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Gender, Power, and Inequality: An Examination of the Causes and Consequences of Queer Intimate Partner Violence

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Abstract

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Violence is a not a new social phenomenon—at least, in the sense that violence has occurred throughout history between individuals, within communities, and practiced by institutions. But mainstream sociological studies of violence are all too often studies of men's violence. This project is an attempt to challenge critically the specter of heteronormativity that haunts the theories and praxis of intimate partner violence (IPV). Under this preexisting framework, studies have focused on men's violence against woman and used patriarchy as an explanation (i.e. the unequal distribution of gendered power, with men benefiting).

However, I want to know if gender is still relevant theoretically or practically, particularly in cases where the partners are the same-sex or a woman is abusing a man. I ask, "if not gender, what?" This is the study of violence, queered. Within the project, I challenge the notion that patriarchy is a grand theory for explaining violence in relationships and propose a more nuanced conceptual tool. While men's power and/or masculinity as power is important, other sources of privilege are, too—for instance, age, race ethnicity, nationality, or socioeconomic status.

I use this critical, feminist intersectional frame to examine not only the prevalence of and risk factors for IPV, but also the structural inequalities in the detection and "treatment" of it: the homophobic, gender-normative, and racist healthcare system and the lacking protections for LGBT individuals and people of color; unequal access to affordable healthcare, the resulting negative health outcomes; and the myriad problematic approaches to educating and training agents of bureaucratic agencies on these issues. The hope is that with new insights from this project, there is a place for macro-level intervention (policy language, training of care providers, funding for specialized program and services, and so on). I demand an approach to ending intimate partner violence that is accountable to the interlocking systems of oppression and privilege, aimed at social justice for all people.

Dedication

To *Liz* – without you, I would not have been able to mentally, or literally, finish this project. I am forever grateful to have you with me in this anti-violence, anti-assimilationist fight.

To *the 61 LGBTQH men and women who we know died at the hands of intimate partner from 2008-2012* – you did not die in vain. We know there are so many more of you. We will do better.

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List of Abbreviations

DV – *domestic violence*

IPV – *intimate partner violence*

SS – *same-sex*

OS – *opposite-sex*

SSIPV – *same-sex intimate partner violence*

OSIPV – *opposite-sex intimate partner violence*

NVAWS – *National Violence Against Women Survey*

NISVS – *National Intimate and Sexual Violence Survey*

CHIS – *California Health Interview Survey*

AVP – *Anti-Violence Project*

CDC – *Center's for Disease Control*

NIH – *National Institutes of Health*

BJS – *Bureau of Justice Statistics*

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Firstly, it is important that I give thanks to the one individual who has guided by from before (if he can remember reading a rough draft of the second chapter of my undergraduate thesis!) the very first day of graduate school: Michael Kimmel. His generous support, time, and guidance, including his inquisitive nature has made this project what it is today. More than that, though, his dedication to public sociology continues to inspire me.

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I. Introduction

Violence is a not a new social phenomenon—at least, in the sense that violence has occurred throughout history between individuals, within communities, and practiced by institutions. In the social sciences, there has been a focus on the macro-level determinants of what, at first, seems like individual violence: the incidence of "stranger crime," issues surrounding violent jobs, the general violence of men's hobbies and/or sport, and acts of self-mutilation and suicide have been well documented (Hearn, 1996, 1998; Kaufman, 1987; Messner & Sabo, 1994; Stanko, 1994). Additionally, sociologists, anthropologists, and political economists are increasingly interested in studying how issues of war, colonialism, terrorism, and other acts of collective and/or political violence are linked to the individual experience—identity formation, health and trauma, and the self-perpetuating cycle of violence (Puar and Rai, 2002; Tilly, 2003; Honwana, 2002; Skjelsbæk, 2001; Blackwell, 2005; Black, 2004). Yet, there is a common thread of heteronormativity and hegemonic masculinity within the mainstream literature on violence that are rarely critically challenged; among others: the war-time terrorist monster formed out of "aggressive heterosexual patriotism" (Puar and Rai, 2002), the "boring, pure and Victorian" framing of Native communities spurred from the logics of settler colonialism and heteropatriarchy (Finley, 2011); and women's sexual deviance and "'erotomania' as 'the primary reason' why women become [political] terrorists" (Sjoberg and Gentry, 2008).

This project is an attempt to critically challenge the specter of heteronormativity that haunts both the theories of intimate partner violence and the academic praxis that follows. Here, "heteronormative' is a concept that reveals the expectations, demands, and constraints produced in U.S. society when heterosexuality is taken as the norm (see Rich, 1980). Heteronormativity describes the assumption and belief that people occupy distinct and complementary genders (men and women), and that these genders are natural and biological (tied to sex; men/males, women/females) (Rubin, 1984, 1992). What is produced from this natural and complementary gender arrangement in society, then, is heterosexuality as the natural and normal sexual orientation – it is seen as natural, given complementary sexes and gender roles, and therefore

becomes the norm and all others become the deviants (Rubin, 1984, 1992; Warner, 1991). Consequently, a heteronormative view is one that involves alignment of biological sex, gender, gender roles, and sexuality (Lovaas and Jenkins, 2006).

Queer Theory

In this paper, I use queer theory as a mode of critique. The process of "queering" reality and social construction involves, as Eve Kosofsky Sedgwick argues in her essay *Queer and Now* (1993): "…the open mesh of possibilities, gaps, overlaps, dissonances and resonances, lapses and excesses of meaning when constituent elements of anyone's gender, of anyone's sexuality aren't made (or can't be made) to signify monolithically." For critique, then, "queerness" is querying, contrasting, challenging and transforming both heteronormativity and homonormativity. *Queer* is also a method for dramatizing inconsistencies in the allegedly stable relations between biological sex, gender and sexual desire (Jagose, 1997). Resisting this supposed stability means focusing on the outcomes and effects of such inconsistencies.[1] From here forward, the use of "queer" is to identify and illuminate the gaps in the research in terms of those who are considered victims/survivors and given weight within the discourse.

It is important, then, to highlight how patriarchy—as related to sex and gender, but also it's own social force—plays a role in the construction of heteronormativity, as it is directly related to the theory and praxis of intimate partner violence studies. Feminist theory initially constructed patriarchy to refer to an unjust social system that is necessarily more oppressive to women (see Tickner, 2001), because it constructs men as superior and women as subordinate (Pateman, 1980). The combined impact of heteronormativity (the binary and believed in construction of male/female; the penalization of gender atypicality, often through the label of sexual deviant) and the construction of patriarchy above (i.e. the devaluation of femininity itself, those who are feminized, and women generally) is what some have called heteropatriarchy[2]

[1] It is important to mention that even within this discussion of IPV, I have been inclusive and discriminatory to a whole group of people: those who identify as transgender. However, at this point, including the voices of these individuals proves difficult, because they are omitted from not only the data collection on IPV, but also the theoretical discourse.

[2] For a more complete description of the five tenets of heteropatriarchy see: Angela P. Harris, Heteropatriarchy Kills: Challenging Gender Violence in a Prison Nation, 37 Wash. U. J. L. & Pol'y 13 (2011), http://digitalcommons.law.wustl.edu/wujlp/vol37/iss1/3.

(Valdes, 1996; Hoagland, 2000): "a system of subordination that burdens not only women and sexual minorities but also the straight-identified men that it purports to privilege" (Harris, 2011).

In essence, when heteropatriarchy is present (in a society, in an academic field) it will necessitate within the construction of violence the invisibility of lesbians and queer individuals, the construction of dominant masculine perpetrators together with intolerance and/or disbelief of women who perpetrate, blaming the 'feminine' victim as we would blame women victims, and the devaluation of men as victims (Hoagland, 2007). As Heather Love (2007) writes, "The history of Western representation is littered with the corpses of gender and sexual deviants."

When looking at the history of both domestic and intimate partner violence (IPV) studies[3], we find an enormous body of literature on *men's* violence; and in the social sciences specifically, men's violence against *women*: an indication to me that both the theories guiding scholarly understandings of IPV and the methodological praxis that follows have been rooted in taken-for-granted assumptions about men, masculinity, patriarchy and sexuality. I am not the first person to suggest this possibility, though perhaps one among few to suggest it as problematic: "Most research in the area of wife abuse focuses exclusively on patriarchy as the explanation for wife abuse" (Lenton, 1995); "The strongest precipitant of victimization for females is simply being female" (Browne, 1987); domestic violence is one "means of social control of women" or a "husband's means of maintaining dominance" (Yllö, 1993); and domestic violence survives "in order to attain the more expansive result of male power and privilege with corresponding female powerlessness and subservience" (Schelong, 1994).

As such, this dissertation dramatically alters the mainstream social scientific understanding of intimate partner violence by shifting and expanding the center of focus by examining queered violence. I may call the violence being studied "queer," not because the individuals involved identify as lesbian, gay, bisexual, transgender or otherwise queer, but because the very understanding of intimate partner violence itself is being queered.[4]

[3] "Domestic" is a term still used today in some studies of violence between spouses, dating partners, and other romantic partners. At some point in the early 2000s "intimate partner" became the more widely used term to describe this type of violence—largely, I believe, because it encompasses more types of relationships than "domestic" initially implies (i.e. between individuals not currently living together); and because of the increasing awareness of same-sex violence and violence against men, not inherently included in the historical/legal definitions of "domestic violence."

[4] *Queer* is defined as Kosofsky Sedgwick argues (1993), "…the open mesh of possibilities, gaps, overlaps, dissonances and resonances, lapses and excesses of meaning when constituent elements of anyone's gender, of

To start, I open my study to all individual experiences of intimate partner violence, including not only women victims/survivors who were abused by men, but also men who have survived abuse by women, and those who have survived abuse by a same-sex intimate partner. Importantly, I study only those who reported violence by a current or former romantic partner since the age of 18. This is key because almost all studies of opposite-sex intimate partner violence have taken this frame, but (as I will detail in the next chapter) most studies of same-sex intimate partner violence are actually studies of violence against LGB-identified individuals that do not take into account the sex/gender of their partner and sometimes are lifetime risk studies that include family members as intimates (i.e. siblings, parents, caretakers).

Secondly, I challenge the notion that patriarchy is a grand theory for explaining violence in relationships. The process of patriarchy is complicated and complex; and, while it is not possible to deny the effects of men's dominance in society, patriarchy is hardly absolute, even within heterosexual relationships (Butler 1993; Wittig 1993; Lorber 1994). I believe there are more nuanced conceptual tools available that offer the possibility of taking into account men's power and/or masculinity as power, in addition to other sources of privilege—perhaps age, race ethnicity, nationality, or socioeconomic status, and so on. In the study of intimate partner violence, we must ask what happens when we challenge the normative theoretical assumptions of heteropatriarchy and make our praxis intersectional: we must account for other axis of power and inequality and how they intersect with gendered forms of power.

With an eye towards the health-related implications of intimate partner violence (a focus I will explain and discuss in more detail below), this dissertation quantitatively assesses how applicable and explanatory the currently identified sources[5] of violence in relationships are for queered violence, as the sources of rooted in previous studies of men's violence against women. I then offer an alternative set of theoretical perspectives—rooted in power and inequality, generally—and explore whether or not taking a critical, feminist intersectional perspective on violence illuminates more about IPV than the current mainstream model. Lastly, I use the physical and mental health effects of IPV and the health care seeking behaviors post-

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anyone's sexuality aren't made (or can't be made) to signify monolithically." Thus, a queer analysis challenges, stands in contrast to, and/or transcends heteronormative ones.

[5] "A combination of individual, relational, community, and societal factors contribute to the risk of becoming a victim or perpetrator of IPV, and understanding these multilevel factors is the first step to identifying various opportunities for prevention" (CDC).

victimization to detail the importance of pushing research forward for not only academia, but more importantly those who continue to be revictimized by the very institutions they seek help from.

The timing is right; in May 2012 after the Senate voted to include protections for LGBT victims of violence in the Violence Against Women Act (VAWA), the House amended the language to exclude them, which led to VAWA falling dormant and not re-authorized for the first time since 1994 (eventually an inclusive bill was signed into law). The current assimilationist[6] LGBT-rights focus on marriage [as] equality has meant a detrimental ignoring of key issues plaguing LGBTQ victims of violence, such as lacking access to (minimum, let alone competent, insured) physical and mental health care; nonexistent, sparse, or inconsistent access to post-victimization facilities (i.e. shelters); and revictimization within the criminal justice system.

What's more, the fight to directly name and include heterosexual men as potential victims to be protected under VAWA[7] has garnered disparaging arguments from many. In 2005, Joe Biden—who spearheaded VAWA originally—claimed,

> The reality is that the vast majority of victims of domestic violence are women and children, and most outreach organizations take those demographics into consideration when providing services . . . The bottom line is – violence is violence no matter what gender the victim. Because of that, the Violence Against Women Act applies to all victims of domestic violence, irrespective of their gender. Nothing in the act denies services, programs, funding or assistance to male victims of violence.

But in actuality, the first part of his statement—the belief about the nature and source of intimate partner violence—and the last part of his statement—that anyone can receive services—go hand in hand to create a heteropatriarchal system that almost exclusively funds women's services and not men's, and almost exclusively trains the criminal justice system to see men as abusers and women as victims; and because of this, all victims are not, in practice, equally protected.

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[6] For more information on the history of gay assimilation vs. queer liberalism see Bernstein, Mary. 1997. Celebration and Suppression: The Strategic Uses of Identity by the Lesbian and Gay Movement. *American Journal of Sociology 103*(3): 531-565.

[7] And by extension, money will then be designated to men's shelters, hotlines, and/or new educational kits and police training.

There is no better time to push the boundaries of our taken-for-granted knowledge and work toward a more intersectional and inclusive framework, to shape equitable institutional change and increase necessary community resources.

Chapter II: Review of the Literature

Intimate partner violence (IPV) is something that researchers discuss as something they can name, identify, measure, and, oftentimes, treat; and much of it has been documented since the 1800s. In this chapter, I present a review of the literature on intimate partner violence. I choose to begin with the first documented accounts of IPV, which come from women recounting abuse by their husbands. This is an important starting point because the history of the study and narratives of heterosexual, man-to-woman intimate abuse informed the theory and praxis of same-sex and LGB intimate abuse research and continues to inform this study (in the direct testing and challenging of theory and the methods chosen to do so).

After examining the development of men's violence against women as a *social issue*, I turn to a review of same-sex and LGBT IPV and its emergence as a social issue, and the very recent beginnings of attention towards women's abuse against men, detailing the rise (and fall) of empirical research on the topics, and the methodological and theoretical complications researchers have encountered. Specifically, in my review, I aim to directly compare the framing of heteronormative violence to "other" forms—i.e., queer violence.

I then examine the emergence of men's violence against women as a *health issue*, the lack of recognition of queered IPV as a health issue, and the importance of propelling the health-related research on IPV forward for all victims and survivors. I argue that new research has the distinct ability to transform how we understand and attempt to remedy the lacking services and protections for survivors.

An Argument for a Historical Framework

Women have been writing about violence in their intimate relationships for centuries. In 1405, Christine de Pizan writes in The Book of the City of Ladies about women's basic humanity and the need for better education and treatment in marriage. Among other things, Pizan accuses men of cruelty and beating their wives (de Pizan & Richards, 1982). In 1872, Mary Wollstonecraft seeks changes in education and kinder treatment for women by husbands and lovers in A Vindication of the Rights of Woman (Wollstonecraft & Brody, 2004). Famously, in

1963, Betty Friedan authors The Feminine Mystique, which captures the discontent of a whole generation of middle class U.S. women who are struggling between aspirations for fulfillment and an ideology that confines them to the home (Friedan, 1963). Even some men chose to speak out, to varying degrees, against the abuse of women: in the 1500s, Abbe de Brantome raises the question, "but however great the authority of the husband may be, what sense is there for him to be allowed to kill his wife?" Much later, in 1861, John Stuart Mill writes The Subjection of Women, pleading for British Parliament to reform the divorce laws to allow women to divorce on the grounds of violence and cruelty (though he waits eight years to publish it because he did not think the public was ready to accept his essay) (R. Dobash, 1992; Lemon, 1996).

But there is a serious absence of narrative, commentary, research, and theoretical development on same-sex intimate partner violence and women's violence against men (intimate violence against other queer identities is altogether missing from the dialogue). This dearth, I believe, is not because this type of violence did not occur, but instead is the outcome of one-sided historicity (Trouillot, 1995): that at the time when early accounts of men's violence against women were being written, same-sex violence and women's violence against men would have been unthinkable and illegible. "The vernacular of the word history thus offers us a semantic ambiguity: an irreducible distinction and yet an equally irreducible overlap between what happened and what is said to have happened" (Trouillot, 1995).

"What is said to have happened" in the U.S. history of violence is Judeo-Christian-centric; in which sexuality and morality are located within a heterosexual, patriarchal context (Hobbel and Chapman, 2009; Szatanik, 2010; Rabinow, 1994). Although philosophers from Plato to Rousseau wrote about the natural inferiority of women, Judeo-Christian doctrine has received the most criticism from feminist thinkers as providing an ideological justification for gender inequality (Yen, 2003). In Genesis, Eve, the prototypical woman, is painted as radically insubordinate (a sin that leaves her and all subsequent women charged with the fall of humanity) and exceedingly carnal. The story of Genesis remains central to the Western construction of gendered hierarchies; indeed, according to the late feminist theologian Mary Daly, "The foundation upon which the case for the subordination of woman is built lies in the older of the two accounts of creation" (1974).

According to Vivian C. Fox (2002), "three great bodies of thought have influenced western society's views and treatment of women: Judeo-Christian cultural beliefs, Greek

philosophy and the western legal code." The idea is that a gender hierarchy, with men as superior, exists to maintain an efficient, well-ordered society; women are unreasonable, emotional, and at times deviant (lustful). Women need not only wise men's guidance, but also control—and this control can and does present itself as violence (Fox, 2002). This violent control of women is then legalized and legitimated within society (Fox, 2002).

Sexuality is, perhaps, more complicated in the Judeo-Christian tradition. Undoubtedly, men and women are seen as complements to one another (in mind, body, and soul), so opposite-sex sexual relations are the only ones commonly written about in the Bible (Diamant, 1995). However, they are not written about as monogamous or "traditional" as U.S. society might seem them as being today. For instance, Abraham is one of the greatest heroes of the Judeo-Christian tradition. When he and wife Sarai found themselves childless they brought their slave Hagar into the bedroom. The resulting son became a great patriarch [Genesis 16:1-3]. Abraham took a second wife, Keturah, and had several more children [Genesis 25:1-6]. He also had children with an uncertain number of mistresses, or concubines. Jacob purchased his first wife, Leah, from her father, then married her sister Rachel. Rachel's servant girl Bilhah soon joined them "as a wife" for at least two children [Genesis 30:3-4]. Then Leah's servant girl Zilpah made it a fivesome [Genesis 30:9-11]. And there is no hint this was irregular. In fact, the opposite—great rejoicing at God's blessings [Genesis 30:12-13].

So, how do we come to understand the transformation from these ideas to the more modern understanding of "biblical marriage" as between one man and one woman, and as homosexuality as one of the greatest sins? Some scholars argue that these "morbid cultural side-effects do not pertain to the true nature of the Judeo-Christian tradition, but to some later and regrettable distortion of its original content" (Levy, 2009). Among the alleged suspects, St. Augustine stands out as a most propitious victim for this great cultural sacrifice. "The man who fused Christianity together with hatred of sex and pleasure into a systematic unity was the greatest of the Church Fathers, St. Augustine" (Ranke-Heinemann, 1991). Augustine viewed sex as a necessary evil, though certainly not something to be enjoyed, between two people of the opposite-sex only (Davies, 1984).

During the Middle Ages, these basic principles continued to be elaborated and extended. The most important figure of the period, and even today the basic source of Catholic moral theology, was St. Thomas Aquinas (Hyde and DeLamater, 2006). Aquinas's "natural law"

approach to ethics was normative in Western Christianity for many centuries and remains so for Roman Catholicism. His argument was that whatever was natural was good, "natural" being defined by the science of 1267 c.e. Anything that was not natural was sinful.

Aquinas believed that sex was intended for procreation and that, therefore, all non-procreative sex violates the natural law and is sinful, being opposed to both human nature and the will of God. In *Summa Theologica*, Aquinas devoted a chapter to various sorts of lust and condemned as grave sin such things as fornication (premarital intercourse), nocturnal emissions, seduction, forced intercourse, adultery, incest, and "unnatural vice," which includes masturbation, bestiality, and homosexuality (Hyde and DeLamater, 2006).

Taken together, the (altered interpretation of, but no less influential) Judeo-Christian tradition transformed ideas about normal vs. deviant (and sinful) sexual practices that led to the legal punitive enforcement of opposite-sex sexual relations; and produced a particular kind of normative opposite-sex relationship/marriage that included legalized violence against women by men. It is not surprising, then, that the early writings on violence between intimates were that of men's violence against women in opposite-sex marriages.

But, that is only the story that is said to have happened—that does not mean that violence between two people of the same sex or violence against men by women did not happen. It simply was not written about. In this way, scholars writing about queered intimate partner violence are without a solid historical ground to stand on; the challenge is "to write about and thus to render historical what has hitherto been hidden from history" (Scott, 1991).

This first step is to critique the foundation from which the theories and methods within queered IPV studies are based. To effectively study queer contexts of intimate partner violence, we need to historicize it—we need to place it within the history of all studies and narratives of IPV. To bolster my claim, let me begin with a thought experiment: if I ask a room of people to close their eyes and imagine a victim of domestic violence, what, do you think, would be the picture an overwhelming majority of them would conjure in their minds?

I've asked this question to undergraduate students, professional sociologists, historians of medicine, and family members; and despite training, background knowledge, and/or a sociological imagination, an overwhelming majority of people picture a woman with black eyes and bruises. The history as it has been written influences everything from the nightly news to college freshman safety-planning lectures; from the government who legislates it to non-profit

organizations who organize missions around it; and the training we fund and legitimate for its detection, treatment, and prevention via the public health and criminal justice systems. The current-day understanding of IPV, including the mainstream studies of it, has been shaped by history; and history has therefore shaped the systematic exclusion of many voices considered to exist "outside."

History of Men's Domestic Violence Against Women

As mentioned above, for quite a long time in U.S. history it was both socially and legally acceptable for men to use reasonable force to correct the behavior of their wives (and, significantly, also against their children, slaves, servants, workers, and many others). As it pertained to their wives, it was seen as their duty; they were bound by law (Foyster, 2005). This type of legal dominance has a long history; during the reign of Romulus in Rome (c. 753 B.C.), wife beating was accepted and condoned under *The Laws of Chastisement*, and around 300 A.D. the Church fathers re-establish the husband's patriarchal authority and the patriarchal values of Roman and Jewish law (Corcoran and Melamed, 1990; Mousourakis, 2003). In the 1500s, Lord Hale, an English Jurist, set the tradition of non-recognition of marital rape, stating that when women marry, they "give themselves to their husbands" in contract, and cannot withdraw that consent until they divorce. "The husband cannot be guilty of a rape committed by himself upon his lawful wife, for by their mutual matrimonial consent a [sic] contract with wife hath given herself in this kind unto her husband, which she cannot retract" (Pateman, 1980).

It was not until almost 1800 that men's violence against wives was first framed, legally, as potentially "cruel and inhuman treatment," "extreme cruelty," or "threats of either." In Evans v. Evan (1790), violence became a legal, legitimate ground for women's divorce. To determine whether a wife's fears were reasonable judges began asking for information about a husband's temper, conduct, and general demeanor towards his wife. This inadvertently gave women the right to describe and record the history of their marriages, and more specifically the history of the violence they experienced (Foyster, 2005). However, at this time, only physical violence—*bodily harm*—or legitimate threat of physical force, were considered to be grave enough cruelty to support divorce grounds; and grave cruelty was seen as the danger to "life, limb, or health" (Black, 1885). As some violence in marital relationships was acceptable, it was necessary to

prove that the violence which spurred the separation or divorce proceedings had been life threatening (Foyster, 2005).

In the late 1800s, what was known as *oral cruelty* came under legal scrutiny and some courts began making decisions in favor of husbands and wives who were chastised, scorned, and abused due to verbal violence (Browne, 1898). It was also at this time that child abuse was ruled as a form of marital abuse (i.e., it is abuse to force a women to watch her children being beaten) (Browne, 1898). However, in 1857 a Massachusetts court upheld the spousal rape exemption (Schechter, 1982). The court in this case, Commonwealth v. Fogerty, relied solely on Lord Hale's statement (from the 1500's) in recognizing that marriage to the victim was a defense to rape—or rather, it was not rape in the first place if the two people were married to each other (Lemon, 1996).

Indeed most cases during this time relied upon the notion of a "common law" rule to determine if a husband is guilty of violence. Common law rulings stem from the notions of men's superiority as laid out in many historical doctrines: Roman law, Biblical law, and English Common law. Under Roman law a man could beat or murder his wife is she was found guilty of disparaging his honor or threatening his property; according to Biblical law, a wife who failed to meet the standards of virtuosity (remaining docile, chaste, and passive) was subject to death by mutilation or stoning; and under English Common law, the feudal doctrine of "coverture" placed women under legal cover of her husband, legally erasing her identity upon marriage—she became his property (Szechtman, 1985; Lewis Tannen, 1980; Sewell, 1989; Eisenberg and Micklow, 1977). Throughout the mid-to-late 1880s courts generally stressed the importance of family autonomy and privacy by their reluctance to intrude in the "domestic sphere."[8]

Nevertheless, the late 1880s was a time of great change for women's rights in opposite-sex intimate relationships. For instance, 1871, both Alabama and Massachusetts declared wife beating illegal (Schechter, 1983). And the Supreme Court of North Carolina ruled in 1874 that "the husband has no right to chastise his wife under any circumstances." However, as is common still in this time, the court goes on to say, "If no permanent injury has been inflicted, nor malice,

[8] See Adams v. Adams, 100 Mass. 365, 373 (1868) (refusal to issue writ of supplicavit against an abusive husband); State v. Rhodes, 61 N.C. (Phil. Law) 453, 454-59 (1868) (court interference was a greater outrage than domestic abuse; state government was subordinate to the family government, which men were charged with ruling).

cruelty nor dangerous violence shown by the husband, it is better to draw the curtain, shut out the public gaze and leave the parties to forget and forgive" (Schechter, 1983).

Most of the influential cases affirming a women's right to freedom from her husband's violence came after the passage of the Married Women's Property Acts (Kanowitz, 1973), which most states had passed by the mid 1860s. Among other things, the acts generally allowed women to reassume legal identities, enter into their own binding contracts (instead of contracts under their husbands names), sue or be sued, own and manage their own property, and work outside the home without her husband's permission (Kanowitz, 1973). Although the exact reasons for the emergence of these laws is of debate and vague in the historical literature, one reason may be the banking crisis of the 1830s, in which a few states introduced laws that would protect a woman's property from her husband's creditors, thus giving women ownership over property could save the "family's" general property if the man went into bankruptcy (Shammas, 1994). In practice, these laws were fraught with "judicial footdragging" and "judicial patriarchy," in the sense that even though they could technically give women more power and equity, in practice they still gave men the upper hand over control of family resources (Shammas, 1994; Grossberg, 1985).

Arguably, what the passage of these Acts across states did most was help to shift policies regarding women's rights into the future. Scholars argue that by the 1900s, the "separate spheres" doctrine took hold over the unities ideology—women were no longer inferior to men, dissolved into their identity; men and women were simply "different," with men relegated to the public sphere and woman to the home (Williams, 1981; Schelong, 1994). In 1911, the first family court is created in Buffalo, NY; and, in 1914, the first adult psychiatric clinic is directly linked to a court in Chicago. Professionals believed that domestic relations courts would better solve family problems in a setting of discussion and reconciliation than in separation and divorce. While intending to provide better protection to women and children (even often boasting of the "success rates" of reconciliation), this is the beginning of the systematic spousal immunity doctrine, which prevented women from bringing tort action against their abusive husbands (R. Dobash, 1992; Schelong, 1994).

In fact, during the first sixty years of the twentieth century was largely ignored or judicially circumvented (Dobash and Dobash, 1979). And in this way, state intervention into the private realm of the home was scarce and marital violence was largely not discussed. Socially, the abuse of women in relationships was still thought of as "normal"; as an example,

psychoanalysis developed the myth of female masochism into its conception of “normal” female psychology in the 1920s and 30s, arguing that women derive sexual gratification from the violence they experience—domestic violence was attributed to the victim's inherent sexual and biological functions (Pleck, 1987). Both the public and private health sectors and general public were persuaded by this argument, and a movement shifting blame from abuser to victim began (Pleck, 1987).

Around the mid-1900s the criminal justice system conceives of *crisis intervention* as an aid to police, courts, and victims, as arrest is deemed inappropriate for solving the social and psychological problems demonstrated in “family squabbles” (Martin, 1979). Police officers become counselors and mediators trained in the skills of crisis intervention, in which violent couples are referred to the appropriate social or psychiatric agency. By the time women’s liberation and feminism take hold in 1960s in the U.S., both the rulings of family courts and the psychiatric/social work approaches have reduced the criminal assaults of men to problems of individual pathology (R. Dobash 1992).

Yet, the U.S. anti-war and liberationist movements of the 60s continued to push for recognition of intimate partner violence as a social issue (S. M. Evans, 1979; Flexner and Fitzpatrick, 1996; Meyer and Whittier, 1994; Schechter, 1983; Taylor, 1989). A study in Chicago revealed that from September 1965 to March 1966, 46.1% of the major crimes perpetrated against women took place in their homes. It also found that police response to domestic disturbance calls exceeded total response for murder, rape, aggravated assault, and other service crimes (Martin, 1979).

Standing in contrast the individual pathology ideology, those aligned with feminism argued that what went on in the privacy of people’s homes is not individual, but conversely, deeply political; and this set the stage for the battered women’s movement (see National Coalition Against Domestic Violence timeline). Women within this movement detailed the conditions of daily life that allowed a person (namely a wife) to call themselves battered—among the conditions are, be it physical, verbal, or control (Arnold, 1995; Schechter, 1983). In 1966, beating, as cruel and inhumane treatment, becomes grounds for divorce in New York, but the plaintiff must establish that a "sufficient" number of beatings have taken place (African American Planning Commission, 2008).

In 1970, the *Journal of Marriage and Family* made it's first reference to violence (Schechter, 1983), indicating a significant academic landmark of an emerging social issue. As a result of these initial changes, we see the slow but steady development of a grassroots movement to end men's domestic violence against women: crisis centers open, mandatory police training laws are enacted, women's advocacy groups develop, conferences and public marches on marital violence and women's abuse are rallied, and state-funded shelters pop up in the United States, Canada, England, and a handful of other European countries throughout the 1970s and 80s (R. Dobash, 1992; Martin, 1979; Schechter, 1983). But early studies indicate that the criminal justice system only casually responds to cases of domestic violence, with some scholars stating that the chattel theory (women as property) was alive and well in the minds (and rulings) of judges and attorneys (Wikler, 1989). Police officers were no different: a 1989 study in the nation's capital found that in over 85% of the domestic violence cases where a woman was found bleeding from wounds, police did not arrest her abuser (Baker et al., 1989).

One interesting case illuminating this is in relation to the marital rape exemption. In *State v. Smith*, the court recognized that the doctrine of "implied consent" (Hale, 1500s) was decreed at a time when women were considered men's property; but women's social status had changed over the years and other areas of the law reflected this change (Litoff, 1982). The court recognized that while an unmarried woman could withdraw consent to sexual intercourse after having previously consented, a married woman, under the traditional view, couldn't, and that this was discrimination against a wife rape victim.[9] Based on these considerations, the court concluded that giving the husband a legally protected right to rape his wife ignores the reality of marital relationships in the twentieth century. But—importantly—the judge had to decide in favor of the common law rule that a man did have the right to have sex with his wife, given that they are married; and that, although he disagreed, it was in the hand of the Legislature to change the law to reflect the modern day.[10]

Many credit the feminists during the 1960s and 70s with the social "discovery" of wife abuse (see Schneider, 1990). During this time, feminists publically discussed that opposite-sex male-female relationships were founded on the unequal distribution of power, and that this power often leads to violence against women: "As the dominant class, men have differential

[9] See *State v. Smith*: 148 N.J. Super. at 226-27, 372 A.2d at 390.
[10] See 148 N.J.Super. 219 (Law Div. 1977).

access to important material and symbolic resources, while women are devalued as secondary and inferior. Violence (such as rape and battering) is the most overt and visible form of control wielded by men as a class over women" (Bograd, 1984). Domestic violence was thus publically characterized as an aspect of unequal gender relation; a reflection of men's power and women's subordination. Viewed this way, some began calling domestic violence "gender terrorism" (Gondolf, 1985).

As late as 1992, scholars were discussing how, although there is no single profile for a typical batterer, they do "generally embrace traditional gender roles more strongly" (McConnell, 1992). They also believe the man is "the master" of the house (Waits, 1998); that men have the "right to a woman's services," including sex (Finkelhor and Yllo, 1985); and that they have the "right to obtain these services through violence" (McConnell, 1992). Specifically, sex is highlighted as symbolic as the total domination of a woman (McConnell, 1992). When not related to sex, beliefs about "discipline" for misbehaving or failing "to serve him in the way he deserves and desires" are detailed (Walker, 1979). As an example of the thinking of the time, Katherine M. Schelong's 1994 article on state responses and rationales to domestic violence discusses only men as abusers and women as victims.

In the years between the 1990 and 2000, courts in the United States began to repeal old laws and enact new ones to protect those who are abused. During this time 48 states enacted or rewrote injunctions that enabled courts to refrain men from abusing, harassing and assaulting the women with whom they lived; and in 23 states, police officers were told they may arrest on "probable cause" in cases of simple or minor assault within the home, with a few states and cities going further by imposing a mandatory duty to arrest the violent offender (R. Dobash, 1992). It is also during this decade that date rape and stalking become institutionalized as serious crimes in most states; and a history of marital violence is considered in child custody cases and in eligibility for gun licensing and possession federally (1994), with some states deciding to enact even stricter laws to protect potential victims (Epstein, 1999; Grace and Britain, 1995; Sherman, Smith, Schmidt and Rogan, 1992; Sproul, LaVally and Research, 1997).[11]

[11] See CAL. FAM. CODE § 6389(a) (2002); DEL. CODE ANN. TIT. 11, §1448(a) (2002); FLA. STAT. CH. 790.233 (2002); HAW. REV. STAT. §134-7(2002); MD. CODE ANN., ART. 27, § 445(d)(2)(v) (2002);N.H. REV. STAT. § 173-B:5 (2002); VA. CODEANN. § 18.2-308.1:4(A)(2002); W. VA. CODE § 61-7-7 (2002); WIS. STAT. § 813.12 (2002); FLA. STAT. CH. 790.233 (2002).

In 1994, the Violence Against Women Act (VAWA) was passed as a part of the Violent Crime Control and Law Enforcement Act, to help overburdened states deal with the issue of domestic violence (to "increase the number of 'cops on the beat'").[12] The Act, among other things, created federal penalties for an abuser who entered another state to continue abusing his victim, required orders of protection to be given "full faith and credit" by other states, and allowed for the expenditure of funds for shelters and training programs.[13]

In 2000, an edit to the Act was passed, which included jurisdiction over interstate stalking, increased funding for women's shelters and transitional housing, and a large section on how to protect battered immigrant women; but, despite some social commentary (as seen on various petition websites and in op-eds), no explicit inclusion of men. The 2005 amendment included a section on improving healthcare's response to violence and notes on providing economic support to victims, and an expansion on non-spousal related violence (specifically dating violence), but by default of the name of the act (The Violence Against Women Act), still no change to the implied victim-offender relationship. Indeed, a search of the 2005 reauthorization document yields only nine results for the words *male, man* or *men*, in which all but first three refer to men's violence against women:

> NONEXCLUSIVITY.—Nothing in this title shall be construed to prohibit male victims of domestic violence, dating violence, sexual assault, and stalking from receiving benefits and services under this title.
>
> STUDY REQUIRED.—The Comptroller General shall conduct a study to establish the extent to which men, women, youth, and children are victims of domestic violence, dating violence, sexual assault, and stalking and the availability to all victims of shelter, counseling, legal representation, and other services commonly pro- vided to victims of domestic violence.
>
> More than 500 men and women call the National Domestic Violence Hotline every day to get immediate, informed, and confidential assistance to help deal with family violence.
>
> In a national survey of more than 6,000 American families, 50 percent of men who frequently assaulted their wives also frequently abused their children.

[12] Violence Against Women Act. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:h3402enr.txt.pdf

[13] See Joseph R. Biden, *Domestic Violence a Crime, Not a Quarrel*, TRIAL, June 1993, at 56, 57 (discussing the goals and provisions of the Violence Against Women Act).

> According to a 3-year study of student-athletes at 10 Division I universities, male athletes made up only 3.3 percent of the general male university population, but they accounted for 19 percent of the students reported for sexual assault and 35 percent of domestic violence perpetrators.
>
> IN GENERAL—The Attorney General, acting through the Director of the Office on Violence Against Women, and in collaboration with the Department of Health and Human Services, shall award grants on a competitive basis to eligible entities for the purpose of developing or enhancing programs related to engaging men and youth in preventing domestic violence, dating violence, sexual assault, and stalking by helping them to develop mutually respectful, nonviolent relationships.
>
> To create public education campaigns and community organizing to encourage men and boys to work as allies with women and girls to prevent violence against women and girls conducted by entities that have experience in conducting public education campaigns that address domestic violence, dating violence, sexual assault, or stalking.
>
> Each year about 324,000 pregnant women in the United States are battered by the men in their lives. This battering leads to complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding.

However, the words *female*, *woman* or *women* appear 209 times, in which all refer to women as victims, not potential perpetrators. As such, I find the clause of nonexclusivity to be not only practically and judicially useless, but also incredibly ironic.

But there is also a substantial whole in this document due to the direct exclusion of same-sex or LGBT victims of intimate partner violence. When some legislators tried to include these victims, VAWA died—leaving many agencies and organizations without funding or resources. Typically, VAWA is easily and without a fight reauthorized every five to six years; but in 2011, the law expired without any attempt to reauthorize. In 2012, Congress attempted to reauthorize a more inclusive and expanded VAWA, but the Republican-sponsored House version favored the reduction of services to undocumented immigrants and LGBT individuals. The two bills were pending reconciliation, but a final bill did not reach the President's desk before the end of the year, temporarily ending the coverage of the Act after 18 years, as the 112th Congress adjourned.

An inclusive and expanded Violence Against Women Act was passed and signed into law in 2013, including extensive protections for LGBT-identified victims. But it should be noted that you will not find the acronym LGBT, nor its singular parts (lesbian, gay, bisexual, transgender),

nor the phrase "same-sex" intimate partner violence referenced anywhere in the bill. In fact, this is the *inclusive* and *expanded* coverage for victims of IPV:

> UNDERSERVED POPULATIONS.—The term 'underserved populations' means populations who face barriers in accessing and using victim services, and includes populations underserved because of geographic location, religion, *sexual orientation, gender identity*, underserved racial and ethnic populations, populations underserved because of special needs (such as language barriers, disabilities, alienage status, or age), and any other population determined to be underserved by the Attorney General or by the Secretary of Health and Human Services, as appropriate.
>
> …developing, enlarging, or strengthening programs and projects to provide services and responses targeting male and female victims of domestic violence, dating violence, sexual assault, or stalking, whose ability to access traditional services and responses is affected by their sexual orientation or gender identity, as defined in section 249(c) of title 18, United States Code.

Yes, Congress was fighting over the one-time inclusion of sexual orientation and gender identity in the long list of "underserved populations," and the acknowledgment later on that a greater number of good programs and projects that provide victim/survivor services to that population are needed.

History of Same-Sex Domestic Violence

Though a handful of criminal same-sex IPV cases arose in the U.S. prior to the passing of VAWA in 1994, they were largely mishandled or seen as inconsequential—due to lacking legal recognition of same-sex relationships and also attorneys' and judges' homophobia (Fray-Witzer, 1999; Elliott, 1996; R. Dobash, 1992; Schechter, 1983). Silence about same-sex violence was present even within the mainstream feminist movement in the U.S. and Europe. In 1975, in England, women from England, Wales, Northern Ireland and Scotland established the feminist oriented National Women's Aid federation to help women and child survivors of domestic violence and child abuse.[14] During the first national gathering a letter was drafted and sent to

[14] The organization provided practical and emotional support as part of a range of services to women and children experiencing violence. The charity was instrumental in lobbying for the 1976 Domestic Violence and Matrimonial Proceedings Act, and for having women and children at risk of domestic violence to count as homeless under The Housing Act 1977. See: http://www.womensaid.org.uk/

social work departments throughout the countries involved: “We are particularly worried and unhappy that there are groups who seem to be trying to use Women's Aid as a platform for *Gay Women's Liberation*. We would strongly advise Social Services and Housing Departments to look very carefully at the groups in their areas who are offering to set up refuge before giving them your support” (R. Dobash, 1992).

In the U.S., the first support group for lesbian victims of violence was established in 1985—which stands in contrast to the first consciousness-raising groups in the 1940s for women abused by men (R. Dobash, 1992). But of the two legal cases brought to trial for lesbian partner violence during the 80s, both disregarded sexuality and thus downplayed and ruled irrelevant the violence within the intimate relationship. During this same time, “battered women's syndrome”—developed by Lenore Walker in 1984, which highlights “learned helplessness” from being in the cycle of violence—is first tried as a defense for a lesbian killing her partner. Annette Green is convicted of first-degree murder of her partner Ivonne Julio in Palm Beach, Florida, and the judge allows the defense, but changes it to “battered person defense,” in a sense dehumanizing the woman involved as “not a woman.”[15]

Then, in 1990, Angela West, deputy city attorney in Los Angeles city Attorney's Office tries the first lesbian battering case in which evidence regarding Battered Women's Syndrome (BWS) is successfully used. The case is significant, however, not for the successful recognition of lesbian women as battered *women*, but because the police described the dispute as battery between two roommates, not between two intimate partners. This is a significant turning point judicially, but is proof of the continued illegibility of same-sex desire and queer individuals, particularly to the state—especially given that BWS was successfully used as a defense for a woman killing her husband in 1977 and by this time most states had begun to implement statutes that allow parole, clemency, and/or self-defense pleas for heterosexual women or women’s opposite-sex IPV under these circumstances (Berns, 2001; Martin, 1976).

Despite the legal turn, it is arguable whether or not same-sex intimate partner violence is seen as a social issue in the U.S. today. Though the first article describing instances of abuse between two same-sex partners was published in 1978, it was within the context of alcohol abuse

[15] This is perhaps proof of what Monique Wittig claimed a few years prior in her work *The Straight Mind* (1978): “...and it would be incorrect to say that lesbians associate, make love, live with women, for ‘woman’ has meaning only in heterosexual systems of thought and heterosexual economic systems. Lesbians are not women.”

among lesbians and was not intended to be an academic article exposing the intimate partner violence (Diamond and Wilsack, 1978). The first narratives on same-sex partner abuse weren't published until 1986 (and were a collection of essays "by and for battered lesbians" exploring dynamics in violent relationships) (see Lobel, 1986); the first empirical academic research referencing same-sex partner abuse was published that same year (see Brand & Kidd, 1986).

In contrast to many heterosexual women who aligned with modern U.S. feminist movements, same-sex victims of violence have not had a mass movement with which to transform their victimization into healing and power. More specifically, the "gay rights" movement in the 1970s and 80s not only left this issue out of its agenda(s), but also emphasized the political necessity in keeping it hidden (Lehman, 1997). In the first public anthology on lesbian intimate partner violence mentioned above (*Naming the Violence: Speaking Out About Lesbian Battering* by Lobel, 1986) there is an extensive section on one cause of silence: publicity on the issue "may enhance the arsenal of homophobes." Additionally, many women write about the myth of a lesbian "community," and how divisive the issue is: "there is an inherent fear that acknowledgement of domestic abuse… will give lesbian partnerships a bad name and perpetuate the myth among heterosexual society that gay relationships are abnormal or dysfunctional."

This seems to be a common thread in the literature among those who have marginalized identities and experience IPV; in 1985, Beth Ritchie writes, "Too many blacks still think this is a divisive issue which should not be aired in public," with regard to men's domestic violence against Black women. Aishah Simmons' more recent work on rape seems to illuminate some possibilities for why those with socially "othered" identities may desire (or feel it's necessary) to keep silent about women's abuse and victimization. She writes that the stereotype of the "Black male rapist" perpetrating violence only against White women produces a strong desire within the Black community to protect Black men from the prison system, a system they are disproportionately represented in from the get go. But the stereotype of the "Black woman whore who can't be raped," is something less discussed; something it seems there is less concern for. She says in a conversation, "I think all of us are trained in terms of a patriarchal point of view, regardless of what race we are, to make men's issues central… the kind of these 'Well, it's so

hard being a Black man'—and not to say that it's not, but what the hell, Black women are not having a picnic."[16]

There is also the issue of victims of same-sex abuse internalizing society's normative assumptions about violence and victims, and not seeing their own experiences as fitting into those molds. McLaughlin and Rozee (2001) suggested that lesbian intimate partner violence, specifically, was shrouded in silence within the lesbian community because "the lesbian community may not be conceptualizing violence in lesbian relationships as domestic violence." This is echoed in the first set of narratives mentioned earlier (in *Naming the Violence: Speaking Out About Lesbian Battering*), in which many women discuss the myth of lesbian utopia, which framed two-women relationships as idyllic because of the social beliefs about femininity and women's behavior (Lobel, 1986). Within the anthology, Barbara Hart writes, that lesbian "domestic violence" "contradicts our belief in the inherent nonviolence of women."

In many ways shame and stigma, within the context of desired public and social acceptance (perhaps the possibility of "un-othering"), is at the center of silence. Guided by Hultberg (1988), Sara Ahmed writes, "…the fear of shame prevents the subject from betraying 'ideals', while the lived experience of shame reminds the subject of the reason for those ideals in the first place" (2004). Among other things, shame is complex because it reveals "failure to live up to the social ideal." It is compounded by stories of intimate partner violence, because both are shameful—IPV is the failure to live up to the "safe haven" standard of the heterosexual nuclear family, while same-sex IPV is all at once the failure to live up to the "safe haven" standard of the heterosexual nuclear family and the failure to be heterosexual.

