV and condom use, and have been shown to be an important pathway between IPV and condom use among studies of heterosexual women [38]. Observed prevalence rates of receipt of IPV were substantially higher (46.1%) than observed rates perpetration of IPV (33.6%). The imbalance in self-reported receipt versus perpetration rates could be due to social desirability bias. Social desirability bias could be magnified among a venue-based sampling, which may feel less anonymous to participants compared to internet recruitment sampling. The survey collected data from an individual perspective, preventing an examination of dyadic influences on IPV and CAI; more research attention is needed to understand how dyadic and relationship factors may shape both IPV and CAI. It is possible that individuals can be both perpetrators and recipients of IPV. In this sample, however, less than 5% of respondents reported both perpetrating and experiencing IPV from a male partner; hence the study did not have a sufficient sample size to examine how the overlap in perpetration and receipt of IPV may be associated with CAI.

CONCLUSION

This study illustrates significant associations between the receipt and perpetration of IPV and condom use among a large, diverse sample of gay and bisexual men from Atlanta. Men who reported receipt of IPV or perpetration of IPV were significantly more likely to report not using a condom at last sex. The results echo the results of studies of heterosexual relationships, in which reduced power and agency among IPV victims and the increased risk taking behaviors of IPV perpetrators have been linked to lowered condom use, and it is likely that the same mechanisms are operating in male couples. In terms of understanding HIV risk, the findings reinforce the need to understand HIV from a syndemic perspective: and illustrate that IPV may be an important syndemic factor to consider in HIV prevention. The results also add to the weight of evidence demonstrating the negative effects of the experience of IPV on men's health, calling attention to address IPV among male couples as a serious public health concern. Gay and bisexual men are currently largely ignored in IPV research and prevention programming, and the results presented call attention to the urgent need for innovative IPV prevention strategies that address the unique contexts of male relationships. Greater research attention is needed to understand the unique drivers of IPV among gay men, with a focus on understanding how minority status may shape their risk of experiencing and perpetrating IPV through the experiencing of minority stress. In particular, there is a paucity of studies that have sampled male dyads to understand how dyadic

differences and relationship characteristics influence the experience of IPV. There remains a lack of both primary and secondary IPV prevention efforts for gay men. Programmatic attention is needed that addresses current gaps in knowledge of IPV among gay men, and provide men with access to counseling and prevention services that are culturally sensitive and appropriate. Embedding IPV screening into HIV testing would also significantly improve the ability to identify men who may be experiencing IPV and provide an opportunity counsel men on the warning signs for IPV in their relationships.

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Figure 1. Self-reported receipt and perpetration of intimate partner violence (IPV) in the 12 months prior to study (n = 750). GBM, gay and bisexual men.

Table 1

Sample characteristics and percentages of each group reporting condomless anal intercourse at last sex, and adjusted odds ratios (95% confidence intervals and P-values for the reporting of condomless anal intercourse at last sex)

	n(%)	% reporting condomless anal intercourse at last sex	Adjusted odds ratios for reporting condomless anal intercourse at last sex OR (95% CI)	P-Value
Receipt of IPV in past 12 months				0.014
Any physical/sexual	177 (23.6)	62.2	1.58 (1.01, 2.46)	0.012
Any controlling	80 (10.7)	61.3	0.98 (0.55, 1.73)	0.214
Any monitoring	162 (21.6)	66.1	1.93 (1.24, 3.00)	0.011
Any emotional	212 (28.3)	59.9	0.95 (0.64, 1.40)	0.148
Perpetration of IPV in past 12 months				0.007
Any physical/sexual	101 (13.3)	67.3	1.73 (1.01, 2.96)	0.008
Any controlling	31 (4.1)	64.5	0.79 (0.31, 2.03)	0.280
Any monitoring	131 (17.5)	67.9	1.66 (1.05, 2.64)	0.001
Any emotional	138 (18.4)	66.7	1.61 (1.03, 2.53)	0.002
Age Group				0.621
18–24	141 (18.8)	56.0	1.00	
25–34	228 (30.4)	53.5	0.82 (0.52, 1.31)	0.962
35–44	201 (26.8)	58.7	0.93 (0.57, 1.51)	0.429
45–56	180 (24.0)	52.7	0.69 (0.41, 1.15)	0.250
Race/Ethnicity				0.010
White	406 (54.1)	63.6	1.00	
Black/African American	244 (32.5)	42.2	0.32 (0.22, 0.47)	0.013
Latino/Other	100 (13.3)	53.0	0.56 (0.35, 0.89)	0.011
Sexual Orientation				0.841
Homosexual/gay	684 (91.2)	56.0	1.00	
Bisexual	66 (8.8)	45.5	0.75 (0.44, 1.13)	0.976
HIV Status				0.051
Negative	508 (67.7)	54.1	1.00	
Positive	190 (25.3)	57.4	1.70 (1.15, 2.51)	0.032
Don't Know/Never Tested	52 (6.4)	55.5	1.01 (0.55, 1.85)	0.479
Employment Status				0.341
Employed	558 (78.4)	56.6	1.00	
Unemployed	162 (21.6)	49.4	0.80 (0.54, 1.18)	0.234
Education Level				0.275
High School or Less	125 (16.7)	52.8	1.00	
Some College	242 (32.3)	55.8	1.07 (0.67, 1.71)	0.324
College or More	383 (51.1)	55.4	0.90 (0.57, 1.44)	0.128
TOTAL	750	55.1		