Heather Love (2007) retorts that, at least within popular discourse, "Pride and visibility offer antidotes to shame and the legacy of the closet…" but that there is a contradiction between the "mass-media image of attractive, well-to-do gays and lesbians and the reality of ongoing violence and inequality." Perhaps it's because the dominant gay and lesbian narrative is White and upper-class; a narrative in which equality is centered on marital rights (as race and class-based equality is/has already been achieved). Within the context of intimate partner violence, these dominant voices view exposing the negative qualities of relationships, no matter how

[16] For full conversation, see: http://www.notherapedocumentary.org/images/articlepdfs/Myth_BlackWomensProgress.pdf

"normal" (i.e. in comparison to men's violence against women), as putting the community—and their quest for "full" rights—at risk.

Thus, much of the discussion of same-sex IPV as a social issue has taken place within academia. However, research has been slow. Some suggest, much like I have argued here, that widespread cultural perceptions that intimate partner violence is limited to male perpetrators abusing female victims, discriminatory biases against the LGBT community and same-sex relationships, and reluctance to acknowledge that large numbers of same-sex intimate relationships exist in the first place all lead to this stalled initiative (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006; Burke and Follingstad, 1999). Poorman, Seelau, and Seelau (2003) point out that, traditionally, violence perpetrated by men against women has been judged to be more serious than other forms of intimate partner violence, thus leading many domestic violence researchers to focus primarily on that targeted to heterosexuals. Indeed, researchers studying the LGBT population have demonstrated a preference for examining other issues, such as HIV and AIDS, over IPV (Byrne, 1996).

Although in the last decade we have seen the advancement of more inclusive definitions of domestic violence—primarily in the reframing of it as "intimate partner" violence—the challenge that remains for researchers as they study same-sex IPV is overcoming the heterosexual paradigm that still defines much of the social and public health movement (Ristock, 2003). When research is informed by a theoretical explanation of violence as rooted in hegemonic masculinity, adherence to gender norms, and/or heteronormativity, the questions asked and the methods used will tend towards an examination of men's violence against women (see Messinger, 2014).

Without doubt, the rate of publication of research examining the dynamics of men's violence against women has far outpaced that of research examining LGB[17] and/or same-sex IPV (Fortunata & Kohn, 2003). Since 1986, fewer than 50 empirical studies on same-sex IPV, its potential causes and, very recently, potential consequences have been published (i.e. not reviews of the literature, nor purely theoretical pieces, but data collection and/or analysis). This contrasts to the thousands of empirical studies on heterosexual or opposite-sex man-to-woman violence

[17] I will now begin using "LGB" without the "T" because there have been only one or two studies examining intimate partner violence in which the victim or perpetrator identified as transgender. This is altogether the most marginalized population with regards to IPV.

during this time, including multiple nationally representative, federally funded surveys that did not ask about or did not include same-sex or LGBT partner violence. L. K. Burke and Follingstad (1999) provide the first review of empirical research examining intimate partner violence within lesbian and gay relationships, citing 19 studies published between the years 1978 and 1995 (all but one of the studies were published between 1986 and 1995). Murray and Mobley (2009) review an addition 17 empirical (but not qualitative) studies published between 1995 and 2006.[18]

In 2014, Messinger reflects upon 35 years of research on same-sex IPV, from the very first article to even mention abuse between two same-sex partners (Diamond and Wilsnack, 1978) up to the findings of the National Intimate Partner and Sexual Violence (NISVS) survey in 2013. From 2006 to publication in 2014, Messinger cites 20 empirical articles (both quantitative and qualitative, utilizing large datasets—such as the NISVS—or small convenience samples, and including youth in addition to adults), six theoretical articles (no data collection or analysis), and three non-U.S. studies of same-sex IPV (Hong Kong, Cuba, and Canada). Not including the one article published in 1978, there have been approximately two data-driven, empirical studies of same-sex or LGB intimate partner violence published each year.

The results of the research on same-sex and/or LGB intimate partner violence are clear: aside from prevalence rates, same-sex IPV is comparable to men's violence against women (Messinger, 2014). In terms of forms of violence, psychological is the most common (this generally includes verbal abuse and control), followed by physical and then sexual IPV (Bimbi et al., 2008; Freedner et al., 2002; Greenwood et al., 2002; Halpern et al., 2001, 2004; Messinger, 2011; Turrell, 2000; Lee et al., 2013). Additionally, research suggests that around half of all violent relationships, whether same-sex or opposite-sex (men's violence against women), are unidirectionally violent (for same-sex accounts see Kelly et al., 2011 and Renner and Whitney, 2010; for men's violence against women see Langhinrichsen-Rohling et al., 2012).

Though, there are some unique forms of violence associated with same-sex/LGB intimate partner violence that do not occur in opposite-sex contexts. For example, non-disclosure of HIV/AIDS status and forced unsafe-sex practices are unique forms of control, sexual, and/or physical violence; some victims are forced to have sex without protection (Craft and Serovich,

[18] These studies had to include a general LGB sample, not more "at-risk" individuals such as: men who have sex with men, women who have sex with women, HIV-positive individuals, or those who are temporary unhoused.

2005), while others fear retaliation if they request protection (Gielen et al., 2000; Heintz and Melendez, 2006). Outing a partner has also been seen as a unique form of violence, whether its in the form of threatening to out the victim to keep them from leaving (Kulkin et. al, 2007) or that the perpetrator themselves is not out, leading to the social isolation of the victim or the victim's fear of retaliation for outing their abuser (Donovan and Hester, 2008; Walters, 2011). Lastly, minority stress has been theoretically linked to the perpetration of same-sex IPV or LGB-initiated violence—i.e., the stress experienced with being seen as a gender or sexual deviant within a heterosexual society leads to abusing your partner, perhaps even as a coping mechanism for that stress (Balsam and Szymanski, 2005; Bartholomew et al., 2008; Brooks, 1981; Carvalho et al., 2011).

The dynamics that occur surrounding same-sex abuse are also comparable to the dynamics of men's violence against women: those who experience abuse as a child are more likely to experience it as an adult (Wallace, 2005; Craft and Serovich, 2005; Fortunata and Kohn, 2003); the cycle of violence, in which there is a honeymoon period, followed by escalation into violence and increasing severity of violence over time is present (Merrill and Wolfe, 2000; Glass et al., 2008; McClennen et al., 2002; Renzetti 1992); and substance abuse is linked to both the perpetration of violence and the odds of being a victim of violence (see Kelly et al., 2011; Lewis et al., 2012; McClennen et al., 2002; Stall et al., 2003).

Moreover, victims stay in violent relationships for largely similar reasons that women abused by men do—being in love, financial dependence, and for the children, as examples (Cruz, 2003; Merrill and Wolfe, 2000). But, as with some of the unique forms of violence experienced, there are some unique reasons for staying: such as and individual's or their partner's HIV/AIDS status, whether or not the individual/their partner are "out" or not, and minority stress. Specifically, research has shown that a victim's positive HIV/AIDS status and the existence of a victim's own minority stress may lead them to believe they are incapable of being loved by anyone other than their abusive partner, keeping them trapped within the cycle of violence (see Balsam and Szymanski, 2005; Letellier, 1996). But, if the victim's abusive partner has a positive HIV/AIDS status, they may also feel guilt over leaving them, especially if their partner is ill or they are their partner's caretaker (Bartholomew et al., 2008; Craft and Serovich, 2005; Letellier, 1996).

Prevalence rates vary depending on the questions asked and methods used, but according to the NISVS—the most up-to-date, nationally representative survey—self-identified lesbian and bisexual women, and women who have sex with women but identify as heterosexual, are more likely to experience IPV than heterosexually-identified women; and bisexual men, and men who have sex with men but identify as heterosexual, are more likely to experience IPV than heterosexual men; however, gay men experience similar rates of IPV to heterosexual men (Walters et al., 2013). A majority of the older nationally representative data sets reveal the same trends, except they also highlight that gay men have a higher risk of victimization than heterosexual men (Cameron, 2003; Messinger, 2011; Tjaden and Thoennes, 2000; Tjaden et al., 1999). These studies are consistent no matter if the violence was same-sex (i.e. did not ask about sexual orientation), or victimization experienced by an LGB individual (i.e. it could have been opposite-sex IPV, but the individual still identifies as a lesbian).

When compared to similar studies on heterosexual IPV, one of the biggest issues is the theoretical framework employed. For instance, mainstream feminist theories, while most popular in explaining heterosexual IPV, have difficulty, in application, accounting for and explaining this violence because they inadvertently employ heterosexist ideologies—for example, it is difficult to conceptualize and measure "gender," "gender performance," or "gender roles" to assess the degree to which one partner adheres to them or does not. If violence is rooted in conformity to heterosexual male-female gender roles, with the more masculine partner as the abuser (see Martin, 1976; Letellier, 1994), how do we explain one man "becoming" the victim, but the other being the typical abuser? Some default to the masculine-feminine ("butch/femme") relationship dichotomy (see Peplau et al., 1998); but this type of division as the norm within same-sex, and opposite-sex, relationships has been discredited—individuals display a wide range of both masculine and feminine gendered behaviors (Faderman, 1992; Bailey et al., 1997; Landolt and Dutton, 1997; Munt, 1995). Regardless, the reliance on masculinity complicates and renders useless any explanation of woman-to-woman violence (Bergen, 1998), which may explain why most studies of same-sex violence are that of men's violence.

Another issue in the studies on same-sex and LGB IPV is that of inconsistent measurement and operationalization of sexual orientation/sexuality (self-identified orientation versus a behavioral definition) and violence (lifetime from any person intimately connected to them, including parents and siblings versus violence from a dating, romantic, or sexual partner)

(see Messinger, 2014). There are many ways to measure "sexual orientation," and many have been used in the research: sexual minority, romantic or sexual attraction to, romantic or sexual behavior with, and/or romantic or sexual relationships with the same sex (Meyer and Wilson 2009; Johnson, 2014; Stotzer, 2014; Woods, 2014). A key void in the literature is the lack of comparison, using the same population-based data, of same-sex IPV to sexuality minority/LGB partner violence (for a rare exception, see Kann et al., 2011); no study to date has assessed the sexual orientation of respondents' partners—a key exclusion given the National Coalition of Anti-Violence Programs data that suggests over one-quarter of all perpetrators of same-sex intimate partner violence identify as heterosexual (NCAVP, 2012).

Additionally, the existing large-scale surveys on IPV fail to question, and thus explain, multiple types of violence. Of them (namely, the National Crime Victimization Survey; the Chicago Health and Social Life Survey; and the General Social Survey), the only type of violence inquired about is physical. The Conflict and Tactics scale measures physical as well as sexual and psychological abuse, but fails to measure manipulation involving children, and any forms of control (economic, isolation, and/or intimidation). This is a major problem since the leading research on heterosexual IPV includes physical and sexual (Gelles and Straus, 1988), psychological or emotional (O'Leary, 2001), control (economic, isolation, etc.) (Johnson and Ferraro 2000; Stark 2009), and using the children (Laing, 2000). The National Violence Against Women Survey measures the most forms of violence, and is commonly used today by researchers, but was last collected in 1995. Lastly, the newest survey, the National Intimate Partner and Sexual Violence Survey (NISVS), while inclusive on most forms of violence, did not initially discussion sexual orientation in its 2010 report; it wasn't until a 2013 supplement was released did we learn that this data set surveyed on same-sex IPV (this data set is not available for any public use).

Sampling has also been a concern. Because the number of individuals who identify as LGB or as having had some sort of relationship with someone of the same sex is so low, researchers of same-sex IPV often resort to quick, inexpensive, convenience sampling at LGB-centric venues like gay pride parades (e.g., Meyer et al., 2009). This is limiting, though, because a very particular subset of the LGB population will choose to locate themselves at such an event (typically younger, politically active, "out" individuals) (see Greenwood et al., 2002). Other venues, which scholars of opposite-sex IPV also utilize, are hospitals and shelters—though there

are also limitations to finding individuals at service-providing agencies, as a very particular kind of individual will have access to or confidence in seeking out care services (e.g. those with health insurance, or those who are not hindered by the fear of retaliation, revictimization, or outing) (see Anderson, 2005).

A probability sample is the other route to go—but because such a small proportion of the U.S. population identifies as LGB and/or admits being in a same-sex relationship of some sort, a very large number of people need to be surveyed in order to arrive at a sample of the target population large enough for statistical analysis (see Messinger, 2014). The National Violence Against Women Survey (NVAWS) is a good example of this—out of 8,000 men and 8,000 women, only 144 individuals identified as ever having been in a same-sex relationship. While this is representative of the overall population—around .25% of the U.S. population reports currently cohabitating with a same-sex partner, and .36% report having done this in the NVAWS—having a sample this small makes advanced statistical techniques much more difficult. In line with previous studies, if we assume that around half of all those individuals will have experienced same-sex IPV, we are left with only around 72 individuals with which to assess the causes and consequences of violence.

Troublingly, because of these issues, the realms of public policy and public health have been slow to respond to this silent epidemic of IPV between same-sex partners and LGBT individuals. We are stuck in a vicious cycle: the lack of public and social awareness/discussion about the topic delayed the onset of scholarly research; the lack of scholarly research led to the silence and exclusion of LGBT and same-sex victims from state laws and major funding sources; the lack of funding sources, and lack of inclusion in domestic violence statutes forced researchers into projects with convenience samples and small datasets; these projects led some to hurried conclusions about same-sex IPV; and these conclusions have been framed (when they are framed) by policy makers as inconsequential and meaningless.

Without better research, we can't inform better policy. But without better policy, we are also limited in how much better we can make our research. There is a dearth of funding from the major agencies (National Institutes of Health; National Science Foundation; governmental agencies), tied to the lacking inclusion of LGBT individuals and victims of same-sex IPV within the state statutes on domestic violence; and within the greater heteronormative framework, men's violence against women is framed as more important and detrimental—our monies should be

allocated to those projects which serve the most victims (Barnes, 1998; Burke et al., 2002; Elliott, 1996). But, of course, as research continues to grow on men's violence against women, we are ultimately perpetuating the myths that only women can be victims and that other forms of IPV are just not that serious.[19]

As such, we see that in 2000 there were five states which specifically excluded same-sex couples from protection by limiting the definition "domestic violence" to violence between only opposite-sex couples: Arizona, Delaware, Indiana, Montana, and South Carolina; two states required that a couple who was not married or related by blood to have a child in common in order to be protected by the statute; and Mississippi limited its statute to "spouses, former spouses, [and] persons living as spouses." Protection from (only) physical abuse was available to same-sex couples in just four states: Hawaii, Illinois, Kentucky, and Ohio (Knauer, 1999).

This legal exclusion is no doubt linked to both state and federal sodomy laws. Specifically, the existence of sodomy laws—which prohibited, in various forms, anal and oral sex between not only same-sex couples, but in some instance opposite-sex couples—presented "a potential catch-22 where a victim of domestic violence may first have to assert that he or she is a criminal in order to qualify for protection" (Knauer, 1999). It is widely discussed that sodomy laws were more regularly enforced in same-sex cases. In 2003, the ruling in Lawrence v. Texas effectively dismantled all remaining sodomy laws in the United States, both at the state level and federally; a potentially positive sign for those victims and survivors seeking legal recourse. But, a 2007 report showed that 34 out of 50 states either did not rule positively on same-sex IPV claims, have silent, unclear, or overly-specific laws in place for same-sex couples, or, intolerably, judges who make inconsistent and vague rulings on the issue.[20] The remainder of the states had ambiguous gender-neutral laws that referred to "partners," "cohabitants," or "household members," instead of identifying the violence occurring as intimate in nature.

As of 2012, out of all of the states, only Hawaii's domestic violence law explicitly mentions same-sex relationships outside of the protection of "married" individuals and a state's

[19] When John Bobbitt had his penis cut off by his wife, Lorena, in 1993, it became material for late night comedy routines and the fodder of pop culture. Lorena was found not guilty by reason of temporary insanity, related to a history of abuse by John—a "battered woman's defense." This public reaction and the use of the defense would have been unthinkable if it was John who had perpetrated the final instance of violence.

[20] Lesbian, Gay, Bisexual and Transgender Domestic Violence in the United States in 2007. NCAVP. < http://www.ncavp.org/common/document_files/Reports/2007%20NCAVP%20DV%20REPORT.pdf>

"marriage equality." Of the remaining states and the District of Columbia, 20 have laws written in gender-neutral language that the courts could interpret in favor of same-sex couples, but do not specifically mention same-sex couples.[21] However, some very conservative states have gone to great lengths to exclude same-sex couples, even if there are gender-neutral terms used. Moreover, Montana, Louisiana, North Carolina, and South Carolina have laws that explicitly exclude same-sex relationships by not having marriage or civil union equality, and/or by identifying opposite-sex relationships—namely through marriage, cohabitation, and children—as solely protected.[22]

One of the most devastating effects of the exclusion of same-sex relationships and LGBT people from protection under state laws—and until very recently, under the federal Violence Against Women Act—is the exclusion of funding for specialized post-victimization services. As late as 2005 there were only one or two emergency housing facilities or shelters established for men and women victims of same-sex violence, and only five U.S. cities had counseling services specialized in same-sex IPV, provided only through a National Coalition of Anti-Violence Programs affiliate/LGBT(Q) community center—New York, Chicago, Boston, Los Angeles and Minneapolis (Jablow, 1999; Potoczniak, Murot, Crosbie-Burnett and Potoczniak, 2003; Wallace, 2005).[23]

In the U.S. many shelters for women victims of violence refuse to shelter any men—regardless of self-identified sexual orientation—for fear that the men who come into the shelters will be abusers, not victims, looking to retaliate against their opposite-sex partner (see *Blumhorst v. Haven Hills, et al.*, Los Angeles Superior Court Case No. BC291977). The Valley Oasis Shelter in Lancaster, CA was the first shelter opened to aid solely men, specifically for this

[21] In alphabetical order: Connecticut, Delaware, Washington D.C., Maine, Maryland, Massachusetts, New Jersey, New York, New Hampshire, Rhode Island, Vermont, Iowa, Illinois, Ohio, Pennsylvania, Florida, California, Nevada, Oregon, Washington.

[22] See: https://www.networkforphl.org/_asset/lmb0yo/Master-List-of-SameSex-Domestic-Violence-Protections-Updated-1262012.pdf

[23] The National Coalition of Anti-Violence Programs, or NCAVP, is a national organization dedicated to reducing violence and its impacts on lesbian, gay, bisexual and transgender (LGBT) individuals in the U.S. It was founded in 1995 by Gloria McCauley of BRAVO and Jeffrey Montgomery of the Triangle Foundation (now Equality Michigan). Its main affiliates are located in largely metropolitan areas (New York, Detroit, Chicago, Boston, Los Angeles, Minneapolis, and Burlington), but there are 40 community-based programs throughout the U.S. Of the major affiliates, only the five listed have specially trained counselors and psychologists, rather than peer advocates.

reason. It is now open to men, women, and children regardless of age, race, gender identity, and/or sexual orientation—but remains committed to helping those with "specialized needs."[24]

Interestingly, this concern is rarely raised regarding women's same-sex violence, despite the fact that it is perhaps easiest for women who abuse women to seek out and find their partner at a shelter; there are around 2,000 women's shelters and there is no routine screening for perpetrators of violence seeking to access services (i.e., under the guise of a victim, a perpetrator could enter a woman's shelter to find her abused partner).[25] The 2010 *Domestic Violence Counts* report on shelters in the U.S. by the National Network To End Domestic Violence makes no mention of LGBT victims of violence, except to note at the end:

> Many victims face additional barriers because they live in isolated and rural areas or because they are members of communities for which resources are limited. This is especially true for victims from culturally or linguistically specific communities and those who are lesbian, gay, bisexual, transgender or queer (LGBTQ). 'Our program has a hard time providing services for these groups,' said a Massachusetts advocate. 'They face discrimination or the available resources aren't culturally competent.'[26]

The 2013 report is similar:

> Victims who identify as members of the LGBTQ community also face unique barriers in accessing safety and justice. Criminal justice and law enforcement systems and personnel frequently struggle to understand the dynamics of domestic violence in the LGBTQ community. Despite laws that prohibit discrimination, LGBTQ survivors sometimes have a difficult times accessing help and protection.[27]

In the first glimmer of hope shone on the subject, the Department of Health and Human Services announced in June 2013 that it would be devoting $300,000 to help LGBTQ victims of

[24] See: http://www.valleyoasis.org/people_we_serve.html
[25] See: http://nnedv.org/downloads/Census/DVCounts2010/DVCounts10_Report_Color.pdf
[26] See: http://nnedv.org/downloads/Census/DVCounts2010/DVCounts10_Report_Color.pdf
[27] See: http://nnedv.org/downloads/Census/DVCounts2013/Census13_FullReport_forweb_smallestFileSizeWhiteMargins.pdf

IPV through its agency Administration for Children & Families. The grant seeks to "expand the capacity of both domestic violence organizations and LGBTQ-specific organizations to more effectively identify and address the unique needs of LGBTQ intimate partner violence victims"; noting the difficulties gay men and transwomen (many shelter and agency workers misgender them as men/male) have in accessing shelter services.[28]

History of Women's Domestic Violence Against Men

The discussion of intimate partner violence utilizing a queer critique wouldn't be complete with more fully addressing the issue of women's violence against men. And among all of the debates in the field of intimate partner violence, perhaps none is more contentious than that of women-initiated violence—a debate that has been raging since the first U.S. National Family Violence Survey of 1975 found women to be more severely violent than men (see Straus & Gelles, 1986), and continues today after the National Intimate Partner and Sexual Violence Survey in 2010 found that 624,000 more men than women reported experiencing physical intimate partner violence in the last year.[29] These findings, on their face, contradict the mainstream feminist explanations of the source of violence in relationships—masculinity; so the findings have sometimes been suppressed, unreported, reinterpreted, or denied by scholars who address intimate partner violence (Carney, Buttell, and Dutton, 2007). Indeed, as discussed earlier in this chapter, "Abuse has been defined as a woman's issue," framing "women as victims and men as trouble-makers" (Loseke, 1987).

As such, most of the conversation on women's violence against men began and continues to take place largely on websites and within organizations affiliated with the Men's Rights and mythopoetic men's movements—something that some feminists, rightfully, take issue with. For instance, there is an online journal managed by MenWeb that is almost entirely focused on domestic violence against heterosexual men.[30] However, MenWeb is a "men's issues site: mythopoetic men's movement, psychology, therapy, healing, men's rights, gender justice." Many feminists and profeminist men have expressed concerns over not only for the surface ideals, but also the underlying messages promoted by the movement (see Kimmel, 2009), including that is

[28] See: http://www.acf.hhs.gov/grants/open/foa/files/HHS-2013-ACF-ACYF-EV-0598_0.pdf
[29] It should be noted that when you take into account rape and stalking, over 1 million more women report IPV than men. See: http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf
[30] See: http://www.batteredmen.com/Journal.htm

depoliticizes and reinforces gender inequalities, such as "the notional that masculinity and femininity are oppositional and, at least in part, timeless qualities of personhood" (Gremillion, 2011).

From what I can gather, RADAR (Respecting Accuracy in Domestic Abuse Reporting) is the leading source of information on the data collection and public press regarding men's victimization.[31] However, RADAR has been recently called out by some as a group for MRAs (Men's Rights Activists), in which the main goal is not to promote "gender equality" in the detection, treatment and prevention of IPV, but to bring women down while promoting the rights of *oppressed* men.[32] In a 2007 report, RADAR reported that because of the Violence Against Women Act, "over 1 million false allegations of domestic violence are filed each year," claiming in a follow-up report that some women who cheat on their husbands report abuse after their husbands discover the affair—an incredibly problematic assertion, given that the source of this data does not even directly address IPV or women's extramarital affairs.[33, 34]

Originally, the study of men and masculinity in the U.S. has had an affiliation with the field of Women's Studies and feminism. As a field, *Men's Studies* grew out of a number of *feminist men's studies of other men*—the goal was to bring a feminist perspective to the study of masculinity, to be critical, and to be focused on gender justice (Brod, 1987a, 1987b; Faludi, 2006; Kimmel, 1986). Of course not all men's studies were feminist, as some work was directly related to the development of a men's liberation movement, which expressed hostility towards the women's liberation movement and feminism (Faludi, 2006).

By the mid-1980s, the issue of Men's Studies as an academic discipline started being legitimately discussed in Women's Studies journals; but there were some strong feminist opponents to the study of men and masculinity (Brod, 1987a, 1987b; Carrigan, Connell, & Lee, 1985; Libertin, 1987). Many wondered if the goals and objectives of Men's Studies align with that of Women's Studies. Women's Studies had the goal of dismantling patriarchy and its lingering effect of constructing a one-sided history: studying women with the intention of

[31] RADAR claims they are "a non-profit, non-partisan organization of men and women working to improve the effectiveness of our nation's approach to solving domestic violence." See: http://www.mediaradar.org/
[32] See: http://feministing.com/2013/08/29/virginias-ken-cuccinelli-worked-with-group-that-thinks-the-vawa-encourages-women-to-fake-domestic-abuse/
[33] Although the original 2007 report has been taken down, you can see the citation for it within this 2007 report: http://www.mediaradar.org/docs/RADARdocument-Agenda-for-VAWA-Reform.pdf
[34] This is the citation for the false allegation/affairs claim: http://www.ejfi.org/family/family-74.htm

placing women's experiences at the forefront of analysis (Bell & Rosenhan, 1981; Brod, 1987b; Coyner, 1991; Libertin, 1987). However, Women's Studies also aimed to maintain the larger feminist project of the production of knowledge for social change that enhances the status of women (Brod, 1987b; Libertin, 1987). In this way, those involved in women's studies were not only interested in reconstructing the history of our social world, with women at the forefront, but also challenging the status quo and influencing a future of equality and justice for women.

It's easy to see how the general incorporation of men into Women's Studies, or of the creation of Men's Studies, may become problematic. At the time, scholars had to prove that the method and praxis of studying men was drastically different than the historical, taken-for-granted, male-centric process that most academic disciplines had been doing since their inceptions (Libertin, 1987). Specifically, scholars of men had to prove that they were critically studying men, and that perhaps it was actually *masculinity,* or men's gender, that was the unit of analysis, rather than men as the norm themselves (see Kimmel, 1986). Prior to beginning work on men's victimization, I had thought this issue had resolved itself within in the social sciences, at least superficially, given that the study of men and masculinity is seen as a legitimate field, having its own journals, conferences, and associations—mind you, journals, conferences, and associations that *are not* seen as anti-feminist (Auslander, 1997; Gardiner, 2013; Urschel, 2000).

But, when it comes to the specific study of intimate partner violence, the historical tension remains alive and well. The theory driving this is a Marxist-feminism perspective first developed by Catherine Mackinnon (MacKinnon, 1989) that posits that domestic violence in which a man hits a woman is "violence against women"– plural– a political act. Women's use of retaliatory violence is not a violence against men, but a singular instance of self defense – a personal act. Early on in the debate on rates of victimization Mildred Pagelow (1985) reported that the number of battered men might be between 3% to 5% of the husbands, but likely not more. She stated that "there must be many husbands who have been beaten severely by their wives more than once," that undoubtedly women can be violent, and that some of them are extremely violent, creating an environment of real fear and danger for their husbands (1985). But at the time, there was not sufficient evidence of a large-scale "syndrome" that could compare to the extensive evidence of a widespread and serious battered-wife problem (1985).

Michael P. Johnson, well known in the field of domestic and intimate partner violence for his typology of violence—distinguishing between what he calls common (later situational)

couple violence, in which arguing and conflict turn into violence, and intimate terrorism, the more severe unilateral form of IPV based on coercive control (see Johnson, 2008 for a review)—believes that the studies showing equal rates of perpetration by men and women are faulty and should not be relied upon (Johnson, 2011).

Originally, the argument that he used to explain the high rates of women's violence against men was the inclusion of "self-defense" as a form of abuse in surveys and small studies (i.e., you initiated the violent episode, but then your opposite-sex female partner hit back) (Johnson and Ferraro, 2000). While the physical violence reported by some men and women could be their partner's self defense tactics, there is no reason to believe this is the case—nor should we believe that only men's levels of reported physical victimization would be elevated by the inclusion of self defense tactics, as this relies on gender normative assumptions about men's general aggression and women's general passivity, and is ultimately reductionist (Carney, Buttell, and Dutton, 2006; Langhinrichsen-Rohling, 2010). A preliminary refutation of this can be found in Migliaccio (2002), in which abused husbands specifically recount their experiences of unilateral victimization; many of them were aware of the social norms and expectations for men and masculinity, noting that even if they were bigger, stronger, and more physically able (i.e. one was a black belt in karate), they did not fight back.

Moreover, this does not seem to hold true for the definitions of violence used by the NISVS—which found that more men than women experienced physical violence in the year prior—as it only asks questions about victimization by a perpetrator (such as chocking, slapping, biting, etc.), not specifically about a perpetrator's use of self defense tactics against the victim as a form of violence itself.[35]

Johnson (2011) and others (see Dragiewicz and DeKeseredy, 2012) have recently turned to a new explanation of reported gender symmetry arguments: calling much of the data on men's and women's perpetration rates, and some research that uses this data to explore health and criminal justice outcomes "anti-feminist." Specifically, Johnson (2011) writes:

> The most recent of a series of anti-feminist attacks from Dutton, Hamel, and their colleagues is 'The gender paradigm in family court processes: Re-balancing the scales of justice from biased social science' (Dutton, Hamel, & Aaronson, 2010),

[35] See page 3: http://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_digest_final-a.pdf

> an ironic title, given the panoply of biases with which it itself is riddled. In this particular article they claim to expose two recent papers (Jaffe, Johnston, Crooks, & Bala, 2008; Kelly & Johnson, 2008) as biased and unsupported by research evidence.

But, I think the framing by all of the scholars above is in some way biased. Dutton et al. (2010) may make claims about a feminist framework for studying IPV that seem sweeping and overgeneralized (i.e. the one espoused at the beginning of this chapter—the framework that does shape much of the current literature on IPV, even if a more inclusive or expansion feminist frame is said to be used); perhaps they do not give enough credence to great intersectional and third-wave feminist analyses of violence as Johnson (2011) suggests they should. But Johnson also paints Dutton et al. as anti-feminist based on their language and word choice, not on the basis of the data they present within the paper; and even further, with typically only his own past work as a citation, contends that research supports the idea that although women can be situationally as violent as men (violence arising from general conflict or argument), men suffer fewer injuries and fear for their lives less often because women do not perpetrate intimate terrorism (coercive control) as often.

In my interpretation of the Dutton et al. paper, while they do at time tend to overgeneralize the past feminist-informed analysis of intimate partner violence (Johnson, 2011), they also highlight studies that dramatically challenge the current framework on gender and parenting that so much of our criminal justice system utilizes during custody battles (it is of note that Johnson does not reference the studies on child abuse and custody battles once in his entire critique of the Dutton et al. (2010) paper). Is it problematic to imply that *all* feminist analyses of intimate partner violence assess men as evil perpetrators and women as victimized saints? Absolutely. But we also cannot overlook the data that indicates the general public, criminal justice system, and service-providing agencies continue to rely on (I believe, subconsciously) the idea that men are evil perpetrators and women are victimized saints. Perhaps it is not academic that still clings to the 1970s feminist understanding of intimate partner violence, developed from the narratives of battered women, but the general public and the structural system that continues to normativize individual men's and women's actions.

For instance, two studies in Canada and the U.S. assessed the rates of child abuse (physical and sexual), neglect, and other forms of violence (emotional maltreatment), including if the claims of abuse were substantiated, unsubstantiated, or just suspected (an important distinction given the assertion by some that parents lie about child abuse in order to maintain custody over the other parent (see Bancroft and Silverman, 2002; Jaffe, Johnston, Crooks, and Bala, 2008; Jaffe, Lemon, and Poisson, 2003). Out of 135,573 child maltreatment investigations conducted by Health Canada, not only did parents, regardless of gender, tell the truth (and conversely lie) about child abuse perpetration by the partner at equal rates (between 52-58% of the time child abuse was substantiated), biological mothers were found to be more likely to perpetrate physical abuse, neglect their children, and engage in emotional maltreatment (Trocme et al., 2001; Trocme et al., 2011). In a U.S. study, the United States Administration for Children and Families analyzed 718,948 reported cases of child abuse, and found that in 2005, women were upwards of 1.3 times more likely to abuse their children than men; what's more, when the parent acted in violence alone, women were twice as likely to commit violence than men, and were the main perpetrators of child homicide (Gaudioisi, 2006).

The most shocking finding of all? Mothers are still far more likely to receive main or full custody of their children, even if the presence of clear and corroborating evidence (Cook, 2009; Douglas and Hines, 2011). For instance, in Washington State between 2009-2010, fathers received majority parenting time in very few cases (Washington Administrative Office of the Courts, 2010). Mothers get majority parenting time in 65% of all cases and 64% of those in which there are no parental "risk factors" for anyone involved. Dads get 17% and 15% full custody, respectively. "Risk factors," such as admissions of domestic violence, drug or alcohol dependence, as abandonment or neglect of the child.

What's more, about one in ten dads and one in 20 moms have at least one risk factor. In this study (Washington AOC, 2010), fathers received full custody in about one in four (26%) cases in which the mother had one risk factor and the father had none, but when the sexes were reversed, mothers got full custody 44% of the time. This means that if the father had no risk factors, but the mother had a chemical dependence (the most common risk factor for women), they still received full custody almost 75% of the time. In the same situation, in which the man has the chemical dependency and the woman has no risk factors, the man receives full custody only a little over half of the time. When the mother had two risk factors and the father had none,

he received full custody only 42% of the time. When the father had two risk factors, the mother received full custody 63% of the time.

After reviewing all the data on child abuse and custody battles, Dutton et al. (2010) and Dutton and White (2013), conclude that these findings are from "the best research data, from the largest and most rigorous studies" and that they "tell a very different story from that related by" other researchers who claim mothers are the best option for their children and that men only lie about the abuse that mothers perpetrate (see Bancroft and Silverman, 2002; Jaffe, Johnston, Crooks, and Bala, 2008; Jaffe, Lemon, and Poisson, 2003). And I have to agree. It seems that not even child abuse, neglect, chemical dependency or the presence of intimate partner violence is bad enough to negate how necessary a mother is, and how gendered the category of "mother" and "father" are, in the eyes of criminal justice system and the individual people in charge of deciding who will be a better parent. Cook (2009) believes that the burden of proof for male IPV victims is especially high.

There is a lot at stake in making these claims, I know—the importance of maintaining a critical interpretation of all the research does not elude me. I cannot deny the existence of anti-feminist literature on intimate partner violence; but I also will not jump to the conclusion that reporting studies and data on intimate partner violence that indicate women are, indeed, violent, and men can, indeed, be victims is inherently anti-feminist. If we removed the purported "caricature" of feminism from Dutton et al.'s (2010) article, were are left to see some stunning and extensive findings on child abuse; and if we remove the "anti-feminist" claim from Johnson's (2011) article, we discover that there is no attempt to refute Dutton et al.'s child abuse findings.

Put another way, I believe that what we are left with, after all is said and done, is a quite telling picture of the current state of feminism, feminist attempts to study and analyze intimate partner violence, and the essential notion of what feminisms purpose is for studying men and masculinity. As an example, depending on the theoretical perspective used in research, there are a range of terms chosen from that are, essentially, interested in studying the same phenomenon (IPV): domestic violence, domestic abuse, wife battering, and wife beating, among others (McHugh et al., 2005). But, does choosing the term *domestic* not imply a necessary relationship between two people (i.e., of or relating to the running of a home or to family relations)—what of those who do not live together? What of those who are not considered a "family" within the

historical tradition, the social construct? When we choose to describe what is happening as battering or abuse against *wives*, are we not necessarily excluding a large group of individuals from the start—what of those who are not married? What of those who do not identify as women?

In the literature and research presented below, I will attempt to be as clear as possible in describing the theory and praxis of the studies on women's violence against men; but I will also be attuned to the particular ways in which the field has, to the detriment of victims, argued more about feminism and its discontents than of violence, and why academia and the general public have been reticent to attempt any legitimate intervention on behalf of abused men.

I'll start by highlighting some of the differences between data collected from general social and community surveys (which use the conceptual tool the "Conflict and Tactics Scale") and agency samples and crime and safety related surveys (which conceive of violence as crimes, and sometimes rely on data regarding violence reported as a crime). Data from general and community surveys suggest that men and women are equally violent in intimate relationships (Straus, 1999), a conclusion borne out by Archer's (2000, 2002) meta-analysis of 82 couple-conflict studies which found that women were more likely to use physical aggression than men and to resort to violence more often than men. These findings are directly refuted by the the Bureau of Justice Statistics (BJS) data on IPV, which has consistently indicated that women are four to five times more likely than men to have been the victims of violence (Rennison and Welchans, 2000, 2004).

These mutually exclusive data sets have led to diametrically opposed conceptualizations of "domestic violence." The measuring tool most often utilized by these social and community survey researchers is the Conflict and Tactics Scale (CTS). As implied by the title, it sets out to measure how men and women deal with conflict in their relationships. "The CTS measures three factorially separate variables: reasoning, verbal aggression, and violence or physical aggression" (Straus and Gelles, 1986). As an example, the CTS asks respondents about what happens "when they disagree, get annoyed with the other person, or just have spats or fights because they're in a bad mood or tired or for some other reason" (Straus, 1997). The outcomes are no physical violence or physical violence. Interestingly, Fiebert (1997) wrote, "Women are as physically aggressive, or more aggressive, than men in their relationships," on the basis that women's physical violence against men as the outcome of disagreement happened just as often or more

often than men's physical violence against women did. These findings have embroiled the CTS in controversy (Dobash and Dobash, 1978; Dobash et al., 1992; Ferraro and Johnson, 1983; Pagelow, 1985; Pleck, Pleck, Grossman, and Bart, 1978).

However, less controversial surveys, such as the National Crime Victimization Survey (NCVS) and the National Violence Against Women survey (NVAWS), have repeatedly indicated that women are much less likely to perpetrate intimate partner violence than are men (i.e., Rennison, 2002 and Tjaden and Thoennes, 2000, respectively). These findings are consistent with traditional, mainstream feminist theories about intimate partner violence (Saunders, 1988; Yllo, 1993) and parallel the evidence from smaller qualitative studies that indicate men generally engage in violent crime, such as homicide, more frequently than do women (Fox and Zawitz, 2007).

How might we explain these differences? On explanation offered by scholars is that the CTS does not survey "context, meaning, and motive" (Dragiewicz and DeKeseredy, 2012). This exclusion thus hides the fact that "a common cause of women's violence is self-defense" (DeKeseredy, 2007). Ellis (2002), agrees: "[i]gnoring context, meaning and motive is misinforming . . . [a]nd not separating different types of violence is misleading" (quoted in Foss, 2002).

I offer another potential set of explanations: crime victimization studies include a wide range of assaults, including sexual assault, in the questionnaires; survey about current and former intimate partner violence, by not only romantic intimates but also strangers, those you went on dates with, and family members; and only ask about those events that individuals experience—or report to municipal authorities—as *crimes*, and therefore miss those events that are neither perceived as nor reported as crimes. There has not been on single study, qualitative, quantitative, convenient or nationally-representative to find that women perpetrate rape as often as men (an issue, perhaps, in the definition of rape used, which I discuss later in the chapter). When we add sexual assault and rape experiences, especially those over the lifecourse (by a parent, or a date, for example), with physical violence experiences, we see a much higher number of women experiencing violence than men.

What's more, although Kimmel (2002) indicates that men are more likely to seek out criminal justice sanctions than women when it comes to intimate partner violence, law enforcement is lax when men are injured in domestic violence disputes (Brown, 2004; Buzawa

and Buzawa, 1990)—which might explain why crime studies pick up that fewer men report criminal IPV than women. Buzawa, Austin, Bannon, and Jackson (1992), in a study of the police arrest policy in Detroit, found that even when controlling for self-defense tactics, "male victims reported three times the rate of serious injury as their female counterparts, 38% compared to 14%," but that police rarely arrested a female perpetrator who had been reported.

As Buzawa et al. (1992) put it: "Not one male victim was pleased with the police response. They stated that their preferences were not respected by the officers, nor was their victimization taken seriously. The lack of police responsiveness occurred regardless of the degree of injury. For example, one male reported requiring hospitalization for being stabbed in the back, with a wound that just missed puncturing his lungs. Despite his request to have the offending woman removed (not even arrested), the officers simply called an ambulance and refused formal sanctions against the woman, including her removal. Indeed, all the men interviewed reported that the incident was trivialized and that they were belittled by the officers" (Buzawa et al., 1992).

What's worse, Brown (2004) found that men were more likely than women to be arrested and prosecuted for IPV, regardless of the circumstances surrounding the violence. For example, in cases where neither partner sustained injury, men were over 15 times more likely than women to be charged with IPV (61% vs. 3.8%). Henning and Renauer (2005) found that men were more likely to be arrested compared to women, even when other factors were controlled (e.g., prior arrests, self-defense tactics). Men also faced harsher legal ramifications post-arrest; in one study 85% of men and 53.5% of women who were arrested were prosecuted (Henning & Renauer, 2005).

No matter the method utilized to obtain prevalence rates, there are marked differences in the experiences of abused men and women post-victimization. For instance, in opposite-sex contexts, women must not only struggle against abusive husbands but also a society that is generally structured to disempower them (Bograd, 1988; Dobash & Dobash, 1978; Dobash, et al., 1992; Kurz, 1993). In contrast, an abused man struggles both internally and externally with the maintenance of a masculine ideal, even if the social structure generally supports him (Migliaccio, 2001). Most members of U.S. society expect men to be bigger and stronger than their wives, regardless of whether they are, which can have significant effects on the masculine identity of a battered husband and whether or not individuals believe he is a "legitimate" victim

(Migliaccio, 2001). As Howard and Hollander (1996) discuss, "Victimization may be so deeply 'female' an experience that a man who is victimized is literally 'feminized' in respondents' cognitive evaluations." In an attempt to refrain from being emasculated, and in many ways revictimized, a man who has been abused may contain his fears, keep from asking for help, and even diminish or completely disregard the abusive situation. Although these are important issues, they have rarely been studied and deserve more scholarly attention (Migliaccio, 2003).

As mentioned earlier, these normative assumption of men's greater size and strength also leads researchers and those within the criminal justice system to downplay the experiences of abused men; in some sense, their abuse is seen as less damaging and less serious than women's experiences of abuse (Pagelow, 1985). Such a notion is based on the belief that if the need arises, men are able to overpower their wives to stop an attack. Migliaccio (2003), however, finds that most men, even if they are bigger or stronger than their abusive wives, don't site that size and strength is a significant factor in their relationships or in their experiences of violence. It may be that were are conflating the *ability* to use size and strength with the *reasons* why individuals resort to violence—they are not, in many cases, the same thing.

In fact, several studies indicate men are just as likely, and often more likely, to experience assaults by perpetrators who use weapons—a factor that can significantly impact whether or not a victim attempts self-defense tactics (Brown, 2004; Buzawa and Buzawa, 1990; Hines et al., 2003). George (1999) separated kicking and punching in his nationally representative sample and recommended what might be an important distinction in physical violence perpetrated by women rather than men—since women have less upper body strength than men, and are more likely to use their legs than their arms during an altercation, we need to include kicking in addition to punching in the questions regarding victimization in order to accurately measure the physical violence that occurs (Basile, 2004).

Generally speaking there is a growing body of literature that shows women use violence against non-violent men, have similar rates of even the most severe forms of abuse to men (Stets and Straus, 1990; Hines, 2007; Hines and Malley-Morrison, 2001), and even seriously harm and injure their male partners (Hines and Malley-Morrison, 2001; Holtzworth-Munroe, 2005; Laroche, 2005; Stets and Straus, 1990). There are even now a substantial number of studies that indicate a variety of motivations for women to engage in intimate partner violence (which is not surprising given the heterogeneous nature of violence in relationships); commonly, self-defense

is not the most cited nor self-reported reason for engaging in violence against men (Hamberger et al., 1997). Moreover, women offenders constitute the fastest growing segment of the criminal justice system, and the National Institute of Justice estimates that the increase in the incarceration rate for violent women is double that of men (Ferraro and Moe, 2003; Mullings, Hartley, and Marquart, 2004).

Despite this evidence, there is a statistical anomaly, pointed out by Kimmel (2003) and others, that asks, "Why is it that when we begin our analysis at the end point of the domestic violence experience—when we examine the serious injuries that often are its consequence—the rates are so dramatically asymmetrical?" Here, Kimmel is questioning the lack of abused men in hospital emergency care facilities and shelters, and the lack of women arrested or incarcerated for IPV. Even if some studies, as indicated above, find that men suffer violence and serious injury as often as women, why are they not found in hospitals and shelters; and more than that, if women are really perpetrating this violence, why does the judge and jury not find the abusive women guilty?

The answer, as had been addressed at various points previously in the chapter, is actually quite simple: because services for men don't exist, and the criminal justice and healthcare systems don't treat men as legitimate victims (see Dutton and White, 2013; Galdas, 2009). Specialized services for women experiencing intimate partner violence have existed since the 1970s. But there is only one, singular, emergency housing (shelter) facility in the United States geared towards men who have suffered intimate partner violence. Shelters for homeless men, yes; shelters for men and women, often LGBT men and women, yes; but not specifically for men abused by women. This is not so surprising, given that the majority of funding for "domestic" violence shelters comes from the state, then federal, then local governments—which funds shelters along the lines of what is indicated as pertinent in the Violence Against Women Act, i.e., women's shelters.

According to RADAR, less than 10% of the United States OVW's (Office of Violence Against Women) funding is used to help male victims. Now, remember, RADAR has been flagged as a Men's Rights organization and has said problematic things regarding the Violence Against Women Act. But, a quick once-over of the grants funded through the OVW does seem to confirm a general trend in funding organizations, shelters, and service-providers whose focus is

on women.[36] This doesn't seem too surprising, though, given that on page 6 of the Department of Justice's most recent solicitation for proposals (for funding) on intimate partner violence and stalking, explicitly state that they will not fund proposals aimed at helping male victims.[37]

No matter who they are geared to help, shelter samples will inevitably produce results that are very different from the general population—as most women who seek emergency housing at a domestic violence shelter have experienced domestic violence. As far back as 1992 Murray Straus had reported that women from shelter samples had 11 times the violence perpetrated against them as did community samples of women. But many studies that employ shelter samples also assume that these women do not (or are not capable) of perpetrating violence themselves. McDonald and her colleagues asked about violence both toward and by women in shelters (McDonald, Jouriles, Tart, and Minze, 2009) and found that 67% of abused women reported using an act of severe violence against their partner—although it is not specified if this was in self-defense or not, these rates would be very high when compared to other self-defense studies (see DeKeseredy, 2007).

An important but often unexposed side of this shelter story is that of men's attempts at access. The Domestic Abuse Project (DAP) of Delaware County, PA has campaigned to assist both men and women victims for decades. DAP Executive Director Rita Connolly spoke out about the misconceptions of the men who seek help from them, saying, "It's a tough thing for a guy to come in." Only around three percent of DAP supported individuals have been men, and Connolly commented that abused men "usually come in to get a female abuser out of the home for the sake of children" rather than seek shelter for themselves—they do not want to leave their children with their abusive spouse.[38]

If we started our research on intimate partner violence at the endpoint of help-seeking crisis hotlines, we would also find a dearth of men as victims; there is only one hotline in North America geared towards them. A study by Hines, Brown, and Dunning (2007) examined calls from men to the American national domestic violence helpline for men. As the authors point out, it would be unlikely for male perpetrators or co-perpetrators to use this line, given its purpose.

When the line opened, it received one call a day. When it was advertised in state

[36] See: http://www.ovw.usdoj.gov/grantactivities.htm
[37] Specifically, they state that they will not fund many proposals, including, "Proposals for research on intimate partner violence against, or stalking of, males of any age." See: https://www.ncjrs.gov/pdffiles1/nij/sl000734.pdf
[38] See: Sullivan, Vince. "Help domestic abuse victims for 35 years". The Delco Times. Retrieved 31 October 2013.

telephone directories, it began to receive 250 calls a day. All but a few callers experienced physical abuse from their opposite-sex partners (only 4% identified as being abused by a same-sex partner), and a "substantial minority" feared their partners' violence (Hines, Brown, and Dunning, 2003). Over 90% experienced controlling behaviors, and several men reported frustrating experiences with the domestic violence system (i.e. shelters and cops); 52.4% of men who were currently in an abusive relationship indicated that they were fearful that their partners would cause a serious injury if she found out that they had called the helpline. Callers also reported forms of violence that are not typically measured in surveys, such as having their partner try to drive over them with a car—this might be considered "other threats of harm" in the National Violence Against Women Survey, but this type of violence is rarely allowed in the limited wording and yes/no response categories of survey questions.

Given the above research, we could say that there is a bias in our culture, in our academic fields, and in our structural systems that finds a more benign context for women's but not men's use of violence in relationships (Hamel et al., 2007). This bias has several negative implications. It may make it more difficult for professionals to ask about or address women's violence, even when it is severe. It may also make it more likely that potentially dangerous women are not receiving the services they need. Moreover, men victimized by violent women may have fewer options in terms of services and support. Unwittingly, this bias may also perpetuate other types of violence in the family (witnessing mother-to-father violence is consistently shown to have strong negative long lasting impact on children and increases their likelihood of becoming a victim and/or perpetrator in adulthood).

One potential solution recently offered to better assess the effect of women's violence against men is to change the questions we are asking. Recent studies indicate that rates of reporting acts of violence are impacted by the method of survey presentation (computer vs. face to face; shame and fear of emasculation is a potential set back for men) whether participants are queried about "aggression" or "violence" (not all those who are abused see their partner as using violence; *violence* is a charged term, especially for those in intimate partnerships), and whether dichotomous ("yes" or "no" only) or continuous response choices (i.e. on a scale of 1-10) are offered (Hamby et al., 2006; Mills, 2003; Regan, 2008; Reddy et al., 2006; Rosenbaum and Langhinrichsen-Rohling, 2006).

One (apparently) controversial suggestion is to reframed questions to be more "gender neutral" (see Johnson, 2011 for why and to whom it is controversial). When questions are reframed, the results show an increase in the number of men who report violence by women (and, for the record, the number of people who report violence by a same-sex partner) (Dutton and White, 2013). In fact, in 2013 the National Crime Victimization Survey (NCVS) turned up a remarkable statistic—likely a result of reframing its questions. In asking 40,000 households about rape and sexual violence, the survey uncovered that 38% of incidents were against men. The number seemed so high that it prompted researcher Lara Stemple (Health and Human Rights Project at UCLA) to call the Bureau of Justice Statistics to see "if maybe it had made a mistake," or changed its terminology.[39] In years past, men had accounted for somewhere between 5-14% of rape and sexual violence victims in every major survey, including the NCVS. The BJS told her it was not a mistake; more men than ever before reported rape and sexual assault. This is because the NCVS recently changed its definition of rape to be analogous across data collection agencies and for the first time no longer "underreports" rape and sexual assault.[40]

As another example, for years the FBI defined forcible rape for data collecting purposes in the Unified Crime Report (UCR) as "the carnal knowledge of a female forcibly and against her will." Carnal knowledge, of course, being an archaic legal euphemism for sexual intercourse, derived from Biblical usage of the verb know/knew, as in the King James Bible and other versions: "And Adam knew Eve his wife; and she conceived, and bore Cain, and said, I have gotten a man from the LORD." – Genesis 4:1.

Eventually localities began to rebel against that limited sex-bound definition. In 2010, Chicago reported 86,767 cases of rape but used its own broader definition, so the FBI left out the Chicago numbers—undercounting instance of rape. Finally, for 2013 data collecting purposes, the FBI revised its definition to be "penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim." A preliminary look over the unofficial January-June 2013 report shows one staggering change – this new definition has not decreased rape and sexual assault rates, but rather amounted to many jurisdictions reporting rape cases for 2013, when it did not report any in 2012

[39] See: http://www.slate.com/articles/double_x/doublex/2014/04/male_rape_in_america_a_new_study_reveals_that_men_are_sexually_assaulted.html

[40] See: http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=18605

(likely because the definition was so limiting for both men and women). It will be interesting to see what the numbers say when the full 2013 UCR is released next January.

The CDC's 2010 National Intimate Partner and Sexual Violence Survey (NISVS) invented a new category of sexual violence called "being made to penetrate." This definition includes victims who were forced to penetrate someone else with their own body parts, either by physical force or coercion, or when the victim was drunk or high or otherwise unable to consent. When those cases were taken into account, the rates of nonconsensual sexual contact for men and women basically equalized, with 1.270 million women and 1.267 million men reporting sexual violence victimization.

Based on these new numbers from the National Crime Victimization Survey, the Unified Crime Report, and the NISVS, Stemple (2014) concluded that we need to "completely rethink our assumptions about sexual victimization." The lack of focus on men, and the taken-for-granted assumption that men are abusers and women are victims, leaves hundreds of thousands of men unprotected, alone, and trapped in the cycle of violence. Importantly, if we are to believe the previous studies that show relative equal rates of other forms of violence perpetration, it's not as if these new reports showcase an increase in women being violent.[41] More than likely, these new reports point to a small, but noticeable change in gender norms, given the new instruments used to survey sexual assault and/or rape. "Perhaps masculine gender norms are shaking loose in a way that allows men to identify themselves—if the survey is sensitive and specific enough—as vulnerable" (Stemple, 2014).

It is important to keep in mind, however, that calling a new measurement device gender-neutral does not necessarily make it so. For example, Houry and colleagues (2008) recommended assessing both men and women with the WEB, a self-described gender-neutral measure that was designed to differentiate battering or abuse from acts of aggression. Yet, the acronym WEB stands for Women's Experiences of Battering and items on this instrument seem likely to evoke some gender-specific sources of abuse described by previous instruments (e.g., reporting feeling unsafe within your own *home* and/or feeling *owned* and controlled). It is also important here to be clear that by focusing on more gender-neutral survey questions, I am not

[41] It is of note that men's reports of almost all forms of IPV victimization are less than women's reports of IPV perpetration (Desmarais, Reeves, Nicholls, Telford, & Fiebert, 2012a; 2012b): "Either the women are bragging or the men are in denial, or both."

asking researchers to reframe violence as *genderless*. I do not support an anti-feminist study of men's victimization; critical studies of men and masculinity are not inherently anti-feminist and should encourage social justice for all victims.

Stemple, who compiled the data on men and violence is a self-proclaimed feminist who fully understands that men have historically used sexual violence to subjugate women and in many places they still do. But, as she sees it, feminism has fought long and hard to end rape myths—that if a woman gets raped it's somehow her fault, that she welcomed it in some way, etc.—and that maybe by ignoring men's experiences of victimization, by denying that they could be "legitimate" victims, we are creating and perpetuating new ones. By portraying sexual violence against men as aberrant, we prevent justice and compound the shame. The she sees it (and I agree), starting an open and honest conversation about men's victimization doesn't need to shut down the one we continue to have about women. "Compassion," she says, "is not a finite resource."[42]

Importantly, we must begin to understand and acknowledge that the existing interventions for intimate partner violence—the ones that are politically supported, judicially mandated, and empirically studied—arose from commonly held, heteronormative beliefs (Austin and Dankwort, 1999). Interventions that target individual skill deficits (learned culturally and socially), relational patterns, and structural inequalities without explicit exclusion of abused men hold the most promise for effective detection, prevention, and treatment of IPV—which is what the academic study and public awareness of intimate partner violence is currently most concerned with achieving (Langhinrichsen-Rohling, 2010).

Intimate Partner Violence as a *Health* Issue

In 1989, the American Medical Association (AMA) launched a campaign to combat family violence and by 1991, there were guidelines for mandatory screening for signs of domestic violence against women; that same year, the U.S. surgeon general ranked abuse by husbands to be the leading cause of injuries to women aged 15 to 44, calling it a "silent

[42] See: http://www.slate.com/articles/double_x/doublex/2014/04/male_rape_in_america_a_new_study_reveals_that_men_are_sexually_assaulted.html

epidemic" (Schornstein, 1997). Following suit in 1996, the World Health Organization declared that violence against women was a public health problem (document WHO/EHA/SPI.POA.2).

Most of the emerging research in the mid-1990s focused not on prevalence rates, but on mental health concerns: depression, post-traumatic stress disorder, anxiety, and personality disorders (Fischbach and Herbert, 1997; Kessler, Molnar, Feurer and Appelbaum, 2001; Roberts, Lawrence, Williams and Raphael, 1998; Roberts, Williams, Lawrence and Raphael, 1999); and the public health crisis of violence against women (Hyman, Schillinger and Lo, 1995; Rodriguez, Craig, Mooney and Bauer, 1998; Stark and Flitcraft, 1996; Warshaw, Ganley, Salber and Fund, 1996). Some scholars, albeit only two, were discussing lesbian and gay violence within a mental health context as well (Byrne, 1996; Renzetti and Miley, 1996).

Through the 2000s, the physical health consequences of intimate partner violence for women were also beginning to unveil themselves in the literature (Campbell, 2002; Coker et al., 2002; Ellsberg, Jansen, Heise, Watts and Garcia-Moreno, 2008; Gandhi et al., 2010; Huang, Yang and Omaye, 2011; Peckover, 2003; Ramsay, Richardson, Carter, Davidson and Feder, 2002; Richardson et al., 2002). Though a handful of articles had been published before this in medical journals about detecting "battered women's syndrome" in a primary care setting, this was the first time in which intimate partner violence became a legitimate cause of both physical and mental health problems in women (Schornstein 1997; Warshaw 1993, 2004).

By 2011, the Institute of Medicine (IOM) had released *Clinical Preventive Services for Women: Closing the Gaps*, an extensive report that identified eight key preventive services that would help ensure women's health and well being (IPV being one of them). That same year, the U.S. Department of Health and Human Services (HHS) adopted these recommendations in the *Women's Preventive Service Guidelines*. Medical practitioners are now extensively and specifically trained to identify women who have experienced intimate partner violence at the hands of men (both in emergency rooms and, most usually, during gynecological and obstetric care—as most women visit the gynecologist once a year).

Specifically, physicians are now required to screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Under the Affordable Care Act, these services are generally covered in new health plans without requiring a co-payment, co-insurance, or deductible (Health Resources and Services

Administration, 2012; The Patient Protection and Affordable Care Act, § 2713). Additionally, the U.S. Preventive Services Task Force (USPSTF) released a recommendation in January 2013 calling for clinicians to "screen all women of childbearing age for intimate partner violence" (U.S. Preventive Services Task Force, 2013).

Not so surprisingly, preliminary studies suggest that emergency room screening of IPV is most effective when there is perceived high risk for the patient—within these studies, perception of severe physical violence or potential for lethal assault—and that IPV is most commonly detected in women patients (Wittig, Furuno, Hirshon, Kurgman, Périssé, and Limcangco, 2006; Snider, Webster, O'Sullivan, and Campbell, 2009). The health indicators that often give away the presence of intimate partner violence in women are often explained away—by both the men themselves who then do not seek help, and by the medical community—as behavioral or general mental health problems in men (as an issue of masculinity itself), not as IPV: broken bones and other bodily injuries, the appearance of low self esteem, a history of alcohol or drug abuse, and a history of anxiety, depression, or suicide attempt (Chuick et al., 2009; Cochran and Rabinowitz, 1999; Hoff, 2012).

What's more, despite the "public health problem" of men's violence against women, few studies have assessed the physical and psychological health and life-outcome effects of IPV on men (Randle and Graham, 2011; see Hines et al., 2007; Dansky, Byrne, and Brandy, 1999 for studies of PTSD and psychological effects). As previously discussed, many studies have shown that women can be just as violent and cause just as much injury as men (Hines, Brown, and Dunning, 2003). But, considerable abuse can also occur without visible physical injury and some scholars argue that psychological abuse itself may be as damaging or more damaging long-term than physical abuse (O'Leary, 1999), and almost always precedes physical abuse (multiple victimization).

One early study found that men who had experienced physical assault by an intimate woman partner were significantly more likely to meet criteria for PTSD than men who had been physically assaulted by someone other than an intimate partner (e.g., by a stranger, in their workplace, by a parent) (Dansky, Byrne, and Brandy, 1999). A reanalysis of the Canadian GSS data by Laroche (2005), based on a sample of 25,876, also strongly refutes the idea that males do not suffer ill effects from intimate partner violence. Laroche (2005) reports that 83% of men who "feared for their life" did so because they were unilaterally terrorized by their female partner,

compared to the 77% of women who were unilaterally terrorized and feared for their lives. Of the terrorized men, 80% reported having their everyday activities disrupted (compared to 74% for terrorized women), 84% received medical care (the same rate as for terrorized women), and 62% sought psychological counseling (63% for women). It's important to make clear here, this is the type of unilateral intimate terrorism that Johnson describes as being the key form of IPV that effects women more often and more seriously than men (see Johnson, 2008; 2011). The findings of the Canadian GSS data by Laroche, then, completely refute that this is always or uniformly true.

But despite the increased reporting rates in the most recent surveys, masculine gender norms seem to be keeping men from seeking out medical and psychological care. The tropes of "be a man," be brave, don't be a victim, real men don't cry, and so on, loom large (see Brannon, 1976). In the National Intimate Partner and Sexual Violence Survey (NISVS), while nearly equal rates of men and women reported violence by an intimate partner (including severe physical violence), only 1 in 10 men who experienced IPV reported seeking help for this violence (e.g., need for health care, contacting a crisis hotline, need for housing services, need for victim's advocate services, need for legal services). This compares to 3 in 10 women. Meaning that even though equal numbers of men and women experience IPV, fewer men seek help.

The awareness of IPV as a "public health problem" for same-sex relationships or LGBT individuals is just as stymied (Klostermann, Kelley, Milletich and Mignone, 2011; Lehavot, Walters and Simoni, 2010). One influential study very early on claimed that IPV is the third most severe health problem among gay men, after AIDS and substance abuse, and may affect 15–20% of both gay and lesbian men and women (Island and Letellier, 1991).

Recently research on same-sex IPV has discovered a number of negative health outcomes stemming from victimization (see Messinger, 2014). These outcomes include substance abuse (Kelly et al., 2011; McClennen et al., 2002; Stall et al., 2003), mental health issues and psychological trauma (Stall et al., 2003; Gillum and DiFulvio, 2014), and physical injuries (Dolan-Soto, 2000; NCAVP, 2012). Although rarely compared, one study did find that lesbian and bisexual victims were more likely to report negative outcomes than heterosexual victims (Walters et al., 2013). Potentially compounding these issues are some unique negative health outcomes that are unique to LGBT individuals generally, such as general substance abuse (see

Kelly et al., 2011; Lewis et al., 2012) and suicidal ideation (Massachusetts Department of Education, 2006; National Transgender Discrimination Survey, 2010).

Health scholars have also been studying men who have sex with men and women who have sex with women. The behavioral category "men who have sex with men" has been used in HIV literature since at least 1990 (Glick, Muzyka, Salkin, and Lurie, 1994; Dowsett, 1990). The acronym MSM, coined in 1994, signaled the crystallization of a new concept as important within the health literature on "sexual minorities." MSM and, more recently, WSW (women who have sex with women) have since moved beyond the HIV literature to become established in both research and health programming for sexual-minority people—in part because the terms held the promise of reducing AIDS stigma, which has been irrationally attached to gay men and lesbians (Young and Meyer, 2005).

With a diverse sample or urban men who have sex with men (MSM), instead of gay or bisexually-identified men, Houston and McKirnan (2007) found that abused men were more likely than nonabused men to report problems such as hypertension, heart disease, obesity, smoking-related illness, depression or other mental health problems, and to engage in unhealthy behaviors such as substance abuse, combining drugs with sex, or unprotected sex. A 2014 review of the literature revealed that in 19 studies with 13,797 victims of IPV, MSM are more likely to engage in substance use, suffer from depressive symptoms, be HIV positive, and engage in unprotected anal sex (Buller, Devries, Howard, and Bacchus, 2014).

Some scholars have noted that the usage of "MSM" and "WSW" is problematic (Young and Meyer, 2005), because of the overwhelming focus on men and not women; potentially a subconscious perpetuation of the HIV/AIDS stigma of yore, under a new guise. While the 2009 California Health Interview Survey (CHIS) did find that women who have sex with women experience the second highest rates of intimate partner victimization (bisexual women have the highest) (Goldberg and Meyer, 2013), no studies have effectively assessed the health outcomes of IPV for women who have sex with women.

To date, the largest focus of same-sex and/or LGBT IPV scholars has been on barriers that victims face in accessing culturally competent healthcare (Aulivola, 2004; Carvalho, Lewis, Derlega, Winstead, and Viggiano, 2011; Duke and Davidson, 2009; Grant, Mottet and Tanis, 2010; Luhtanen, 2007; McClennen, Summers, and Vaughn, 2002). Because of the continued social stigma associated with being LGBT, many LGBT youth and adults do not openly disclose

their sexual orientation to others publically or privately. Findings from discussions with advocates and healthcare professionals in the city of New York showed that the healthcare environment is heterosexist and gender-normative; providers lack knowledge about health disparities affecting LGBT people; LGBT individuals experience hostility and discrimination in care; and concerns about homophobia and transphobia keep LGBT individuals from using healthcare services (Grant, Mottet and Tanis, 2010).

This growing concern moved from the margins straight to the center in 2011 when the National Institute of Health (NIH), under pressure from researchers, academics, and policy organizations, commissioned a special inquiry through the Institute of Medicine to assess of the field of "LGBT Health." The findings?

> At a time when lesbian, gay, bisexual, and transgender individuals—often referred to under the umbrella acronym LGBT—are becoming more visible in society and more socially acknowledged, clinicians and researchers are faced with incomplete information about their health status… Researchers still have a great deal to learn and face a number of challenges in understanding the health needs of LGBT populations… *The IOM finds that to advance understanding of the health needs of all LGBT individuals, researchers need more data about the demographics of these populations, improved methods for collecting and analyzing data, and an increased participation of sexual and gender minorities in research* [emphasis added].

Now, more than a dozen NIH research grants focused on studying, and ultimately improving, the lives of specific health subpopulations include "LGBT individuals" (as well as the traditionally included subpopulations: youth and young adults, minority populations, people of low income, people with low education, and people with mental health or medical co-morbidities). This kind support for LGBT health research is important and, in many ways necessary, but there are still very real structural and political barriers conducting and receiving funding for this research. For instance, despite the NIH's inclusion of "LGBT individuals" in its health subpopulations, one queer-identified health researcher was recently asked by an NIH program officer to change the title of her funding proposal to conceal the fact that LGBT

individuals were the focus of her project.[43] This same researcher, among others, has also received feedback on grants that include homophobic and discriminatory language.

These issues are compounded when the LGBT health concerns are a product of intimate partner violence. From a public health perspective, unlike the adverse effects of smoking or alcoholism (a popular focus for LGBT health researchers)—or other commonly cited general health issues like obesity, cancer, or depression—same-sex intimate partner violence remains a seemingly controversial issue. More than individual vices or diseases, intimate partner violence seems to threaten the social and moral fabric of relationships and families. While the public health sector has been able to admit, officially since 1989 in the U.S. and 1996 globally, that violence against women by men is a social problem and that ending it should be a priority, it has been reticent to admit the same is true for men abused by women and those abused by a same-sex partner.

Perhaps this reluctance comes from the general continued reliance on gender normativity and patriarchy in explaining why violence occurs (as I will detail in Chapter Five of this project, the public health sector lists "adherence to traditional masculine gender norms" as the only social cause of intimate partner violence). What's more, there is a clear anti-feminist association with the literature produced on women's violence against men—and scholars of men's violence against women are quick to point it out. Although it was discussed earlier in this chapter, it is important to again mention that because of the taken-for-granted historical male-centered viewpoint, men have not and likely will not ever be considered a priority or minority health population for research purposes; the funding initiatives stemming from the Violence Against Women Act still precludes research on them and their needs; healthcare providers are not trained to access and detect men as victims, or create an environment of acceptance, understanding, and post-traumatic care that takes into account masculinity and gender-specific barriers; and our nationally representative surveys (both criminal and healthcare) have only recently recognized the need for specific, sensitive, inclusive questions.

But the answer also lies in heteronormativity and heterosexism—which not only hinders our ability to recognize and admit men are victims, but also directs the aims and goals of the

[43] Dr. Alicia Matthews of The Network for LGBT Health Equity in a letter to the NIH, October 2011. Source: https://lgbthealthequity.wordpress.com/2011/10/18/dear-nih-please-demonstrate-that-you-welcome-lgbt-disparity-research/Source: https://lgbthealthequity.wordpress.com/2011/10/18/dear-nih-please-demonstrate-that-you-welcome-lgbt-disparity-research/

public health sector and the modern LGBT rights movement. Those against LGBT equality (vis-à-vis marriage) can point to same-sex violence as a reason for upholding inequity, and those for equality (vis-à-vis marriage) might desire same-sex violence to be kept silent as to avoid any negative associations with LGBT relationships and families. Either way, those in charge of prioritizing and legitimizing LGBT health and the effects of same-sex IPV (e.g., the National Institutes of Health) have failed to do so; going so far as to perpetuate homophobia and deny researchers access to funding for the very initiatives it claims are necessary and critical.

Moving Research Forward

Despite three decades of research on same-sex partner violence, and a few recent interventions within the last decade on behalf of men abused by women, few new approaches to describing, analyzing, and collecting information on IPV have arisen. Because traditional, mainstream feminist theories and approaches to studying IPV arose from the historical oppression of women and the historical "first cases" of battered women in psychological and physical health trauma centers, the use of feminist theory in examining and attempting to treat IPV is often myopic and fixed. It is this focus that has prohibited researchers from taking seriously the effects of women who abuse their men partners, men who abuse their men partners, and women who abuse their women partners.

While it would also be myopic of me to disregard the effect of men's social dominance, it would be equally naive to continue to write about men as if they are all unilaterally impacted and shaped by patriarchy. We know that more than two, fixed biological sexes exist (see Fausto-Sterling, 2000), and we know that there are myriad gender identities and gender presentations both cross-culturally and within a single culture (Lang and Kuhnle, 2008). As we've seen from Butler (1993), Kinsey (1953), and Stein and Plummer (1994), sexual orientation and sexual identity are also more fluid than we (as a society) tend to acknowledge.

Indeed, many scholars have already challenged and dismantled their general assumptions about sex, gender, and sexuality; but fewer are willing to similarly challenge and dismantle their assumptions about how the categories of "sex" and "gender" then operate (or do not) within relationships, influence (or do not) roles within relationships, and determine (or do not) who is capable of perpetrating violence and who is capable of being a victim. Without queering our ideas about men, women, and relationships, we cannot explain half of all violence that occurs

between adult romantic partners. Yes, when we take together all those who experience non-heteronormative violence—men abused by women, and those abused by a same-sex partner—we have a group of victims and survivors that is the same numerical size as the group of women abused by men (NISVS, 2010). It is imperative to move research forward.

Research Objectives

With the goals of queering theory and praxis in mind, I call for an critical, feminist intersectional study of intimate partner violence that takes into account "the multiple nature of identity, and the interlocking nature of systems of privilege and oppression to show how the categories of race, class, sex, gender, and sexuality rely on each other to function within systems of domination" (Ristock, 2005). I approach this project as one of mainly knowledge-building and framework-constructing, but I am guided by three major analytical queries (all within a U.S.-based context):

1. Does queered intimate partner violence occur for similar or different reasons than heteronormative intimate partner violence?

   Here, when I reference "queer," I mean all those instances of violence that do not conform to the mainstream feminist understanding of perpetrators and victims; men abused by women and those abused by a same-sex partner. See the beginning of this chapter for a more detailed explanation.

2. If so, can sex/gender explain these differences exclusively, or are other sources of power and inequality important?

   Here, the question is whether or not sex/gender socialization (and social norms) impact those who will be abusers and those who will be victims in the same ways. If the first analysis reveals that men can be victims, and that women can be perpetrators, then other sources of power (such as age, race/ethnicity, social class, and so on) may be equally as important as gender within the context of violence. Of importance to this particular query is that of sexuality—is there a difference between opposite-sex and same-sex IPV, or is there only a difference between queer and heteronormative IPV? As such, sexuality becomes a potential source of power and/or inequality.

3. What are some of the consequences of studying IPV from the current popular framework?

Here, I will explore how expanding our perspective on intimate partner violence necessarily betters the lives of men and women who experience violence—particularly as it relates to health, help-seeking, and healthcare.

Contributions of Proposed Research

My work is significant for two main reasons: scientific knowledge advancement and public policy change. These aims are intimately related. As not only a member of academia, but also a public sociologist and activist researcher, I believe that all of my research should have a broad public outreach focus. My research should be not only accessible to a wide audience, but should have a direct engagement with current and relevant public discourse (see Burawoy, 2004). I esteem to this active and crucial engagement in public debate with my theoretical and empirical contributions.

Furthering scientific knowledge, this research is the first to apply and test feminist theoretical explanations for IPV to both heteronormative and queer contexts utilizing a nationally representative dataset. However, this project also considers and tests alternate hypotheses/explanations for heteronormative and queered IPV; explanations rooted in power and inequality from an intersectional perspective. Moreover, this project extends existing research in three key ways: 1) I study only those who have been abused by a romantic or sexual partner in their adult (18 years and older) life, to ensure comparable results to the majority of previous heteronormative IPV research; 2) I examine four unique forms of violence in relationships: physical, sexual, emotional, and control; and 3) I identify, measure, and test multiple types of inequalities within relationships to determine the factors that not only increase the likelihood of experiencing IPV, but also how these inequalities impact negative health outcomes and help-seeking following victimization.

But this research is also aimed at policy change. This project addresses specific concerns (medical, health, legal, family) that have been historically understudied: my work aims to add to the growing discussion on non-heteronormative violence; an addition that I hope will spur further research to alleviate the stress, strain, and anguish experienced by both men and women, regardless of sexuality or gender identity, who feel (and know) they are not only at risk of victimization from their partners, but also at risk of victimization from a legal, political, and social system that does not take them seriously. The utility of the new model (an intersectional power and inequality model) used to understand the dynamics of intimate partner violence that I

believe will emerge from my research may inform public health and public policy more adequately; generating important new ideas about violence for healthcare providers, the criminal justice system, shelters and clinics, and all those who deal with the issue of intimate partner violence and currently have inadequate training, experience and/or resources.

Roadmap for the Project

To start, Chapter 3 discusses the specific methods and data used in this research project. Specifically, I outline the dataset chosen for this analysis (the National Violence Against Women Survey), describe the general characteristics of the sample, and highlight the construction of the general violence variables that will remain constant throughout the project.

Chapter 4 (see page 70) is a detailed quantitative risk assessment of IPV, which tests the four major "levels" of risk factors associated with IPV: individual, relationship, community, social (as outlined by the CDC and the public health sector today). I utilize Event History Analysis regression techniques to determine which risk factors are actually, and not theoretically, linked to the experience of physical and sexual intimate partner violence after age 18. I find that while all levels are important risk factors for most people, the most influential predictors of experiencing intimate partner violence are childhood victimization and "power" inequalities.

Chapter 5 (see page 94) takes the most influential risk factors from Chapter 3 and attempt to disentangle mainstream feminist notions of power (e.g., masculine gender norms) from other sources. Specifically, I add emotional and control violence to physical and sexual IPV and run binary logistic regression models with various inequality indicators (theoretically informed: age, race/ethnicity, income level, educational attainment, employment status, and health status) as key predictor variables, controlling for the experience of childhood victimization. I find that for some types of violence and some types of identity inequality is important, but for others it is not—what is most interesting is that men and women experience the effects of inequality very differently, and emotional and control violence appear to be very different experiences than physical and sexual IPV.

In Chapter 6 (see page 121), I turn my focus to the consequences of violence in intimate relationships—or, rather, what all we miss by ignoring or disregarding queered IPV. I examine the negative physical and mental health effects of violence and the healthcare (both medical and psychological) help-seeking behaviors of those abused who suffered injury, comparing rates for

men and women. I find that in-line with previous research, women report negative physical health outcomes more often than men, but all individuals report equally high levels of psychological trauma. What's more, I find that all individuals, regardless of sex or the sex of their abuser avoid seeking help from the healthcare system and avoid discussing the exact source of their injuries with a healthcare provider. Given low reporting rates, the effects of power and inequality are discussed with caution.

Lastly, Chapter 7 (see page 157) takes into account all of the conclusions of this project's three analyses and offers suggestions for not only future data collection and research—namely, the important of qualitative interventions—but also the need for structural transformations in public health and criminal justice system, with regards to cultural competency training and policy language; and the very real need for service-providing "outside of the system," such as grassroots organizing and anti-violence activism.

I also include an Epilogue to the dissertation (see page 214), that highlights the important and critical gaps in the current literature that could also not be filled by this project and discusses some of the preliminary findings of my time volunteering and working with victims and survivors of intimate partner violence in NYC.

Chapter III. Data and Variables

In this chapter I briefly outline the dataset and the basic violence variables used in this study. As each chapter of analysis has its own data and methods section, including its own way of conceptualizing violence (by necessity of the research queries and also the limitations of the existing survey questions), the information in this chapter is intended to be introductory. I begin with the project's methodological framework. Then, I discuss the research design and major variables. After outlining the methods, I discuss the issues of reliability and validity with the data and methods and also the limitations of the dataset chosen.

Framework

The most recent meta-review (content analysis) of the literature on same-sex and LGB intimate partner violence indicated the necessity for a grounded theoretical perspective (see Messinger, 2014), specifically calling for future research that takes into account how "power differentials that characterize many opposite-sex IPV relationships reappear and may be augmented in same-sex IPV," explores "the unique dynamics of IPV," and uses a method "that will improve population representativeness wherever possible," to ensure an accurate depiction of the problem at hand. Dutton and White (2013), concur that more research is needed on non-heteronormative IPV: "A major revision of our thinking is required, one that is empirically based" in order to change the notion of IPV that we thought was true.

In this project, I take care to heed these suggestions and maintain a theoretically informed, population-based analysis of violence in relationships—but I add a critical, intersectional, and ultimately queered understanding of violence that shapes the theories being tested and the methods being used.

Analysis

Source of Data. Data come from the "Violence and Threats of Violence Against Men and Women in the United States, 1994-1996" subsection of the National Violence Against Women Survey (NVAWS), a telephone survey of men's and women's experiences with violent

victimization. The survey was conducted from November 1995 to May 1996 by interviewers at Schulman, Ronca, Bucuvalas, Inc. (SRBI) under the direction of Dr. John Boyle. Tjaden, Thoennes, and Allison designed the survey questionnaire and conducted the analysis. The national sample was drawn by random-digit dialing from households with a telephone in all 50 states and the District of Columbia. Only female interviewers surveyed female respondents. For male respondents, approximately half of the interviews were conducted by female interviewers and half were conducted by male interviewers.[1] A Spanish-language translation was administered by bilingual interviewers for Spanish-speaking respondents. The survey was introduced to respondents as a survey on "personal safety."[2]

Sample. There were 8,000 men and 8,000 women surveyed. Ages of respondents range from 18 to 97. Approximately 98.9% (15,856) of the respondents reported having only ever been in an opposite-sex relationship; of those who reported being in a current or having had a past same-sex relationship (144), .41% (65) were men and .49% (79) were women. Additionally, less than .19% of the respondents reported having relationships with both men and women (18 men and 12 women).

Most (87%) respondents are White, followed by Black (9.75%), Asian or Pacific Islander (2%), and American Indian or Alaskan Native, mixed race, and "don't know" racial category (all just under 1%). Just over 7% of respondents also reported being Hispanic (a separate question from "race"). Income was fairly normally distributed, with most respondents reporting a yearly income between $15,000 to $80,000 (57%). Most respondents received at least a high school degree (31%) or attended some college (34%). In terms of employment, most reported being employed full time (66%), though approximately 16.5% of respondents were employed part-time or a homemaker.

To determine the representative nature of the sample, select demographic characteristics of the NVAWS sample (e.g., age, race, Hispanic origin, marital status, and education) were

[1] All analyses in the following chapters take into account interviewer's sex effects—i.e., while there were sometimes small differences in coefficients and strength of significance, direction and overall significance did not generally change when a man was interviewed by a man versus a woman.

[2] This is not an uncommon introduction to the topic of violence victimization via telephone survey. The Bureau of Justice Statistics often frames its crime victimization surveys in this way; so does the Australian Bureau of Statistics, with its Personal Safety Survey, which is all about "domestic violence." The Census' American Community Survey has an entire section on "personal safety," which includes a list of things the respondent may or may not do to put themselves at greater risk of victimization—often troublesome, but not uncommon.

compared with demographic characteristics of the general population as measured by the U.S. Census Bureau's 1995 Current Population Survey (CPS) of adult men and women. Estimates from the 1995 CPS were used because the NVAWS sample was generated in 1995. The demographic characteristics of the NVAWS sample are similar to the general population from which it was drawn. This includes sexual orientation/sexuality, as is discussed later in this chapter.

However, differences between point estimates from the NVAWS and those from the CPS are outside the expected margin of error. Specifically, the NVAWS sample underrepresents older people, African-Americans, Hispanic men, and those with less than a high school education. This is because of the absence of interviews with phoneless households results in an underrepresentation of certain demographic characteristics typical of such households. It was determined that 94% of households at the time had a home telephone, making the representation differences statistically small; and differences in weighted and unweighted samples and outcomes were not large enough to make weighting the data statistically unnecessary. All of the studies and publications that utilize NVAWS data use unweighted data.

Experience of Violence. In the simplest of terms intimate partner violence is a pattern of behaviors used to coerce, dominate or isolate within a relationship whereby one partner seeks enhanced power and control over the other (see Lehman, 1997). It is a systemic and cyclical pattern with one partner in power and the other in fear. Hart (1986) indicates that behaviors - as violent as they may be - are *not* considered IPV unless they result in the perpetrators greater control of the victim. Leeder (1988) and Renzetti (1992), and Merrill (2000) consider the contextual *relevance* of behavior and Lundy (1993) introduced the idea of *unwanted* force and abuse. Central to all of these works is the concept of *power* and *control*.

A broad operationalization of intimate partner violence might be: *the unwanted systemic set of ongoing behaviors which falls outside normative boundaries and spirals multi-directionally over time around issues of control and power with the intention of enhancing the perpetrator's power at the expense of the victim* (Lehman, 1997).

Four specific forms of abuse dominate IPV literature - physical, sexual, emotional and verbal, while others (intellectual, spiritual, and use of the children) are largely ignored. Some argue that imposed social isolation and/or control (now most often examined in terms of emotional abuse) is best considered alone, as an independent form, given the frequency and

impact with which it strikes (Stark, 2009). The quantitative analysis examines four unique forms of violence: physical, sexual, emotional—which includes verbal, and control violence. Specific questions from the National Violence Against Women Survey codebook used to create these violence variables can be found in Chapter VIII: Supplemental Material.

Physical Abuse. Physical abuse can be defined as any forceful physical behavior that intentionally or accidentally causes bodily harm or property destruction. Physical IPV items in the NVAWS were adapted from the Conflict Tactics Scales (Straus, 1979). Physical IPV is measured as physical attacks or threats of physical attacks against one's partner. One binary yes-no variable (yes to any of the following questions=violence happened) was constructed based on an individual's response to the following questions about things their same-sex ("1") or opposite-sex partner ("2") might have done: "throw something at you that could hurt you"; "push, grab or shove you"; "pull your hair"; or "slap or hit you"; "kick or bite you"; "choke or attempt to drown you"; "hit you with some object"; "beat you up"; "threaten you with a gun"; "threaten you with a knife or other weapon besides a gun"; "use a gun on you"; or "use a knife or other weapon on you besides a gun."

Sexual Abuse. Sexual abuse can be defined as any nonconsensual sexual act or behavior motivated by power and control. Sexual IPV items in the NVAWS were adapted from The Women Study (1992). Sexual IPV is measured using binary yes-no responses to the following questions: has a current or previous spouse or partner, or previous same sex or opposite sex partner "attempted to make you have vaginal, oral or anal sex against your will, but intercourse or penetration did not occur," "put fingers or objects in your vagina or anus against your will by using force or threats," "ever made you have oral sex by using force or threat of harm? Just so there is no mistake, by oral sex we mean that a man or boy put his penis in your mouth or someone, male or female, penetrated your vagina or anus with their mouth or tongue," "has a man or boy ever made you have sex by using force or threatening to harm you or someone close to you? Just so there is no mistake, by sex we mean putting a penis in your vagina," and "has anyone ever made you have anal sex by using force or threat of harm? Just so there is no mistake, by anal sex we mean that a man or boy put his penis in your anus."

Emotional Abuse. Emotional abuse is often framed in terms of eroding self-esteem, confidence, hopefulness, and sense of self, and can typically include verbal abuse such as ridicule, intimidation, and harassment. Emotional IPV items in the NVAWS were also adapted

from the Canadian Violence Against Women Survey (1993). Emotional IPV was constructed from binary (yes-no) items asking whether the respondent's current spouse or partner, previous spouse, or previous same-sex or opposite-sex partner "has a hard time seeing things from your point of view," "tries to provoke arguments with you," "makes you feel inadequate," "is frightened of you," or "frightens you"; with instances of verbal IPV including "called you names or put you down in front of others," or "shouted or swore at you."

Imposed Social Isolation and Control. Imposed social isolation and control occurs with such frequency in IPV that it deserves independent examination. With social isolation and control, men and women are robbed of contact with other people and made to be dependent on their partner for emotional, social, and economic security. Control IPV items were also adapted from the Canadian Violence Against Women Survey (1993). Control IPV was constructed from binary (yes-no) items inquiring whether the respondent's current spouse or partner, previous spouse, or same sex or opposite sex partner has ever "been jealous or possessive," "tried to limit your contact with family or friends," "insisted on knowing who you were with at all times," "prevented you from knowing about or having access to the family income," "prevented you from working outside the home," or "insisted on changing residences even when you didn't need or want to."

The specific survey questions used are available in copies of the codebook, found in Appendix A. National Violence Against Women Survey Questions (pages 206-213).

Reliability and Validity.

Joppe (2000) defines reliability as:

> …The extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. Embodied in this citation is the idea of replicability or repeatability of results or observations.

Kirk and Miller (1986) identify three types of reliability referred to in quantitative research, which relate to: the degree to which a measurement, given repeatedly, remains the same; the stability of a measurement over time; and the similarity of measurements within a given time period. Crocker and Algina (1986) indicate, "Test developers have a responsibility of

demonstrating the reliability of scores from their tests." The reliability of the National Violence Against Women Survey is confirmed in multiple ways: 1) all violence variables are based on previously tested instruments, measures, and questions from surveys and empirical research; 2) the instruments, measures, and survey questions were repeated over time (from the 1970s until the administration of the NVAWS in 1994-1996); and 3) researchers have continued to use these instruments, measures, and survey questions to guide their own studies and the analysis of the data using the same study design has been replicated (the most recent publication utilizing the data is 2010).

However, although I may be able to confirm the research instrument repeatability and internal consistency, and, therefore reliability, the instrument itself may not be valid. An empirical measure is valid if it actually measures what it claims to measure (Cronbach and Meehl, 1955). The concept of validity, when used in this context, is better regarded in terms of degree rather than an all-or-none property of an instrument (Nunally, 1978). It is important that empirical measures are valid because they are frequently used for making a wide range of important decisions—including public policy decisions. To the degree an empirical measure used in one of these contexts is not valid, it is more likely that decisions or policies made based on the results of that measure will be erroneous.

Wainer and Braun (1998) describe validity in quantitative research as "construct validity". The construct is the initial concept, notion, question or hypothesis that determines which data is to be gathered and how it is to be gathered. Construct validity is the degree to which the variables that are measured represent the theoretical construct on which they are based, and the degree to which that construct relates to other constructs in the expected manner. Messick (1995) posited there are two principal threats to construct validity. The first one is *construct under-representation*, which means that an empirical measure is too narrow such that it misses dimensions or facets of the construct. The second one is *construct-irrelevance*, which means that an measure is too broad, and thus contains excess reliable variance that is actually associated with other constructs, the measurement method itself, or other kinds of error.

The National Violence Against Women Survey utilizes no less than five and no more than 15 questions about any given type of violence. All questions are theoretically-driven and informed by previous research. Specific, multiple (rather than single, direct) questions were used for each type of violence to specifically "leave little doubt in the respondent's mind as to the type

of information being sought." Moreover, the NVAWS uses randomized selection of participants to ensure accurate representation of the population at the time—which also ensures reliability as outlined previously by Joppe (2000).

Lastly, all analyses conducted in this project are easily replicable: and I utilize commonly agreed upon statistical procedures and provide accurate and thorough description of all variables used.

Limitations. While a quantitative research design, based off of survey responses, is well suited to study the breadth of a phenomenon and predictive relationships between important concepts can be established, this type of method cannot produce in-depth descriptions of the social phenomena being studied; researchers would have to break down complex behavioral patterns into simple components (single variables with often limited operationalization). Moreover, correlational relationships are not equivalent to casual ones, and establishing causality in this type of research design is impossible. While causation may be intuitive and can be grounded in theory, researchers should employ caution in making such finite conclusions. Although I cannot know the entirety of the lived reality of IPV from these results, it is an important first step in establishing the foundation for future analyses.

The main limitation in this project is that the National Violence Against Women Survey is an old dataset (collected between 1994-1996). The funding for the survey came from the Centers for Disease Control and Prevention (CDC) and the National Institute of Justice (NIJ), jointly sponsored through a grant to the Center for Policy Research. It has not been collected again because there was no additional funding to repeat the survey. In 2010, the CDC announced that it would attempt to annually collect IPV victimization data via its new National Intimate Partner and Sexual Violence Survey. Unfortunately, there is no indication as to whether or not they will allow researchers to publicly access this data for their own analyses.

There are, potentially, two other options for datasets to use—though both also come with limitations. For instance, the CDC's Behavioral Risk Factor Surveillance System survey offered an optional module in 2005, 2006 and 2007: a 7-question module on intimate partner violence. While 12 states reported collecting this data in 2005 (N=561), only 8 did in 2006 (N=5445), and only 3 did in 2007 (N=1992). When broken down by the victim's sex and the sex of their intimate abusive partner (a behavioral understanding of sexual orientation, like the NVAWS), we are left with fewer women abused by women and men abused by women than the NVAWS gives

us. What's more, the module only specifies verbal (in one year), physical and sexual violence as IPV outcomes—the NVAWS indicates that the most commonly experienced forms of violence are emotional and control, which is in-line with previous research on psychological abuse. Taking the sample size and forms of IPV into account, I still believe the NVAWS is a better option for this project.

We could also turn to the California Health Interview Survey, a nationally representative survey on health and lifestyle conducted every two years in California. The survey includes 42,000 to 56,000 households per cycle and is conducted in six languages (English, Spanish, Chinese (Cantonese and Mandarin), Korean, and Vietnamese). The 2007 and 2009 surveys ask questions about physical and sexual intimate partner violence and has, perhaps, the most extensive questioning measures for sexuality—not only do they ask your sex and the sex of the intimate partner who abused you, they also ask you about the sex of your past sexual partners, your self-identified orientation (straight or heterosexual; gay, lesbian, or homosexual; bisexual; not sexual, celibate, none; and other (specify)), and in 2009 whether or not you are in a legal marriage or domestic partnership with someone of the same-sex. The results from 2009 show that 3% of men and 1.6% of women reported same-sex sexual partners in their adult lifetime, while 0.7% reported both male and female sexual partners. Out of the total 47,614 adults surveyed, this equates to just over 1400 men with only male sexual partners, almost 500 women with only female sexual partners, and around 330 with both. Similarly, 2.5% of men identify as gay/homosexual, 1.1% of women as lesbian/homosexual, and 2.7% of men and women as bisexual. By either measure, the sample size for LGB individuals is substantially larger than with the NVAWS.[3]

What's more, with reporting rates of IPV similar to other nationally-representative surveys (all self-identified orientations: 21.6% for heterosexual women, 31.87% for lesbian women, and 51.99% for bisexual women; 11.38% for heterosexual men, 26.94% for gay men,

[3] Surveys that categorize individuals based on sexual behaviors, such as cohabitation, see much lower response rates than those that categorize people on the basis of sexual identification category. According to the U.S. Census Bureau, in 2008, there were 230,117,876 Americans aged 18 or older (U.S. Census Bureau, 2008), and 564,743 or 0.25% were at the time cohabitating with a partner of the same-sex (O'Connell & Lofquist, 2009). Of the original NVAWS sample of 16,000 Americans aged 18 or older, 58 or 0.36% of respondents were cohabitating with a partner of the same-sex at the time of the survey. Based solely on same- sex cohabitation rates, the NVAWS closely mirrors the population.

and 19.57% for bisexual men), this means that the sample size for IPV and its health related outcomes and help-seeking behaviors is also substantially larger than the NVAWS. As an example, in the CHIS 2009, 1.5% of women self-identified as lesbian (N=267). The NVAWS indicates that .99% of women indicated having only ever been in romantic or intimate relationships with someone of the same-sex (N=79). In the CHIS, the number of lesbian women experiencing IPV would equate to 85 individuals; in the NVAWS the number of "lesbian" women experiencing IPV would equate to around 20 (depending on the type of violence). In terms of possible quantitative statistical testing, this difference of 65 people is significant.

Troublingly, the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health and the Department of Health Care Services does not release "sexual behavior" or intimate partner violence data for public use (it does allow you to look at health disparities by gender, race/ethnicity, age, and geographic location, though)—indicating that it is too confidential in nature to do so. In order to obtain access to the CHIS data, you must first petition to use the data and have your petition approved by the CHIS Data Disclosure Review Committee,—a process I went through, and received acceptance for, in the fall of 2010—but then you have to fund $500 for the "data file set up," and an additional $140/hour to have a statistician code/program the tests you want run or $120/hour to have a statistician run code that you have already programmed. The minimum project fee is $1000. The issue with this method, aside from the obvious cost prohibitiveness for a graduate student, is that without access to the dataset itself, it becomes a tedious back-and-forth process of creating code (but not being able to run it to make sure the output looks "normal"), getting word back that there was an error or receiving output back that doesn't make sense, but not being able to transform the data yourself to see where the error is, and so on.

The NVAWS has a smaller sample of LGB individuals experiencing violence and fewer men abused by women, but asks questions about more forms of violence—including emotional and control—and also asks more comprehensive follow-up questions said experiences of IPV. Ultimately, I must also take into account the difficulty in obtaining full access to the data, and the inability to work with it myself. Lastly, except for the newly released NSIVS, rates of physical and sexual IPV victimization are fairly consistent across surveys (see below).

- National Intimate Partner and Sexual Violence Survey 2010 (CDC sponsored):
    - Heterosexual Women 35%
    - Heterosexual Men 29%
    - Lesbian Women 43.8%
    - Gay Men 26%
    - Bisexual Women 61.1%
    - Bisexual Men 37.3%

- California Health Interview Survey 2009 (analyzed by Goldberg and Meyer, 2012):
    - Heterosexual Women 21.6%
    - Heterosexual Men 11.38%
    - Lesbian Women 31.9%
    - Gay Men 26.9%
    - Bisexual Women 52%
    - Bisexual Men 19.6%

- National Violence Against Women Survey 95-96 (analyzed by Tjaden and Thoennes, 2000):
    - Opposite-Sex Women 21.7%
    - Opposite-Sex Men 7.4%
    - Same-Sex Women 39.2%
    - Same-Sex Men 23.1%

Chapter IV. Intimate Partner Violence Adult Lifetime Risk Assessment

According to the public health sector, there are a combination of individual, relational, community, and societal factors that contribute to the risk of becoming a victim or perpetrator of IPV, and understanding whether or not these multilevel factors are is the first step to identifying various opportunities for prevention (Centers for Disease Control).[1]

These *risk factors* were originally identified from small studies of interviews with male perpetrators or female victims who sought help from or were mandated to receive counseling or treatment. It's important to note that these are not casual factors—i.e., not all those at risk because of these factors will experience victimization—but the behaviors and situations included in these studies are said to contribute to a person's likelihood of experiencing violence (Saunders, 1995; Gondolf, 2004). Overall, the most cited risk factors are violence in the family of origin; socioeconomic factors; personality variables such as low self-esteem; substance abuse; and situational factors related to life course (Kanter and Jasinski, 1998).

However, no previous studies have assessed the various risk factors using advanced statistical techniques (only correlation analyses have been completed) using a population-based sample, and none have attempted to do so for queer intimate partner violence. In fact, a recent meta-review of physical, psychological, and sexual aggression studies noted the altogether absence of literature on same-sex IPV and risk factors (Capaldi, Knoble, Shortt, and Kim, 2012). Out of a possible 877 refereed journal articles (both qualitative and quantitative) within this meta-review, only 228 met all of the criteria for inclusion (response rate over 50% and specific IPV outcomes variables among others), and only 170 were studies with adult respondents and not adolescents. Even with an exponential increase in risk factor analyses between 2001 and 2011 (over half of the articles were written in this timeframe), the authors noted:

> Male-to-male and female-to-female IPV was not excluded, but unfortunately no studies that exclusively examined same-sex relationships met the inclusion criteria, and only two studies (Golinelli et al., 2009; Moracco, Runyan, Bowling, & Earp, 2007) included both heterosexual and same-sex relationships in their

[1] See: http://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html

> analyses. A lack of representative sampling methodology was the primary reason for the exclusion of same-sex IPV studies, and where representative samples were used (e.g., Bartholomew, Regan, Oram & White, 2008, random digit dialing), studies did not meet the response rate criterion. The present study underscores the need for high-quality same-sex IPV research and its persisting underrepresentation in the literature (Burke & Follingstad, 1999), which is likely because of a combination of factors such as public policy (e.g., research funding), challenges with sampling strategies, and socially desirable responding (Murray & Mobley, 2009).

This is a key void in the literature, because these risk factors were parsed out through a heteronormative framework (i.e. with *battered* women and/or their battering male partners). This chapter utilizes the National Violence Against Women Survey, one of the 95 unique samples found to meet the criterion set forth by Capaldi et al (2012). But this is the first time it will be used to specifically examine risk factors for same-sex IPV and only the second time used to examine male-to-female IPV. Below I detail the general academic and public health understanding of intimate partner violence "risk factors"; then, I quantitatively test whether or not these risk factors are found to be significant for heteronormative IPV and/or queer IPV; lastly, I discuss the importance of developing a new framework that has the ability to take into account multiple sources of violence in a way that leaves the door open to all potential perpetrators/victims, regardless of sex or gender.

Research Objectives

I revisit this project's three major analytical queries from Chapter Two (pages 55-56):

1. Does queered intimate partner violence occur for similar or different reasons than heteronormative intimate partner violence?
2. If so, can sex/gender explain these differences exclusively, or are other sources of power and inequality important?
3. What are some of the consequences of studying IPV from the current popular framework?

This chapter aims to answer the first major query.

Risk Factors

Individual Level

On the individual level, there are both aspects of the victim's and the perpetrator's identity that impact a person's likelihood of experiencing violence. For instance, age is an important factor for heterosexually-identified women. Women between the ages of 18-24 are at the highest risk of physical and sexual intimate partner violence (Rodriguez, Lasch, Chandra, and Lee, 2001; Kim, Laurent, Capaldi, and Feingold, 2008).

But by far the most studied individual level risk factor is violence within the family of origin. Specifically, witnessing or experiencing abuse as a child within one's family leads to increased risk of intimate partner violence as an adult (Rosenbaum and O'Leary, 1981; Edleson et al., 1985; Caesar, 1988; Dutton, 1988; Brendtro and Bowker, 1989; Murphy, 1993; O'Leary, 1994, Shields et al., 1988; Coleman, 1994).

Generally, it has been found that children who witness their parents physically attack each other are more likely to perpetrate violence against intimate partners later in life (Hotaling, 1986; Marshall and Rose, 1990), with one studying finding that children who are abused are three times as likely to perpetrate IPV than children from non-violent homes (Straus et al.,1980). Similarly, Renner and Slack (2006) found in the Illinois Families Study that childhood physical and sexual abuse were predictive of adult IPV victimization even after controlling for demographic and childhood history factors.

You are also at risk for violence victimization if you have had a partner who is psychologically unstable and/or who abuses drugs or alcohol. The cluster of problem behaviors related to the adult diagnosis of antisocial personality disorder (e.g., impulsive and societal rule-breaking behaviors, including delinquent and aggressive behaviors) have been studied as developmental risk factors for IPV, particularly in the past 10–15 years. Specific psychological risk factors include depression, anxiety, fears of abandonment, jealousy inadequate responses to rejection, antisocial behaviors, and excessive anger (Leeder, 1988; Maiuro et al., 1988; Coleman, 1994; O'Leary, 1994; Pan et al., 1994; Hamberger and Hastings, 1986; Hastings and Hamberger, 1988; Flournoy and Wilson, 1991; Capaldi and Kim, 2004).

The associations of personality disorders, other than antisocial personality disorder, with IPV have been little examined. In the only longitudinal study found, Ehrensaft, Cohen, and Johnson (2006) examined the association of DSM-IV diagnosed disorders including Cluster A

(paranoid, schizoid, and schizotypal), Cluster B (histrionic, narcissistic, and borderline disorders), and Cluster C (avoidant, dependent, and obsessive compulsive disorder) with IPV. After controlling for SES, race, sex, age, and other personality disorder symptoms, Cluster A and B symptoms in the early 20s predicted later perpetration of IPV. Cluster C symptoms, however, decreased an individual's risk of IPV victimization.

Additionally, while violence does not inevitably follow from alcohol use, alcohol is the drug most consistently related to intimate assaults (Kanter and Jasinski, 1998). Alcohol facilitates aggression in many ways, including pharmacological effects that interfere with reasoning, perceptions, calculations of the consequences of behavior and perceptions of threat (Kanter and Jasinski, 1998; Saunders, 1995; Elanzer, 2005). White and Chen (2002) found that for men and women, after controlling for other risk factors (e.g., age, education, marital status, parental fighting), current problem drinking was significantly associated with IPV victimization and perpetration, although the magnitude of associations was small.

Relationship Level

There are also relationship specific risk factors that impact a person's likelihood of experiencing violence. Most commonly, violence increases during courtship and early marriage, pregnancy, separation, and divorce (Jasinski and Kantor, 2001). For instance, O'Donnell et al. (2002) found higher risk for victimization among separated and divorced women versus married women and Hyman, Forte, Mont, Romans, and Cohen (2006) found that the strongest risk factor for IPV was marital status, with women who were single, divorced, separated, or widowed being 10 times more likely to report IPV as compared to women who were married or living with a common-law partner.

Moreover, relationship or marital discord is considered a proximal risk factor to IPV and it sometimes considered psychological IPV in itself. Aldarondo and Sugarman (1996) examined persistence in perpetration/victimization over time and found that that low levels of marital agreement increased the risk, while DeMaris et al. (2003) found in multivariate analyses that couples who had more frequent disagreements or exhibited a more hostile disagreement style showed higher levels of IPV. Interestingly, after controlling for marital history (number of marriages) and duration of current marriage, Bookwala, Sobin, and Zdaniuk (2005) found that

women compared to men used calm discussions less (the least reported by women who were young) and heated arguments more.

Community Level

Within the past decade, neighborhood and community-level variables have been an emerging focus in the literature for risk factors for partner violence. In a prospective longitudinal study, Jain, Buka, Subramanian, and Molnar (2010) paired data from the PHDCN with 1990 U.S. Census data to assess the contribution of collective efficacy (e.g., community cohesiveness, willingness to intervene with a neighbor) as a risk factor for young-adult dating violence. After controlling for confounding variables (gender, age, parent education, race, neighborhood poverty, and perceived neighborhood violence), higher levels of collective efficacy significantly reduced the risk of dating violence victimization for heterosexual men only.

Other neighborhood-level variables examined in cross-sectional studies included neighborhood disadvantage (e.g., Benson, Wooldredge, Thistlethwaite, and Fox, 2004; Van Wyk, Benson, Fox, and DeMaris, 2003) as well as neighborhood connectedness and support (e.g., Banyard, Cross, Modecki, 2006; Champion, Foley, Sigmon-Smith, Sutfin, and DuRant, 2008; Smith Slep et al., 2010).

Societal Level

Specific aspects of hostile cognitions or attributions towards women have been examined in relation to IPV. Overall, hostility toward women by men, and attitudes approving of or justifying IPV by either men or women, are low to moderate proximal predictors of IPV (see Capaldi, Knoble, Shortt, and Kim, 2012); and the CDC lists “traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)” as societal level risk factors for IPV perpetration.

Methods

Event History Analysis, an advanced regression technique, is used to test the utility of the above risk factors of IPV. Four exponential regression models were constructed (one for each risk factor level), in which two outcome variables were predicted: experiencing physical and/or sexual intimate partner violence since age 18. You are either “at risk” for experiencing

heteronormative or queer violence; with those "at risk" for heteronormative violence being all behaviorally heterosexual-identified women (women who had never at any point been in a relationship with or cohabitated with a woman), and those "at risk" for queer violence being all men (either behaviorally heterosexual-identified or behaviorally gay/bisexual-identified) and all women behaviorally lesbian/bisexual-identified).

Because of the limitations of the time variables in the National Violence Against Women Survey (i.e. lower than normal response rates), I am not able to separate heterosexual men from gay/bisexual men and/or lesbian/bisexual women to run the regression analyses and note potential differences. I can only combine all those who experience theoretically queer IPV. While there is a theoretical reason to merge these categories, it is important to note that very few individuals abused by a same-sex partner answered all of the questions necessary to complete the analysis. Thus, in this chapter, the regression results identify mostly men abused by women. Summary statistics for all variables can be found in Appendix A, Table 1. In the discussion section, I detail the limitations of this merging and highlight the importance of the analysis in Chapter Five, which more directly parses out the importance of not only the type of violence experienced (heteronormative vs. queer), but also the sex (and other demographic characteristics) of the perpetrator.

Outcome Variables

In this continuous time model, an outcome variable was constructed to measure the first time (in historical years) a person experienced physical or sexual intimate partner violence since the age of 18. This was constructed by first finding the difference between the year of the interview (1995 or 1996) and the number of years ago the first violent event occurred. So, if a person was interviewed in 1996 and the first time they experienced a violent event was 15 years ago, they experienced a violent event for the first time in 1981. The historical start time is age 18, so a variable was constructed in which 18 years is added to the historical year of birth reported. Someone born in in 1932, then, turned 18 in 1950.

Using these variables, the outcome variable is the risk period of time between age 18 and the first violent event. If the same person who experienced their first violent event in 1981 turned 18 in 1950, they were at risk for intimate partner violence for 31 years.

For a more detailed understanding of what is considered physical and/or sexual violence, see Chapter Three (pages 57-58). Summary statistics the outcome variables can be found in Appendix A, Table 1.

Predictor Variables

In this study, predictor variables were chosen based on the various risk factors that are testable given the dataset (i.e. questions asked in the survey) and the corresponding theoretical literature.

Individual level factors. Age is an important risk factor for experiencing violence. For this analysis, age was used as a risk factor if a person was between the ages of 18 and 25 when they first experienced violence.

Experiencing violence as a child was also taken into account. There are twelve questions that pertain to violence experienced in childhood, all physical violence. An interval variable was constructed to indicate how much physical violence a respondent had experienced in childhood, one point for each question they answered "yes" to. The scale has a potential range of 0-12. Questions stated, "when you were a child, did any parent, step-parent, or guardian ever": "throw something at you that could hurt you," "push, grab, or shove you," "pull your hair," "slap or hit you," "kick or bite you," "choke or attempt to drown you," "hit you with some object," "beat you up," "threaten you with a gun," "threaten you with a knife or other weapon besides a gun," "use a gun on you," and "use a knife or other weapon besides a gun?"

Three separate variables (jealousy, anger, and mental illness) were constructed measure some presence of a psychological component to the victim's partner's perpetration of violence, including answers to "what started or triggered this incidence?" that indicated "he/she had emotional problems, was mentally ill, was a rageaholic," "he/she was jealous," "he/she was angry at something, someone else," "he/she was angry, wanted to punish me." Additionally, answers to "can you tell me why he/she started using or threatening to use physical [sexual] force during this incident?" were included if "he/she was in a rage, out of control," "he/she is short-tempered, his/her temper," "he/she was angry, upset," "he/she was mentally ill, screwed up, nuts, crazy," "he/she was depressed," or "he/she was jealous." A scale variable was created, with "0" indicating no psychological risk factors for violence, and "1-3" indicating one, two, or three risk factors (jealousy, anger, and/or mental illness).

Issues of addiction were addressed by the respondent indicating that "what started or triggered" the most recent incidence was that their partner was "intoxicated, high on drugs" or that the partner was intoxicated or high on drugs at the time, even if that is not what triggered the incidence.

Relationship level factors. Various relationship stressors have been identified as increasing the risk of experience violence. For physical violence, the variable "bad relationship" was constructed by using responses to "what started or triggered this incidence?" that indicated "we were arguing,"; in addition to responses to "can you tell me why he/she started using or threatening to use physical [sexual] force during this incident," that were "We had an argument, disagreement," "Our relationship started falling apart," "I broke up with him/her," "I asked him/her to leave," "I told him/her I was going away," or some general mention of the negative status of their relationship.

For sexual violence, a "bad relationship" variable was constructed if the victim indicated that the violence was triggered because "we were arguing."

A variable for divorce was also constructed and included if the victim was divorced or separated at the time the violent event occurred, or if the victim indicated that what triggered the violence was that "he/she was upset about the divorce."

Additionally, for physical violence (sexual violence does not include a question relative to this) pregnancy was taken into account as a risk factor; this includes if the victim was pregnant at the time the violence occurs or if the victim reported that being pregnant was what triggered the violent event.

Community level factors. Poverty and an individual's connection to their community or neighborhood (also referred to as social capital) are important risk factors for experiencing violence. A poverty variable was constructed that indicated whether or not a person's income was below the poverty line, while social capital was measured by whether or not a neighbor/close friend was the one who reported the violent event to the police and/or if the victim talked to a neighbor/close friend about the violent event after it occurred.

Social level factors. Power and control, gained from social sources, is detailed as a risk factor for experiencing violence. To assess the influence of power or control for physical violence, answers to "what started or triggered this incident," were included if the victim indicated that the violence was caused by "His/her need to control, have way, be a man," "I was

disrespectful, made him mad" (i.e., he/she asked for it); and answers to "can you tell me why he/she started using or threatening to use physical force during this incident?" were included if the reason was "I didn't obey him/her," "he/she wanted me to be quiet or to shut-up," or a general mention of control.

To assess the influence of power or control for sexual violence, answers to "what started or triggered this incident," were included if the victim indicated that the violence was caused by "he/she needed to control, have way, his/her ego," "he/she needed sex," "I was stupid, too friendly," "I was vulnerable, "was date rape, we were necking, fondling, cuddling" (i.e. he/she asked for it).

Summary statistics for all independent variables can be found in Appendix A, Table 1.

Results

The duration of interest is the number of years between the eighteenth birthday and the first experience of violence by an intimate partner. The sample contains 11,967 individuals who had not experienced physical violence, and 12,918 who had not experienced sexual violence by the time of the survey and whose durations are therefore right censored.

For this analysis the Log-Logistic regression model is used. Both visual inspection and log-likelihood of the fit of other parametric models (Gompertz, Weibull, Exponential, and Log-Normal) and semi-parametric models (Cox) were found to be inadequate (graphical results shown in Appendix B).

The log-logistic regression model is a continuous probability distribution for a non-negative random variable. It is used in survival analysis as a parametric model for events whose rate increases initially and decreases later (in this case, the risk of violence following age 18 increases through mid-life before decreasing again into older age).

For interpretation of the results, the following guide is useful:

- $\exp(\beta)$ - also written as $e\beta$ - is called the relative risk
- For each 1-unit increase in x the hazard is multiplied by $\exp(\beta)$
- $\exp(\beta)>1$ implies a positive effect on hazard, i.e. higher values of x associated with shorter durations
- $\exp(\beta)<1$ implies a negative effect on hazard, i.e. higher values of x associated with longer durations

Model 1a: Individual Level Risk Factors for Heteronormative IPV

For physical violence (see Table 1 below), both the use of drugs and/or alcohol and the scale variable indicating psychological issues surrounding anger, jealousy, or mental illness were not significant. However, both young age at the time of violence ($p<.001$) and experiencing physical child abuse ($p<.05$) were.

Specifically, the relative risk of age on experiencing physical violence is 1.14 (exp(-β)). Thus, for each 1-unit increase in the variable for young age, the hazard is multiplied by 1.14. As the variable for young age is binary, this means that heterosexually-identified women between the ages of 18-25 (a one unit increase from "0" meaning 25 years old or older, to "1" meaning ages 18-25) are 14% ((exp(-(-.132)) – 1)*100) more likely to experience physical violence. The time to failure, in this case experiencing physical violence, is shortened by 14% when taking into account age.

The relative risk of physical child abuse on experiencing violence is 1.01 (exp(-β)). Physical child abuse is a scale variable (ranging from 0-12), meaning that each 1-unit increase in child abuse increases the risk of experiencing violence by 1% ((exp(-(-.006)) – 1)*100). Therefore, heterosexually-identified women who experienced two forms of child abuse versus one form have a 1% greater chance of experiencing physical violence as an adult, while women who experienced ten forms of child abuse versus one has a 10% greater chance of experiencing physical violence as an adult.

None of the individual level risk factors were significant for sexual violence against heterosexually-identified women.

Table 1. Model 1 Event History Analysis of Individual Level Risk Factors on Intimate Partner Violence

		Physical IPV		Sexual IPV	
		Heteronormative	Queer	Heteronormative	Queer
Individual Level	Young Age (18-25)	-.123*** 1.141 .013	-.174*** 1.19 .012	.033 1.03 .027	-.185* 1.20 .089
	Child Abuse Victimization	-.006** 1.006 .002	-.010*** 1.01 .003	-.003 1.00 .004	-.020 1.02 .017
	Partner's Psychology	-.003 1.003 .007	-.006 1.006 .009	.021 1.02 .027	.007 1.01 .058
	Partner's Drug/Alcohol Abuse	.005 1.005 .009	-.002 1.002 .012	.015 1.02 .022	.057 1.06 .124
AIC		-895.074	-354.614	-138.101	2.716
Wald *x*2		122.46***	228.76***	4.15	14.16**
df		4	4	4	4
Observations		846	364	241	18

1) The first number is the unstandardized beta coefficient (β), the second number is exp(β) , and the third number is the robust standard error.

2) *** $p < .001$; ** $p < .01$; * $p < .05$

Model 1b: Individual Level Risk Factors for Queer IPV

For physical violence (see Table 1 above), both the use of drugs and/or alcohol and the scale variable indicating psychological issues surrounding anger, jealousy, or mental illness were not significant. However, both young age at the time of violence ($p<.001$) and experiencing physical child abuse ($p<.001$) were.

Specifically, the relative risk of age on experiencing violence is 1.19 (exp(-β)). Thus, for each 1-unit increase in the variable for young age, the hazard is multiplied by 1.19. As the variable for young age is binary, this means that heterosexually-identified men, gay men, and lesbian and bisexual (LB) women between the ages of 18-25 are 19% ((exp(-(-.174)) – 1)*100) more likely to experience physical violence.

The relative risk of physical child abuse on experiencing violence is 1.01 (exp(-β)). Physical child abuse is a scale variable (ranging from 0-12), meaning that each 1-unit increase in child abuse increases the risk of experiencing violence by 1% ((exp(-(-.010)) – 1)*100). Therefore, men and LB women who experienced two forms of child abuse versus one form has a 1% greater chance of experiencing physical violence as an adult, while those who experienced ten forms of child abuse versus one has a 10% greater chance of experiencing physical violence as an adult.

For sexual violence, the only individual level risk factor found to significantly predict violence was young age ($p<.05$). In this case, heterosexually-identified men, gay men, and LB women between the ages of 18-25 are 20.3% ((exp(-(-.185)) – 1)*100) more likely to experience sexual violence.

Model 2a: Relationship Level Risk Factors for Heteronormative IPV

For physical violence (see Table 2 below), both the indicators of a being in a bad relationship (arguing, fighting, the relationship falling apart, etc.) and being divorced (or violence being triggered because of the divorce or separation) were not significant. However, being pregnant at the time of violence or experiencing violence because of the pregnancy was significant ($p<.05$).

The relative risk of pregnancy on experiencing physical violence is 1.05 ((exp(-β)); specifically, being pregnant increases the risk for experiencing physical violence by 5% ((exp(-(-.046)) – 1)*100).

None of the relationship level risk factors were significant for sexual violence.

Table 2. Model 2 Event History Analysis of Relationship Level Risk Factors on Intimate Partner Violence

		Physical IPV		Sexual IPV	
		Heteronormative	Queer	Heteronormative	Queer
Relationship Level	Perceived "Bad Relationship"	-.001 1.001 .011	-.038* 1.04 .018	-.027 1.03 .035	-.112 1.12 .062
	Divorced/Separated	.026 1.026 .033	-.013 1.01 .035	.058 1.06 .036	.042 1.04 .240
	Pregnancy	-.046* 1.047 .015	-.171* 1.19 .079	---	---
AIC		-744.558	-223.934	-141.659	2.252
Wald *x*2		9.76*	8.41*	3.02	--
df		3	3	2	2
Observations		846	364	241	18

1) The first number is the unstandardized beta coefficient (β), the second number is exp(β) , and the third number is the robust standard error.

2) *** $p < .001$; ** $p < .01$; * $p < .05$

Model 2b: Relationship Level Risk Factors for Queer IPV

For physical violence (see Table 2 above), both the indicators of a being in a bad relationship (arguing, fighting, the relationship falling apart, etc.) and being pregnant at the time of violence or experiencing violence because of the pregnancy were significant ($p<.05$, for both). Being divorced (or violence being triggered because of the divorce or separation) was not significant.

The relative risk of being in a bad relationships on experiencing physical violence is 1.04((exp(-β)); specifically, reporting a being in a bad relationship at the time of experiencing violence increases men's and LB women's risk for experiencing violence by 4%. Being pregnant increases the risk of experiencing physical violence by 19% ((exp(-(-.172)) – 1)*100). Though, it should be noted that no men reported being pregnant, this statistic is based on three lesbian and/or bisexual women who reported being pregnant at the time of violence.

None of the relationship level risk factors significantly predicted sexual violence for men or LB women.

Model 3a: Community Level Risk Factors for Heteronormative IPV

For physical violence (see Table 3 below), poverty (p<.001) was a significant risk factor, but social capital was not. Specifically, being in poverty increases the risk of experiencing violence by 4.5% ((exp(-(-.043)) – 1)*100).

Neither poverty nor the social capital scale were significant risk factors for sexual violence.

Table 3. Model 3 Event History Analysis of Community Level Risk Factors on Intimate Partner Violence

		Physical IPV		Sexual IPV	
		Heteronormative	Queer	Heteronormative	Queer
Community Level	Poverty	-.043** 1.044 .014	-.063 1.07 .050	.002 1.00 .025	---
	Social Capital	-.017 1.017 .010	-.040* 1.04 .020	-.016 1.02 .023	-.029 1.03 .113
AIC		-748.426	-227.114	-138.861	2.615
Wald $x2$		12.08*	10.99**	0.53	0.07
df		2	2	2	1
Observations		846	364	241	18

1) The first number is the unstandardized beta coefficient (β), the second number is exp(β) , and the third number is the robust standard error.

2) *** p < .001; ** p < .01; * p < .05

Model 3b: Community Level Risk Factors for Queer IPV

For physical violence (see Table 3 above), poverty was not a significant risk factor, but social capital was (p<.05). Specifically, for men and LB women, reporting a connectedness to friends and/or neighbors increases the risk of experiencing violence by 4.5% ((exp(-(-.043)) – 1)*100).

For sexual violence, the poverty variable was omitted because none of the men or LB women who reported sexual violence lived in poverty. The social capital variable was not significant.

Model 4a: Social Level Risk Factors for Heteronormative IPV

For physical violence, the power and control scale was not a significant predictor of experiencing violence (see Table 4 below). However, for sexual violence, the power and control scale was a significant risk factor. Specifically, aspects of power and control typically gained via masculinity or masculine power, and/or tactics and excuses for violence used to control women, increased heterosexually-identified women's chances of experience sexual violence by 9% ((exp(-(-.085)) – 1)*100).

Table 4. Model 4 Event History Analysis of Social Level Risk Factors on Intimate Partner Violence

		Physical IPV		Sexual IPV	
		Heteronormative	Queer	Heteronormative	Queer
Social Level	Power and Control	-.018 1.02 .013	-.072** 1.08 .025	-.085*** 1.09 .021	-.264*** 1.30 .072
AIC		-740.824	-227.571	-154.068	-3.804
Wald $x2$		1.93	7.99**	16.77***	13.62***
df		1	1	1	1
Observations		846	364	241	18

1) The first number is the unstandardized beta coefficient (β), the second number is exp(β) , and the third number is the robust standard error.

2) *** $p < .001$; ** $p < .01$; * $p < .05$

Model 4b: Social Level Risk Factors for Queer IPV

For physical violence against men and LB women (see Table 4 above), the power and control scale was a significant risk factor ($p < .01$). Specifically, and interestingly, the aspects of power and control typically associated with masculinity or masculine power increases the risk of men and LB women experiencing physical violence by 7.5% ((exp(-(-.072)) – 1)*100).

For sexual violence, the power and control scale was significant (p<.001). This means that men and LB women experienced a 30.3% ((exp(-(-.265)) – 1)*100) increased risk of sexual violence if their partner was assessed to be controlling, coercive, or otherwise manipulative.

Comparing Models for Heteronormative IPV

Akaike's information criterion and Bayesian information criterion were used to compare model fits. The AIC penalizes for the addition of parameters, and thus selects a model that fits well but has a minimum number of parameters (i.e., simplicity and parsimony). In itself, the value of the AIC for a given data set has no meaning. It becomes interesting when it is compared to the AIC of a series of models specified a priori, the model with the lowest AIC being the best model among all models specified for the data at hand (Mill, 2011).

For physical violence, all of the models improve fit over the null model (see Table 5 below), but Model 1, individual level risk factors, improved the null model the most. For heterosexually-identified women, being between the ages of 18-25 and having experienced physical child abuse were the most important risk factors for experiencing physical violence as an adult.

For sexual violence, only the last model (power and control) improved the fit over the null model (see Table 5 below). For heterosexually-identified women, having a male partner who you assessed was controlling or coercive, or took advantage of you or the situation, was the most important risk factor for experiencing sexual violence.

Table 5. Akaike's Information Criterion for all Event History Analysis Models

		Physical IPV		Sexual IPV	
		Heteronormative	Queer	Heteronormative	Queer
Model	Null (empty)	-740.997	-222.66	-142.338	0.695
	1	-895.074	-354.614	-138.101	2.716
	2	-744.558	-223.934	-141.659	2.252
	3	-748.426	-227.114	-138.861	2.615
	4	-740.824	-227.571	-154.068	-3.804

1) The lowest AIC is the best model among all models specified for the data at hand.

Comparing Models for Queer IPV

For physical violence, all of the models improve fit over the null model (see Table 5 above), but Model 1, individual level risk factors, improved the null model the most. For men and LB women, being between the ages of 18-25 and having experienced physical child abuse were the most important risk factors for experiencing physical violence as an adult.

For sexual violence, only the last model (power and control) improved the fit over the null model (see Table 5 above). For men and LB women, having a male partner who you assessed was controlling or coercive, or took advantage of you or the situation, was the most important risk factor for experiencing sexual violence.

Discussion

There are two key findings of this analysis: 1) the applicability of risk factors framed within a heteronormative context (risk factors that are the product of interviews with "battered" women and/or the men who abused them) are limiting to not only those who experience queer violence, but also women who experience violence by male partners; and 2) all levels of risk factors associated with men's sexual violence against women were found to be insignificant, except adherence to traditional gender norms/belief in gender ideals

I'll start with the first key finding. Contrary to what most studies have previously indicated, drug and alcohol use did not significantly increase any individual's risk of experience physical or sexual violence. Psychological issues surrounding anger, jealousy, or mental illness were also not significant, despite strong previous findings from other nationally representative and community-based surveys. Though, it does seem that there is something universal about young age and being a victim of abuse as a child. For all people, regardless of sex or who abused them, being between the ages of 18-25 and having experienced violence at the hands of a parent, increased risk of adult physical violence; in fact, the risk, given both of these variables, was equivalent for both heteronormative and queer physical IPV. For abused men and LB women, young age was also a significant risk factor for sexual violence.

The relationship-level risk factors were only sporadically applicable. For instance, none of the relationship-level factors increased risk of experienced sexual violence. However, being pregnant was a significant risk factor for physical violence for both LB women and heterosexually-identified women. Though, while being in a "bad relationship" was not

significant for heterosexually-identified women, it did increase men's and LB women's, risk for physical violence. Lastly, while being separated or divorced is typically a strong risk factor for experiencing violence, it was not in this analysis.

The community-level risk factors also had differing significances, depending on perpetrator and victim. Poverty significantly increased a woman's risk of physical abuse by a man, but was did not increase the risk of physical abuse for men or LB women (likely because very few men, lesbian or bisexual women lived in poverty at the time of violence). The social capital variable (an indication of connectedness to local community, neighborhood, and friends and family) did not effect a woman's chance of abuse by a man, but did increase men's and LB women's risk of physical violence.

The social level risk factors, largely deduced from years of interviews with women abused by men, not only significantly increased women's risk of physical abuse by men, but also significantly increased men's and LB women's risk of both physical and sexual abuse by their partners. This means, interestingly, that the power and control most typically associated with masculine gender norms or given to men, theoretically, by default (i.e. the person abused asked for it, deserved it; or that violence was the result of control or power over that person) increased the risk of queer IPV more than the risk of heteronormative IPV. This could mean that masculinity is only one avenue to garnering power over another individual—meaning that when we look at the specific questions answered by victims of violence, we apply a normative masculine lens (i.e. "she asked for it"), rather than applying a more general power and control lens in which race, income, education, age, etc., are probable sources of any person (*genderless*) being taken advantage of by an intimate partner.

The second key finding is related to this. While previous studies assessing risk factors on the experience of IPV utilized general regression techniques, this event history analysis allows for a more specific and direct risk hazard analysis. When calculating an individual's adult lifetime risk of experiencing sexual violence in time from age 18 onwards, we see that only the social level risk factors are significant in predicting men's sexual violence against women. This means that more than drug use, violence in the family of origin, or the typical risk factors often played out on the nightly news and popular primetime shows—i.e. psychological disorder—power and control are the only and best predictors of risk of intimate sexual violence for heterosexually-identified women over the age of 18.

When taken together with the findings about power and control (the social level variables through to imply *masculinity* as power) for queer physical and sexual IPV, we might reason that it is not only masculinity, but also other sources of power and control that account for violence in relationships. In fact, if looked at more specifically, these other sources of power might be able to explain and predict men's physical violence against women, when masculine gender norms in this analysis were not. Power and privilege are conferred socially on many levels and in many ways, but for the purposes of first examining the dominant public health discourse and risk factors, a variety of power sources were left unexamined in this chapter. For instance age, physical power or stature, income, employment, education and/or social skills extend into relationship dynamics and instigate abuse or violence (Aizer, 2010; Renzetti and Miley, 1996; Steinmetz and Straus, 1974; Kandel and Lesser, 1972; McDonald, 1980; Coleman, 1994; Hastings and Hamberger, 1988; Hotaling and Sugarman, 1986; Marshall and Rose, 1990; Kandel and Lesser, 1972; McDonald, 1980). This is explored in more detail in Chapter Five.

It is also important to discuss the findings of the model comparisons in more detail. While risk factors were analyzed for individual impact on violence, the various risk factors were combined into models and those models were also compared to assess which grouping of risk factors (individual level, relationship level, community level, or social level) was the best at predicting risk of violence. The findings here are very interesting: regardless of victim/perpetrator, the individual level factors increase the risk of experiencing physical violence the most, and the social level factors increase the risk of experiencing sexual violence the most. This is to say, for both heterosexual women, and men and LB women, being young/experiencing child abuse increases your risk of physical violence more than any other risk factors; and having a partner who you assessed was controlling or coercive, took advantage of you or the situation, or (when applicable) held sexist/hostile beliefs about women, increases your risk of sexual violence more than any other risk factors.

Lastly, I want to point out that this analysis confirms what many others have about the experience of childhood abuse victimization: it is a very important factor for determining risk later in life. A study that followed a group of 500 children over 20 years found that witnessing parental violence was the single strongest factor for involvement in intimate partner violence as an adult (Ehrensaft, Cohen, Brown, Smailes, Chen, and Johnson, 2003). This analysis finds that childhood abuse victimization was a key factor for every single form of both queer and

heteronormative violence. In fact, because of the statistical significance of childhood victimization, the "individual level" of risk factors explained the experience of physical abuse the best out of any other levels.

Conclusion

According to the public health sector, there are a combination of individual, relational, community, and societal factors that contribute to the risk of becoming a victim or perpetrator of IPV, and understanding whether or not these multilevel factors are is the first step to identifying various opportunities for prevention (Centers for Disease Control).

This analysis found that for heterosexually-identified women, only some factors within each of the levels are significant for physical violence and only the social level factors (constructed from understandings of normative masculine ideals and beliefs) are significant for sexual violence. For men and LB women, some factors were the same as for heterosexually-identified women, but many were different.

For instance, it appears that individual risk factors are important for all people when it comes to the risk of experiencing physical violence—both young age and the experience of child abuse increase your risk of adult victimization. For all women, being pregnant is a significant risk factor. And for both heteronormative and queer physical violence, the social level factors were significant. But the similarities for risk factors end there. For men and LB women, but not heterosexual women, young age significantly increased the risk of sexual violence victimization. For heterosexual women, being in poverty increased risk of physical violence, but social capital did not; the opposite was true for men and LB women. Lastly, being in a bad relationship significantly increased risk of physical violence for heterosexual women, but not men or LB women.

However, when taken together into risk factor levels, the individual level increases risk of physical violence more than the other levels, and the social level increases risk of sexual violence more than the other levels, for all men and women.

Before making too many conclusions about what this all means, though, we have to take into account the way violence was being studied in this chapter. First and foremost this analysis assessed risk of intimate physical and sexual violence since age 18. This means that many of the complexities (perhaps, variables) of violence within a particular relationship or setting were not

considered—for instance, the age, race, or sex/gender of the perpetrator. When thinking about power and control beyond a gender normative perspective, it is essential to include these types of characteristics into an analysis. The next chapter does just that, by examining a variety of characteristics on how they impact experiences of myriad forms of violence in addition to physical and sexual.

Secondly, this chapter relied on the self-reports of the victims as to the reasons why violence occurred. While there is no reason to disbelieve a victim, there is some evidence that suggests victims are not always able to clearly discern a "justification" for the violence that occurred against them (Flynn and Graham, 2010), while some victims believe the violence occurred for a reason that the perpetrator disagrees with (i.e., in one study victims reported characteristics related to the personality/psychological of the perpetrator, but the perpetrators listed reasons such as alcohol/drugs and attributes of the victims) (Henning, et al., 2005). In future analyses of risk factors, which must take into account characteristics and beliefs of perpetrators, both victims and perpetrators should be surveyed.

Lastly, for both theoretical and practical reasons, this chapter examined queer IPV in a way that merged heterosexually-identified men and gay, lesbian, and bisexual men and women into one category. It was stated at the beginning of the chapter, however, that there were very few individuals abused by a same-sex partner that answered all of the relevant questions necessary for an event history analysis (i.e. how long ago, in years, did the event take place; and "can you tell me what triggered the incident"). While this chapter unveiled some interesting differences and similarities between heteronormative and queer IPV, it was largely an analysis of women abused by men and men abused by women. Are the same risk factors important for who identify as lesbian, gay, or bisexual? Perhaps. The only way to know for sure is to collect more comprehensive data in a format suitable for event history analysis.

In the next chapter, I carry over the key findings from this analysis, but shift theoretical frame to better understand power and inequality, and also uses new methodologies in order to better understand the issue of intimate partner violence as it explicitly relates to those abused by a same-sex partner.

Appendix A. Tables

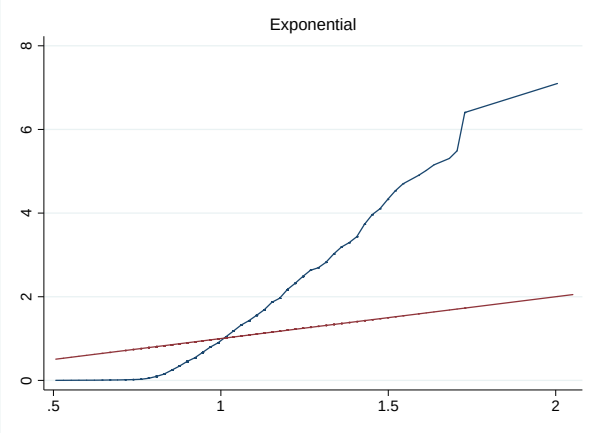
Table 1. Descriptive Statistics for Chapter Four Variables

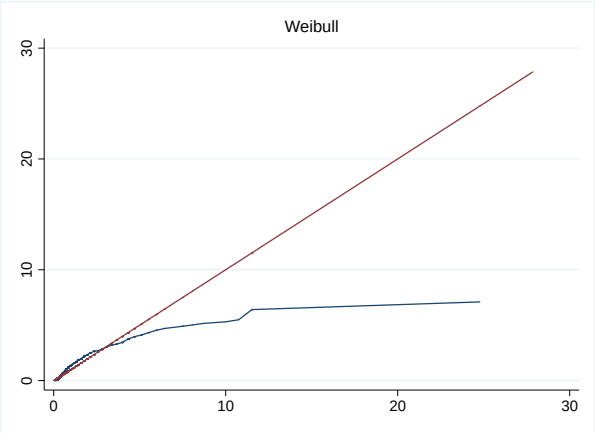
				Percent Experienced	Mean/Mode	Minimum	Maximum	N
Outcome Variables		Physical Violence	Heterosexual Women	13.60%	34.17	18	75	846
			Heterosexual Men	4.90%	30.45	18	68	333
			Lesbian and Bisexual Women	26.60%	33.62	19	55	21
			Gay and Bisexual Men	15.40%	29.9	22	38	10
		Sexual Violence	Heterosexual Women	3.90%	36.71	18	80	241
			Heterosexual Men	0.15%	28	20	38	10
			Lesbian and Bisexual Women	8.90%	35.86	28	45	7
			Gay and Bisexual Men	1.50%	32	32	32	1
Predictor Variables	Individual Level	Young Age (18-25)	Heterosexual Women	9.10%	0	0	1	6233
			Heterosexual Men	2.10%	0	0	1	6800
			Lesbian and Bisexual Women	15.20%	0	0	1	79
			Gay and Bisexual Men	9.20%	0	0	1	65
		Child Abuse Victimization	Heterosexual Women	41.20%	0	0	12	6233
			Heterosexual Men	54.80%	0	0	12	6800
			Lesbian and Bisexual Women	59.50%	0	0	12	79
			Gay and Bisexual Men	70.80%	0	0	12	65
		Partner's Psychology	Heterosexual Women	13.50%	0	0	3	6233
			Heterosexual Men	18.20%	0	0	3	6800
			Lesbian and Bisexual Women	40.50%	0	0	3	79
			Gay and Bisexual Men	25.20%	0	0	3	65
		Partner's Drug/Alcohol Abuse	Heterosexual Women	9.20%	0	0	1	6233
			Heterosexual Men	0.81%	0	0	1	6800
			Lesbian and Bisexual Women	21.50%	0	0	1	79
			Gay and Bisexual Men	15.40%	0	0	1	65
		Perceived "Bad Relationship"	Heterosexual Women	11.80%	0	0	1	6233
			Heterosexual Men	15.80%	0	0	1	6800
			Lesbian and Bisexual Women	22.80%	0	0	1	79
			Gay and Bisexual Men	23.10%	0	0	1	65
	Relationship Level	Divorced/Separated	Heterosexual Women	2.50%	0	0	1	6233
			Heterosexual Men	0.84%	0	0	1	6800
			Lesbian and Bisexual Women	8.90%	0	0	1	79
			Gay and Bisexual Men	0.15%	0	0	1	65
	Community Level	Pregnancy	Heterosexual Women	2.70%	0	0	1	6233
			Heterosexual Men	0%	0	0	1	6800
			Lesbian and Bisexual Women	3.40%	0	0	1	79
			Gay and Bisexual Men	0%	0	0	1	65
		Poverty	Heterosexual Women	17.10%	0	0	1	6233
			Heterosexual Men	4.20%	0	0	1	6800
			Lesbian and Bisexual Women	11.40%	0	0	1	79
			Gay and Bisexual Men	0.15%	0	0	1	65
		Social Capital	Heterosexual Women	15.60%	0	0	1	6233
			Heterosexual Men	14.80%	0	0	1	6800
			Lesbian and Bisexual Women	43%	0	0	1	79
			Gay and Bisexual Men	38.50%	0	0	1	65
	Social Level	Power and Control (Physical)	Heterosexual Women	5.10%	0	0	1	6233
			Heterosexual Men	5.10%	0	0	1	6800
			Lesbian and Bisexual Women	2.50%	0	0	1	79
			Gay and Bisexual Men	7.70%	0	0	1	65
		Power and Control (Sexual)	Heterosexual Women	5.70%	0	0	1	6233
			Heterosexual Men	0.78%	0	0	1	6800
			Lesbian and Bisexual Women	12.70%	0	0	1	79
			Gay and Bisexual Men	13.80%	0	0	1	65

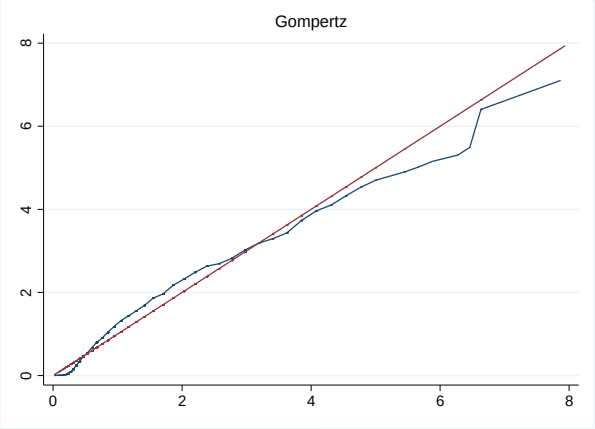
1) Mode is used for binary 0/1 variables, mean is used for interval/scale variables.
2) Percent experienced for outcome and predictor variables represents the percentage out of the entire applicable sample. N for the outcome variables represents only those who did experience violence.
3) In an event history analysis, the outcome variable is measured as the first time (in historical years) a person experienced physical or sexual intimate partner violence since the age of 18. In this table that time is shown as their age at the time of first violence.
4) Sexual violence did not take into account pregnancy as a potential risk factor for violence.

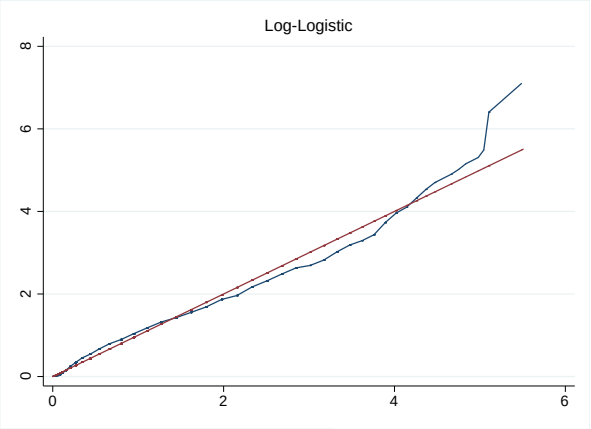
Appendix B. Model Fit Graphs

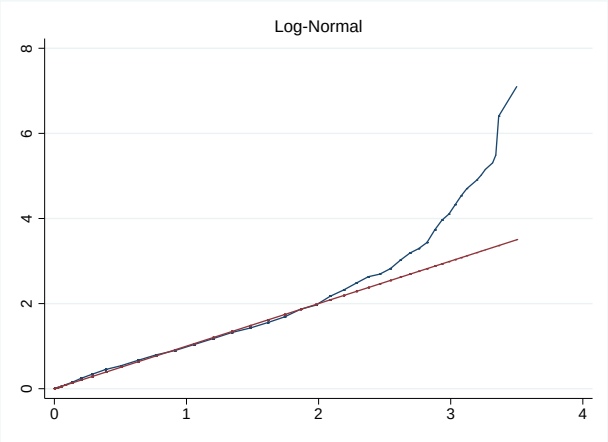
Graphs for Physical Violence



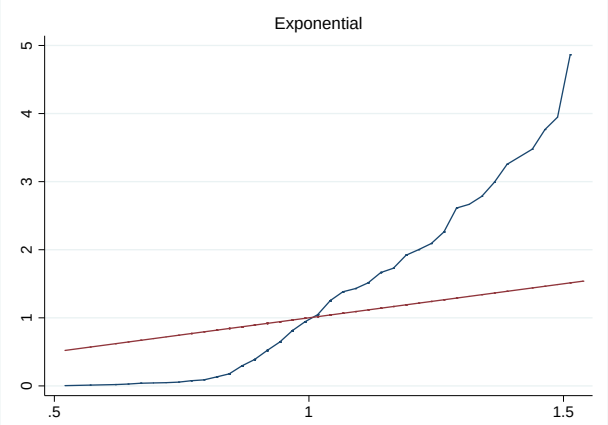


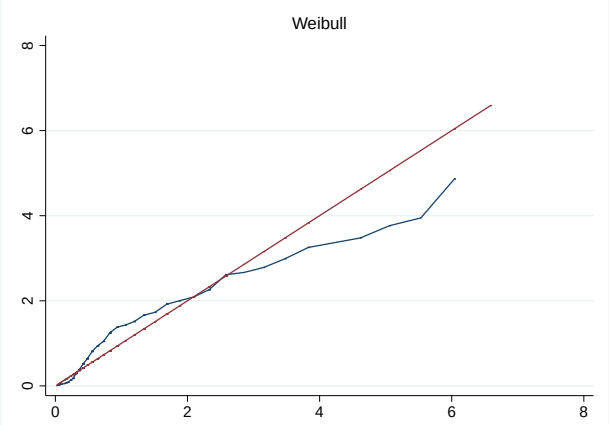


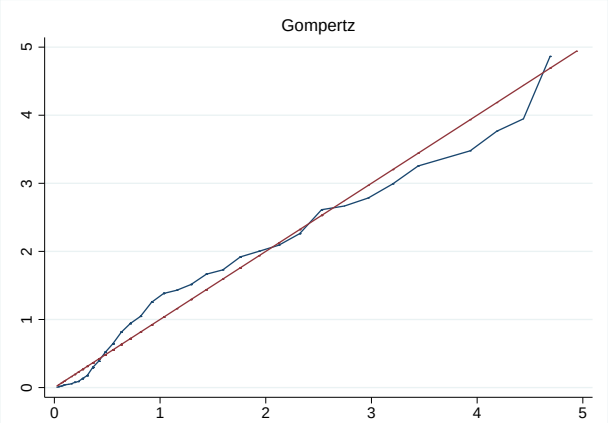


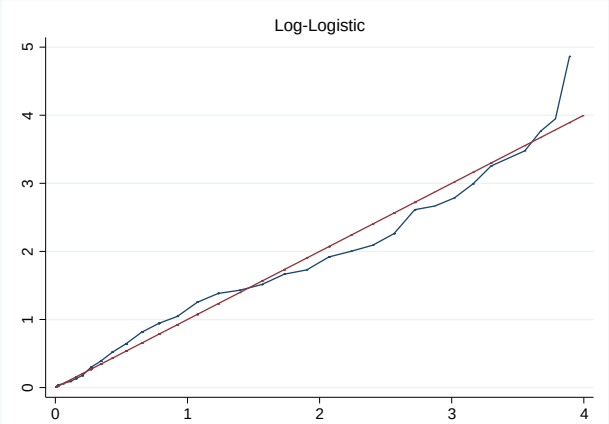


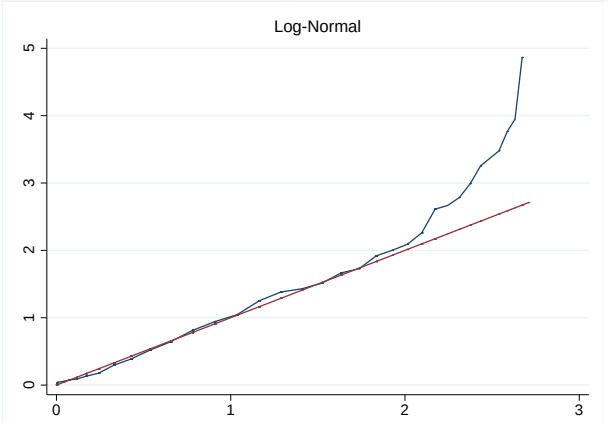
Graphs for Sexual Violence











Chapter V. Expanded Effects of Power and Inequality on Intimate Partner Violence

In the previous chapter, issues related to power and control proved to be the most useful theoretical explanation for the risk associated with sexual intimate partner violence from age 18 onwards, while certain individual characteristics (age and experiencing child abuse) proved to be the best predictor of risk of physical intimate violence. However, the analysis was not able to parse out any particulars related to power and control—for instance, specific sources of power and control other than a general idea that violence happened because of perceived power differentials. As the public health sector sees social level power and control as sourced from hostile cognitions or attributions towards women and belief in/adherence to "traditional gender norms" (see Capaldi, Knoble, Shortt, and Kim, 2012; CDC), the analysis constructed power and control from answers to "what started or triggered this incident," that indicated that the violence was caused by the partner's need for control or victim obedience, the need to "be a man," and responses that indicated the victim "asked for it." This overlooks the array of literature that indicates power in relationships occurs for reasons beyond just gender (see Goode, 1971 for an overview on how social inequalities influence individual actions and interactions between individuals).

The analysis in Chapter Four also compared those at risk for heteronormative IPV to those at risk for queer IPV—because of the limitations in questions asked, this meant that I included people in these risk categories based on their behaviorally-based sexual orientation identification. If you were a woman who had never reported being in any type of intimate relationship with a woman, for instance, you were at risk for only heteronormative IPV; however, if you were a woman who had at some point reported being in a relationship with a woman, you were at some point at risk for queer IPV. However, the analysis was not specifically about same-sex versus opposite-sex intimate partner violence. This is an important distinction to make, because we know from various nationally representative surveys that bisexually-identified women, and women who sleep with women but do not identify as lesbian or bisexual, have the highest risk of intimate partner violence from their male partners, not their female partners (see:

National Intimate Partner and Sexual Violence Survey 2010, California Health Interview Survey 2007-2009).

The limitations of the survey design also meant that I was unable to study emotional violence and control. Leading research on IPV indicates that emotional violence is a serious issue (O'Leary 2001; Johnson and Ferraro 2000), and Stark (2009) contends control violence (whether economic or isolation tactics) is the most severe form of violence today. The CDC includes emotional violence as a unique form of IPV, and the most recent survey (the NISVS) found that nearly half of all women and men in the United States have experienced psychological aggression by an intimate partner in their lifetime (48.4% and 48.8%, respectively).

In this chapter, I extend the analysis of power and control and attempt a different kind of assessment than the previous chapter was aimed at. Instead of risk factors, I examine all reported instances of same-sex and opposite-sex intimate partner violence (including psychological and control violence, in addition to physical and sexual) and test, as predictors of that violence, the key socially-conferred characteristics that would theoretically give individuals power or make them powerless within relationships.

Research Objectives

I revisit this project's three major analytical queries from Chapter Two (pages 55-56):

1. Does queered intimate partner violence occur for similar or different reasons than heteronormative intimate partner violence?
2. If so, can sex/gender explain these differences exclusively, or are other sources of power and inequality important?
3. What are some of the consequences of studying IPV from the current popular framework?

This chapter aims to answer the second major query.

Including (but not limited to) Traditional Gender Norms

The first step in moving the conversation on power dynamics forward is to better understand what theoretical explanation we might have for violence, outside of gender, or masculinity specifically. As argued previously, the scholarly understanding of IPV is anchored in patriarchy, and the use of feminism as a theoretical guide has perpetuated reductionist models of

studying violence that inadequately capture the complexity and *variety* of factors that contribute to violent behavior. Dutton (1996) points to how the underlying assumptions have influenced not only the questions we ask, but the answers we'll receive:

> When feminists ask 'Why do men beat their wives?' their answer will necessarily exaggerate differences between males and females and minimize differences among males. The categories of study are framed by the question.

But, there are alternatives.[1] For example, power resources theory extends the core sociopolitical concepts of power and privilege that stem from feminist theories into a more complex model of power distribution. First suggested by Goode (1971), power resources theory strives to identify all of the key indicators of social inequality (not just gender) and how social inequality influences individual actions and interactions.

Specifically, power resources theory examines how imbalances in power between two individuals results in violence. Couples that share power equally experience lower incidence of conflict, and when conflict does arise, are less likely to resort to violence; but if there is imblanace, and one partner desires control and power in the relationship, the partner may resort to violence (Kurz 1992). Within a heteronormative context, this may be related to gender and power, insomuch that men's cultural and historical authority give them a general sense of power in life and a specific sense of power over their women partners; when this power is threatened, men resort to violence.

Men's power has been produced and reified in daily life indiscriminately, and men are constantly reminded of their supposed need for it. For instance, Lehmann (1997) discusses an article titled "Take Control of Your Home Life: Winning strategies for becoming king of your own universe" that appeared in the 90s in Men's Health, a popular men's magazine:

> When you consider all the crazy, cockamamie reasons men have for doing all the crazy cockamamie things they do, you walk right past money, shrug off power and go right to the heart of it all: control. Control is everything… …Because the

[1] For a comprehensive review of the literature on biological, psychological, and sociological theories (including feminist and queer perspectives) that attempt to, but inadequately, explain and describe non-heteronormative IPV see Bethany M. Coston. 2011. "Issues in Intimate Violence: Heterosexism and Exclusion," in Matthew Ball and Burkhard Scherrer (Eds.), Queering Paradigms II. New York: Peter Lang Publishers (Chapter 9, pp. 295-312).

> more control a man has over his life, the happier he is... Our various daily miseries out there …are usually traceable to lack of control (Men's Health, December 1996).

Gender is not the only social inequality that could cause a struggle to regain power and control in life and relationships, and certainly heterosexual men are not the only ones who struggle with real or perceived relationship or social power imbalances. Power resources theory points to inequalities revolving around (but not limited to) knowledge or education level, social status and class issues, race and/or ethnicity, work status, or health and disability to explain intimate partner violence (Aizer 2010; Bhatt 1998; Bograd 2005; Kantor and Jasinski 1998; Melzer 2002; Renzetti and Miley 1996; Steinmetz and Straus 1974). Moreover, it should be stressed that it is not necessarily a shift in control of resources (perceived or real) that is most important to violence occurring—i.e., an individual does not have to go from having the power to losing it to use violence as a tactic to regain power again (Lehman, 1997). Many studies have confirmed that within the power resources framework, violence erupts most often from significant *perceived* inequalities within a relationship or between two intimates (Hotaling, 1986; Hastings, 1988; Marshall, 1990; Coleman, 1994; Pan, 1994).

There is, however, a significant competing theory within the literature on power dynamics and inequalities in relationships: social exchange theory. Social exchange theory focuses on how power dynamics benefit the powerful in cases of intimate partner violence, not the powerless. Specifically, in the very real case that some individuals control most of the highly valued resources, inequality results as those without power incur social debts; social debts that Blau (1964) argued were repaid via subordination. Over time, these singular instances of subordination by the less powerful (or the domination by those with power) become self-perpetuating. This leads to a general understanding that those who have power in one (or multiple contexts) can rightfully do as they wish to those who have less (see Cook and Rice 2003).

The literature on social exchange (back to early fundamental work by Blau (1964), Emerson (1962, 1964) and Homans (1958)) suggests the opposite of what Goode claims is true about power in relationships. The argument is that violence is a logical consequence of greater power rather than of an attempt to regain power somehow otherwise lost. For instance, Van de

Rijt and Macy (2006) and Sprecher (1998) argue that individuals exercising power over their partners is a result of socio-economic or affect-related imbalances in the relationship (the abuser earns a higher income or loves the partner less).

In a heteronormative context, instead of men's lacking power leading them to be violent we would argue that it is their general power that allows for seeing their violence as normative and/or expected. Rusbult & Martz (1995) argue that the reason men in heterosexual relationships get away with IPV is that their female partners are economically or otherwise dependent on them (there are structural barriers to them leaving the relationship, and potentially accessing care services).

The social exchange understanding of why violence occurs has greatly influenced the public discourse surrounding IPV. Indeed, many scholars and activists argue that economic justice is linked to ending men's violence against women—the idea being that violence will decrease when women's economic resources increase to the level of men's (Gelles, 1983; Hampton, Oliver, and Magarian, 2003; Smith, 2005; Websdale and Johnson, 1997). When men do not have economic power over women, their continued subordination lessens; she is able to either bargain for a better situation for herself within the relationship or threaten to leave (England and Farkas, 1986; Farmer and Tiefenthaler, 1997; Gibson-Davis, Magnuson, Gennetian and Duncan, 2005). Yet, power resources theory might argue that in the instance of women's greater economic power, men's social and personal stability is threatened, and violence results regardless.

One thing remains consistent as these theories apply to IPV—much like feminist theories on violence, power and inequality are frequently examined in relation to men's violence against women; but both power resources theory and social exchange theory allow for the addition of other factors (variables) in the analysis, such as social class or race/ethnicity, in addition to gender.

Methods

This study employs both descriptive and inferential statistical techniques using Stata/SE 13 quantitative data analysis software for large datasets. First, measures of central tendency and measures of variation were calculated to summarize the general demographic characteristics of the sample versus the characteristics of those who experience violence. Measures of central

tendency indicate averages of the distribution, and measures of variation indicate the spread, or range, of the distribution (Hinkle, Wiersma and Jurs, 1988).

This study also conducts a *t*-test analysis to compare individuals abused by opposite-sex partners to individuals abused by same-sex partners in terms of the key demographic variables of themselves and their partners. Specifically, this study is interested in first examining if there were significant differences between those abused by a same-sex partner and those abused by an opposite-sex partner in age, race ethnicity, income, education, employment, and health status, or if people abused by same-sex partners are comparable, on average, to people abused by opposite-sex partners.

This study also employs Fisher's Exact Test for small frequencies, used to determine similarities and differences between opposite-sex violence and same-sex violence (Stevens, 2002)—that is, this study tests whether or not the inequality indicators described below have the same impact on the incidence of violence for men abused by women, men abused by men, women abused by women, and women abused by men.

Lastly, this study conducts binary logistic regression models, assessing the effect (degree and direction) of the inequality indicators (i.e. age, race, income and so on) on the violence types (physical, sexual, emotional, and control described below) in order to answer the question: is the effect of inequality on violence the same for both those abused by a same-sex partner and those abused by an opposite-sex partner? Each regression model predicts violence as a function of inequality.

Dependent Variables

This chapter examines physical, sexual, emotional (which includes verbal), and control violence. For a more detailed understanding of what is considered physical, sexual, emotional, and/or control violence see Chapter Three (pages 56-57).

Independent Variables

In this study, the key independent variables are what I will call "inequality indicators." All of the regression models involving both current and previous instances of intimate partner violence included separate variables (inequality indicators) for each type of inequality in addition to an inequality scale variable that summed the individual variables together to create a scale of

an individual person's theoretical power along lines of age, race/ethnicity, educational attainment, employment status, income, and health status (including permanent or temporary disability).

Age was a continuous variable transformed into a scale variable to make it comparable to the other inequality indicators. The age ranges in each category were: 18-25, 26-35, 36-45, 46-55, 56-65, 66-97 (six categories). Race/ethnicity was binary (two categories), as I did not want to distinguish a rank order of race ethnicities, thus White is the majority category and non-White (including Asian/Pacific Islander, Black, Indian/Alaskan Native, mixed race, "other" race, and Hispanic). Education varied from no high school attainment to receiving a post-graduate degree (seven categories). Income was scaled using the 1995 Census quintiles with those making no income separated (as the dataset was 1995-1996): those with no income, $5-15k, $15-25, $25-50k, $50-100k, and over $100k (six categories). Employment included three categories: unemployed, employed part-time, and employed full time (other categories of employment were left out of this variable because of the difficulty with ordering those who are "retired" or "homemakers," for example). Lastly, health status included those who are disabled or have self-reported poor health, fair health, good health, very good health, and excellent health (three categories).

All of the above variables were then combined into one inequality scale variable. Based on the coding, an individual could have a minimum score of six and maximum score of twenty-eight. Not all individuals answered all of the questions necessary to be included in the inequality scale variable; individuals with missing responses for any of the questions were dropped from the scale. Summary statistics can be found in Table 1 below.

Control Variables

In the previous chapter, the most significant risk factor for physical violence was the experience of physical child abuse victimization, while the general mention of power/control (i.e. traditionally masculine power/control) was most significant risk factor for sexual violence. While the physical child abuse victimization variable can be included in all of the regression models, the power/control variable only takes into account a specific subset of perpetrators, not all past perpetrators, so it is not included in the analysis.

Results

In terms of the independent variables, I first revisit the descriptive statistics for the sample. Most respondents were White. Income was fairly normally distributed, with most respondents reporting a yearly income between $15,000 to $35,000. Most respondents received at least a high school degree or attended some college. In terms of employment, most reported being employed full time. Lastly, more individuals rated their overall health as very good (see Table 1 below).[2]

The t-tests for the significance of the difference between same-sex victims and opposite-sex victims of violence (Table 1) shows that, on average, men in both populations are similar (except for a four-year average difference in age). However, women victims do significantly differ in terms race, education, employment, and income. Women abused by women are more likely to be White ($t = 3.802$, $p < .001$), have a higher level of education ($t = -3.794$, $p<.001$), are more likely to be employed full time ($t = 2.651$, $p < .05$), and make more money ($t = -2.056$, $p<.05$). These differences are important to note, given that this analysis is specifically interested in the effect of inequality on violence.

[2] Heteroskedasticity is not a problem. Skewness and kurtosis were flagged, but is likely because of the binary dependent variables, probit models were run and they did not change the direction, significance or standard errors of the predictor variables. Therefore, logit models with robust standard errors are used.

Table 1. Descriptive Statistics for Chapter Five Variables

		Same-Sex Victims		Opposite-Sex Victims	
		Men (*N*=56)	Women (*N*=50)	Men (*N*=3568)	Women (*N*=3481)
Independent Variables	Average Age	57.5	56.2	53.6	53.8
	% White	76.36	92	76.34	77.27
	Average Education	> Some College	> Some College	< Some College	< Some College
	Average Income	$25-35k	$20-25k	$25-35k	$15-20k
	% Employed Full Time	86.27	83.3	80.96	67.75
	Average Health	Very Good	Very Good	Very Good	Very Good
	Average Inequality Score	14.17	14.05	14.54	15.37
Depdendent Variables	*N* Physical IPV	20	22	506	1412
	N Sexual IPV	3	8	17	504
	N Emotional IPV	39	44	3042	2988
	N Control IPV	41	41	2557	2257

Notes:

a) Averages for independent variables interpreted from raw data, not edited scales.
b) The inequality scale variable can range from 6-26.
c) There was a statistically significant difference in age between same-sex men victims and opposite-sex men victims; $p<.05$
d) Significantly more opposite-sex women victims than same-sex women victims are non-white; $p<.001$
e) There was a statistically significant difference in education level between same-sex women victims and opposite-sex women victims; $p<.001$
f) There was a statistically significant difference in income between same-sex women victims and opposite-sex women victims; $p<.05$
g) Significantly more same-sex women victims than opposite-sex women victims were employed full time; $p<.05$
h) The average inequality score for opposite-sex women victims was significantly higher than for same-sex women victims; $p<.01$

Table 2 (below) shows the Fisher's Exact results for the independent variables (inequality indicators) and the dependent variables (types of violence). These tests will tell us if the impact of inequality on violence is significantly different for those abused by a same-sex partner versus those abused by an opposite-sex partner. For men, the results are largely as expected. While men abused by same-sex partners are significantly older, age inequality does not differently impact same-sex victims' experiences of any type of violence. For that matter, no inequality variables were related to the reported experience of physical or sexual violence, and the only variable effecting men's differing experiences with emotional ($p=.003$, $N=3075$) or control ($p=.002$, $N=2591$) violence is education level.

Interestingly, even though women abused by same-sex partners were significantly different than women abused by opposite-sex partners in terms of their race, education level, income, and employment status, none of these factors impacted the reported experience of sexual violence. In fact, none of the inequality indicators made a significant difference in the experience of sexual violence. However, race was significantly related to physical ($p=.003$, $N=1422$),

emotional (p=.026, N=3008), and control (p=.009, N=2277) violence, while education level was significant to reported emotional (p=.045, N=3027) and control (p=.044, N=2292) IPV. It seems that experiences of control violence are the most related to inequality indicators, as in addition to race and education level, employment (p=.045, N=1755) and health status (p=.023, N=2293) were also significant.

The cumulative effect of inequality (i.e. taking all of the inequality factors together) did not significantly impact reported same-sex versus opposite-sex physical or sexual violence; however, for men, it was related to emotional violence (x^2=28.90, p<.05, N=2460), and for women, it was related to control violence (x^2=27.17, p<.05, N=1482).

Table 2. Fisher's Exact Tests for Differences In Outcomes Between Same-Sex and Opposite-Sex Intimate Partner Violence Over Adult Lifetime

	Physical		Sexual		Emotional		Control	
	Men	Women	Men	Women	Men	Women	Men	Women
Age Inequality	0.13	0.71	0.57	0.88	0.59	0.79	0.80	0.80
	N=525	*N*=1420	*N*=20	*N*=503	*N*=3060	*N*=2990	*N*=2576	*N*=2271
Racial/Ethnic Inequality	0.14	.003**	0.15	0.21	0.38	.026*	0.41	.009**
	N=521	*N*=1422	*N*=20	*N*=510	*N*=3044	*N*=3008	*N*=2562	*N*=2277
Education Inequality	0.15	0.45	0.06	0.84	.003**	.045*	.002**	.044*
	N=525	*N*=1430	*N*=20	*N*=512	*N*=3075	*N*=3027	*N*=2591	*N*=2292
Employment Inequality	0.48	0.75	1.00	1.00	0.80	0.15	0.55	.045*
	N=486	*N*=1100	*N*=18	*N*=384	*N*=2875	*N*=2345	*N*=2416	*N*=1755
Income Inequality	0.11	0.48	0.81	0.48	0.94	0.14	1.00	0.13
	N=483	*N*=1242	*N*=19	*N*=463	*N*=2672	*N*=2546	*N*=2248	*N*=1980
Health Status Inequality	1.00	0.40	0.76	0.89	0.66	0.07	0.82	.023*
	N=526	*N*=1432	*N*=20	*N*=512	*N*=3080	*N*=3028	*N*=2596	*N*=2293
Inequality Scale	0.55	0.12	0.59	0.54	28.90*	25.12	28.88	27.17*
	N=441	*N*=946	*N*=18	*N*=342	*N*=2460	*N*=1933	*N*=2059	*N*=1482

Notes:
* $p < .05$
** $p < .01$
*** $p < .001$
1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.
2) For emotional and control violence, the sample size (N) was too large to compute a Fisher's Exact p, thus $x2$ was used instead.

Given the above results, namely that the men in this sample are not significantly different from one another other and that men's same-sex experiences of violence are not significantly different from men's opposite-sex experiences of violence, they will be collapsed into one category for the regression analysis that follows. Women, although they are significantly different from one another, do not experience same-sex or opposite-sex physical or sexual violence differently because of those characteristics; but they do experience same-sex or opposite-sex emotional and control violence differently because of those characteristics. Thus, women will be merged together for physical and sexual violence, but not emotional or control violence, in the regression analyses below.

Regression Analysis – Men

The first set of regression models analyzes the relationship between inequality and experiences of violence, specifically comparing men who experience violence to men who don't. All referenced regression estimates are located in Table 3 (below).

Model 1 – Physical Violence

The results of the regression indicated the two inequality indicators were significantly related to reported physical violence (x^2=446.93, *df*(7), p<.001): age inequality (β = .223, p<.001) and health status inequality (β = .153, p<.001). Specifically, the odds ratio for the age inequality coefficient is 1.25 (95% CI: 1.19, 1.32). With each one-unit increase in age inequality, a man's odds of having experienced physical violence are 1.25 times higher. The age inequality variable was created to increase as age decreases, thus the odds of having experienced physical violence are 1.25 times higher for those who are 56-65 years old compared to those 66 or older, while the odds of physical violence are 2.5 times higher for those who are 46-55. This means that the youngest men, aged 18-25, have 7.5 times higher odds of having experienced physical IPV than the oldest men, aged 66 and up.

The odds ratio for health status inequality is 1.17 (95% CI: 1.07, 1.27). For each one-unit increase in the health inequality variable, a man's odds of having experienced physical violence is 1.17 times higher. As an example, the odds of reported physical violence is 1.17 times higher for men who have only good or fair health, compared to those with very good or excellent health, while the odds are 2.34 times higher for those with poor health or who are disabled.

When taken together, the cumulative effect of inequality is also significant (β = .041, $p<.001$); meaning that although some variables of inequality are not significant on their own, inequality itself does have an additive effect ($x^2=365.04$, $df(2)$, $p<.001$). The odds ratio is 1.04 (95% CI: 1.02, 1.06), which is fairly sizable considering the inequality scale variable ranges in value from 7-26 for men in this sample. With each one-unit increase in inequality (higher scores representing greater inequality), men's odds of having experienced physical violence are 1.04 times higher. This means that those men at the top of the scale (score of 26) have odds of past physical IPV 19.76 times higher than those at the bottom of the scale (score of 7).

Lastly, the control variable, experiencing physical child abuse, which was the key risk factor determining physical violence from the previous chapter, remains significant even in the presence of the other variables (β = .434, $p<.001$). Specifically, with each one-unit increase in childhood victimization (ranging from 0-12), a man has 1.54 times higher odds (95% CI: 1.47, 1.62) of reporting physical IPV as an adult.

Model 2 – Sexual Violence

Sexual violence, as shown in the previous chapter, appears to be a very different kind of violence than physical. As you see in Table 3 (below), only education (β = -.239, $p<.001$) and income inequality (β = .260, $p<.01$) are related to men's experience of sexual violence ($x^2=128.01$, $df(7)$, $p<.001$). Note that education and income inequality did not impact men's experience of physical IPV.

Also interestingly, education and income inequality have an opposite relationship to the reported experience of sexual violence. With each one-unit increase in education inequality, a man's odds of having experienced sexual violence are .79 times lower (95% CI: 0.69, 0.90) than the education level prior. As education inequality was constructed so that greater numbers indicated less education, this means that the more education a man has, the lower his odds of having experienced sexual violence. For instance, men's odds, with a post graduate degree, of having experienced sexual violence are 1.27 times[3] higher than men's odds with a four-year degree, and 2.54 times higher than men's odds with only some college education.

[3] This number is obtained by dividing 1 by the odds ratio of .79, as the odds of success and failure are reciprocals of one another.

However, with each one-unit increase in income inequality, a man's odds of past sexual violence increases by 1.30 times (95% CI: 1.10, 1.53); i.e., the less money a man makes, the higher his odds of having experiencing sexual IPV. As an example, men's odds of past violence are 6.5 times higher when for those with no income or less than $5,000 a year (scale score of 6) compared to those men who make over $100,000 a year (scale score of 1).

Experiencing childhood physical violence was also significant ($\beta = .303$, $p<.001$). With each one-unit increase in childhood victimization, a man's odds of reported sexual violence are 1.35 times higher (95% CI: 1.27, 1.44).

However, unlike physical violence, there is not an additive effect of inequality on the past experience of sexual violence.

Table 3. Binary Logistic Regression Estimates for Men's Experiences of Same-Sex and Opposite-Sex Intimate Partner Violence

	Violence Type							
	Physical		Sexual		Emotional		Control	
Age Inequality	.223*** 1.250 .032		.057 1.059 .076		.150*** 1.162 .031		.144*** 1.155 .031	
Racial/Ethnic Inequality	.039 1.039 .079		.004 1.003 .201		.192** 1.211 .093		.575*** 1.778 .137	
Education Inequality	-.032 .968 .026		-.239*** .787 .055		.061* 1.062 .029		.170*** 1.186 .033	
Income Inequality	-.022 .979 .030		.260** 1.300 .109		.175*** 1.191 .038		.147*** 1.158 .038	
Employment Inequality	-.022 .978 .050		.084 1.087 .141		-.080 .923 .048		-.092 .912 .048	
Health Status Inequality	.153*** 1.166 .053		.063 1.065 .126		.158*** 1.172 .054		.112* 1.118 .052	
Childhood Victimization	.434*** 1.543 .037		.303*** 1.354 .043		.313*** 1.370 .029		.247*** 1.280 .024	
Inequality Scale		.041*** 1.041 .010		.035 1.036 .028		.117*** 1.125 .012		.155*** 1.168 .013
Constant	-9.40	-8.59	-11.15	-11.42	-11.81	-13.46	-16.02	-17.83
Wald $x2$	446.93***	365.04***	128.01***	105.55***	370.98***	342.33***	407.16***	360.15***
df	7	2	7	2	7	2	7	2
Observations	5295	5295	5295	5295	5050	5050	5050	5050

Notes:

1) The first number is the unstandardized coefficient, the second number if the odds-ratio, and the third number is the robust standard error.

2) The inequality scale variable was dropped because of collinearity in the full models, so it was re-run without any of the individual variables. The number reported reflects this.

3) The constant is expressed in terms of a *z* score.

* $p < .05$

** $p < .01$

*** $p < .001$

Model 3 – Emotional Violence

The regression estimates (see Table 3 above) indicate that emotional violence is related to all of the inequality variables except for employment (x^2=370.98, *df*(7), p<.001): age (β = .150,

$p<.001$), race/ethnicity ($\beta = .192$, $p<.01$), education ($\beta = .061$, $p<.05$), income ($\beta = .175$, $p<.001$), and health status ($\beta = .158$, $p<.001$).

Specifically, a man's odds of having experienced emotional violence in the past or being currently victimized are 1.16 times higher (95% CI: 1.10, 1.22) with each one-unit increase in age inequality (in this case, every 9 years younger than 66+); 1.21 times higher (95% CI: 1.04, 1.41) for non-White men than White men; 1.06 times higher (95% CI: 1.01, 1.12) with each one-unit increase in education inequality (thus, 1.06 times higher for those with only a four-year degree versus post-graduate work, but 6.36 times higher for those with no schooling); and 1.17 times higher (95% CI: 1.07, 1.28) with each one-unit increase in health inequality.

The inequality scale variable, taking into account the additive nature of inequality, is also significant ($\beta = .117$, $p<.001$), indicating that with each one-unit increase on the inequality scale, a man's odds of current or past emotional IPV are 1.12 times higher (95% C1: 1.10, 1.15).

The control variable, which could not be tested as a risk factor for emotional violence in the previous chapter, was also significant ($\beta = .313$, $p<.001$). For not only physical and sexual violence, but also emotional violence, childhood abuse victimization is significantly related to a man's odds of experiencing violence as an adult. In this case, for each additional instance of childhood abuse experienced, a man's odds of current or past emotional IPV are 1.38 times higher (95% CI: 1.31, 1.42).

Model 4 – Control Violence

Control violence, much like emotional IPV (see above), is related to all of the inequality variables except for employment ($x^2=407.16$, $df(7)$, $p<.001$): age ($\beta = .144$, $p<.001$), race/ethnicity ($\beta = .575$, $p<.001$), education ($\beta = .170$, $p<.05$), income ($\beta = .147$, $p<.001$), and health status ($\beta = .112$, $p<.001$).

Specifically, a man's odds of experiencing current or past control violence are 1.16 times higher (95% CI: 1.10, 1.22) with each one-unit increase in age inequality (for example, men aged 46-55 have odds 2.32 times higher than men 66+); 1.78 times higher (95% CI: 1.53, 2.09) for non-White men than White men; 1.19 times higher (95% CI: 1.12, 1.25) with each one-unit increase in education inequality (i.e., 1.19 times higher for those with only a four-year degree versus post-graduate work, and 7.14 times higher for those with no schooling); and 1.12 times higher (95% CI: 1.02, 1.22) with each one-unit increase in health inequality.

Similarly to emotional violence, the inequality scale variable (β = .155, $p<.001$) and the control variable (β = .247, $p<.001$), childhood abuse victimization (which could not be tested as a risk factor for control violence in the previous chapter), were both significant. A man's odds of experiencing control violence are 1.17 times higher (95% CI: 1.14, 1.19) for each one-unit increase in overall inequality, and 1.13 times higher (95% CI: 1.23, 1.33) for each one-unit increase in childhood physical abuse victimization.

Regression Analysis – Women

The second set of regression models analyzes not only the impact of inequality, but also of victim-perpetrator relationship on experiences of violence, specifically comparing women who experience physical and sexual violence to those who do not, and women who experience emotional and control IPV by a same-sex partner to those who do not. All referenced regression estimates can be found in Table 4 (below).

Model 1 – Physical Violence

The results of the regression indicated that all of the inequality variables, with the exception of income, are significantly related to physical violence (x^2=274.12, df(7), $p<.001$): while age inequality (β = .162, $p<.001$), race/ethnicity inequality (β = .256, $p<.01$), education inequality (β = .079, $p<.05$), employment inequality (β = -.182, $p<.01$), and health status inequality (β = .333, $p<.001$).

Interestingly, while age, race/ethnicity, education, and health status increase the odds of having experienced violence, employment inequality decreases the odds. A woman's odds of experiencing physical violence are 1.18 times higher (95% CI: 1.11, 1.25) with each one-unit increase in age inequality (in this case, every 9 years younger than 66+); 1.29 times higher (95% CI: 1.08, 1.54) for non-White women than White women; 1.08 times higher (95% CI: 1.01, 1.16) with each one-unit increase in education inequality (thus, 1.08 times higher for those with only a four-year degree versus post-graduate work, and 6.48 times higher for those with no schooling); and 1.39 times higher (95% CI: 1.25, 1.56) with each one-unit increase in health inequality.

However, with each one-unit increase in employment inequality a woman's odds of experiencing physical violence are .84 times lower (95% CI: .74, .94). This can be interpreted by

taking the inverse of the OR (1/.84)—women's odds of past physical IPV are 1.19 times higher for those employed full time compared to those employed part-time.

The cumulative effect of inequality is also significant (β = .069, p<.001), and is important to look at as it takes into account all of the inequality variables, and thus could act as a buffer between the increased odds of certain types of inequality and decreased odds of others. Overall, the additive effect of inequality is such that with each one-unit increase a woman's odds of having experienced violence are 1.07 times higher (95% CI: 1.04, 1.10). With values ranging from 6-25, this means that the odds of violence are 20.33 times higher for those women with the greatest inequality (score of 25) compared to those with the least inequality (score of 6).

The control variable, experience of childhood physical abuse victimization, remains significant (β = .360, p<.001), despite the significance of the other predictor variables. Specifically, with each one-unit increase in childhood victimization (ranging from 0-12), a woman's odds of physical IPV in adulthood is 1.43 times higher (95% CI: 1.36, 1.51).

Model 2 – Sexual Violence

Women experience sexual violence for very different reasons than men do. While education and income inequality are the only signifcantly related to men's sexual violence, this regression indicates that age (β = .169, p<.001), employment (β = -.154, p<.05), and health status inequality (β = .348, p<.001) effect women's experience of past sexual violence (x^2=308.64, df(7), p<.001).

Just as with women's physical IPV victimization, while age and health status increase the odds of violence, employment inequality decreases the odds of violence. Specifically, with each one-unit increase in age inequality a woman's odds of having experienced sexual violence are 1.18 times higher (95% CI: 1.10, 1.27). Likewise, with each one-unit increase in health status inequality, a woman's odds of having experienced sexual violence are 1.42 times higher (95% CI: 1.25, 1.61).

However, with each one-unit increase in employment inequality, the odds of experiencing sexual violence are .86 times lower (95% CI: 0.74, 0.99). When we examine the inverse, this means that the odds of past sexual violence are 1.16 times higher for women who are employed full time compared to part-time, and 2.32 times higher compared to the unemployed or otherwise not working.

Taken together, the cumulative effect of inequality, the inequality scale variable, is also significant (β = .054, p<.001). For each one-unit increase in the inequality scale, a woman's odds of past sexual IPV are 1.06 times higher (95% CI: 1.02, 1.09). As an example of the effect, the odds for those women with inequality scores around the average (14 points) are 8.48 times higher than women at the bottom of the inequality scale (score of 6 points).

The experience of childhood abuse is also significant (β = .352, p<.001). With an odds ratio of 1.42 (95% CI: 1.36, 1.49), women who have experienced 8 instances of child abuse (for example) have odds 9.94 times higher than those who experienced 1 instance of child abuse.

Table 4. Binary Logistic Regression Estimates for Women's Experiences of Same-Sex and Opposite-Sex Intimate Partner Violence

	Violence Type											
	All Women				Opposite-Sex				Same-Sex			
	Physical		Sexual		Emotional		Control		Emotional		Control	
Age Inequality	.162***		.169***		.054		.117***		-.125		.043	
	1.176		1.185		1.055		1.125		.883		1.044	
	.035		.043		.031		.034		.159		.194	
Racial/Ethnic Inequality	.256**		-.017		.176*		.517***		-2.00*		-1.69	
	1.291		.983		1.193		1.677		.136		.184	
	.115		.105		.108		.149		.131		.181	
Education Inequality	.079*		.023		.188***		.217***		-.115		-.120	
	1.082		1.023		1.207		1.242		.891		.887	
	.038		.042		.041		.044		.147		.153	
Income Inequality	-.019		.003		.040		.038		.144		.153	
	.982		1.003		1.041		1.039		1.55		1.166	
	.035		.044		.036		.037		.198		.200	
Employment Inequality	-.182**		-.155*		-.231***		-.148**		-.932*		-1.174*	
	.834		.857		.794		.862		.394		.309	
	.051		.062		.045		.050		.172		.173	
Health Status Inequality	.333***		.348***		.340***		.373***		-.195		-.329	
	1.395		1.417		1.404		1.452		.823		.720	
	.081		.093		.080		.082		.299		.277	
Childhood Victimization	.360***		.352***		.328***		.268***		.443***		.373***	
	1.433		1.422		1.389		1.307		1.56		1.452	
	.039		.033		.040		.032		.125		.112	
Inequality Scale		.069***		.054***		.091***		.135***		-.134		-.100
		1.071		1.055		1.095		1.144		.875		.905
		.014		.016		.014		.0154		.065		.067
Constant	-10.95	-10.36	-11.16	-11.11	-7.05	-7.93	-12,91	-13.04	-0.35	-2.51	-0.79	-3.15
Wald $x2$	274.12***	215.47***	308.64***	270.50***	231.01***	183.35***	293.18***	224.85***	52.21***	36.75***	45.85***	29.17***
df	7	2	7	2	7	2	7	2	7	2	7	2
Observations	3844	3844	3844	3844	3625	3625	3628	3628	1756	1756	2204	2204

Notes:

1) The first number is the unstandardized coefficient, the second number if the odds-ratio, and the third number is the robust standard error.

2) The inequality scale variable was dropped because of collinearity in the full models, so it was re-run without any of the individual variables. The number reported reflects this.

3) The constant is expressed in terms of a z score.

* p < .05

** p < .01

*** p < .001

Model 3 – Emotional Violence

The Fisher's *p* analysis indicated that women abused by women and women abused by men experienced emotional and control violence in significantly different ways, so the regression analysis of both emotional and control violence separated these two groups.

This analysis confirms the findings of the Fisher's test: race (β = .176, $p<.05$), education (β = .188, $p<.001$), employment (β = -.231, $p<.001$) and health status (β = .340, $p<.001$) inequality are important to women's experience of opposite-sex emotional violence; while only race (β = -2.00, $p<.05$) and employment (β = -.932, $p<.05$) are significant for same-sex emotional IPV.

Specifically, for women's experiences of emotional abuse by men, the odds for non-White women are 1.19 times higher (94% CI: 1.00, 1.42) than White women. Additionally, for each one-unit increase in education inequality, a women's odds of having experienced current of past emotional abuse by a man is 1.21 times (95% CI: 1.13, 1.29) higher, while each one-unit increase in health inequality increases odds by 1.40 times (95% CI: 1.26, 1.57).

Just as with women's experiences of physical and sexual violence, increased employment inequality decreases the odds of reported emotional IPV. With each one-unit increase in employment inequality, a woman's odds of current or past opposite-sex emotional abuse decreases by .79 times (95% CI: 0.71, 0.89).

For women's experiences of emotional abuse by women, we find different results. While non-White women were more likely to be abused by men than White women, the opposite is true for women abused by women; specifically, the odds for non-White women are .14 times (95% CI: 0.02, .0.90) lower. This means that while the odds of opposite-sex abuse was 1.19 times higher for non-White women, the odds of same-sex abuse was 7.14 times higher for White women.

The effect of employment inequality on same-sex emotional abuse, however, does mimic the effect on opposite-sex abuse; for each one-unit increase in employment inequality the odds of reported same-sex abuse are .39 times lower (95% CI: 0.17, 0.93).

Interestingly, the cumulative effect of inequality on emotional IPV (also important for men's experience of emotional abuse) is important for opposite-sex, but not same-sex emotional violence. For each one-unit increase in the inequality scale, women's odds of reported emotional IPV by men are 1.10 times (95% CI: 1.07, 1.12) higher.

Childhood physical abuse victimization remains significant for both opposite-sex and same-sex emotional IPV. For each one-unit increase in childhood abuse victimization, women's odds of experiencing emotional abuse by men are 1.39 times (95% CI: 1.31, 1.47) higher, while womens odds of experiencing emotional abuse by women are 1.56 times (95% CI: 1.33, 1.82) higher.

Model 4 – Control Violence

Similar to emotional violence, women's experience of opposite-sex control violence is different than same-sex control violence. Opposite-sex control IPV is related to all inequality indicators except income, while same-sex control IPV is only related to employment inequality ($\beta = -1.17$, $p<.05$).

Specifically, for women abused by men, age ($\beta = .117$, $p<.001$), race ($\beta = .517$, $p<.001$), education ($\beta = .217$, $p<.001$), and health ($\beta = .373$, $p<.001$) inequality all increase the odds of current or past control violence, but employment inequality ($\beta = -.148$, $p<.01$) decreases the odds. Control violence is 1.12 times (95% CI: 1.06, 1.19) higher with each one-unit increase in age inequality; 1.68 times (95% CI: 1.41, 2.00) higher for non-White women than White women; 1.24 times (95% CI: 1.16, 1.33) higher for each one-unit increase in education inequality; and 1.45 times (95% CI: 1.30, 1.62) higher with each one-unit increase in health inequality.

For both women abused by men and women abused by women, increased employment inequality decreases the odds of having experienced control violence. For opposite-sex IPV, the odds of current or past control violence are .86 times (95% CI: 0.77, 0.97) lower for each one-unit increase in employment inequality; while the odds of control violence are .31 times (95% CI: 0.10, 0.93) lower for same-sex IPV. When interpreted as the inverse, the odds of having experienced opposite-sex control violence is 1.16 times higher for those who are employed full time over part-time, and the odds of having experienced same-sex control violence is 3.23 times higher for employed full-time versus part-time workers.

Just as with emotional violence, the additive effect of inequality on control IPV is significant for opposite-sex, but not same-sex violence. For each one-unit increase in the inequality scale, a woman's odds of having experienced emotional IPV by a man is 1.41 times (95% CI: 1.11, 1.17) higher.

Lastly, the control variable, childhood abuse victimization, is significant for both opposite-sex and same-sex control violence. For each one-unit increase in childhood abuse victimization, a woman's odds of experiencing control abuse by a man is 1.31 times (95% CI: 1.25, 1.37) higher, while a woman's odds of experiencing control abuse by a woman is 1.45 times (95% CI: 1.25, 1.69) higher.

Discussion

The findings in this analysis highlight both the impact and the variability of power and inequality on intimate partner violence, even despite the significant impact of childhood physical abuse victimization—laid out in the previous chapter as a significant risk factor for violence and confirmed here as well. Most of the results—albeit without knowing the specific dynamics of the violent relationships the victims had with the perpetrators—point to a social exchange explanation: those with less power experience violent victimization; as inequality increases, violence is more likely.

To start, we see that age and health status are among the most common predictors of any form of violence for any individual. For men, age and health status significantly predicted physical, emotional, and control violence; and for women, age and health status significantly predicted physical, sexual, and opposite-sex emotional and control violence. Being in the youngest age group (18-25) can increase an individual's odds of experiencing violence by 62.5% or more, while poor health or disability can increase odds by up to 108.6%.[4]

But, many other factors were significant—just sometimes only for men, or only for women, or not for women abused by a same-sex partner at all. For example, while income inequality significantly increases a man's odds of sexual, emotional, and control IPV, it is not a significant predictor of any form of violence against women. With each decrease in level of income, a man's odds of experiencing these forms of violence goes up by 15-30%—for women, there is no effect.

Education and race/ethnicity almost always had the same effect on violence--non-White men and less educated men had higher odds of emotional and control violence than White men

[4] OR–1* 100 = percent change. In the case of age, the smallest odds are 1.125 (opposite-sex control violence). 1.125-1*100 = 62.%, or the minimal percent change because of age inequality for any form of violence.

and more educated men, while non-White women and less educated women had higher odds of physical violence and opposite-sex emotional and control IPV.

Employment inequality is the only inequality indicator that had the opposite effect of what would be expected within a social exchange framework (and only for women—employment inequality was not a significant factor for violence against men): the odds of experiencing every single form of violence as a woman, no matter the perpetrator, increases for those with greater power, rather than less. In this analysis, women working full time have 48-78% (opposite-sex) and 462-672% (same-sex) lower odds of experiencing violence than women who are unemployed or otherwise not working. This type of relationship to violence indicates support for power resources theory: those with more power experience violent victimization; as inequality decreases, violence is more likely.

Despite employment inequality indicating a converse effect for women (employment inequality was not significant for any form of violence against men), the inequality scale variable—designed to take into account the additive, or cumulative, effect of inequality from all possible sources—was still significant for most forms of violence against women: physical, sexual, and opposite-sex emotional and control. This means that even though employment inequality acted in the opposite manner of the other inequality indicators, it did not negate the overall effect of inequality on intimate partner violence. What's more, the inequality scale was significant for men's experience of physical, emotional, and control IPV.

Perhaps one of the most interesting findings lies in the results that men's experiences of same-sex violence and opposite-sex violence are so similar, while women's experiences of same-sex and opposite-sex violence are so different. The *t*-tests indicated that men's experiences of violence were so similar, on average, that they could be categorically merged; but the results of the *t*-tests for women guided me to keep them separate when examining emotional and control violence. And indeed, the results of the regression indicate that aside from employment and race/ethnicity, no other inequality indicator is significant for same-sex emotional or control IPV (very much unlike women's opposite-sex emotional and control IPV). What's more, race/ethnicity inequality actually works in the opposite way for same-sex and opposite-sex violence. Non-White women have 19% higher odds of experiencing opposite-sex emotional IPV

than White women, and 635%[5] lower odds of experiencing same-sex emotional IPV. There is, in fact, no single inequality indicator that increased a woman's odds of same-sex emotional or control violence—the only type of violence in which this is true.

It's important to point out, then, that physical, sexual, and emotional/control violence are three very unique and different types of violence—and not just between groups (i.e. between men and women, or between opposite-sex and same-sex), but also within the same group of men. When taking into account the inequality indicators separately, only young age and negative health status increased men's odds of physical violence, while young age, minority race/ethnicity, lower income and negative health status increased men's odds of both emotional and control violence. Only lower income increased men's odds of sexual violence; less education actually decreased men's odds of sexual violence, and was the only inequality indicator for any violence against men to decrease odds. When taken together, the increased odds based on income, but decreased odds based on education level, meant that the inequality scale did not significantly effect men's sexual violence victimization.

When taking into account the inequality indicators separately for women, young age, minority race/ethnicity, less education, and negative health status increase the odds of physical violence; while only young age and negative health status increase the odds of sexual violence. In this way, physical violence against men is most comparable to sexual violence against women, while sexual violence against men is most comparable to physical violence against women. And, much like emotional and control violence against men (odds increase because of every inequality indicator except employment), the odds of opposite-sex emotional and control violence against women increase because of every inequality indicator except income and employment.

Lastly, there may just be an interesting story happening in this analysis about gender after all—while lower levels of income increased men's odds of experiencing violence, income level was never a factor for violence against women. This finding directly contradicts arguments made for increasing women's economic standing as a way to decrease violence against them (great income did not decrease the likelihood of violence). In fact, if anything, this analysis points to

[5] This finding is due to the fact that only 4 out of 44 (9%) of women who experienced same-sex emotional violence were non-White, while 27.6% of women who experienced opposite-sex emotional violence were non-White. The direction and degree of the results regarding non-White women's experiences of violence are overemphasized; it is, in essence, a small *N* issue. The same can be said for the effect size of employment inequality on same-sex emotional and control violence.

the importance of income equality for men and their experiences of violence, as men in poverty had much higher odds of experiencing most forms of violence.

Likewise, employment inequality actually decreased women's odds of experiencing violence, but employment was never a factor for violence against men. In this way, we could say that women's not working in the paid labor force, and thus adhering to traditional gender norms/expectations, mitigates their experiences of violence for other reasons; while men's employment in the paid labor force—the adherence to traditional gender norms for men—is so expected of men, and was the norm within this sample, that it did not impact men's experience of violence.

Conclusion

This chapter set out to expand the previous analysis of power, inequality, and violence. Chapter Four assessed adult lifetime risk of physical and sexual violence based on risk factors outlined by the academic and public health sectors: problems related to the individual (psychology), relationship, community, or society. However, as the theoretical framework for violence between intimates is rooted in patriarchy, the public health sector sees social level power and control as sourced from hostile cognitions or attributions about women and belief in or adherence to "traditional gender norms" (see Capaldi, Knoble, Shortt, and Kim, 2012; CDC). Thus, Chapter Four constructed power and control from answers to "what started or triggered this incident," that indicated that the violence was caused by the partner's need for control or victim obedience, the need to "be a man," and responses that indicated the victim "asked for it." But as noted before, this construction overlooks the array of literature that indicates power in relationships occurs for reasons beyond just gender (see Goode, 1971 for an overview on how social inequalities influence individual actions and interactions between individuals).

This analysis expanded the scope of not only the previous chapter, but much of the previous literature on intimate partner violence, by directly testing multiple sources of an individual's power or inequality—instead of relying on gender; by explicitly studying opposite-sex and same-sex *intimate partner* violence—instead of examining lifetime risk by non-intimate partners such as family members and acquaintances, or IPV experienced by LGB individuals regardless of the sex of their intimate partner (i.e. a self-identified lesbian who experiences violence by a previous male intimate). Moreover, this analysis was able to separate and study

emotional and control violence, often treated as a non-unique form of violence (a type of violence that precedes physical or sexual IPV), or left out of the discussion entirely.

However, there were limitations. The largest is the non-diverse sample of victims of violence, specifically with regard to race/ethnicity, age, and gender identity. In this study, around 77% of abused men and women abused by men, and 92% of women abused by women, were White.[6] The median age of abuse victims is 40 years old.[7] What's more, this survey does not ask questions related to gender (masculine, feminine, other) or gender identity (cisgender, transgender, other), only biological sex (male or female). While none of these facts make this sample unrepresentative of the population as a whole, they do effect the results regarding intimate partner violence. The 2012 National Coalition of Anti-Violence Programs 2012 *Report on Intimate Partner Violence in Lesbian, Gay, Bisexual, Transgender, Queer and HIV-Affected Communities in the U.S.* found that "people of color made up the majority (62.1%) of intimate partner violence survivors…" while "youth and young adults were close to two times (1.8) as likely to face anti-LGBTQ bias in IPV tactics as compared to non-youth…" and "transgender survivors were two (2.0) times as likely to face threats/intimidation within violent relationships, and nearly two (1.8) times more likely to experience harassment within violent relationships."

Another limitation is that this analysis did not study the relationship between the victim's inequality and the perpetrator's inequality. This is potentially problematic, as both power resources and social exchange theory understand violence as a result of not only the presence of power or inequality within one individual, but also the presence of power dynamics within relationships or between two people. Specifically, social exchange theory (which I argue garners the most support in this chapter), views violence as the result of first, the social structural conferring of power to certain individuals rather than others (i.e. to the rich vs. the poor); and second, the powerful individuals' reification of that structural power over a specific intimate partner, within a relationship. Because this chapter focused on all previous violent intimate partners, and the survey only asked about demographic characteristics of the current partner,

[6] A 1995 supplement to the Current Population Survey (CPS) indicated that the percentage of people identifying as White was 75.22% when Hispanic was included in the list of racial categories, and 79.81% when Hispanic origin was a separate question. In the NVAWS (1995-1996), Hispanic/Latino is a separate question, and as such the racial diversity of this sample is comparable to 1995 levels. However, according to the 2010 U.S. Census, approximately 63.7% of the population is now White; with estimates indicating that by 2060 less than 50% of the population will be White, non-Hispanic.

[7] Average age shown in table for purposes of *t*-tests; average age was 53-57 years. The 2010 Census indicates the median age in the U.S. is 36.8 years. Thus, the median age in this sample is comparable.

there is no way of knowing whether or not victim and perpetrator had differing or similar levels of social inequality.

What this chapter does find, though, is that gender alone does not account for the totality of violence individuals experience at the hands of their partners. For example, the previous chapter indicated that gender-normative related power was the most significant risk factor for all forms of sexual IPV, including sexual IPV against men by women; this chapter highlights that the source(s) of perpetrators' negative thoughts towards victims (i.e. demanding or forcing obedience; needing or having the right to control; because they victim "asked for it" or "wanted it") are not solely rooted in gender. Specifically, if we take a social exchange perspective, we find the source of such beliefs could be rooted in the victim's young age, poor health, and/or poverty/low income.

Additionally, for women abused by men, the previous chapter found that, instead of socially gendered beliefs, the victim's young age and experience of physical abuse as a child were the most significant risk factors for experiencing physical abuse. In this chapter, when we introduce the other sources of power and inequality, we find that in addition to young age and child abuse victimization still being significant, now so is minority race/ethnicity, low levels of education, and poor health status. Inequality is important, despite the predictive significance of age and child abuse.

In sum, this chapter opens the door to new frameworks for studying intimate partner violence in the future. Based on these findings, I suggest that future research acknowledge 1) the complexity and variability of multiple forms of power and inequality, not just gender and patriarchy, specifically within relationship contexts; 2) the unique and separate instances of physical vs. sexual vs. emotional and control violence; and 3) the need for more knowledge and information on intimate partner violence against young LGBTQ men and women of color.

In the chapter that follows, I highlight why continued research is necessary by examining how the predictors of violence within this chapter (the "causes" of violence; i.e. inequality indicators) impact health and are tied to healthcare-seeking behaviors (the "consequences" of violence).

Appendix A. Tables

Table 1. Descriptive Statistics for Intimate Partner Violence Outcome Variables

		Percent Experienced	Mode	Minimum	Maximum	N
Physical IPV	Men	14.5%	0	0	1	526
	Women	40.6%	0	0	1	1434
Sexual IPV	Men	0.6%	0	0	1	20
	Women	14.5%	0	0	1	512
Emotional IPV	Men	85.0%	1	0	1	3081
	Women Abused by Women	88.0%	1	0	1	44
	Women Abued by Men	85.8%	1	0	1	2988
Control IPV	Men	81.6%	1	0	1	2598
	Women Abused by Women	82.0%	1	0	1	41
	Women Abued by Men	64.8%	1	0	1	2257

Notes:
1) Total sample is 6,000 men and 6,000 women. Only those who answered all relevant questions are included in this table.

VI. The Health-Related Consequences of Inequality and Intimate Partner Violence

This dissertation project argues, largely, for the continued (and hopefully increasingly more consistent) research on intimate partner violence. Chapter Five highlighted the importance of statistically analyzing, with a nationally-representative sample, the theoretical risk factors, purported by public health and political agencies as related to the experience of IPV—individual (psychological), relationship, community, and social (mostly: adherence to traditional gender norms or presence of gendered beliefs about women—i.e., men have the right to abuse and control women). When examined closely, the most important risk factors vary depending on the sex/gender of the perpetrator and sex/gender of the victim, and also what form of violence (physical or sexual) is being studied. Chapter Five underscored the importance of including other sources of power and control, and other forms of violence, in our studies of IPV. Specifically, Chapter Five illuminated the complexity and variability of violence—it is not a uniform experience for men and women, and not every form of IPV happens for the same reasons.

This chapter is an attempt to underscore the importance of expanding understandings of intimate partner violence. Between 1989-1996, multiple agencies both domestic (American Medical Association) and international (World Health Organization) began a campaign to end violence against women, because violence against women was a "public health problem" and health care's "silent epidemic" (document WHO/EHA/SPI.POA.2; Schornstein, 1997). What has resulted is an ever-increasing body of literature on the negative health outcomes of (mostly) physical and sexual IPV on women abused (mostly) by men. This body of literature exposes a grim reality for many women: victims of physical and sexual intimate partner violence suffer higher levels of both acute and chronic physical health problems than those who are not abused (R. Campbell & Wasco, 2005; Ann L Coker et al., 2002; Fischbach & Herbert, 1997; Stacey B Plichta, 2004; Porcerelli et al., 2003; Wolkenstein & Sterman, 1998).

Among the negative health outcomes studied are increased mortality, injury and disability, problems with general health, chronic pain, obesity, substance abuse, reproductive disorders, sexually transmitted diseases, vaginal bleeding, and poorer pregnancy outcomes (J. C. Campbell, 2002; Hellen Y Huang, Wei Yang, & Stanley T Omaye, 2011; Kovach, 2004;

McCauley et al., 1995; McFarlane et al., 2005; Stacey B Plichta, 2004). Moreover, women physically and sexually abused by men are more likely to sustain acute injuries to the head, face, neck, breasts, or abdomen, which can lead to chronic conditions such as headaches, migraine, and constant pain (Campbell, 2002; Kovach, 2004). In terms of psychological health and emotional well-being, studied have found higher than expected levels of depression and post-traumatic stress disorder (PTSD) (J. C. Campbell, 2002; Ann L Coker, et al., 2002; Dienemann et al., 2000; Dutton et al., 2006; Houry, Kaslow, & Thompson, 2005; Jones, Hughes, & Unterstaller, 2001; Stein & Kennedy, 2001).

Studies conclude: these health outcomes lead to women abused by men constituting a significant proportion of female patients seeking emergency medical services, obstetric care, and primary medical care (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; Koziol-McLain et al., 2004). In quantifiable terms, for only women abuse by men, this equates to approximately $8.3 billion a year for medical care, mental health services, and lost time from work due to injury and death (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004). And although half of the women abused by men report a physical injury, only around 4 in 10 of these women seek medical health assistance (Rennison & Welchans, 2003).

For men victims of IPV and women abused by women, the health-related outcomes of violence have not been well documented. For example, even though the California Health Interview Survey (2007 and 2009) and the Centers for Disease Control and Prevention's (CDC) National Intimate Partner and Sexual Violence Survey (NISVS 2013) released detailed reports on same-sex victimization, this data has yet to be used to examine health disparities related to violence in relationships—and has yet to be publicly released for such examination by scholars and activists.

Although "the short and long-term effects of domestic violence are health care issues that nearly every practicing physician encounters in the course of routine clinical practice" (Alpert, 1995), no study using a representative, probability sample has assessed whether or not there are disparities in negative health outcomes and/or disparities in health care/medical service utilization between those abused by a same-sex partner and those abused by an opposite-sex partner after an experience of violence. This analysis examines these very issues: first by comparing negative health outcomes (physical and psychological) of violence, and second by

examining the medical and psychological health care seeking and utilization behaviors, controlling for injuries suffered.

Research Objectives

I revisit this project's three major analytical queries from Chapter Two (pages 55-56):

1. Does queered intimate partner violence occur for similar or different reasons than heteronormative intimate partner violence?
2. If so, can sex/gender explain these differences exclusively, or are other sources of power and inequality important?
3. What are some of the consequences of studying IPV from the current popular framework?

This chapter aims to answer the third and final major query.

What We [Don't] Know About Health and IPV

In general, we know that women victims of intimate partner violence are less likely to receive needed medical services and more likely to report having a poor relationship with their health care provider (Stacey Beth Plichta, 2007). This stems mostly from the health care system's inconsistent response to IPV; most health care systems are not equipped to assist either victims or the providers seeking to help the victims (Fugate, Landis, Riordan, Naureckas, & Engel, 2005). Only one study has assessed health disparities between same-sex and opposite-sex IPV using population-based data. Blosnich and Bossarte (2009) found that those abused by a same-sex partner do not suffer perceived physical or mental health effects significantly more often than women abused by men—instead, an overwhelming majority of all victims report low satisfaction with life (85% for same-sex violence, 85.8% for women abused by men), poor perceived health (79% for same-sex, 77% for women abused by men), and almost half report more than 7 poor mental health days a month (44.6% for same-sex, 33.7% for women abused by men).

There are specific concerns that we must take into account when examining same-sex IPV, however. Qualitative studies confirm that in addition to the health care system itself, social, political, and cultural barriers also keep victims of same-sex IPV from seeking help, which leads to the "double closet" – feeling the need to keep secret not only one's sexual orientation or

intimate relationships, but also the abuse and trauma they are experiencing (McClennen, 2005; St Pierre & Senn, 2010). Findings from discussions with advocates and health care professionals in New York City showed that the health care environment is heterosexist[1] and gender-normative.[2] Providers lack knowledge about health disparities affecting LGBT people; LGBT individuals experience hostility and discrimination in care; and concerns about homophobia and transphobia keep LGBT individuals from using health care services (Grant et al., 2010).

The social stigma surrounding "alternate" sexualities and relationships (Poorman, Seelau, & Seelau, 2003) also produces several large structural problems that prevent the primary care system from being able to adequately meet the mental health needs of LGBT youth and adults. These include: lack of LGBT-specific training for health care providers (in schooling or mandatory employee workshops), lack of financial incentives to treat LGBT youth (who, say, may not have health insurance or do not want to use their parent's), a failure to deal with the intersection between mental health and substance abuse issues, and a general lack of information about LGBT health needs (Eliason, Dibble, Gordon, & Soliz, 2012; Winter, 2012).

This lack of training and "cultural competence" may cause care providers to misdiagnose or underestimate the extent of emerging disorders in the LGBT population (Ida, 2007; Logie, Bridge, & Bridge, 2007). Poorly trained medical practitioners may even make the mistake of viewing homosexuality and gender nonconformity as illnesses that can be overcome with appropriate "reparative" therapy, further amplifying the trauma that these men and women experience everyday because of perceived LGBT status (Dean et al., 2000; Haas et al., 2010).

Men abused by women face special concerns, also. Cronholm (2006) argues, "The medical model of IPV has historically been limited to male perpetration of IPV against female victims in heterosexual relationships." While heterosexual men may benefit socially, politically, and culturally from a general masculine privilege, it is precisely this masculinity that keeps some of them from reporting their opposite-sex abuse victimization to their health care providers. For instance, a recent study found that men are more likely than women to suffer serious injuries in intimate partner relationships (Felson & Cares, 2005); and Laroche (2005) reports that of the

[1] "Heterosexism" describes "an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship or community." Gregory M. Herek, "The Context of anti-gay violence: Notes on cultural and psychological heterosexism, "*Journal of Interpersonal Violence*, No. 5, pp. 316-333. http://psychology.ucdavis.edu/rainbow/html/prej_defn.html#Herek90_txt

[2] Here, the term describes an environment in which individuals' "gender identity [is expected to] correspond to their birth-assigned sex and/or stereotypes associated with that sex." 2005. Transgender Law Center, "10 Tips for Working with Transgender Individuals. A guide for health care providers." www.transgenderlawcenter.org

"unilaterally terrorized men" in the Canadian General Social Survey data, 84% received medical care (the same rate as for terrorized women), and 62% sought psychological counseling (63% for women). But, the qualifications for "terrorism" in this context is severe physical violence. What happens when the violence is not physical?

Coker and colleagues (2002) noted that, with very few "exceptions, the majority of past studies addressing the health effects of IPV measured physical assaults alone without considering the co-existing chronic psychological abuse characteristic of violent relationships." Utilizing the same survey as this project (the NVAWS), Coker et al. (2002) extended prior analyses, and determined that men who reported being victims of physical abuse, reported increased risk of current poor health, depressive symptoms, substance use, a chronic disease, chronic mental illness, and injury. Moreover, psychological abuse increased the odds of current poor health, and sexual IPV was associated with the reporting of current chronic disease. However, this study did not examine IPV within the context of the gender of perpetrator—in essence, all men regardless of who abused them were grouped together. While Chapter Five determined that men's experiences of violence were similar, regardless of the victim-perpetrator relationship, it has not yet been determined whether or not men abused by women and men abused by men suffer similar negative health outcomes.

Methods

This study employs both descriptive and inferential statistical techniques using Stata/SE 13 quantitative data analysis software for large datasets. First, measures of central tendency and measures of variation were calculated to summarize and describe the various health-related outcomes of violence and health care seeking behaviors following injuries.

This study then conducts a *t*-test analysis to compare individuals abused by opposite-sex partners to individuals abused by same-sex partners to determine if there are significant differences in who is negatively effected by intimate partner violence and/or who accesses health care following victimization for physical and psychological injuries suffered.

Fisher's Exact Tests for small frequencies are then conducted to determine similarities and differences between groups (opposite-sex relationships and same-sex violence) in terms of health-related outcomes and health care seeking behaviors (Stevens, 2002)— specifically, this

study tests whether or not the inequality indicators described in Chapter Five impact negative health outcomes and health care seeking behaviors.

Lastly, this study conducts binary logistic regression models, assessing the effect (degree and direction) of the inequality indicators (i.e. age, race, income and so on) on the negative health outcomes and health care seeking behaviors in order to answer the question: is the effect of inequality on negative health outcomes/health care seeking the same for both those abused by a same-sex partner and those abused by an opposite-sex partner? Each regression model predicts health and/or health care seeking as a function of inequality.

Dependent Variables

Just as with Chapter Five, this analysis examines physical, sexual, emotional (which includes verbal abuse), and control violence. For a more detailed understanding of what is considered physical, sexual, emotional, and/or control violence see Chapter Three (pages 62-64).

However, as this analysis seeks to better understand the health-related effects of intimate partner violence on individuals and their health care seeking behaviors, new dependent variables were constructed following from these violent contexts.

Physical Health Outcomes. To measure physical health-related outcomes, variables were constructed that took into account the specific injuries received from the reported physical or sexual violence. Specifically, an individual was included as having experienced a physical injury following physical violence if they responded yes to the question, "Were you physically injured during this incident," and/or reported specific injuries such as broken bones, scratches, bruises, being knocked unconscious, or suffered such outcomes as a miscarriage or spinal cord injury (there were 15 separate possible outcomes and each of these outcomes had a handful of related physical injuries listed).

Following sexual violence victimization, individuals were included as suffering physical injuries if they responded that they got pregnant from the victimization and had an abortion or miscarriage following, if they contracted a sexually transmitted infection from the victimization, if they responded yes to the question, "Were you physically injured during this incident," and/or reported specific injuries such as broken bones, scratches, bruises, being knocked unconscious, or suffered such outcomes as a miscarriage or spinal cord injury (there were 15 separate possible outcomes and each of these outcomes had a handful of related physical injuries listed—these

groupings and the descriptions provided in the codebook were the same as for physical violence victimization health outcomes).

Psychological Health Outcomes. If, following physical or sexual violence victimization, the individual reported that the injury they sustained was "psychological, emotional stress" they were included as suffering a psychological health outcome. Additionally, any individual that reported violence from a current spouse or partner was able to complete a post-traumatic stress disorder inventory[3]. This PTSD inventory measured the stressful and depressive thoughts experienced by the individual within the last seven days.

Health Care Seeking Behaviors. To measure health care seeking behaviors, variables were constructed to indicate if a person sought out medical care, emergency services, or surgery for their physical injuries or psychological counseling/treatment (via licenses practitioner or conversations with a crisis hotline, victim's advocate, or support group) for their psychological injury or emotional stress. Additionally, if an individual reported that they have received counseling for the emotions and feelings described in the PTSD Inventory, they were included as having sought health care services. Due to limitations with the survey, this analysis can only examine health care seeking behaviors that directly follow physical and sexual violence, or the current intimate partner violence (physical, sexual, emotional, control, stalking, or threats—undistinguished from one another).

Independent Variables

Just as with Chapter Five, this analysis uses the "inequality indicators" age, race/ethnicity, education level attained, income level, and work status. Health status was left out of this analysis because of the inability to distinguish cause-effect (the question regarding health does not account for the negative perceived health status being a possible result of past IPV instead of a cause of it). Summary statistics can be found in Chapter Four, Appendix A, Table 1 (see page 91).

In addition to the scale variable for an individual's inequality (a combination of their age, race/ethnicity, income, education level, and employment status) previously used in Chapter Five (see page 99-100), this chapter also includes an inequality scale variable that compares a

[3] Questions in the PTSD Inventory were adopted from the Impact of Event Scale developed by Daniel Weiss, San Francisco VA Medical Center, 4150 Clermont Street, San Francisco, CA 94121.

person's inequality to their current partner's for the current victimization violence assessment (current emotional, control, physical, sexual, stalking, or general threats of violence). For each variable, the person's score was subtracted from their partner's and then transformed to be from 0-100, so that there were no negative values. As an example, the age variables were scaled 1-5 (to represent ages 18-25 and then10-year intervals until 65 and up). If a person was 20, they would have a score of "6." If this same person has a current violent partner who is 34, their partner would also have an age score of "6." Thus, the difference between their ages would be "0."

A variable was constructed that totaled all of these differences (from age, race/ethnicity, income, education level, and employment status). When transformed, scores of "0", or no differences between you and your partner, are anchored at 50, the midpoint of the 0-100 scale. Differences between partners that were originally negative (indicating you have more power than your partner) are thus located between 0-49, and differences that were positive (indicating you have less power) are now between 51-100. Descriptive statistics can be found in Appendix A, Table 1 at the end of this chapter.

It should also be noted that taking out health status from the individual inequality scale changed the possible minimum and maximum scores; now that there are only five variables, the minimum score is "5" and the maximum score is "25." For women abused by men, the range is now 7-23; for women abused by women: 8-19; for men abused by women 6-22; and for men abused by men: 8-21.

Descriptions of the coding and construction of the individual inequality variables can be found in Chapter Five (see page 99-100).

Results

In line with previous literature and the myriad physical and mental health outcomes of intimate partner violence, this analysis finds that around half of all women (see Table 1 below) report having physical injuries from physical and/or sexual violence. Physical injuries that were reported included, but were not limited to, pregnancy-related outcomes (unwanted pregnancy, abortion), sexually transmitted diseases, spinal cord injuries, bullet wounds, burns, internal injuries.

Interestingly, very few women report negative psychological effects following sexual and physical violence (see Table 1 below). Specifically, no women abused by women report psychological distress following violence, and only 1.3-2.2% of women abused by men report that the injury they sustained following IPV was psychological or emotional in nature.

The findings from the post-traumatic, life stress inventory highlight the effect of experiences of violence within the current relationship. There were 20 questions, with possible values ranging from "1" (not at all) to "4" (quite a bit); meaning that any women with a score over 20 reported at least one negative emotional/psychological experience related to their current victimization. Almost 90% of women abused by men, and 100% of women abused by women scored over 20 on the PTSD inventory (see Table 1 below). The maximum score was 79 for opposite-sex IPV, and 57 for same-sex IPV, both out of possible 80 points.

Table 1. Health and Mental Health-Related Effects of Intimate Partner Violence for Women

			Percent Experienced	Mode	Minimum	Maximum	N
Physical Violence	Physical Injuries	Opposite-Sex	43.7%	0	0	1	1306
		Same-Sex	45.0%	0	0	1	20
	Psychological Stress	Opposite-Sex	1.3%	0	0	1	828
		Same-Sex	0.0%	0	0	1	14
Sexual Violence	Physical Injuries	Opposite-Sex	37.7%	0	0	1	504
		Same-Sex	62.5%	0	0	1	8
	Psychological Stress	Opposite-Sex	2.2%	0	0	1	360
		Same-Sex	0.0%	0	0	1	5
Current Victimization	PTSD Inventory	Opposite-Sex	88.2%	21	1	79	329
		Same-Sex	100.0%	---	22	57	3

Notes:
1) Mode 0=no injury(ies), mode 1=injury(ies)
2) The PTSD Inventory has a possible range of 1 (for no stress/depression reported) to 4 (for maximum amount of stress/depression reported), for each of 20 total questions. Percent experienced represents the total number of people who scored 20+ on the scale.
4) All individuals in the survey reported some level of stress related to violence in their current relationship, even if just by answering one question.
5) Sample size varies depending on how many individuals answered the questions. For all variables, non-responses were coded as missing ("."). *N* represents the total number of individuals abused who reported having or not having injuries.

Men experience somewhat similar trends in reporting injury and emotional distress, though with less frequency than women (see Table 2 below). Between 12-28% of men abused by

women, for instance, report physical injury following physical or sexual violence; and between 33-42% of men abused by men report such injuries. This makes the injuries suffered by men in same-sex relationships more comparable to women abused by men, but not as high as the injury rates reported by women in same-sex relationships.

As with women, men are also very unlikely to report psychological trauma following abuse (see Table 2 below). No men report psychological distress following sexual assault and intimate rape, and only 0.2% of men abused by women report such injury following physical violence. However, 7.1% of men abused by men report that the injury they suffered following physical abuse was psychological in nature.

Lastly, almost 100% of men abused by women, and over 70% of men abused by men reported some level of PTSD from their current violent relationships (see Table 2 below). Out of a possible 80 maximum points, the highest score for this inventory was 70 for men in opposite-sex relationships and 37 for men in same-sex relationships (only slightly lower in comparison to women: 79 for women in opposite-sex relationships and 57 for women in same-sex relationships).

Table 2. Health and Mental Health-Related Effects of Intimate Partner Violence for Men

			Percent Experienced	Mode	Minimum	Maximum	N
Physical Violence	Physical Injuries	Opposite-Sex	28.1%	0	0	1	499
		Same-Sex	42.1%	0	0	1	19
	Psychological Stress	Opposite-Sex	0.2%	0	0	1	432
		Same-Sex	7.1%	0	0	1	14
Sexual Violence	Physical Injuries	Opposite-Sex	11.8%	0	0	1	17
		Same-Sex	33.3%	0	0	1	3
	Psychological Stress	Opposite-Sex	0.0%	0	0	1	15
		Same-Sex	0.0%	0	0	1	2
Current Victimization	PTSD Inventory	Opposite-Sex	99.4%	21	12	70	153
		Same-Sex	71.4%	---	4	37	7

Notes:

1) Mode 0=no injury(ies), mode 1=injury(ies)

2) The PTSD Inventory has a possible range of 1 (for no stress/depression reported) to 4 (for maximum amount of stress/depression reported), for each of 20 total questions. Percent experienced represents the total number of people who scored 20+ on the scale.

4) All individuals in the survey reported some level of stress related to violence in their current relationship, even if just by answering one question.

5) Sample size varies depending on how many individuals answered the questions. For all variables, non-responses were coded as missing (“.”). *N* represents the total number of individuals abused who reported having or not having injuries.

The Fisher’s *p* test for differences between groups (see Tables 2 and 3 in Appendix A) reveals that there are no significant differences in the reporting rates of injuries or PTSD between women abused by women and women abused by men or between men abused by women and men abused by men. Likewise, there is no significant difference in reporting rates between women and men abused by same-sex partners (see Table 4, Appendix A), but there is a significant difference between men and women abused by opposite-sex partners in physical injuries following physical and sexual IPV and psychological trauma following physical violence—in this case, women suffer injury more often than men (see Table 5 in Appendix A).

Table 3 (below) details that on average, women are more likely to seek out both medical and psychological care for sexual IPV than physical. Following physical violence, 11% of women abused by same-sex partners and 30.9% of women abused by opposite-sex partners seek out medical care; following sexual violence 40% of women abused by same-sex partners and 33% of women abused by opposite-sex partners seek care. One quarter of women abused by same-sex partners seek out psychological care after physical violence, but three quarters seek it

out following sexual violence. For women abused by opposite-sex partners, the rates for psychological care are between 27-34%.

For those women who are experiencing intimate partner violence by their current opposite-sex partner and reported some level of PTSD because of that violence, only 17.6% sought counseling. Only one woman, out of three, abused by a same-sex partner admitted seeking care. This is an important finding, given that between 88-100% of women reported some level of PTSD.

Table 3 also underscores the trend in previous literature that woman, even if they do seek out medical care for their injuries, are not discussing the exact nature (source) of their injuries with their doctor or medical professional. To start, very few women even answered the question about the nature of their injuries with a “yes” or “no”; most of the women who suffered injuries following IPV had missing responses for this potentially sensitive question. But, of those who did answer, only 20-23% of women abused by men told the doctor exactly why they were there, and only 11% of women abused by women discussed the source of their injuries following physical violence.

Table 3. Healthcare Seeking Behaviors of Women Survivors of Intimate Partner Violence

			Percent Experienced	Mode	Minimum	Maximum	N
Physical Violence	Medical care	Opposite-Sex	30.9%	0	0	1	567
		Same-Sex	11.1%	0	0	1	9
	Psychological care	Opposite-Sex	27.3%	0	0	1	1310
		Same-Sex	25.0%	0	0	1	20
	Discussed nature of physical injuries with medical care provider?	Opposite-Sex	20.3%	0	0	1	567
		Same-Sex	11.1%	1	0	1	9
Sexual Violence	Medical care	Opposite-Sex	33.0%	0	0	1	179
		Same-Sex	40.0%	0	0	1	5
	Psychological care	Opposite-Sex	33.9%	0	0	1	504
		Same-Sex	75.0%	1	0	1	8
	Discussed nature of physical injuries with medical care provider?	Opposite-Sex	23.5%	0	0	1	179
		Same-Sex	40.0%	0	0	1	5
Current Victimization	Counseling for PTSD	Opposite-Sex	17.6%	0	0	1	324
		Same-Sex	33.3%	0	0	1	3

Notes:

1) Mode 0=did not seek care, mode 1=did seek care

2) Sample size varies depending on how many women answered the questions. For all variables, non-responses were coded as missing (“.”).

Men have mostly similar rates of self-reported medical and psychological care following intimate partner violence (see Table 4 below). Around one-quarter of all men, regardless of who abused them, seek out medical and psychological care following physical violence, while 25% of men abused by women seek out psychological care following sexual violence. However, very few men answered the questions necessary to make significant claims about their medical care seeking behaviors following sexual violence. Both of the two men abused by women who answered the question sought care, while the one man abused by a man who answered did not. Moreover, while 33% of men abused by men seek out psychological care following sexual violence, this represents one out of three men who answered the question.

Much like women, men are unlikely to discuss the nature of their violence with a doctor of medical professional. Around 20% of men abused by women and 12.5% of men abused by men do so following physical violence; but only one man reported doing so following sexual violence (only three men answered the question to begin with).

For those men currently experiencing opposite-sex IPV and reporting some sort of PTSD because of it, 13.8% report seeking counseling. None of the seven men abused by a current same-sex partner have sought care for their PTSD. This is interesting and important, given that between 71-99% of men reported some level of PTSD.

Table 4. Healthcare Seeking Behaviors of Men Survivors of Intimate Partner Violence

			Percent Experienced	Mode	Minimum	Maximum	N
Physical Violence	Medical care	Opposite-Sex	27.1%	0	0	1	140
		Same-Sex	25.0%	0	0	1	8
	Psychological care	Opposite-Sex	20.1%	0	0	1	497
		Same-Sex	26.3%	0	0	1	19
	Discussed nature of physical injuries with medical care provider?	Opposite-Sex	20.0%	0	0	1	140
		Same-Sex	12.5%	0	0	1	8
Sexual Violence	Medical care	Opposite-Sex	100.0%	1	0	1	2
		Same-Sex	0.0%	0	0	1	1
	Psychological care	Opposite-Sex	25.5%	0	0	1	17
		Same-Sex	33.3%	0	0	1	3
	Discussed nature of physical injuries with medical care provider?	Opposite-Sex	50.0%	---	0	1	2
		Same-Sex	0.0%	0	0	1	1
Current Victimization	Counseling for PTSD	Opposite-Sex	13.8%	0	0	1	152
		Same-Sex	0.0%	0	0	1	7

Notes:
1) Mode 0=did not seek care, mode 1=did seek care
2) Sample size varies depending on how many men answered the questions. For all variables, non-responses were coded as missing (“.”).

The Fisher’s *p* test for differences between groups (see Tables 2-4 in Appendix A) reveals that there is no significant difference in the reporting rates medical or psychological care

for injuries between women abused by women and women abused by men, with the exception of psychological care following sexual violence (remember from Table 3 that women abused by women sought care more often). There are no differences between men abused by women and men abused by men. Likewise, there is no significant difference in care reporting rates between women and men abused by same-sex partners, but, just as with injury rate itself, there is a significant difference between men and women abused by opposite-sex partners in psychological care following physical violence—in this case, women seek care more often than men (see Table 5 in Appendix A).

The Fisher's *p* test for differences between men abused by women and women abused by women (see Table 6 in Appendix A) indicates that although men's opposite-sex and same-sex reporting rates are statistically similar, and men's same-sex and women's same-sex reporting rates are similar, there is a difference between men's opposite-sex and women's same-sex rates of physical violence and psychological care seeking following sexual violence. For comparison (from Tables 1-4 above): 11.8% of men abused by women and 62.5% of women abused by women reported physical injuries after sexual IPV; while 25.5% of men abused by women and 75% of women abused by women sought psychological care following sexual victimization.

Inequality Indicators

Low reporting rates for the additional violence questions (regarding health effects and medical care) and a lacking diversity among men and those who experienced same-sex violence, makes a regression analysis impossible and the success of applying Fisher's *p* tests variable.

For instance, Table 5 (below) shows the results of the Fisher's *p* tests for the outcomes of physical violence on men. There was only one inequality indicator that is significantly related to the outcomes of same-sex physical violence: age inequality—and it is only related to psychological care following victimization. The Fisher's test simply reports the exact probability that there is a significant difference between groups: those who were physically abused but did not seek out psychological care and those who were physically abused and did seek out psychological care. In this case, 60% of those who did seek out psychological car were between the ages of 46-55, while an additional 20% were 65 and older. But, almost 80% of men who did not seek out care were 35 or younger. It seems that young age may act as a barrier to psychological care services for men physically abused by men.

Men abused by women saw a similar pattern with age and psychological care services. Almost half of all men who did not seek out care were 35 and younger, but almost 70% of those who did were 36 and older. Race and ethnicity and income were significant for physical injuries resulting from physical abuse by women—while 26% of White men reported physical injuries, 35% of non-White men did; moreover, those making $25,000 or less are more likely to report physical injury than those making $25-50,000, and more less likely than those making $100,000 and up.

Education is significantly related to seeking both medical and psychological care following men's opposite-sex victimization, and also in the discussion of how the injuries happened (the source of the injuries). In general, the more education a man has, the more likely he was to report seeking care and telling his doctor that his injuries happened from intimate partner violence. Over 60% of those with at least some college education reported seeking medical care, but over 50% of those with no education or only some high school reported they did not seek medical care; similarly over 70% of those with at least some college education reported seeking psychological care, but almost 50% of those with some high school or less reported they did not. Lastly, over 70% of those with at least some college discussed how they were injured with a doctor, while only around 50% of those with high school education or less discussed the source.

In all of these cases—age, race/ethnicity, income, and education—those with theoretically less power (those who are young, non-White, less educated, and poor) report injuries more often, seek care less often, and discuss that the injury came from IPV. For psychological care, the inequality scale variable confirms this relationship, indicating that those with numbers higher on the scale (indicating less power) reported not seeking care far more often than those with scores lower on the scale. However, there were no reported differences between men who experienced sexual violence, and those who did not, in injuries or care seeking based on the inequality indicators (see Table 7, Appendix A).

Table 5. Fisher's Exact Tests for Differences In Physical Violence Outcomes Among Men

	Physical Injuries		Psychological Injuries		Medical Care		Psychological Care		Discuss Injury	
	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex
Age Inequality	0.401	0.940	1.000	1.000	0.699	0.643	0.001***	0.045*	0.795	1.000
	N=498	*N*=19	*N*=431	*N*=14	*N*=140	*N*=8	*N*=496	*N*=19	*N*=140	*N*=8
Racial/Ethnic Inequality	0.050*	0.359	0.762	0.857	0.139	---	0.085	0.490	0.278	---
	N=495	*N*=18	*N*=428	*N*=14	*N*=139	*N*=7	*N*=493	*N*=18	*N*=139	*N*=7
Education Inequality	0.481	0.907	0.667	0.429	0.031*	0.143	0.002**	0.241	0.013*	0.625
	N=498	*N*=19	*N*=431	*N*=14	*N*=139	*N*=8	*N*=496	*N*=19	*N*=139	*N*=8
Employment Inequality	0.799	0.228	1.000	0.786	0.904	0.750	0.162	0.390	0.691	0.875
	N=462	*N*=19	*N*=402	*N*=14	*N*=127	*N*=8	*N*=460	*N*=19	*N*=127	*N*=8
Income Inequality	0.007**	0.285	---	0.429	0.720	0.214	0.271	1.000	0.347	0.625
	N=457	*N*=19	*N*=397	*N*=14	*N*=129	*N*=8	*N*=456	*N*=19	*N*=129	*N*=8
Inequality Scale	0.792	2.294	---	0.536	0.614	---	2.045*	1.828	1.002	---
	N=418	*N*=18	*N*=364	*N*=14	*N*=117	*N*=7	*N*=417	*N*=18	*N*=117	*N*=7

Notes:

* $p < .05$

** $p < .01$

*** $p < .001$

1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.

2) The inequality scale results are an F statistic from a discriminant function analysis.

For women, only psychological care seems to be impacted by inequality following physical violence (see Table 6 below). For women abused by men, age, race/ethnicity, education, and the overall inequality scale significantly impact whom reports seeking care; while employment is a key factor for women abused by women. Specifically, women abused by an opposite-sex partner who reported seeking psychological care were mostly middle-aged (over 60% were between the ages of 35-65), while those who are 25 or younger or 65 and older were more likely to not seek care. Additionally, non-White women were more likely to report they did not seek out care than White women. At each level of education beyond some college we see more women reporting they sought care than did not, but with each level of education below high school we see more women reporting that they did not seek care. Almost 70% of women abused by an opposite-sex partner who sought psychological care had at least some college education. The overall inequality scale reflects the above findings—those with less power are more likely to report they did not seek care.

For women abused by women, employment has a different relationship to care seeking than women abused by men: women who were employed full time were more likely to report not seeking psychological care than seeking it.

Table 6. Fisher's Exact Tests for Differences In Physical Violence Outcomes Among Women

	Physical Injuries		Psychological Injuries		Medical Care		Psychological Care		Discuss Injury	
	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex
Age Inequality	0.720	0.489	0.682	---	0.529	0.556	0.037*	0.771	0.452	0.556
	N=1293	*N*=20	*N*=820	*N*=14	*N*=561	*N*=9	*N*=1298	*N*=20	*N*=561	*N*=9
Racial/Ethnic Inequality	0.394	---	0.603	---	0.173	---	0.000***	---	0.359	---
	N=1294	*N*=20	*N*=819	*N*=14	*N*=563	*N*=9	*N*=1298	*N*=20	*N*=563	*N*=9
Education Inequality	0.783	0.696	0.481	---	0.825	1.000	0.011*	0.904	0.672	1.000
	N=1302	*N*=20	*N*=825	*N*=14	*N*=566	*N*=9	*N*=1306	*N*=20	*N*=566	*N*=9
Employment Inequality	0.353	0.603	0.501	---	1.000	---	0.658	0.050*	0.808	---
	N=1013	*N*=17	*N*=645	*N*=12	*N*=435	*N*=7	*N*=1016	*N*=17	*N*=435	*N*=7
Income Inequality	0.523	0.562	0.881	---	0.776	0.556	0.386	0.533	0.682	0.556
	N=1131	*N*=18	*N*=709	*N*=12	*N*=499	*N*=9	*N*=1135	*N*=18	*N*=499	*N*=9
Inequality Scale	0.637	---	1.117	---	0.444	---	2.445**	1.950	0.929	---
	N=868	*N*=15	*N*=549	*N*=10	*N*=377	*N*=7	*N*=871	*N*=15	*N*=122	*N*=7

Notes:

* $p < .05$

** $p < .01$

*** $p < .001$

1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.

2) The inequality scale results are an F statistic from a discriminant function analysis.

In terms of sexual IPV (see Table 7 below), women who reported physical injuries tended to be young to middle-aged (26-45), but not the youngest or the oldest. Moreover, while White women are equally likely to report seeking out psychological care and not seeking care, non-White women were more likely to report they did not seek it. The inequality scale mimics these results, indicating that women with more theoretical power are more likely to report they sought out psychological care services following opposite-sex sexual violence. However, there were no reported differences between women who experienced same-sex sexual violence, and those who did not, in injuries or care seeking based on the inequality indicators (see Table 7, Appendix A).

Table 7. Fisher's Exact Tests for Differences In Sexual Violence Outcomes Among Women

	Physical Injuries		Psychological Injuries		Medical Care		Psychological Care		Discuss Injury	
	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex
Age Inequality	.022*	1.000	0.930	---	0.204	1.000	0.663	1.000	0.388	1.000
	N=495	*N*=8	*N*=351	*N*=5	*N*=178	*N*=5	*N*=495	*N*=8	*N*=178	*N*=5
Racial/Ethnic Inequality	0.347	---	0.156	---	0.457	---	.005**	---	0.594	---
	N=502	*N*=8	*N*=358	*N*=5	*N*=178	*N*=5	*N*=502	*N*=8	*N*=178	*N*=5
Education Inequality	0.143	0.786	0.312	---	0.812	1.000	0.680	0.071	0.268	1.000
	N=504	*N*=8	*N*=360	*N*=5	*N*=179	*N*=5	*N*=504	*N*=8	*N*=179	*N*=5
Employment Inequality	0.447	0.500	0.633	---	0.116	0.333	0.985	0.667	0.376	0.333
	N=378	*N*=6	*N*=270	*N*=5	*N*=132	*N*=3	*N*=378	*N*=6	*N*=132	*N*=3
Income Inequality	0.482	1.000	0.468	---	0.260	0.600	0.979	0.571	0.182	0.600
	N=455	*N*=8	*N*=320	*N*=5	*N*=168	*N*=5	*N*=455	*N*=8	*N*=168	*N*=5
Inequality Scale	0.965	0.929	0.963	---	1.379	---	1.953*	0.357	1.498	---
	N=336	*N*=6	*N*=223	*N*=5	*N*=124	*N*=3	*N*=336	*N*=6	*N*=124	*N*=3

Notes:
* p < .05
** p < .01
*** p < .001
1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.
2) The inequality scale results are an F statistic from a discriminant function analysis.

Only 20 men reported sexual violence victimization—17 men reported opposite-sex, and 3 men reported same-sex IPV. Because of these low reporting rates and that varied answers to the inequality indicator questions, a Fisher's analysis could not be completed.

Of the Fisher's tests that could be run on current victimization, none of the inequality indicators made outcomes significantly differ for PTSD/emotional distress from current violence or psychological counseling for current emotional distress (see Table 8 below). It should be noted that race/ethnicity and employment were flagged as statistically significant *F* ratios, but upon further examination all men who reported some level of emotional distress were the same race/ethnicity and had the same employment status as their abusive partner, thus there is no way to reasonably understand this statistic as significant (an *F* ratio details that there is or is not a difference between one or more groups out of at least three – but in this case, there is only one group).

Table 8. Fisher's Exact Tests for Differences In Current Victimization Outcomes

	PTSD Inventory				PTSD Counseling			
	Men		Women		Men		Women	
	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex	Opposite-Sex	Same-Sex
Age Inequality	0.270	0.640	0.910	---	0.283	---	0.552	---
	N = 132	*N* = 5	*N* = 288	*N* = 2	*N* = 131	*N* = 6	*N* = 285	*N* = 2
Racial/Ethnic Inequality	0.020	77.85	0.360	5.090	0.136	---	0.665	---
	N = 111	*N* = 5	*N* = 254	*N* = 2	*N* = 110	*N* = 6	*N* = 253	*N* = 2
Education Inequality	1.740	0.730	1.050	---	0.730	---	0.302	---
	N = 135	*N* = 5	*N* = 291	*N* = 2	*N* = 134	*N* = 6	*N* = 287	*N* = 2
Employment Inequality	1.380	44.53	0.890	---	0.832	---	0.430	---
	N = 99	*N* = 3	*N* = 196	*N* = 2	*N* = 98	*N* = 4	*N* = 196	*N* = 2
Income Inequality	0.190	0.050	1.020	---	0.808	---	0.269	---
	N = 115	*N* = 5	*N* = 236	*N* = 2	*N* = 113	*N* = 6	*N* = 234	*N* = 2
Inequality Scale	1.340	0.510	0.000	27.000	0.707	---	0.244	0.667
	N = 153	*N* = 7	*N* = 329	*N* = 3	*N* = 152	*N* = 7	*N* = 324	*N* = 3

Notes:

* p < .05

** p < .01

*** p < .001

1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.

2) The inequality scale results are an F statistic from a discriminant function analysis.

3) PTSD Inventory results are significance levels for ANOVA *F* statistics.

Discussion

This analysis set out to add to the slowly growing body of literature on intimate partner violence as a health issue by illuminating the importance of including men and those abused by a same-sex partner. Previous nationally-representative research had, to this point, revealed that a higher percentage of women who identify as lesbian and/or bisexual (or who report same-sex sexual and intimate relationships) experience violence by a current or former intimate partner than heterosexually-identified women (or women who report opposite-sex sexual and intimate relationships) (see: National Intimate Partner and Sexual Violence Survey 2010, California Health Interview Survey 2007-2009). Additionally, contrary to the popularly dialogued (and institutionalized) belief that men are not victims, men also experience high levels of violence by both same-sex and opposite-sex partners (see National Intimate Partner and Sexual Violence Survey 2010, California Health Interview Survey 2007-2009; White and Dutton, 2013). However, these analyses and reports stopped short of testing for statistically significant differences between these groups utilizing a probability sample. What's more, only one study examined the negative health outcomes of violence, and this study did not also explore potential causes (Blosnich and Bossarte, 2009). We were left to wonder whether or not the outcomes were significantly disparate and why they might be occurring.

This study confirms that for some health outcomes of violence and some health care seeking behaviors, same-sex partnership and/or gender does matter; though, perhaps not as we might expect. For this sample, women abused by women experienced physical, sexual, and current IPV victimization at a significantly similar rate as women abused by men. Meanwhile, the rates of injury suffered by men in same-sex relationships are comparable to women abused by men, but not as high as the injury rates reported by women in same-sex relationships—though, there is not a significant difference in the rates among any of these groups. Around one-quarter of men abused by women do report physical injuries following physical and sexual victimization, but this proves to significantly lower than the rates reported by women abused by men.

The question is, what can account for the similar to higher rates of injury among men and women abused by same-sex partners? A gender-based argument might be able to account for men's perpetration, but could not entirely get at men's experience of victimization, nor could it account for women's perpetration of violence. I posit another possible explanation: minority

stress. Minority stress is a concept that, when related to sexual orientation, argues that LGBT people in a heterosexist society are subjected to chronic stress related to their stigmatization (Meyer, 1995). This stress can be directly related to the rejection, discrimination, and violence they experience in everyday life, but it can also manifest because of internalized homophobia (projecting society's negative views of you inwards towards yourself). Studies have shown that minority stress has numerous mental health effects, such as depression and distress, but also feelings of helplessness and anger (Meyer, 1995). In the end, the result of this distress and anger is often lower relationship quality, higher levels of arguing and fighting, and in some cases, the desire to keep secret your own sexual orientation or relationship, and/or control your significant other's contact with the outside world (Balsam, 2001; Balsam & Szymanski, 2005; Mohr & Daly, 2008; Otis, Rostosky, Riggle, & Hamrin, 2006). More research is needed to confirm this proposition, additional qualitative data, which has the power to ask more targeted questions related to minority stress, mental health, relationship quality, and violence types (emotional, control, physical, sexual, and so on).

The findings on care seeking are perhaps the most interesting. For example, while men abused by opposite-sex partners tend to seek out medical and psychological care more often, they do not do so significantly more than other men. However, women abused by women do seek out psychological care significantly more often than women abused by men. When comparing men and women, we see that women abused by men suffer physical injuries significantly more often and seek out psychological care significantly more often than men abused by women; but there are no differences between men and women abused by same-sex partners.

What might explain women abused by women seeking out psychological care lies in the demographic characteristics of the sample. In this sample, women abused by women are, on average, significantly older, have a higher level of education, are more likely to be employed full time, and make more money. Given that psychological care is often expensive and/or requires decent medical/insurance coverage, it is not surprising that those most likely to seek psychological care would be those who are employed full time or making more money. Beyond that, there is a social stigma attached to seeking out psychological care that has been shown to be less strong for older and more educated individuals, who tend to seek out psychological care more often than younger, less educated individuals (Gonzalez, Alegria, Prihoda, Copeland, &

Zeber, 2011; Surgenor, 1985). This finding is only slightly confirmed by the findings of the Fisher's tests that indicate that in opposite-sex contexts young age and low levels of education result in women not seeking psychological care.

Another interesting finding regarding care seeking behaviors is that both men and women are more likely to seek out psychological care following victimization than medical care—even if they suffered physical injuries that might have required medical care and despite not reporting psychological trauma or distress as the injury suffered from violence. That is to say, in the presence of physical and not psychological injuries, men and women are still more likely to seek out psychological care for their victimization. For example, after physical violence, 175 women abused by men and one woman abused by a woman sought medical care, but 358 women abused by men and five women abused by women sought psychological care. Following sexual violence, 59 women abused by men and two women abused by women saw a medical doctor, while 166 women abused by men and six women abused by women saw a psychologist or mental health professional. For men, the increases are similar: 38 men abused by women and two men abused by men saw a medical doctor following physical IPV, but 100 men abused by women and five men abused by men saw a psychological; after sexual violence victimization, two men sought medical care (both abused by an opposite-sex partner), while five men (four men abused by an opposite-sex partner and one man abused by a same-sex partner) sought help from a psychologist.

This is an intriguing finding, but it would useful to know how these interactions went for the victims. Follingstad et al. (2004) found that psychologists are not immune to the gender bias in assuming men are perpetrators of violence, women are victims, and men's victimization is less severe than women's. Two scenarios describing the context of psychologically abusive behaviors with the sexes reversed were given to 449 clinicians (56% male), and they rated male perpetrated behaviors as more abusive and severe than a female's use of the same actions—such as "made to account for whereabouts at all times," "would not allow to look at members of the same sex," "mad derogatory comments," and "threatened to have committed to an institution." Contextual factors (e.g., frequency/intent/perception of recipient) did not affect the results.

Ultimately, this analysis details the ineffectuality of the health care system in scanning for and treating IPV, as well as the general experience of victim/survivor non-reporting. The reported rates are psychological care above still only account for 25% or less of people who

experience violence. For instance, Chapter Five detailed that 1412 women reported being physically abused by a male intimate partner. But only 358 sought psychological care for this violence—a rate of around 25%. What's more, of those who answered the question regarding injuries suffered from this abuse, 581 women reported physical or psychological injury; 533 sought medical care (either medical or psychological), but only 115 discussed the exact nature of the injury with the medical practitioner who treated them. This means that of the 1412 women physically abused by men, the institution of medicine is only identifying a little over 8% of the victims *as victims*. For sexual IPV victimization, the rate is much, much lower: out of the 504 women sexually abused by a man, 33% (166) sought psychological care, but only 0.4% ever told a doctor what had happened to them. For women physically abused by women, we see a psychological care seeking rate around 25%, but medical reporting/detection rate of 4.5%; while the care seeking and detection rate for sexual victimization is higher at 75% and 25% respectively, this represents only eight total women who reported same-sex rapes/sexual assaults.

For men, the rates are similar to lower. Of the 506 men who reported physical abuse by a woman, 19.8% (100) sought psychological care for their victimization; but only 28 discussed the exact source of their injuries with their doctor. This means that following opposite-sex physical IPV, the institution of medicine is only detecting men's victimization 5.5% of the time. For sexual victimization, this rate stays almost the same at 23.5% care seeking and 5.9% detection (though this represents reporting out of 17 total men who experienced opposite-sex sexual IPV). For men who experience same-sex physical IPV, psychological care seeking is 22.7% and detection rates hover around 5%; while for sexual victimization only 4.5% sought psychological care and not one single man discussed the source of his injuries with a doctor.

Thus, even though psychological care seeking happens more often than medical care seeking, rates still vary between 4.5% and 33%; and even when individuals are seeking medical care, the stark reality is that they are not discussing their intimate partner violence victimization as the reason they are there—only around 5% of the time will a doctor be made aware of IPV.

If an individual responded that he/she did not discuss the nature of her injuries with the medical care provider, it could be because the provider did not ask how it happened or it could be that the provider asked, but the individual did not want to discuss his/her victimization. This analysis thus confirms that health care service providers aren't asking the right questions and/or men and women are lying about the causes and circumstances of their injuries. This has been

discussed before with men's violence against women, i.e. women report clumsiness, such as falling down the stairs or tripping as the source of their IPV injuries (Schornstein, 1997); but has also been discussed within the context of masculinity and gender norms for men, i.e. men do not have to explain away their physical injuries because they are assumed to be involved in more violent and dangerous activity in the first place (sports, jobs, household chores (i.e. electrical, falls from ladders, etc.) (Goldberg, 1979). But, there are plenty of other reasons why the victim might not admit their victimization to their doctor: their abuser is present during the consultation; their abuser is their interpreter if they don't speak English (and could convey and/or translate anything, changing responses to key victimization questions); believing they are to blame for the violence against them; still loving the person who abused them and not wanted anything bad to happen to their abuser; and/or the health care practitioner's general demeanor, attitudes, beliefs, perceptions, and degree of sensitivity towards the subject matter (Schornstein, 1997).

This latter reason for non-reporting/non-disclosure is key for LGBT and same-sex IPV victims as well. One study found a lacking cultural competency in health care regarding non-heterosexualities (Grant, Mottet and Tanis, 2010); and this can lead to not only an inefficiency in detecting, treating, and helping LGBT-identified individuals who are abused, but also revictimization from the hostility and homophobia of care providers. This may be why over 53% of victims of LGBT or same-sex intimate partner violence do not seek out medical care (NCAVP, 2011). But what this analysis adds is a potentially even more complicated and complex picture of the lacking effectiveness of health care, because the violence studied is same-sex, not violence against those who identify as lesbian, bisexual, gay, and/or transgender. Indeed, almost 13% of victim's of same-sex IPV (abuse that the victim identifies as being of an intimate nature within some context of a romantic or sexual relationship) identify as "heterosexual," with an additional 3% identifying as "unsure," "questioning," or "other." But more than that, 27.4% of the perpetrators of same-sex or LGBT IPV identify as "heterosexual," which means that a substantial amount of IPV against even LGBT-identified individuals is by a person who does not identify as LGBT. Thus the detection and treatment of same-sex IPV with the health care system is firstly limited by heteronormativity, but can be made even more difficult by homonormativity.[4]

[4] "Homonormativity" refers to "A politics that does not contest dominant heteronormative assumptions and institutions, but upholds and sustains them, while promising the possibility of a demobilized gay constituency and a

What's more, the above findings are in regards to any past physical or sexual violence victimization and only take into account mostly physical injury (as previously discussed, psychological injury was rarely reported). But, importantly, 80% of all people, male or female, reported some level of distress/PTSD from current victimization – physical, sexual, emotional or control – but rarely sought psychological care for this distress. Only 17.6% of women abuse by men sought counseling. Only one woman, out of three, abused by a same-sex partner admitted seeking care. For those men currently experiencing opposite-sex IPV and reporting some sort of PTSD because of it, 13.8% report seeking counseling; while none of the seven men abused by a current same-sex partner have sought help. So, while individuals are more likely to seek psychological care for the physical and sexual violence they have experienced in the past, they are still not very likely to seek care for the negative mental health effects of victimization that is currently ongoing.

I believe this finding speaks very directly to the victim's perceived risks of "outing" their victimization status—one of the biggest risks reported in the literature being that their violent partner will find out that they told someone about the violence, become angry or even angrier, and perpetrate violence against them, either with more severity or more often (Dichter and Gelles, 2012; Meyer, 2012; Wallace, 1996). We see this in studies of women's reluctance to seek police protective orders and/or criminal proceedings (Wallace, 1996), in one study on men's fears regarding criminal help seeking (Migliacchio, 2002), and in a qualitative examination of a men's IPV help hotline that highlighted the high likelihood of re-victimization by the very system set up to "protect" victims of violence: "When men are victimized by women, they may be additionally victimized through their dealings with domestic violence advocates" (Hines, Brown, and Dunning, 2007).

In the latter study, the authors report that a number of male victims "reported calling several different domestic violence helplines only to be turned away, laughed at, or accused of being a male batterer" (Hines, Brown, and Dunning, 2007). This type of interaction with the structural support for intimate partner violence is also common of victims of same-sex violence.

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privatized, depoliticized gay culture anchored in domesticity and consumption" (Duggan 2003); i.e. the belief in, or acting upon, an LGBT identity that mimics a heterosexual one and values heteronormative ideals (family, marriage, gay tourism and business districts, and non-political assimilation (i.e. military inclusion)).

The National Coalition of Anti-Violence Programs reported that in 2011[5] alone: 61.6% of same-sex IPV victims were denied access to violence shelters; 97.3% of survivors did not seek criminal recourse or protective orders; 28.4% of the incidents involved the arrest of the victim (when they were not actually mutually abusive); 44.7% of survivors reported the police were indifferent or hostile regarding their victimization; and survivors also experienced other forms of police misconduct including non-specific negative experiences (18.7%), verbal abuse (13.4%), slurs or bias language (12.7%), and physical violence (2.2%) and sexual violence (2.2%) (NCAVP, 2011).

The negative experiences that victims and survivors have within the criminal justice system is especially important to take into account given the mandatory reporting laws in 46 states (as of late 2013), which require a medical practitioner to criminally report domestic and/or intimate partner violence when it is detected or disclosed; and the fact that often they do so without the individual's permission and sometimes without informing them (Rodriguez, McLoughlin, Bauer, Paredes, & Grumbach, 1999; Rodriguez, McLoughlin, Nah, & Campbell, 2001; Smith, 2000). One focus group study found that of 61 women interviewed, 60 were unanimous in their belief that mandatory reporting by health care professionals should not be the common practice until there are numerous changes to the system to promote victim's safety: for instance, these women reported revictimization and structural abuse after mandatory reporting from child protection services and criminal legal system, among others (Sullivan and Hagen, 2005).

Revictimization from disclosing violence can even occur in the health care system itself, as only 44 states currently prohibit health insurance discrimination on the basis of intimate partner violence; i.e., in six states (Idaho, Mississippi, Vermont; and in the case of individual, but not group insurance: North Carolina, South Carolina, and Wyoming), and the District of Columbia, an individual can lose their health insurance if they submit claims for injuries sustained from IPV because they are not explicitly protected from this kind of discrimination. It should be noted that these states and D.C. do have mandatory reporting laws, so disclosing your victimization status could very likely lead to future health insurance discrimination. One large study found that the United States largest insurance companies used to routinely deny and/or

[5] The 2012 report saw a general decrease in these forms of discrimination due massive funding cuts at their Los Angeles, CA affiliate program—2013 will be released soon.

cancel life and health insurance coverage when doctor's filed "domestic" violence claims (Power, 1994).

In general, this analysis confirms that there is a great need for better data on same-sex and LGBT violence and health. Future research should take into account many of what could be considered the limitations of this study: increased sampling of men, especially in regards to sexual violence victimization (barriers can be particularly bad for gay and transgender men) (Jeffries & Ball, 2008; Kay & Jeffries, 2010; Merrill & Wolfe, 2000); increased sampling of diverse populations (the men and women in the survey, for example, were mostly White, non-Hispanic, moderately educated, middle-class, working, and reasonably healthy); and more focused studies of emotional and control violence, which effect a large proportion of both men and women, and of which we do not fully understand the physical and psychological health effects.

Conclusion

In 1989, the American Medical Association (AMA) launched a new campaign to combat family violence and by 1991, there were guidelines for mandatory screening for signs of domestic violence against women; that same year, the U.S. surgeon general ranks abuse by husbands to be the leading cause of injuries to women aged 15 to 44, calling it a "silent epidemic" (Schornstein, 1997). Following suit in 1996, the World Health Organization declared that violence against women was a public health problem (document WHO/EHA/SPI.POA.2). It wasn't until 2011 that the Institute of Medicine of the National Academies suggested that the National Institute of Health and other data collection entities include sexual orientation and gender identity in its surveys and research. In 2012, the National Institute of Health began including LGBT individuals as a specific minority health population (they join the other traditionally included subpopulations: youth and young adults, minority populations, people of low income, people with low educational attainment, and people with mental health or medical co-morbidities). In 2013, the CDC released it's sexual orientation supplement to the 2011 National Intimate Partner and Sexual Violence survey, which detailed the breadth of IPV against those who identify as LGB or who have sexual relationships with people of the same sex—but the report focuses solely on reporting and victimization rates, and does not study the myriad negative health effects previous scholars have discussed in smaller, qualitative studies.

From a public health perspective, unlike the adverse effects of smoking or alcoholism (a popular focus for LGBT health researchers)—or other commonly cited general health issues like obesity, cancer, or depression—same-sex intimate partner violence remains a seemingly controversial issue. More than *individual* vices or diseases, intimate partner violence seems to threaten the social and moral fabric of relationships and families. While the public health sector has been able to admit, for some time, that violence against women by men is a social problem and that ending it should be a priority, it has been reticent to admit the same is true for men abused by women and those abused by a same-sex partner. Perhaps this reluctance comes from this sector's continued reliance on gender normativity and patriarchy in explaining why violence occurs (remember from Chapter Five that the public health sector lists "adherence to traditional masculine gender norms" as the *only* social cause of intimate partner violence). Perhaps the answer also lies in heteronormativity and heterosexism. Those against LGBT equality can point to same-sex violence as a reason for upholding inequity, and those for equality can desire same-sex violence to be kept silent as to avoid any negative associations with LGBT relationships and families.

This silence goes hand-in-hand with concerns that acknowledging men as victims will direct funds away from the already stretched resources currently available to women and children who experience intimate partner violence. The idea that men are victims has thus led to a highly politicized and adversarial context in which men and women's experiences of violence are placed in competition with each other. In fact, the development of effective responses will be based on a better understanding of the complexities of each form of victimization. Anyone can be a victim or perpetrator of IPV. Ultimately, a one-dimensional approach is a disservice to the complexity of the manifestation of IPV.

The veil of silence and the politically-charged infighting amongst scholars and even some activists keeps the issue of queer intimate partner violence, and its detrimental negative health and mental health outcomes, in the closet—leaving the very men and women who need our concern and care severely unprotected, stuck in a cycle of violence, that continues to lead them back into the hands of those who have previously abused them (see Cobb, 2012).

Appendix A. Tables

Table 1. Descriptive Statistics for Chapter Six Intimate Partner Violence Current Relationship Inequality Indicators

			Mode	Minimum	Maximum
Same-Sex Violence	Men	Age	50	25.0	62.5
		Race/Ethnicity	50	50.0	100.0
		Educational Attainment	50	28.6	64.3
		Income Level	50	20.0	60.0
		Employment Status	50	0.0	100.0
		Inequality Scale	50	25.0	62.5
	Women	Age	50	25.0	75.0
		Race/Ethnicity	50	50.0	50.0
		Educational Attainment	50	28.6	57.1
		Income Level	50	40.0	70.0
		Employment Status	50	0.0	100.0
		Inequality Scale	50	33.3	62.5
Opposite-Sex Violence	Men	Age	50	12.5	100.0
		Race/Ethnicity	50	0.0	100.0
		Educational Attainment	50	0.0	85.7
		Income Level	40	0.0	90.0
		Employment Status	50	0.0	100.0
		Inequality Scale	50	4.2	79.2
	Women	Age	50	25.0	87.5
		Race/Ethnicity	50	0.0	100.0
		Educational Attainment	50	7.1	85.7
		Income Level	50	0.0	100.0
		Employment Status	50	0.0	100.0
		Inequality Scale	50	0.0	87.5

Table 2. Fisher's Exact Tests for Differences In Outcomes Between Women in Opposite-Sex and Same-Sex Relationships

		Fisher's p	N
Physical Violence	Physical Injuries	0.541	1326
	Psychological Stress	0.831	842
	Medical care	0.184	576
	Psychological care	0.523	1330
	Discuss Injury	0.430	576
Sexual Violence	Physical Injuries	0.144	512
	Psychological Stress	0.895	365
	Medical care	0.537	184
	Psychological care	.023*	512
	Discuss Injury	0.344	184
Current Victimization	PTSD Inventory	-0.82	332
	Counseling for PTSD	0.444	327

Notes:

* $p < .05$

** $p < .01$

*** $p < .001$

1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.

2) The number for "Live Stress/Depression Inventory" is a z-test statistic for the Mann-Whitney test, used for independent samples with ordinal level data.

Table 3. Fisher's Exact Tests for Differences In Outcomes Between Men in Opposite-Sex and Same-Sex Relationships

		Fisher's p	N
Physical Violence	Physical Injuries	0.142	518
	Psychological Stress	0.062	446
	Medical care	0.628	148
	Psychological care	0.34	516
	Discuss Injury	0.511	148
Sexual Violence	Physical Injuries	0.404	20
	Psychological Stress	---	17
	Medical care	0.333	3
	Psychological care	0.601	20
	Discuss Injury	0.667	3
Current Victimization	PTSD Inventory	0.729	160
	Counseling for PTSD	0.363	159

Notes:

* $p < .05$

** $p < .01$

*** $p < .001$

1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.

2) The number for "Live Stress/Depression Inventory" is a z-test statistic for the Mann-Whitney test, used for independent samples with ordinal level data.

Table 4. Fisher's Exact Tests for Differences In Outcomes Between Women and Men in Same-Sex Relationships

		Fisher's p	N
Physical Violence	Physical Injuries	0.556	39
	Psychological Stress	0.500	28
	Medical care	0.453	17
	Psychological care	0.606	39
	Discuss Injury	0.735	17
Sexual Violence	Physical Injuries	0.424	11
	Psychological Stress	---	7
	Medical care	0.667	6
	Psychological care	0.279	11
	Discuss Injury	0.667	6
Current Victimization	PTSD Inventory	-1.026	10
	Counseling for PTSD	0.300	10

Notes:

* $p < .05$

** $p < .01$

*** $p < .001$

1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.

2) The number for "Live Stress/Depression Inventory" is a z-test statistic for the Mann-Whitney test, used for independent samples with ordinal level data.

Table 5. Fisher's Exact Tests for Differences In Outcomes Between Women and Men in Opposite-Sex Relationships

		Fisher's p	N
Physical Violence	Physical Injuries	.00***	1805
	Psychological Stress	.046*	1260
	Medical care	0.226	707
	Psychological care	.001***	1807
	Discuss Injury	0.523	707
Sexual Violence	Physical Injuries	.021*	521
	Psychological Stress	0.719	375
	Medical care	0.112	181
	Psychological care	0.270	521
	Discuss Injury	0.420	181
Current Victimization	PTSD Inventory	-0.866	482
	Counseling for PTSD	0.183	476

Notes:

* $p < .05$

** $p < .01$

*** $p < .001$

1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.

2) The number for "Live Stress/Depression Inventory" is a z-test statistic for the Mann-Whitney test, used for independent samples with ordinal level data.

Table 6. Fisher's Exact Tests for Differences In Outcomes Between Women Abused by Women and Men Abused by Women

		Fisher's p	N
Physical Violence	Physical Injuries	0.089	526
	Psychological Stress	0.939	451
	Medical care	0.261	152
	Psychological care	0.371	524
	Discuss Injury	0.438	152
Sexual Violence	Physical Injuries	.006**	43
	Psychological Stress	---	37
	Medical care	0.500	8
	Psychological care	.028*	43
	Discuss Injury	0.714	8
Current Victimization	PTSD Inventory	0.119	161
	Counseling for PTSD	0.253	155

Notes:

* $p < .05$

** $p < .01$

*** $p < .001$

1) Fisher's Exact Test calculates the exact probability of the table being as unevenly distributed as observed given independence of rows and columns.

2) The number for "Live Stress/Depression Inventory" is a z-test statistic for the Mann-Whitney test, used for independent samples with ordinal level data.

VII. Conclusion

This project was an attempt to critically challenge the specter of heteronormativity that haunts both the theories of intimate partner violence and the academic praxis that follows. As such, I set out to study women's violence against men in addition to instances of same-sex intimate partner violence. With the goals of queering theory and praxis in mind, I called for an intersectional study of intimate partner violence that takes into account "the multiple nature of identity, and the interlocking nature of systems of privilege and oppression to show how the categories of race, class, sex, gender, and sexuality rely on each other to function within systems of domination" (Ristock, 2005). As there has been a theory-method disconnect in studies of non-heteronormative IPV, I was guided by three major analytical queries (all within a U.S.-based context):

1. Does queered intimate partner violence occur for similar or different reasons than heteronormative intimate partner violence?

   Here, when I reference "queer," I mean all those instances of violence that do not conform to the mainstream feminist understanding of perpetrators and victims; men abused by women and those abused by a same-sex partner. See the beginning of this chapter for a more detailed explanation.

2. If so, can sex/gender explain these differences exclusively, or are other sources of power and inequality important?

   Here, the question is whether or not sex/gender socialization (and social norms) impact those who will be abusers and those who will be victims in the same ways. If the first analysis reveals that men can be victims, and that women can be perpetrators, then other sources of power (such as age, race/ethnicity, social class, and so on) may be equally as important as gender within the context of violence. Of importance to this particular query is that of sexuality—is there a difference between opposite-sex and same-sex IPV, or is there only a difference between queer and heteronormative IPV? As such, sexuality becomes a potential source of power and/or inequality.

3. What are some of the consequences of studying IPV from the current popular framework?

Here, I will explore how expanding our perspective on intimate partner violence necessarily betters the lives of men and women who experience violence—particularly as it relates to health, help-seeking, and healthcare.

Explanations for Intimate Partner Violence

According to the public health sector, there are a combination of individual, relational, community, and societal factors that contribute to the risk of becoming a victim or perpetrator of IPV, and understanding whether or not these multilevel factors are is the first step to identifying various opportunities for prevention (Centers for Disease Control).[1] These *risk factors* were originally identified from small studies of interviews with male perpetrators or female victims who sought help from or were mandated to receive counseling or treatment. It's important to note that these are not casual factors—i.e., not all those at risk because of these factors will experience victimization—but the behaviors and situations included in these studies are said to contribute to a person's likelihood of experiencing violence (Saunders, 1995; Gondolf, 2002).

On the individual level, risk factors include young age and experiencing abuse as a child; within relationships, periods of separation and divorce, pregnancies, and marital dissatisfaction can all increase the chances of IPV; neighborhood connectedness and support have been shown to decrease IPV victimization, but neighborhood disadvantage (e.g. poverty) has been seen to increase it; while socially, only one variable has been named as key to IPV: adherence to or belief in traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions). However, no previous studies had assessed the various risk factors using advanced statistical techniques (only correlation analyses had been completed) using a population-based sample, and none had attempted to do so for queer intimate partner violence.

In Chapter Four, this project found that there are some similarities and some differences in the explanations (risk factors) for heteronormative IPV and queer IPV. For instance, individual-level risk factors are important for all people when it comes to experiencing physical violence—both young age and the experience of child abuse increase the risk of adult victimization. Being pregnant—a relationship-level risk factor—is significant for all women. And the social level factors (yes, the factors thought to be related to masculine gender norms)

[1] See: http://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html

were significant for physical violence in both heteronormative and queer contexts. But there are also differences. For men and lesbian/bisexual (LB) women, but not heterosexual women, young age significantly increased the risk of sexual violence victimization. For heterosexual women, being in poverty increased risk of physical violence, but social capital did not; while the opposite was true for men and LB women. Lastly, being in a "bad relationship" significantly increased risk of physical violence for heterosexual women, but not men or LB women.

The analysis confirmed that the experience of child abuse is a very important factor for determining IPV risk later in life. A previous study that followed a group of 500 children over 20 years found that witnessing parental violence was the single strongest factor for involvement in intimate partner violence as an adult (Ehrensaft, Cohen, Brown, Smailes, Chen, and Johnson, 2003). This analysis finds that childhood physical abuse victimization was a key factor for every single form of both queer and heteronormative violence. In fact, because of the statistical significance of childhood victimization, the "individual level" risk factors explained the experience of physical abuse the best out of any other levels.

What is perhaps most interesting is that when all of the factors that make up a level are taken together, the individual level increases risk of physical violence more than the other levels, and the social level increases risk of sexual violence more than the other levels, for all men and women. This finding—that the social level factors, though to be about masculinity, were significant for men's experiences of violence by women, and also same-sex violence—led me to question whether or not the factors included in the analysis were as extensive as necessary to adequately explain IPV: in essence, are there not social sources of power in addition to masculinity?

The analysis constructed power and control from answers to "what started or triggered this incident," that indicated that the violence was caused by the partner's need for control or victim obedience, the need to "be a man," and responses that indicated the victim "asked for it." While these questions could be theoretically deduced from masculine gender norms, they could also come from other sources. Power and privilege are conferred socially on many levels and in many ways: for instance age, physical power or stature, income, employment, education and/or social skills extend into relationship dynamics and instigate abuse or violence (Aizer 2010; Renzetti and Miley 1996; Steinmetz and Straus 1974; Kandel and Lesser 1972; McDonald 1980; Coleman 1994; Hastings and Hamberger 1988; Hotaling and Sugarman 1986; Marshall and Rose

1990; Kandel and Lesser 1972; McDonald 1980). The second major query in this project asked directly about this issue—is sex/gender the only explanation for the differences in violent experiences—and I explored it in more detail in Chapter Five.

Power and Inequality within Violent Relationships

The first step in moving the conversation on power dynamics forward was to better understand what theoretical explanation there might be for violence, outside of gender norms, or masculinity specifically. Dutton (1996) points to how the underlying assumptions have influenced not only the questions we ask, but the answers we'll receive:

> When feminists ask 'Why do men beat their wives?' their answer will necessarily exaggerate differences between males and females and minimize differences among males. The categories of study are framed by the question.

But, there are alternatives. In Chapter Five, I introduced two important alternatives, neither of which completely disregards gendered power: power resources theory and social exchange theory. Power resources theory contends that couples that share power equally experience lower incidence of conflict, and when conflict does arise, are less likely to resort to violence; but if there is an imbalance, and one partner desires control and power in the relationship, the partner may resort to violence (Kurz 1992). Social exchange theory focuses on how power dynamics benefit the powerful in cases of intimate partner violence, not the powerless; the continued subordination of some people/groups leads to an understanding that those who have power in one (or multiple contexts) can rightfully do as they wish to those who have less (see Cook and Rice 2003).

Most of the results—albiet without knowing the specific dynamics of the violent relationships the victims had with the perpetrators—point to a social exchange explanation: those with less power experience violent victimization; as inequality increases, violence is more likely. Employment inequality is the only inequality indicator that had the opposite effect of what would be expected within a social exchange framework (and only for women—employment inequality was not a significant factor for violence against men): as inequality increases, violence is less likely.

One of the most interesting findings in this chapter lies in the results that men's experiences of same-sex violence and opposite-sex violence are so similar, but women's experiences of same-sex and opposite-sex violence are so different. The *t*-tests indicated that men's experiences of violence were so similar, on average, that they could be categorically merged for the rest of the analyses; but the results of the *t*-tests for women guided me to keep them separate when examining emotional and control violence. And indeed, the results of the regression indicated that aside from employment and race/ethnicity, no other inequality indicator is significant for women's same-sex emotional or control IPV (very much unlike women's opposite-sex emotional and control IPV). What's more, race/ethnicity inequality actually works in the opposite way for women's same-sex and opposite-sex violence. Non-White women have higher odds than White women of experiencing opposite-sex emotional IPV, but Non-White women have lower odds than White women of experiencing same-sex emotional IPV. There is, in fact, no single inequality indicator that increased women's odds of same-sex emotional or control violence—the only type of violence in which this is true.

It is also important to point out, then, that the analysis in Chapter Five found that physical, sexual, and emotional/control violence are three very unique and different types of violence—and not just between groups (i.e. between men and women, or between opposite-sex and same-sex), but also within the same group. For example, when taking into account the inequality indicators separately, only young age and negative health status increased men's odds of physical violence, while young age, minority race/ethnicity, lower income and negative health status increased men's odds of both emotional and control violence.

Importantly, while Chapter Four indicated that gender-normative related power was the most significant risk factor for all forms of sexual IPV, including sexual IPV against men by women. Chapter Five is able to illuminate that the source(s) of perpetrators' negative thoughts towards victims (i.e. demanding or forcing obedience; needing or having the right to control; because they victim "asked for it" or "wanted it") are not solely rooted in gender. Specifically, if we take a social exchange perspective, as supported by the findings, we could locate the source of such beliefs in the victim's young age, poor health, and/or poverty/low income status. These results were significant even in the presence of the predictive significance of age and child abuse (seen as important risk factors in Chapter Four).

But, what are the consequences of this violence, and does our continued reliance of gender norms/masculinity as the major explanation compound these consequences? This project's third major query asked directly about this—how expanding our perspective on intimate partner violence necessarily betters the lives of men and women who experience violence—and Chapter Six dealt with it explicitly.

Health and Healthcare-Related Consequences of Intimate Partner Violence

Ultimately, that goal of this dissertation project was to make a case for the continued (and hopefully increasingly more consistent) research on intimate partner violence against all people. A primary interest of mine was to explore this within the context of the health-related consequences of IPV.

Between 1989-1996, multiple agencies both domestic (American Medical Association) and international (World Health Organization) began a campaign to end violence against women, because violence against women was a "public health problem" and health care's "silent epidemic" (document WHO/EHA/SPI.POA.2; Schornstein, 1997). What has resulted is an ever-increasing body of literature on the negative health outcomes of (mostly) physical and sexual IPV on women abused (mostly) by men. This body of literature exposes a grim reality for many women: victims of physical and sexual intimate partner violence suffer higher levels of both acute and chronic physical health problems than those who are not abused (R. Campbell & Wasco, 2005; Ann L Coker et al., 2002; Fischbach & Herbert, 1997; Stacey B Plichta, 2004; Porcerelli et al., 2003; Wolkenstein & Sterman, 1998).

And although "the short and long-term effects of domestic violence are health care issues that nearly every practicing physician encounters in the course of routine clinical practice" (Alpert, 1995), no study using a representative, probability sample has assessed whether or not there are disparities in negative health outcomes and/or disparities in health care/medical service utilization between those abused by a same-sex partner and those abused by an opposite-sex partner after an experience of violence.

The analysis in Chapter Six found that for some health outcomes of violence and some health care seeking behaviors, same-sex partnership (and/or gender) does matter; though, perhaps not as we might always expect. For this sample, the rates of injury suffered by men in same-sex relationships are comparable to women abused by men, but not as high as the injury

rates reported by women in same-sex relationships—though, there is not a significant difference in the rates among any of these groups. In essence, men abused by women self-report the lowest levels of injury resulting from violence victimization. Around one-quarter of men abused by women do report physical injuries following physical and sexual victimization, but this proves to significantly lower than the rates reported by women abused by men.

The findings on care seeking are perhaps the most interesting. While men abused by women tend to seek out medical and psychological care more often than anyone else, they do not do so at a significantly higher rate than other men. However, women abused by women do seek out psychological care significantly more often than women abused by men. When comparing men and women, we see that women abused by men seek out psychological care significantly more often than men abused by women; but there are no differences between men and women abused by same-sex partners. In the end, both men and women are more likely to seek out psychological care following victimization than medical care—even if they suffered physical injuries that might have required medical care and despite not reporting psychological trauma or distress as the injury suffered from violence. That is to say, in the presence of physical and not psychological injuries, men and women are still more likely to seek out psychological care for their victimization.

But, this analysis confirmed that the healthcare system is likely not the most influential mediator for IPV: though psychological care seeking happens more often than medical care seeking, rates still vary between 4.5% and 33%; and even when individuals are seeking medical care, the stark reality is that they are not discussing their intimate partner violence victimization as the reason they are there—only around 5% of the time will a doctor be made aware of IPV. If an individual responded that he/she did not discuss the nature of her injuries with the medical care provider, it could be because the provider did not ask how it happened or it could be that the provider asked, but the individual did not want to discuss his/her victimization. Health care service providers aren't asking the right questions and/or men and women are lying about the causes and circumstances of their injuries.

Overall, these results point to the incredible need for culturally competent healthcare services and healthcare service workers. It wasn't until 2011 that the Institute of Medicine of the National Academies suggested that the National Institute of Health and other data collection entities include sexual orientation and gender identity in its surveys and research. In 2012, the

National Institute of Health began including LGBT individuals as a specific minority health population (they join the other traditionally included subpopulations: youth and young adults, minority populations, people of low income, people with low educational attainment, and people with mental health or medical co-morbidities). In 2013, the CDC released it's sexual orientation supplement to the 2011 National Intimate Partner and Sexual Violence survey, which detailed the breadth of IPV against those who identify as LGB or who have sexual relationships with people of the same sex—but the report focuses solely on reporting and victimization rates, and does not study the myriad negative health effects previous scholars have discussed in smaller, qualitative studies. The battle cry for abused men, as I have detailed, has yet to be heard; there is much we do not yet know about queer IPV.

Where Do We Go From Here

From a public health perspective, unlike the adverse effects of smoking or alcoholism (a popular focus for LGBT health researchers)—or other commonly cited general health issues like obesity, cancer, or depression—same-sex intimate partner violence and women's violence against men remains a seemingly controversial issue. More than *individual* vices or diseases, intimate partner violence seems to threaten the social and moral fabric of relationships and families. While the public health sector has been able to admit, for some time, that men's violence against women is a social problem and that ending it should be a priority, it has been reticent to admit the same is true for men abused by women and those abused by a same-sex partner. Perhaps this reluctance comes from this sector's continued reliance on gender normativity and patriarchy in explaining why violence occurs (remember from Chapter Five that the public health sector lists "adherence to traditional masculine gender norms" as the *only* social cause of intimate partner violence). Perhaps the answer also lies in heteronormativity and heterosexism. Those against LGBT equality can point to same-sex violence as a reason for upholding inequity, and those for equality can desire same-sex violence to be kept silent as to avoid any negative associations with LGBT relationships and families.[2]

This silence goes hand-in-hand with concerns that acknowledging men as victims will direct funds away from the already stretched resources currently available to women and

[2] Heteronormativity also impact our assumptions about the legitimacy of heterosexual men's victimization and heterosexual women's perpetration.

children who experience intimate partner violence. The idea that men can be victims has thus led to a highly politicized and adversarial context in which men and women's experiences of violence are placed in competition with each other. In fact, the development of effective responses will be based on a better understanding of the complexities of each form of victimization. Anyone can be a victim or perpetrator of IPV. Ultimately, a one-dimensional approach is a disservice to the complexity of the manifestation of IPV.

The veil of silence and the politically-charged infighting amongst scholars and even some activists keeps the issue of queer intimate partner violence, and its detrimental negative health and mental health outcomes, in the closet—leaving the very men and women who need our concern and care severely unprotected, stuck in a cycle of violence, that continues to lead them back into the hands of those who have previously abused them (see Cobb, 2012). Ultimately, it is really an epistemological cop-out; an unwillingness to admit that feminist theory cannot account for an accumulating set of empirical studies that indicate women are not the only possible victims of IPV, but rather equally impacted by relationship violence.

Yet even this project, by the very methodological nature of it, was forced to leave out some of the more complex populations—at the intersections of violence—becoming an increasing focus of grassroots organizations: youth (under 18 years old), those who are temporarily or permanently unhoused, and transgender men and women.

Violence and Youth

There has been an increasing focus on youth and young adult violence since the early 2000s, largely legitimating that IPV is possible for those who are young, not cohabitating, and/or only dating. For opposite-sex IPV, samples of teenagers and young adults (dating, cohabiting, married) have found rates of physical violence toward partners are considerably higher than in general survey populations, including several studies find young women are more frequently violent than young men. Magdol et al. (1997) reported that women perpetrated violence 37.2% of the time toward their partners and men 21.8% in a community-representative sample of young adults. In a sample of antisocial, aggressive teenagers and young adults, women self-reported higher rates of perpetration of violence than men (43% vs. 34%) (Capaldi & Owen, 2001). Douglas and Straus (2006) found that, among dating couples in 17 countries, young women assaulted their partners more often than did young men (30.0% vs. 24.2%).

One study (Freedner, Freed, Yang, and Austin, 2002) collected self-report surveys from 521 adolescents at a GLB youth rally, regarding dating violence, types of abuse, and threats of outing. Reported dating violence was prevalent in all sexual orientation groups, and there were few statistically significant differences. Compared with heterosexuals (see Halpern, Oslak, Young, et al., 2001) and controlling for age, bisexual young men had greater odds of reporting any type of abuse, and bisexual young women had greater odds of experiencing sexual abuse. Controlling for age, young lesbians had greater odds of being scared about their safety, compared with heterosexual young women, and young bisexuals were more likely to be threatened with outing, compared with young gay men/lesbians.

The 2012 NCAVP report also found that youth and young adults were close to two times (1.8) as likely to face anti-LGBTQ bias in IPV tactics as compared to non-youth. Gillum and DiFulvio (2012) also surveyed 109 LGBT young adults 18-24 regarding dating violence and found that four main factors contributed to dating violence among same-sex couples (according to the young adults themselves): homophobia (societal and internalized)—specifically, eens whose dating patterns are outside of the norm are often teased or bullied, and therefore isolated; they are less likely to reach out for help because of the fear of being outed or the expectation of negative reactions from others; internalized homophobia may lead them to believe they are not worthy of being treated well; negotiating socially prescribed gender roles—i.e. attempting to force their relationships into stereotyped models of dating can lead to conflict (who will do the housework); assumed female connection—that women intuitively know what women feel, need and want, thus communication is not necessary; and other relationship issues-- such as a lack of family or peer support or heightened jealousy (Gillum and DiFulvio, 2012).

Taking into account the fact that most social service providers indicate the number one reason LGBT youth are homeless is because they are LGBT (Williams Institute, 2012), and the homophobic/heterosexist nature of many primary educational settings, in which students are not only ridiculed but frequently harassed and victimized by physical violence (GLSEN, 2011); it is difficult to provide nurturing and supportive environments for all lesbian and gay people, particularly those who are particularly anxious, distressed or confused about their sexual identities or the violence they have experienced. Rebecca Waggoner, Anti-Violence Program Director, at OutFront Minnesota in Minneapolis reported “We need more programs and services focused on LGBTQ youth… These findings indicate the need for policymakers and funders to

support LGBTQ and HIV-affected anti-violence organizations that conduct intimate partner violence prevention initiatives, and particularly those prevention initiatives that are aimed at youth and young adults."

Outside of the system, Cody and Welch's study (1997) demonstrated the importance of social and community groups in working through issues around internalized homophobia and constructing `families of choice'. One participant in the study stated, "The support group helped me to feel better about being gay...being happy and gay is not an oxymoron. You can have both" (Cody and Welch, 1997). Because of the age of respondents in the above study, a sense of community was achieved by young men through extracurricular groups and friendship networks rather than through participation in the commercial gay 'scene.' This may be particularly valid for young women for whom there is often a dearth of commercial venues that are not exclusively of dominantly for gay men. Such groups appear to often play a vital role in providing accurate information, discussing salient issues and working on skills (e.g. assertiveness, negotiating safer sex, etc.) and strategies both formally and informally within a safe and explicitly gay-affirmative environment.

But these friendship networks and communities of choice are often, unfortunately, found "on the streets" (Hammer, Finklehor, and Sedlak, 2002; Reeg, 2003). Indeed, in major urban centers like New York, San Francisco, and Chicago, up to half of all of homeless teens self-identify as lesbian, gay, bisexual, or transgender (Cianciotto and Cahill, 2002; Williams Institute, 2012). This brings me to the second major intersection.

Violence and Homelessness

Homelessness intersects with violence in that many of those who are temporarily or permanently unhoused are so because of us violence they experienced; but are, unfortunately, much more likely to experience violence once unhoused. For instance, over 30% of all homeless LGBT youth report they are homeless because of physical, emotional, or sexual abuse at home, while an additional 14% report homelessness because of neglect (Williams Institute, 2012). Over 54% report experiencing violence in the home even if it was not the main reason they left (Williams Institute, 2012). But homelessness also exposes LGBT youth to a host of troubling problems, including increased risk of becoming victims of crime and assault, as well as police harassment for minor infractions like loitering, public drinking, or subway turnstile jumping-or

for nothing at all (Cochran et al., 2002; Casciano et al., 2001). Some new research indicates that unhoused youth are more likely to engage in risky sexual behavior with intimate partners, participate in sex work, and begin relationships (that often turn into violent intimate partnerships) for access to money and/or temporary housing (National Gay and Lesbian Task Force, 2006).

What may be even more troubling is that these youth are at an increased risk of being victims of violence in homeless youth housing facilities (Hunter, 2008). Not only do they face experience anti-LGBT discrimination from service providers, they also experience physical and sexual abuse by other youth within the facilities (Hunter, 2008). What's more, no matter the type of service provider for unhoused youth (drop-in center, street outreach program, or housing program), all service providers indicated that over 40% of their clients were LGBT youth and there were significant barriers to providing these youth with adequate care (Williams Institute, 2012). Five of the top six factors identified as barriers to improving services related to a lack of funding: the top three barriers were a lack of state, local, and federal funding, in that order (Williams, Institute).

However, even though they are disproportionately effected, (LGBT) young adults are not the only individuals who experience being temporary or permanent unhoused—indeed, homelessness has been linked to adult women's experiences of IPV for quite some time.[3] A handful of more recent studies have found that an overwhelming majority (sometimes upwards of 80%) of women in homeless shelters have experienced intimate partner violence (Hunger and Homelessness Report, 2007; Passaro, 2014; Walsh, Rutherford, and Kuzmak, 2009; Wenzel et al., 2009). Remember, these are *homeless* shelters, not *domestic violence* shelters—an important distinction when thinking about the deep connection between intimate partner violence and being unhoused.

When speaking of domestic violence shelters, specifically, Baker et al. (2010), discuss how they are essential life-saving resources for many victims of domestic violence, and can be a first step to accessing resources for longer-term stability. "They offer a 24-hour safe haven, often with a confidential location, making it more difficult for abusive partners to locate women" (Baker, Billhardt, Warren, Rollins, and Glass, 2010). One more recent study demonstrates that a majority of women who stay at shelters benefit from the services provided there and view the

[3] See The United States Conference of Mayors. 2007. *Hunger and Homeless Survey: A Status Report on Hunger and Homelessness in America's Cities, a 23-City Survey*, December 2007. Washington DC: The United States Conference of Mayors.

experience positively (Lyon, Lane, & Menard, 2008). What's more, the longer women are able to stay in shelter, the greater their chance of independence—not returning to an abuser—upon leaving that shelter (Corupton, Michael, Krasavage-hopkins, Schnciderman, and Sick Man, 1989). This is critical, because once women return to their partners, they are less likely to seek professional outreach assistance (Ben Porat and Itzhaky, 2008).

However, just as with LGBT youth, there are barriers to care for LGBT adults who experience violence and are temporarily or permanently unhoused—which can ultimately lead many, if not most, LGBT adults to return to their abusive partners (Aulivola, 2003). The AIDS Counsel of New South Wales Housing Project provides advocacy and support to LGBT and intersex adults and youth who are homeless or at risk of homelessness (ACON, 2004), and recently found that an increasing number of their clients are disclosing experiences of same-sex domestic violence. It also found a lack of appropriate housing options and referral for support specific to the needs of victims of same-sex domestic violence (ACON, 2004). ACON noted that when people experiencing same-sex domestic violence are not able to access services, they would be at risk of homelessness, which would put their safety at additional risk. In 2012, NVACP reported that only 3.7% of all same-sex IPV survivors sought access to domestic violence shelters. However, of those seeking shelter, only 14.3% were turned away, while 85.7% were admitted. But this is a dramatic change from the 2011 report where 61.1% of survivors seeking access to shelters were turned away, and could be a one-year anomaly. The risk of being turned away is much higher for youth and men, whom often cannot access any shelters or housing services because of funding and the legislation preventing them from entering a women's facility (see Violence Against Women Act, 2013; Aulivola, 2003; Todahl, Linville, Bustin, Wheeler, & Gau, 2009).

But it is important to also discuss that the most in-need demographic when it comes to violence at the intersections, are not only those who are young, and those who are homeless, but also those who identify as transgender. While transgender youth make up only 0.5% (from what we can best account for; see Williams Institute, 2013) of the total U.S. youth population, transgender youth make up about 20% of those under age 18 who are homeless in any given year (National Gay and Lesbian Task Force, 2006). And while only approximately 1 in 20 cisgender individuals will ever access a homeless shelter, 1 in 5 transgender people will (Xavier, 2002).

Unfortunately, transgender people facing homelessness also face discrimination from agencies that should be helping them, with nearly one in three (29%) reporting being turned away from a shelter due to their transgender status (one report even found that a homeless shelter in Atlanta had posted a sign that read "No Transvestites"[4]) (National Gay and Lesbian Task Force, 2006). While leading experts on homelessness recommend providing emergency housing consistent with a person's gender identity, 42% of trans people facing homelessness have been forced to stay in a shelter living as the wrong gender (National Gay and Lesbian Task Force, 2006).

Violence and Transgender Identity

But there are other unique and specific concerns that must be accounted for at the intersection of violence and gender identity. The National Coalition of Anti-Violence Programs (NCAVP) confirms that transgender women, specifically, have the highest risk of IPV victimization and are the most likely to be murdered by an intimate partner (NCAVP, 2012). This is compounded by race/ethnicity, as transgender women of color make up an overwhelming majority of the cases of transgender IPV. The 2012 report found that transgender survivors were two (2.0) times as likely to face threats/intimidation within violent relationships, and nearly two (1.8) times more likely to experience harassment within violent relationships. This led Aaron Eckhardt, Training and Technical Assistance Director at Buckeye Region Anti-Violence Organization (BRAVO) in Columbus to conclude "Transgender people face increased risk of violence because of their gender identity and transphobia within intimate partnerships." He stated, "To really address the needs of transgender survivors, we need to address transphobic laws, policies and institutions while also providing supportive programs that address transgender people explicitly and that engage transgender survivors in preventing this violence."

One of the biggest barriers to preventing IPV against transgender men and women, outside of the shelter situation discussed above, lies within the healthcare system. In 2011, the National Healthcare Disparities Report excerpted findings from the National Transgender Discrimination Survey Report on Health and Health Care (Grant, et al., 2011), indicated that transgender men and women are the most vulnerable among the LGBT population—they face

[4] Anita Beaty, director of Atlanta's Metro Task Force for the Homeless, interviewed by Lisa Mottet on December 6, 2003.

restricted access to healthcare (both preventative and emergency), experience harassment and discrimination from healthcare workers, and are less likely to have health insurance coverage. Not only that, but only a little over 4% of transgender individuals utilize the emergency room—which is on of the key IPV screening locations.

What remains most true about the intersection of violence and gender identity is that we are only at the beginning of discovering just how at-risk transgender men and women are when it comes to the magnitude of the violence they experience and the discrimination they face afterwards (National Gay and Lesbian Task Force, 2006).

Final Thoughts

In 2009, Chavis and Hill created the Multicultural Power and Control Wheel to expand on the original Power and Control Wheel of abusive tactics (the one discussed in the literature review as being sourced from narratives of women "battered by men"). The original wheel includes male privilege and sexism as ways in which abusers gain power and control over their victims, but the Multicultural Power and Control Wheel takes into consideration multiple forms of oppressions. It highlights "the infinite ways in which oppressed identities… and their related oppressions [can] transpose the power and control tactics" (Chavis & Hill, 2009, p. 142).

This idea is particularly salient for me, in thinking about the concerns raised by this project—the need for new theory and praxis regarding queer intimate partner violence—and the concerns raised by those at the grassroots—the need to include the voices of those who are young, and/or homeless, and/or transgender. The National Coalition of Anti-Violence Programs highlights some specific policy recommendations, such as:

- All anti-sexual and intimate partner violence service providers, including institutions such as law enforcement, courts, and hospitals, should receive LGBTQ-specific training on screening, assessment and intake—and this should be supported and funding by policymakers.

- Policymakers and funders should fund LGBTQ and HIV-affected anti-violence organizations to conduct intimate partner and sexual violence prevention initiatives, particularly prevention programs for youth and young adults.

- Policymakers should ban discrimination in employment, housing, and public accommodations based on sexual orientation, gender identity, gender expression, and HIV-status to protect LGBTQ and HIV-affected survivors from economic and financial abuse.

From an academic perspective, future research should take into account the concerns raised by this project, the concerns raised by grassroots organizations and activists for attention to specific at-risk populations, and the policy recommendations made by NCAVP—i.e., we need better research on the socio-cultural and institutional effects of homophobia, heterosexism, and transphobia on the study, support and funding of same-sex and LGBTQ intimate partner violence. At every turn we must challenge the specter of heteronormativity within the construction of "real," "legitimate" and "serious" intimate partner violence, and we must fight for those who struggle each and every day to survive. Because last year, there were 21 intimate partner violence (IPV) homicides of LGBTQ people documented (NCAVP, 2013); the highest yearly total ever recorded—and that was only for those instances in which we knew the individual was non-heterosexual, and in which we knew they were murdered by an intimate partner. Twenty-one men and women, many young, many transgender, many who could have been helped at some point by any or all of us implicated within the intimate partner violence prevention system. We simply do not know how many could have been saved. *We simply must do better.*

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SECTION E: POWER, CONTROL AND EMOTIONAL ABUSE✶

E2 - E14 ARE ANSWERED ONLY IF RESPONDENT HAS A CURRENT SPOUSE OR PARTNER

E2 **I would like to read you some statements that some women (men) have used to describe their husbands (wives)/partners. Thinking about your current husband (wife)/ partner would you say he/she...**

Has a hard time seeing things from your point of view?

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E2 219

E3 **Is jealous or possessive?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E3 220

E4 **Tries to provoke arguments?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E4 221

E5 **Tries to limit your contact with family or friends?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E5 222

✶Many of the questions included in this section were adopted from the Canadian Violence Against Women Survey. See Statistics Canada, Canadian Centre for Justice Statistics, 19th Floor, R.H. Coats Building, Ottawa, Canada K1A 0T6.

E6 **Insists on knowing who you are with at all times?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E6 223

E7 **Calls you names or puts you down in front of others?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E7 224

E8 **Makes you feel inadequate?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E8 225

E9 **Is frightened of you?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E9 226

E10 **Shouts or swears at you?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E10 227

E11 **Frightens you?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E11 228

E12 **Prevents you from knowing about or having access to the family income even when you ask?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E12 229

E13 **Prevents you from working outside the home?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E13 230

E14 **Insists on changing residences even when you don't need or want to?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

E14 231

E16 - E41 ARE ANSWERED ONLY IF RESPONDENT HAS ONE OR MORE PREVIOUS HUSBAND/WIFE

*Can be provided upon request.

SECTION F: RAPE VICTIMIZATION

Two different sets of rape screening questions were fielded during Wave A and Wave B of the survey. Wave A respondents (N=500 women) were asked Version A rape screening questions and Wave B respondents (N=501) were asked Version B.

Version A consists of two questions:

> *Has a man or boy ever made or tried to make you have sex by using force or threatening to harm you or someone close to you? Just so there is no mistake, by sex we mean putting a penis in your vagina, anus, or mouth?*
>
> *Has anyone, male or female, ever put or tried to put their fingers, tongue or objects in your vagina or anus against your will by using force or threats?*

Version B consists of four questions:✶

> *Has a man or boy every made or tried to make you have sex by using force or threatening to harm you or someone close to you? Just so there is not mistake, by sex we mean putting a penis in your vagina?*
>
> *Has anyone, male or female, ever made or tried to make you have oral sex by using force or threat of harm. Just so there is no mistake, by oral sex we mean that a man or boy put his penis in your mouth, or someone, male or female, penetrated your vagina or anus with their mouth or tongue?*
>
> *Has anyone ever made or tried to make you have anal sex by using force or threat of harm? Just so there is no mistake, by anal sex we man that a man or boy put his penis in your anus?*
>
> *Has anyone, male or female, ever put fingers or objects in your vagina or anus against your will by using force or threats?*

Results from Wave A and Wave B were analyzed to determine which set of rape screening questions was more useable. Version C of the questionnaire, which was administered during subsequent waves of the survey, consists of all four of the questions in Version B, plus one question pertaining to attempted rape (see below). Lifetime prevalence estimates for attempted and completed rape reported by the Center for Policy Research are derived from data generated by Version C of the questionnaire

✶These questions were used in The Women Study. See *Rape in America: A Report to the Nation,* National Victim Center and the Crime Victims Research and Treatment Center, 211 Wilson Boulevard, Suite 300, Arlington, VA 22201, April 23, 1992.

F1 *ANSWERED ONLY IF RESPONDENT IS FEMALE.*

[VERSION A INCLUDES VAGINAL, ANAL OR ORAL PENETRATION BY PENIS] Regardless of how long ago it happened, has a man or boy ever made you have sex by using force or threatening to harm you or someone close to you? Just so there is no mistake, by sex we mean putting a penis in your vagina.

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

F1 501

F2 **[VERSION A INCLUDES VAGINAL PENETRATION BY FINGERS, TONGUE OR OBJECTS] Has anyone, male or female, ever made you have oral sex by using force or threat of harm? Just so there is no mistake, by oral sex we mean that a man or boy put his penis in your mouth or someone, male or female, penetrated your vagina or anus with their mouth or tongue.**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

F2 502

F3 **IN VERSION B AND C ONLY: Has anyone ever made you have anal sex by using force or threat of harm? Just so there is no mistake, by anal sex we mean that a man or boy put his penis in your anus.**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

F3 503

F4 **IN VERSION B AND C ONLY: Has anyone, male or female, ever put fingers or objects in your vagina or anus against your will by using force or threats?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

F4 504

SECTION G: PHYSICAL VICTIMIZATION✶

EXPERIENCED AS AN ADULT

G13 **Not counting any incidents you've already mentioned, after you became an adult did any other adult, male or female ever...**

Throw something at you that could hurt you?

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G13 580

G14 **Push, grab or shove you?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G14 581

G15 **Pull your hair ?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G15 582

G16 **Slap or hit you?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G16 583

G17 **Kick or bite you?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G17 584

G18 **Choke or attempt to drown you?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G18 585

G19 **Hit you with some object?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G19 586

G20 **Beat you up?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G20 587

G21 **Threaten you with a gun?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G21 588

G22 **Threaten you with a knife or other weapon besides a gun?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G22 589

G23 **Use a gun on you?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G23 590

G24 **Use a knife or other weapon on you besides a gun?**

1 Yes
2 No
3 (VOL) Don't know
4 (VOL) Refused
9 Missing

G24 591

Epilogue

In Memoriam

DESIREE HARRELL, 43, Black, cisgender lesbian woman
Milwaukee, WI January 2, 2012

SHANNON WASHINGTON, 20, Black, cisgender lesbian woman
Tallahasee, FL January 22, 2012

DAMON LANCASTER, 37 (race/sexual orientation/gender identity unknown)
Phoenix, AZ February 25, 2012

CHARITY KAY GILBERT, 20 (race/sexual orientation/gender identity unknown)
Montrose, CO February 25, 2012

JOHN LAUBACH, 57, White, cisgender gay man
New York City, NY March 2, 2012

JOHN E. ATKINSON, 25, Latino, cisgender gay man
Chicago, IL March 6, 2012

UNKNOWN, 50s, lesbian woman
Miami, FL March 27, 2012

JEFFREY E. CALDWELL, 56, White, cisgender gay man
Columbus, OH April 6, 2012

TORY CURTIS, 23, Black, cisgender gay* man
Brooklyn, NY April 17, 2012

LORENA ESCALERA, 25, Latina, transgender woman
Brooklyn, NY May 12, 2012

CHRISTOPHER ASHTON MARTIN, 30, cisgender gay man (race unknown)
New Port Richey, FL May 13, 2012

BRANDY M. STEVENS-ROSINE, 20, White, lesbian woman
Cochranton, PA, May 17, 2012

JUN “JUSTIN” LIN, 33, Chinese, cisgender gay man
Montreal, Quebec May 24-25, 2012

STEVEN “ERIQ” ESCALON, 28, Latino, gay cisgender man
San Francisco, CA, June 12, 2012

CRAIG DOUGLAS WOLFE, 63, cisgender gay man (race unknown)
Miami, FL June 15, 2012

CRAIN CONAWAY, 47, Black, transgender woman
Oceanside, CA, July 18, 2012

JESSIE MCCASKILL, 50, White, cisgender lesbian woman
Phoenix, AZ August 27, 2012

MALENA SUAREZ, Transgender woman
Carolina, Puerto Rico October 2012

JANETTE TOVAR, 43, Latina, transgender woman
Dallas, TX October 15, 2013

MARCEL IVORY, 37, Latino, cisgender gay man
New Orleans, LA October 17, 2012

SHAUN WOOLFORD, 31, Black, cisgender gay man
Brooklyn, NY November 7, 2012

DANIEL TURMAN, 43, White, cisgender man (sexual orientation unknown)
Montgomery, Alabama December 1, 2012

YVONNE MARIE KIRK, 65, Black cisgender heterosexual woman
San Jose, CA December 30, 2012

“CODY”, Native American, transgender woman
Details unknown (kept anonymous by a cousin who reported it)

In the long six years between starting this journey and this very moment, I have thought of nearly a million ways to start this story. Indeed, I have battled with what would resonate most with you. What would captivate you; stir you into action. I’ve struggled with the juxtaposition of my personal story and my professional one. What should I divulge, or, rather, what should I leave out? I am all at once guided by not only my own uncertainties, but also the reality that *the personal is political.*

And I was struggling with the start of my story when I got the email – Mark Carson had been shot and killed. It was May 18th, late in the day. *"AVP is deeply disturbed…"* such a way to frame my emotions. Disturbed. Yes, disturbed for so many reasons. This was the 5th incident in NYC in the month of May alone. There would be five more before April 2nd finally sprung us free from victimization (at least until April 28th). These incidents of hate violence were made all the more emotional because, at the time, I was constructing the homicide narrative sections of the 2012 Hate Violence and Intimate Partner Violence reports, taking stock of the immense loss that had happened in one year alone. Twenty-four deaths by an intimate partner; twenty-six on the basis of hate bias; these are not so unrelated.

So, while I may have nearly one million ways to start this, I'm choosing just one; because I think I may have finally figured out how to tell you why this matters.

Lately, I've been grieving. You know, it's funny, grief. Sometimes it really sneaks up on you. I guess that's why they have the 5 stages. It starts with denial: *I'm fine,* I'll say. *This can't be happening, not really*, we'll muse. Then, there's anger: *Why me?* you'll ask. *Who can I blame*, I'll want to know. If we continue the transition, we even bargain: a stage where we still have hope that we can postpone, delay, or stop whatever it is that is happening to us. Maybe we try to negotiate, compromise, or buy time. But when we learn there is no negotiating, no buying time, depression hits – the inability to cope; the sadness; the unending listlessness. And somehow, some way, when we pull ourselves from the depths of depression, the final stage: acceptance.

But acceptance is a funny thing. Acceptance is the ability to not only say *it's going to be OK*, but also accept that it's going to happen no matter what you do, and prepare for it. Acceptance? More like succumbing. Letting go? Giving in. And for those of us who are not only embroiled professionally in the battle, but also personally, these stages don't always make a lot of sense. I don't understand the bargaining part—I haven't yet wrapped my mind around the idea that I have to negotiate my existence for your compassion. I've been depressed for too long—something I've seen day in and day out on the faces of those around me. I'm clearly stuck on the anger stage—and I'm not proud of it, either.

But mostly, I don't know where my anxiety fits in.

So, I've been thinking about this grieving I've been doing and I'm starting to think it's not grief at all, but a totally different beast: *fear*. Fear is an emotion that activates the fight or flight response. Fear comes from horror or terror. Fear is not only the ability to recognize danger and then pull away and hide or stand your ground, but also, to freeze. Fear can be a paralysis. A reminder of your inability to help yourself, let alone anyone else. As an activist-scholar I have two venues in which to help myself and others; and still, I am paralyzed.

We hold a rally on March 16th for the victims of four hate crimes in the first two weeks of the month, we march and we scream, we stomp and we yell; and the next night, a murder. We organize an even bigger meeting of the minds, some 2-3000 of us gather to show the city that we won't stand for this treatment, for this violence, for this fear; and in the evening and morning hours that followed, the 6th, 7th, and 8th incidents of hate violence occur.

And I had denial, and anger, and maybe even a bit or bargaining before the depression hit. It sure feels like grief. But if acceptance is what comes next, then I sure as hell can't be grieving. Acceptance in unacceptable.

I could tell you that from 2010 to 2011, there was a 13% increase in reports of hate violence in New York City, which followed an 11% increase from the year before. I could tell you that in 2011, the National Coalition (NCAVP) reported the highest number of LGBTQ bias-related homicides in its 15-year history. I could highlight that it's not anti-LGBT bias crimes that continue to rise, but that there has been an increase in just about every form of violence experienced by LGBTQ-identified men and women: intimate partner, dating, sexual, hook-up, police, military, health (HIV-related), employment, and housing (to name a few). And this is violence on the individual level; it doesn't account for the cultural and structural violence that influences and reifies violence from one person to another.

From the criminal justice system to the institution of healthcare, from our education to our religion, because of our race, color, creed, national original, abilities or (dis)ability status, who we love, who we are, we are victimized and revictimized and the cycle seems unending.

And, I'm scared. Every one of us probably wonders lately not *if* it could be us, but *when*. Will it be when you're walking to the subway and someone calls you "filthy" for holding hands with your girlfriend. Will it be when you're in a new part of town and someone who doesn't think you should be there tells you they will "fuck you up, you fucking dyke." Will it be when you go back to where you grew up, and someone in the mall yells, "I bet they have HIV!"

Will it be when you're walking your dog? When you're doing your laundry? When you're having coffee with friends?

Acceptance says I should let go, give in, and accept that it's going to happen. Acceptance demands that I figure out a way to deal with it. Acceptance is bullshit.

LaLa, 18, is a Queens girl to the core… tough and stoic, with a soft voice and a badass sense of style. When she thinks about her future, it's so bright she can barely contain herself, "I'm going to study criminal justice in college." But her past hasn't been easy. She admits one day in a focus group that when she was in first grade, she used to "do things that we weren't supposed to do" with a next-door neighbor's daughter, and when her mom found out—by finding and reading the journal she'd hid between the mattress pads—her mom threw a fit. She told LaLa that there was no room for liking girls in her house, and occasionally slapped her across the face to remind her of how serious she was.

It might have been her mother's temper that made her more susceptible to violence, but by the age of 16 she had already been beaten up by a girlfriend. She met Tashi when she was in high school—Tashi was two years older. She goes back and forth on whether or not they fought often; whether or not it was serious. She often rubs a thin raised line of keloids on her neck. "This scar, on my neck? From her nails," she says softly. She explained to the group that the violence only happened when they got into an argument. It would escalate. She wasn't always mean, but she would definitely swing at her if she felt disrespected or cheated.

Even despite the (visible) scars she has, LaLa insists the two didn't physically fight often in their almost two years together. But she also had a tendency to explain away her girlfriend's

violence. Akin to the stories I had read about of “battered women” explaining away their black eyes and broken arms to doctors in emergency rooms, LaLa just figured that sometimes, when people get mad, they swing at you. She said she never saw it was abuse. We’re talking about these excuses—although, in group, we call them alternate interpretations—when LaLa offers, “But you know how a couple can argue and then just be back to normal? We would argue, be back to normal. When we argued again, she would bring up the last argument. And it would just build up. But we’d always find normal again.” It was this sense of normality that LaLa clung to for 19 months.

LaLa described Tashi as very insecure. Around the six month mark Tashi would tell LaLa who she could and couldn't hang out with, enforcing the list (even as it changed week-to-week) by punching LaLa in the leg or arm anytime she violated it. Around eight months, Tashi bought LaLa a cell phone and then almost immediately took it back when she thought LaLa was texting other girls. It was common, during the very end of their relationship for Tashi to scream, "I hope you die of AIDS," or “I hope you get raped in the street,” and call LaLa a slut.

If you’re wondering why no one ever bothered to step in, it’s not because they didn’t notice. People would come to LaLa and ask what happened, because she would usually have scratches or a little bruise on her face; and she would often forget to hide the larger ones on her arms and legs. LaLa blames it on love. She would tell people that when you’re love, you have to accept people for who they are. True love doesn’t want to change people. True love is love unconditional… no conditions.

After the last time the two broke up—one of at least four or five times—LaLa said that Tashi tried to get back with her, and it was painful and torturous to say no: “I was still in love with her [Tashi], but I didn't want to be with her anymore." One afternoon, Tashi found out she’d be at a local community space for LGBTQ youth and came in silently through a side staircase door. When Tashi approached, she was ranting and raving about love. “We weren't even together, and she was, quote-unquote, in love with me” (LaLa). When LaLa pushed her away, Tashi swung at her, in front of everyone at the community center, and got in two strong hits to the face before people could pull her away. LaLa says that’s the last time they saw each other.

Soon after, LaLa met the girlfriend she is currently seeing and says that she has definitely learned from her experience with Tashi. At her final day with the group she tells us, “The girlfriend I have now, she's so much different. It’s so much better. You know, if we argue, we

just won't talk to each other for a few days. If we play-fight, and we know it's about to get serious, we'll stop. She'll stop." LaLa, 18, is a Queens girl to the core… tough and stoic, with a soft voice and a badass sense of style.

Chris's story is one of constant revictimization. When we first met he was always upset at the staff of the very organization tasked with helping him through the litigation that he was about to undergo against his attacker, and former lover, Oscar. Every time we saw each other he wanted to know if I'd come in for a "special meeting" to discuss his revictimization within the organization. He once asked me to make an official statement on the "offensive treatment" by one of the coordinators of the survivors' speaker's bureau.

One of Chris's earliest childhood memories was of a mother who hit his father, who would then turn around and hit him and his two brothers. When he was 10, his uncle died of AIDS—it would take more than a decade for anyone in the family to acknowledge he was a "homosexual"—their words. His father left when he was 15, and his mother never really recovered.

Chris moved from Chicago to New York when he was 21 so that he could live life as an out gay man, "I had a full time job, full time benefits, and my own apartment." He met Oscar at a lounge on the Upper West Side in late September 2004 and was immediately smitten. The light behind his eyes, the way he dressed, his charisma; Oscar was tall, husky, and Latino and Chris was in love. They fell into a whirlwind romance and within three months the two were living together. Chris said he devoted himself fully to Oscar, alienating friends and family in the process. And that's when the violence started. It started with verbal abuse: put downs about the apartment being a mess, about Chris looking a mess; but it didn't take long before it turned into everything. Chris remembers a depression setting in because Oscar wasn't happy with anything he did. He lost the self-esteem that he had found when I came to NYC and came out. "He just made me feel like so much less than I was."

Six months into their relationship, Oscar pushed him to the ground in a fit of rage and ripped the clothes off his body:

> "We had gone out dancing, and when we got home, I was changing in front of him. I had on my favorite pair of underwear; it was the pair I had worn the first time we went out. He saw the underwear, and just flew into a rage, saying, 'How dare you wear those! Those are for me!'"

Oscar threw him on the floor of their bedroom closet, and smashed the only light bulb in the room, leaving them in darkness. He loomed above Chris on the floor as he tore the underwear away. Since it was the first time, Chris blamed it on the drinking. But, the second time was worse. “He was angry at something—I can't remember what—and I was laughing.” Oscar was infuriated, but managed to stroll for calmly into the kitchen that Chris didn’t even see him grab the butcher knife. The next thing Chris knew, he was being pulled by the hair to the ground; forced to stay put by a butcher knife at his neck. That night, Oscar locked Chris in the bedroom while they slept, for fear that Chris would escape and tell someone. The next morning, he told Chris he didn’t mean to do it.

When we meet up for a one-on-one outside of group at a local East Village café, Chris divulges that he knew he wasn’t alone. He knew a lot of gay couples from the Bronx who “beat the shit out of each other.” He thought it was normal for a relationship with passion, especially between two men. I asked him if he thought this was why he never told anyone about what he was going through—what Oscar was doing to him. “I didn't tell anybody, because I knew they were just going to tell me what I didn’t want to hear.” He told me he tried to bring it up to his mother, but she refused to acknowledge Chris was gay. She didn’t want to hear about his fights with “friends.”

She didn’t pick up the phone for almost six months after Chris told her about his hospitalization from Oscar’s rage. He doesn’t like talking too much about his hospitalization. It brings up a rage of its own within Chris. It all started the summer after Oscar moved in, after those first incidents of violence. Chris was mugged on the street outside their apartment; the thief punched him in the nose, but when Chris went to run after him, Oscar grabbed his arm and stopped him. Chris tells me that Oscar didn’t have “legal papers” to be in the U.S. and was scared that they would investigate him and he would get deported.

Furious, traumatized, and gushing blood, Chris turned around and backhanded Oscar on the street. So Oscar threw Chris through the glass panes of their apartment complex door. There were witnesses this time, though, and camera footage, and somebody called the cops and an

ambulance. Five hours and about $600 in medical bills later, Chris was stitched from his wrist up to his elbow—the scars would be deep and permanent—and the official hospital records and police reports would categorize the event as a … Although he did divulge to the doctor that stitched him up that Oscar was his boyfriend, Oscar denied ever having a sexual relationship with Chris, and refused to admit they were anything but friends.

It took almost two years, but Chris finally threw out and put a restraining order on Oscar. One week after the break up, Oscar broke down Chris' locked apartment door. Chris wasn't home, but when he came back, he knew. He immediately moved into temporary housing (he couldn't afford to break his lease or pay rent on two apartments) and, then, a month later, into Section 8 housing in Harlem—a far cry from his semi-luxury East Village studio near NYU. One month after moving to Harlem, he tried to commit suicide, but woke up the next morning to find he hadn't taken enough of the Klonopin… or maybe hadn't had enough to drink… he doesn't know for sure. His mother has only spoken to him once or twice since then. Chris's story is one of constant revictimization.

"But… I'm still here," Julius* affirmed, matter-of-factly. His story is one of incredible survival in the face of extreme violence and loss. He is a formidable reminder of the human capacity. His story touched me probably more than any other. We spent the most time together during my two years at AVP. At 40 years old, he is an almost lifetime resident of the Bronx, whose own experience of violence started at an early age. His mother—an immigrant from a small island in the Caribbean—was raped by an HIV positive man before her 17th birthday, and Julius entered the world an HIV positive child to a single mom.

The first few years were difficult, but full of love. It wasn't until his mother got sick and was forced to move in with a male acquaintance, because she couldn't afford rent, that his memory of trauma and pain began. The first incident was on a stormy day in June. He was maybe five or six years old. His "dad"—something his mother insisted he call the man they lived with—was drunk. Julius could smell the Courvoisier on his breath as he hovered over Julius with his 1964 Mickey Mantle Louisville slugger. When it was over—as he would come to learn much

* All names have been changed.

later in life after x-rays—Julias' right hip was splintered and his femur cracked in two. Julius' mom was too scared of his "dad," and the violence he would enact on her, to take Julius to the hospital, so today he walks with a severe limp and a four-pronged cane to keep him stable. He's in constant pain. He's also addicted to Oxycodone.

When he was old enough to move out, or rather run away, he did. He hopped from friend's house to friend's house until he didn't have any friends left and ended up homeless, shifting his time between Marcus Garvey and Morningside parks—he was still so afraid of his "dad" that he couldn't risk being homeless in a Bronx park. He was thrown in jail two or three times (he doesn't remember exactly) before the rape happened. He awoke in the middle of the night to a man penetrating him from behind. Julius' hands had been bound to the park bench, and his legs weren't strong enough to push him up and away. His screams lasted for at least five minutes, he says, before he was unable to vocalize a scream anymore; so he just cried. When the man was done, he collected his things and walked away, leaving Julius tied to the bench, pants down, completely exposed. He lay there for hours before he was arrested for the third or fourth time—only this time the charge was lewd and lascivious exhibition within the presence of those under the age of 16 (children and their parents found him in the morning as they approached to use the nearby swing-set). It was a Class A misdemeanor that earned him the full 12-month sentence.

When he got out, he landed on the couch of his cellmate's sister and met a nice woman named Terri, who lived next door, and would bring him cookies after she got off of her third-shift job. She was transgender, but this didn't seem matter to Julius. He figured that after all he'd been through, he was "more damaged than her." They would get married a few weeks later—albeit, not legally, he recounts the time with his wife as being a happy one, even though they didn't live in the same house and she worked almost 12-hour days. But, like most of his life, this happiness would be short lived. After a raid on the house, which resulted in his brutal beating by seven NYC police officers, he would learn that his former cellmate's sister was dealing in illegal arms and cocaine for a local gang. Julius would spend almost two weeks in the hospital, part of it unconscious, before the becoming conscious enough to be arraigned. Because of his recent prior—and, as he puts it, "the totally racist pigs" that beat him up without warning, cause, or questioning—he would spend five years in prison for his "involvement" in dealing drugs and unlicensed handguns. Terri "divorced" him before he was even out of the hospital.

At some point between getting of our prison the second time and the present day, he would reconnect with his mother (his “dad” had now been dead for many years) just before her death and inherit the house that she had inherited from his “dad.” This would give him just the right amount of stability to get a job as the third-shift gas station attendant at a small gas station three blocks from his house. And it would be this job that introduced him to Shayla; “wife” number two. She was a prostitute who was also HIV-positive. She had been addicted to meth for a few years, but was finally going to call it quits. Julius was just the love she needed to pull through. They would stay together for over 22 years—“divorcing” only very recently to the present time—and have a son together.

But Shayla would beat him with his own cane almost every night and convinced him to sign over the house to her, because she was in better health and they weren’t legally married—if anything should happen to him, she cried, what would she and their son do? So he did, and not seven days later, she had him removed by the police for violating a restraining order that he didn’t even know she had taken out against him. He was 38, and as he puts it, “She took my house and she took my son. But… I’m still here.”

In the past two years, I’ve come to learn that acceptance is not what we think it is. Acceptance is not the process of giving in and giving up. Certainly, acceptance is not about mediating and adjusting to the maelstrom coming your way. Acceptance is about knowing the difference between being a victim and being a survivor, and navigating a system set up to fail you. Acceptance is about learning the reality of the outside world, of heteronormativity and homonormativity, and making an active decision to dismantle it. This might seem radical, but it’s really not for most of those I’ve met and developed community with.

In an interview with AVP officials (during the drafting of the 2012 IPV report) Tre'Andre Valentine, the Community Programs Coordinator at The Network/La Red, a Boston-based domestic violence support group specifically for LGBTQ people, discussed the issues of heteronormativity explicitly. Because “domestic violence” is still thought of as a heterosexual problem, there can be major hurdles when trying to find funding and conduct research, as well as when providing services to people who don't fit in the stereotype of a domestic violence

survivor. “The idea that a woman can be the one who's abusive throws a wrench in the traditional view,” Valentine said. “The idea that only men can be batterers makes it a lot harder for men to get access to shelter.”

But it’s tough to find shelter in the first place. Kristen Clonan is a spokesperson for Safe Horizon, New York City's largest provider of domestic violence residence, has nine shelters and around 725 beds throughout the city. Clonan said that in 2011, nearly 2,500 women, children, and men sought out shelter at Safe Horizon, and Safe Horizon's three hotlines field 163,000 calls annually. That's almost 3.5 times as many individuals who need shelter, than beds ever available.

Shelters that cater to LGBT people are even less prevalent. Cassildra Aguilera, the LGBTQ program coordinator for Safe Space, said in a 2013 interview there is one shelter in New York City that identifies as LGBTQ-specific, with just 200 beds. Of the mainstream domestic violence shelters, only 12 are LGBTQ friendly, and all are based in Manhattan. According to Network/La Red in Boston, only two of the 30 domestic violence shelters in Massachusetts are specifically geared toward LGBTQ people: Network/La Red, and the Gay Men's Domestic Violence Program. Of mainstream programs, only eight accept LGBT people. Many shelters, even if they say they're LGBT-friendly, reportedly fail when it comes to providing for LGBT safety needs.

For instance, lesbian women in particular can have a very hard time finding safe shelter, as sometimes an abuser will call a shelter claiming to be a victim and wanting to know if a “friend” is there. “What may happen,” said Valentine, “is that both a survivor and an abuser can access services, so it might not be the safest harbor for a lesbian survivor.” Valentine also reported that there's a lot of homophobia in non-LGBTQ shelters among shelter residents: “The staff might have a non-discrimination policy, but it's not enforced, and that definitely affects a lot of survivors.”

Transgender men and women have an especially hard time, according to Jessica Newman (of the Violence Recovery Program in Boston). They might not find a shelter, because often neither men's nor women's shelters take trans* men and women. For instance, if transwomen finds a place in a homeless shelter, they might be housed with the men, which could be and often is dangerous; but they may also be housed with women, which can “agitate” shelter residents who believe the transwoman is, in reality, a man. On a micro-aggressive level, curious people

may ask intrusive questions or make transphobic remarks. It's no surprise, then, that only 3.7% of LGBTQ victims/survivors sought shelter last year (NCAVP, 2013).

Lisa Gilmore, Director of Education and Victim Advocacy at Center on Halsted in Chicago, Illinois, calls out all those working for the traditional criminal justice and shelter system to take stock of the problem: "Lack of access to shelters and other supportive services increases a survivor's risk of immediate danger and puts their lives at risk. We are calling on policymakers to institute LGBTQH-specific non-discrimination provisions to increase support and safety for all survivors and to put an end to discriminatory laws and policies that currently increase barriers and decrease safety for LGBTQH survivors when seeking support."

In reality, we just do not know how big of a problem same-sex and LGBTQ intimate partner violence is. We have just begun to scratch the surface of the issue with our most recent surveys. But, Curt Rogers, executive director of the Gay Men's Domestic Violence Program, reminds us, "Statistics are very controversial. It's possible that men are underreported. The bottom line for me [is that] it happens to men, period, so we should be inclusive in our approach and not marginalize the male victim population."

Not only that, but "Reporting can be really difficult, and historically we [LGBTQ people] have not had a very good relationship with police and law enforcement, so folks may not be reporting it" (Valentine). In any case, Valentine made sure to point out that the police might not believe the victims when they call, the attitude often being, "You're both men, work it out between yourselves," or, "Women aren't violent; they don't hit each other." It's no surprise, then, that according to the NCAVP report, only 16.5% of survivors ever interacted with the police, and in one-third of those cases, the survivor was arrested instead of the abuser.

But, Valentine also made sure to note that "It is not surprising that these homicides tended to be reported in regions where NCAVP member organizations are located. LGBTQH-specific anti-violence programs are more likely to recognize the signs of intimate partner violence, which law enforcement may overlook, and can document these homicides because we spend every day raising awareness about the issue of LGBTQH intimate partner violence."

Indeed of all those who reported their IPV victimization to the police, over 30% said that the police did not classify their victimization as intimate. The classification of IPV is important because many resources, such as housing, shelter, and orders of protection, rely on official police reports recognizing the violence as between intimate partners to determine victim/survivor eligibility.

But, one of the most common places where intimate partner violence is screened for is within the healthcare system—so, how do we measure up in that regard? Well, there is legal discrimination regarding access to health insurance and a shortage of providers who are culturally competent in and knowledgeable about LGBT people and their health needs (Department of Health and Human Services, 2013). In one illuminating example, a 2012 literature review of 17 studies of nurses' attitudes toward the LGBT population discovered that every single study found evidence of negative attitudes (Dorsen, 2012).

There is a truly terrifying end result of coupling these outright negative attitudes with the lack of training on LGBTQ identities—and by proxy the lacking/inappropriate/offensive language and lacking/inappropriate/offensive questioning about sexual orientation and same-sex relationships. The same NCAVP report that highlights only 16.5% of survivors seeking criminal justice interventions, shows us that only 24% seek medical intervention, even though over 53% sustained serious injuries.

So, even though medical providers are trained to and often can assess IPV based on the types of injuries, the trauma that IPV survivors present, and the stages of healing for these injuries, LGBTQ survivors are not seeking the care that may get them help very often. But even for those who do seek care, medical providers may not have the training and knowledge to recognize IPV as it affects LGBTQ and HIV-affected survivors.

We must do better. Nearly three decades of feminist thought—including queer, indigenous, postcolonial, and pro-feminisms—has critically challenged our notions of sex, gender, and sexuality (hooks, 1984; Johnson and Pihama, 1995; Lorde, 1984; Mohanty, 1991; Butler, 1996). Nearly three decades of work on same-sex and LGBT intimate partner violence has attempted to critically challenge our notions of perpetrator, victim, and survivor (see Messinger, 2014). This

work attempted to problematize the culturally dominant "second-wave" representation of gender as a singular variable unchanged by other forms of difference, such as age, race/ethnicity, and social class (Ringrose, 2007); this work attempted to open our eyes to the complexities of power and inequality—attempted to show us that not many people are untouched by violence.

The original goal of the "gender paradigm" in intimate partner violence—that men are perpetrators and women victims—was to generate social change to right a centuries old inequity against women (see Dobash & Dobash, 1978, 1979; Dobash, Dobash, Wilson, & Daly 1992; Patai, 1998; Walker, 1989; Yllo & Bograd, 1988). But, as Coleman (2009) points out, the "last two decades have been marked by an increasing divide between academic feminist theory and grass roots feminist activism." While there is new work emerging that indicates the need to for intersectional, multifaceted analyses of violence, it remains that our conception of intimate partner violence within popular dialogue and public policy is essentialist and problematic. The result of this "gender paradigm" has been a social and legal policy misdirect: one that has misinformed custody assessors, police, and judges; one that has meant the academic disregard of data sets contradictory to the prevailing theory; and one that has excluded many potential perpetrators and victims from attempts at structural change (see also Corvo & Johnson, 2003; Dutton, 1994; George, 2003). What's more, the goals of those organizing "outside" the system, at the grassroots, are not always the goals of those within academia—there is a growing disconnect between the scholarship that we, the academics, produce and the structural change that we, the survivors of violence, need.

The survivor's bureau decided to hold a public forum meeting following a particularly traumatic group session, to discuss the findings of the 2013 IPV report, just recently released. The discussion that followed brought up many key issues that I had been struggling with academically for some time:

> "Perceptions of who is a victim and who is an abuser is heteronormative!"
>
> "And focusing on physical violence is heteronormative, too!"
>
> "We would see in increase in the use of LGBTQ services is the advertising all over NYC wasn't of women with black eyes/bruises."
>
> "Can LGBTQ and people of color feel safe/see themselves using these services? How do we know we can trust you to not be homophobic, transphobic, or racist?"

> "Homonormativity is a problem, too. I was once told by a gay friend, "but, gay people aren't violent – my queens are just too nice and innocent for that."
>
> "Sexism and rape culture is so real, but why can't anyone see the clear link between that and violence against LGBTQ people?"
>
> "Yes, sexism is not separate from heterosexism. Patriarchy is not separate from heteropatriarchy."
>
> "There is no knowledge, no representation in our institutions… even people studying it don't talk about it."
>
> "It's double-closeted – you have to tell the 'right' people; you can't tell just anyone."
>
> "We don't take victims seriously… how many times have we had a friend, a victim, arrested when they called the cops? Raise your hand. I thought so."
>
> "Most of the push back definitely comes from the staff; especially at shelters… we need to see men as victims, too; it's just a fear of change, a fear of the unknown."
>
> "So many service providers also don't want to speak badly about LGBTQ people – like somehow it's more politically correct to say nothing… to be silent… than to help us."

We simply must do better. Curt Rogers (Gay Men's Domestic Violence Program) agrees: "We need to change the way we look at domestic violence." For him, and as you can see in the voices of survivors above, intimate partner violence is not just a women's issue; nor is it a man's issue, either, as the newest White House campaign might have you believe. "I don't see it in any way as a gender issue. I see it as a power and a control issue" (Rogers). For so many of the survivors, and those tasked with helping them, the struggle is to combat a non-heteronormative, crosscutting and intersectional sense of entitlement, power, and control; to see it within all systems and levels of oppression; and to recognize the transformative power of community and grassroots interventions—i.e., interventions "outside" the traditional criminal justice and healthcare systems.

A mere two days after his death, a march and rally for Mark Carson—and the survivors of May's month of violence—almost 2000 people communed in silence and grief. Not one single person I met, nor one single person who spoke at the rally, advocated for acceptance in the traditional sense. Not only single person told us to take self-defense classes; not only single person told us that we shouldn't parade our sexuality around in front of others; not only single person told us that it was because of the passage of "gay" marriage. No one told us to prepare for it to continue and get used to the idea that we would continue to be victimized.

In fact, both LGBTQ people and allies showed up to publically state that we would *not* be taking it anymore. Acceptance is *unacceptable.*

Sarah Karlan

Macey Foronda

Sarah Karlan

The above picture is particularly moving for me, because it includes two powerful quotes from historic rights' activists. The sign on the left says "No one is FREE while we are all UNFREE," a take on the writings of Audre Lorde. The sign on the right says, "If a Bullet should enter my brain, Let that Bullet destroy every closet Door," a quote made famous by Harvey Milk.

Sarah Karlan

Though not religious myself, I was moved by a reverend who spoke of what might be the only form of acceptance possible, given these circumstances.

God would not want for this. God would not condone this. God would not see fit that this happen to our brothers and sisters. For God is love, and all are welcome at the table of love.

The cheering and clapping after that statement was deafening. In that moment, I think we were all taken aback—perhaps all for different reasons. For me, it was an awakening. It's been right here in front of me all along. It's been what we've all been doing anyway. We've been loving as long as we've been breathing and it is love that can be a strategy for social change. Maybe inwardly and outwardly love is the most radical tactic of all.

I brought this up to the group one day and Diandre, who had never spoken before, even despite attending three or four sessions, told me (us) that it reminded her of one of her favorite Martin Luther King speeches. She spoke a few lines. We were all moved. It was 10 days after Mark was shot and killed. So, while I may have thought of one million ways to start this, I have only one way to end it—and the credit goes to Diandre, the countless men and women who I

have created and sustained community with as survivors, and the 24 (known) victims of IPV in 2012 alone who will never again be able to love. I do this for all of them. And I do this for me.

> "Here and there an individual or group dares to love, and rises to the majestic heights of moral maturity. So in a real sense this is a great time to be alive. Therefore, I am not yet discouraged about the future.
>
> Granted that the easygoing optimism of yesterday is impossible. Granted that those who pioneer in the struggle for peace and freedom will still face uncomfortable jail terms, painful threats of death; they will still be battered by the storms of persecution, leading them to the nagging feeling that they can no longer bear such a heavy burden, and the temptation of wanting to retreat to a more quiet and serene life. Granted that we face a world crisis, which leaves us standing so often amid the surging murmur of life's restless sea.
>
> But every crisis has both its dangers and its opportunities. It can spell either salvation or doom.
>
> So it goes. ... Returning hate for hate multiplies hate, adding deeper darkness to a night already devoid of stars. Darkness cannot drive out darkness: only light can do that. Hate cannot drive out hate: *only love can do that.*"
>
> --Martin Luther King, Jr.